THE IMPACT OF THE HILL-BURTON REGULATIONS ON HOSPITALS AS ORGANIZATIONS

by

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A.B., Clark University
(1977)

SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE
DEGREE OF

MASTERS OF CITY PLANNING

at the

MASSACHUSETTS INSTITUTE OF TECHNOLOGY

May 1979

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Submitted to the Department of Urban Studies and Planning
on May 25, 1979 in partial fulfillment of the requirements
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ABSTRACT

This thesis investigates the effects of a regulation, the Community Service Requirement of the Hill-Burton Act, on a particular hospital. The regulation requires that hospitals which received Federal construction grants or loans (1946 to present) provide uncompensated services to indigents. The effects of the regulation are analyzed at two levels; first, the outcomes of the regulation (the amount of free care provided) are described; and second, its effects on the hospital organization are examined. This second level of analysis provides insight into the long-term effects and success of the regulation.

Several hypotheses about the impact of the regulation on the hospital organization were developed. First, it was hypothesized that hospitals make compliance decisions based solely on financial considerations, not out of any social responsibility. Second, the hospital may choose to leave eligibility guidelines flexible to give itself some discretion in decision-making. Third, the regulation may have had dysfunctional consequences such as the hospital may try to "process" indigents quickly to minimize the uncollectable bill. Fourth, the hospital administration seeks stability which leads it to comply with the regulation when the costs of non-compliance are too great. Last, the physician's professionalism circumscribes his behavior and limits the impact of the regulation on his treatment of patients.

Through analyses of the history of the regulation, financial records, interviews, and minutes of meetings, it is concluded that although the amount of free care given out annually has increased, the accessibility of medical care has not been significantly improved. By highlighting the goals and impact of the regulation on various actors in the free care delivery process, it is shown that the individual actors respond to personal and departmental goals, not necessarily in concert with the objective of providing free care.

The study concludes that the original goals of the Hill-Burton Act were long since met but that the last remaining objective, providing free care, has not been totally met. Suggestions are made to improve the present regulatory system. However, it is noted that the remaining issue of inaccessible care could be more effectively addressed with other redistributive programs.

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PREFACE

The health care system is increasingly being regulated. Often, these regulations are ineffective because they do not take into account the organizational structure which they are attempting to change. I was interested in studying two different aspects of regulation. First, I wanted to analyze a regulation as a solution to a problem--what was its purpose, how did it attempt to work, and was it successful? Second, I wanted to understand how hospitals react to imposed regulation. How does the organization accomodate change, are the changes permanent, and what levers can the regulation use most effectively?

I felt that if I could understnad how the hospital was impacted by the regulation and how it responded, that this information would feed back into the regulatory design process in developing more effective regulation. If the hospital is going to be increasingly regulated, there might as well be fair and effective policies.

I am well aware of the fact that my own attitudes about the health care system have colored my perception of the issues discussed in this thesis. Two attitudes seem particularly important to address here before I begin. First, I believe that the current financing system of health care is totally inadequate in the coverage it provides. This inadequacy results in a lack of finances which act as a barrier to health care for thousands of Americans. Second, I feel that the hospitals are limited in their ability to control costs until the power of physicians is reduced. Until then, hospitals will continue to have minimal control over the real leverage points for containing costs and improving "efficiency." In many ways, the hospitals are in the position of being increasingly regulated

yet having very limited options in terms of the meaningful changes that it can make.

The thesis begins with a description of the history of the regulation and analyzes its general impacts in light of the original objectives. Next, the implementation of the regulation of the case hospital is explained and its outcomes are summarized. The effects of the regulation on the hospital organization are then outlined, revealing both functional and dysfunctional consequences. Finally, the study concludes with several recommendations to improve the present regulation and alternative redistributive programs are discussed.

CHAPTER ONE

INTRODUCTION AND HISTORY

Selection of the Regulation

This study analyzes the implementation of the Community Service Requirement of the Hill-Burton Act (Federal Register 42 CRF 53.111). Although this Act was passed in 1946, the clause that requires facilities "provide uncompensated services" was overlooked for almost twenty years. When this provision was reenacted, it specifically required hospitals to give free or reduced cost care to individuals who needed it. The regulation employs a number of sanctions designed to encourage compliance, ranging from bad publicity to impeding Certificate of Need applications and further Hill-Burton funding.

This regulation was selected for analysis for several reasons. First, it directly affected hospital finances and service availability through the funding offered by the Hill-Burton Office. I figured regulations which had dollars attached to them would be effective. Second, the regulation itself is straightforward and appears to be simple to implement. Hospitals are required to process applications for free care on the basis of eligibility guidelines and to "award" free care. Third, the regulation appealed to my social conscious by attempting to improve the accessibility of medical care. Finally, the regulation had enough of a history to understand the changes it has undergone and to assess its impact.

The Hospital

I will call the hospital chosen for this study Prescott Hospital. It is located within a metropolitan area in a town of about 100,000. It

was founded in 1887 and currently offers medical/surgical, obstetric, pediatric, and psychiatric services. Prescott is both a teaching affiliate and a community hospital, whose status seems to fluctuate depending on the immediate circumstances. Like most hospitals, it began as a charity service to the poor--while the rich were treated at home. As the distinct advantages of hospital treatment became apparent the hospital clientele shifted to consisting of middle and upper middle class patients. Many physicians, reflecting back on pre-regulation days, described the hospital as being a "club" for both doctors and socialites. As a middle class institution, payment was never an issue at the admitting desk. It was assumed that anyone admitted could afford the hospital bill. Therefore, when indigents were admitted, they were not subject to questions about their finances. This middle class status still exists; thus there is little pressure on the hospital to expand its provision of free care.

Prescott Hospital was selected for two reasons. First, the hospital is of average size--it is not a large teaching hospital, nor is it a small community hospital. In addition, it is a private hospital and therefore is relatively uninvolved with local city politics or a religious group. I wanted to eliminate as many outside special interests as possible so that I could come close to looking exclusively at how the organization was affected by an imposed regulation. Second, the administration was genuinely interested in the project and its findings. The chief administrator offered total cooperation and seemed to understand the study's purpose and conceptualization. I felt this support was extremely important in order to gain access to information and interviews with various staff members. Similarly, initial interviews with the individuals directly involved with the administration of the regulation revealed that they too

were interested in the project and therefore were going to be very helpful and accessible.

Methodology

This thesis takes the form of a case study. After selecting the hospital and drawing up several hypotheses to investigate, I spent about five weeks at the hospital collecting data. Various methodologies were employed. First, I interviewed about 30 staff, the interviews taking between one to one and a half hours.[1] My technique was to go into the interview with a list of topics and to get the individual talking. If all the topics were not covered I would ask specific questions. The topics covered generally included the following: what they thought of the concept of providing free care; how they administered its provision or how they were involved with the free care delivery process; their impression of how successful the hospital was at reaching indigents; their impressions of how other hospital staff reacted and implemented the policies of treating indigents; how the system of providing free care could be improved; and their impressions of the State Hill-Burton Office. Obviously, the list of topics shifted depending on who was being interviewed. For example, I did not ask the Board members about the State Office since the Board has no contact with that office. Rather, I concentrated my questions about how the Board made its policies, whether the Board was concerned about providing free care since doing so created hospital losses, and the relationship

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[1] Persons interviewed included: 3 physicians, Chief of Medicine, the Chief Executive, 1 assistant administrator, 1 nurse, inpatient and outpatient accounts managers, 1 from the Controller's Office, assistant Fiscal administrator, 1 from Quality Assurance, 3 from Social Services, 1 from psychiatric services, and 2 members of the Board of Trustees.

the Board sought with the community.

The second method of data collection was to review the records and minutes of the Free Care Committee (FCC)[2] meetings. These minutes indicate changes in policies and procedures, describe issues being discussed in the meetings, and document the exact decisions made for each week's applications. The records kept by the FCC Secretary include the applications, the FCC responses to each application, and monthly and annual tabulation of statistics. Statistics are kept on the number of acceptances and denials, the number of preadmission acceptances, the number of acceptances which are inside and outside the service area, the dollar amount of free care and reduced cost care given out by both the inpatient and outpatient departments, and quarterly figures on individuals accepted and the dollar amount. These statistics are used to write the annual compliance report required by the State Office. These annual reports were also reviewed for both their statistical content and the policies officially taken by the hospital. These reports were compared with the documents of the FCC for consistency. From these documents it was also possible to see how the Committee's policies have changed since 1976.

In addition to the interviews and collection of statistics and documents, I observed the Committee in action. By attending these meetings I was able to observe how the Committee deviated from its stated policies, the informal decision-making which goes on but does not get recorded, and the discretion involved in seemingly straightforward policies. Moreover, it allowed me a chance to observe the dynamics of the FCC, the relation-

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[2] The FCC is an eleven member committee which meets weekly to review and decide on all inpatient applications and outpatient accounts exceeding $100.

ships of various groups within the hospital, and the total environment which affects the decisions taken weekly. These observations proved to be invaluable in piecing together and understanding the behavior and incentives of the actors in the application process.

Although the case study format is often used in theses out of convenience, this methodology was well suited to my interests. In trying to study regulation and its impact on organizations, it is necessary to do analyses at two levels. First, from an outcome point of view, I was interested in the effect of the regulation on the amount of free care provided. I wanted to evaluate the "success" of the regulation. Second, I wanted to study how the regulation affected the organizational structure--how decisions were made and by whom? Did the regulation cause any adjustments in terms of personnel and authority? Did it create incentives for actors to act in certain ways? A case study lends itself very well to these two objectives by integrating data analysis and an organizational study. It allows the different methodologies (interviewing, data and document analysis, and observation) to be used simultaneously in a complementary way. For example, the accuracy of perceptions recorded during interviews can be checked with data and vice versa. Similarly, these statistics do not reveal anything about how an organization adjusts to imposed regulation and how decisions are made. Yet all of this information is necessary if we are to understand the long-term success and effectiveness of the regulation.

Thus, the case method improves the accuracy and range of the data collection, allows for a synthesis of the functional significance of the various actors within the larger organization, and encompasses explanatory hypotheses testing. Put another way, the case study method allows for

alternative conceptual frameworks besides causal determination, such as the systems and dramaturgic approaches. The systems approach attempts to explain the interrelationships of the various actors, while the dramaturgic approach identifies issues and actors, and the story line of the action taken. These two frameworks are much more meaningful than causal determination when trying to explain organizational behavior.[3]

For all the above mentioned reasons, a case study seemed to be the most flexible and complete form for my research. Needless to say it is not perfect. The greatest criticism of case studies is that they are not "typical" and cannot be representative of other experiences. Any generalizations which are made based on one case study are subject to revision with the investigation of other cases. However, as Peter Blau pointed out, it is probably better to propose generalizations which later have to be modified than not to present any at all.[4]

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[3] Robert Weiss and Martin Rein, "The Evaluation of Broad-Aim Programs: Experimental Design, Its Difficulties, and an Alternative," in Administrative Science Quarterly, March 1970, pp. 97-109.

[4] Peter Blau, Dynamics of Bureaucracy (Chicago: University of Chicago Press, 1963), p. 99.

HISTORY OF THE HILL-BURTON ACT

Introduction

This next section describes the history of the Hill-Burton Act from its conceptualization in 1946 to present. The Act has undergone many revisions with its goals changing considerably in the process. In addition, Massachusetts has adopted its own set of requirements and sanctions for non-compliance. The history is analyzed to outline 1) the purposes of the bill the Congress intended, and 2) the general impacts which the Act has had with respect to its objectives.

The Initial Bill

The Hospital Survey and Construction Act, often referred to as the Hill-Burton Act (or Title VI of the Public Health Service Act, PL79-725), was passed in 1946. The Hill-Burton Act represented the first major involvement of the federal government in the development of health care facilities. By offering grants-in-aid, it sought to 1) survey the nation's need for hospital facilities and develop programs of construction and 2) construct public and non-profit hospitals. The grants were awarded to facilities on the basis of relative need (number of beds/1,000 population), relative size of state population, and per capita income. In Massachusetts the approximate average size of grant was $236,035, representing on average 25% of the total cost of the project.[5] The Act responded to the lack and poor distribution of health facilities and attempted to initiate the planning of such services. It was particularly aimed at

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[5] Estimated from a random sample of projects (1947-1970). Actually this figure would be larger if the figures used had been in constant 1970 dollars. Figures from Hill-Burton Project Register, July 1, 1947 - June 30, 1970. DHEW, Public Health Service, Rockville, Maryland.

reducing the differences in service availability between states and between rural and urban areas.

Although the bill was introduced by senators from rural states (Senator Hill of Alabama and Senator Burton of Ohio), it received support from both urban and rural communities. The 1946 Hearings reflected strong support from community and national leaders, the hospital industry, health care professionals, farmers, and blue collar workers. Specifically, testimony was heard from such diverse groups as the American Medical Association (AMA), American Hospital Association, Catholic Hospital Association, American Federation of Labor, U.S. Steelworkers of America, U.S. Conference of Mayors, National Farmers Union, American Farm Bureau Federation, Congress of Industrial Organizations, and the National Council of Parents and Teachers.

Such strong support has three probable explanations. First, after World War II the country was in desperate need of health facilities construction and medical care. About 40% of the 3,000 counties were without a registered hospital.[6] Moreover, about 50,000 physicians had been released from the army and needed working space. Data such as bed and physicians per thousand population by state, maternal deaths, and infant mortality were used to support the need for facilities.

In addition, the tendency of these newly released physicians to locate in urban areas further intensified urban/rural differences. This exerted pressure on rural areas to develop facilities and thereby attract doctors. This decentralization hoped to improve both the distribution of

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[6] Testimony of Mr. Erickson, American Public Health Association, Hearings before the Subcommittee of the Committee on Interstate and Foreign Commerce, "Hospital Construction Act" S.191, March 7, 1946.

medical resources and the general health of the rural population. The Surgeon General contended that "maldistribution is singly the most important factor in deterring adequate health care."[7]

Arguments were also made that the lack of rural care induced migration to urban areas, which could not afford to be indifferent to the needs of rural people.[8] Essentially, the Act responded to a general need for hospitals, and in particular favored rural facilities.

A second probable explanation is simply that increasing the supply of medical facilities had few, if any, opponents. Every interest group had something to gain, whether it was the financiers of construction projects or rural farmers. This broad coalition guaranteed passage of the bill. Of particular importance was the support of the AMA, who Surgeon General Parran commented "contributed unquestionably to the ready acceptance of the bill."[9]

Third, support for the Act echoed the New Deal philosophy that the government was assuming new roles. One such role was being the provider of last resort for medical services, previously played by charity organizations and the church. Due to the increasing costs of construction and medical care, such institutions could no longer rely on church support and philanthropy to cover their operating and construction costs. Therefore, the government assumed this responsibility, reflecting the increase in

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[7] Testimony of Surgeon General Parran, U.S. Health Service, Hearings, March 7, 1946, p. 15.

[8] Testimony of Mrs. Weagly, President of the Association of Women of the American Farm Bureau Federation, Hearings, March 7, 1946, p. 136.

[9] Thomas Parran, ACMEL Papers and Discussions, 1947, p. 19, quoted in James G. Burrow, AMA: Voice of American Medicine (Baltimore: Johns Hopkins Press, 1963), p. 287.

acceptability and legitimacy of the "welfare state."

An additonal argument was made that more facilities could induce preventive medicine and thereby reduce medical costs.[10] Given the overwhelming support for this bill, it is unlikely that this last rationale was necessary to ensure its passage. It is, however, interesting to note this presently used argument as early as 1946.

The regulations specified that any facility receiving Hill-Burton assistance must provide assurances to the State that it would furnish a "reasonable volume of services" to persons unable to pay. Although "reasonable volume" was not defined, the "free services" could take the form of free care or care offered at a reduced cost. It is not clear how this goal of providing free services was linked to those of hospital construction--it was not directly addressed in any of the testimony nor in the Senate or House reports. It appears to be an insignificant qualifier probably to mention that hospitals, which historically had always given free care to indigents, should continue to provide uncompensated services. Perhaps it also reinforced the notion that community hospitals (fairly new institutions) should provide free services to indigents, a role which had always been played by government and church-run hospitals. This implies a desire to distribute fairly the costs of providing free care; however, this was not made explicit. This clause was included in all subsequent amendments and extensions and was not questioned or clearly defined until the early 1970's.

Each state had to develop a State Plan to ensure that there were adequate facilities to provide a reasonable volume of free care. This

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[10] Testimony of Honorable Chandler, Vice-President of the U.S. Conference of Mayors, Hearings, March 7, 1946, p. 110.

state office was also responsible for surveying need and allocating funds. At the federal level, the Surgeon General approved State Plans and individual projects. The Surgeon General could halt certification of new projects or withhold all funds otherwise payable if it was determined that a state agency was not ensuring a reasonable volume of free care.

Hill-Burton is Expanded

In 1954 this Act was expanded with the "Medical Facilities Survey and Construction Act" to specifically include grants to diagnostic and treatment (outpatient) centers, rehabilitation centers, and hospitals for the chronically ill. In 1964, the Hill-Burton was further amended to modernize any existing facility. This program, the "Hospitals and Medical Facilities Amendments of 1964," had a marked effect on improving old urban hospitals which desperately needed renovations but had "enough" beds to disqualify them from funds previously earmarked for new construction.

Loans are Offered

In 1970, over Nixon's veto, the Hill-Burton was again amended and extended. The "Medical Facilities Construction and Modernization Amendments" provided two major changes: first, it shifted emphasis from projects in rural poverty areas to include any poverty area; and second, it supplemented the grants program with loans and loan guarantees. Most of the new construction was for long-term care beds and out-patient clinics. This amendment responded to the growing needs for ambulatory facilities and services in poverty areas and the virtually non-existent demand for the construction of new, short-term hospital beds.

"Reasonable Volume" Defined

There was increasing concern over the lack of specificity of the 1947 statute regarding the reasonable volume of free service to be offered for those individuals unable to pay. In response to several court cases which were pending, HEW issued new regulations (July 22, 1972) which defined a reasonable volume of free services, furnished guidelines to state agencies on eligibility criteria and qualifying services, and set forth requirements for evaluation and enforcement of compliance. Specifically, it stated that a reasonable volume could be satisfied by: 1) offering free or below cost services annually equaling the lesser of either

- 3% of operating costs, not including Medicare and Medicaid reimbursement, or
- 10% of total Federal assistance received (no provisions for amortizing capital grants were made);

or 2) certifying that free or below cost services would not be refused to any persons regardless of their ability to pay (the "open door" policy).[11] Services were to be valued at their cost determined by Medicare formulae (Title XVIII of the Social Security Act, 42 USC 1395).

In addition, the state agencies were to monitor and evaluate each facility's compliance, with each facility reporting its level of uncompensated services, except for these facilities choosing the "open door" option. The Act did not, however, provide specific funds for the monitoring or auditing of operating costs or levels of free care dispensed. The evaluation simply required matching the required amount of free services with that amount of services, relying heavily on the honesty of the facility. Given the lack of funds to ensure honest reporting and the

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[11] Federal Register, Vol. 37, No. 142, July 22, 1972 §53.111(d)

number of hospitals to be monitored (about 150 in Massachusetts in 1979), the state office has little choice but to rely on complaints to monitor compliance.

The eligibility requirements for receiving free care were also to be determined by the state agency based on the following set of criteria: insurance coverage; income and other resources; family size; and other financial obligations. The time limits for these obligations were 20 years for grants and the entire payback period for loans.

With the enactment of the National Health Planning and Resources Development Act of 1974 (PL93-641) and the final extension of the Hill-Burton expiring, the Hill-Burton Title VI was replaced by Title XVI of PL93-641. Like Title VI, Title XVI-assisted applicants had to give assurances of offering free services. Although the original Hill-Burton goals had been met long ago, its evolution of new goals through various amendments kept the Hill-Burton alive. The 1974 revisions saw as its objectives: 1) providing outpatient facilities in poor areas; 2) modernization of existing facilities; and 3) construction of new facilities in areas which have experienced rapid population growth.

ANALYSIS

The Legislative History

There are several points worth noting about the regulations presently in existence. First, it is probably safe to infer that Congress, in amending and extending the Hill-Burton program, did not realize that it was also expanding the availability of free care. There is no such acknowledgement in either the hearings or committee reports.

Also of interest is the way in which the volume of free services was calculated in the 1972 regulations. Not only did it ignore the distribution of these benefits (how many people or who received the free care) but it also created potential perverse incentives. If the purpose of Hill-Burton was to fund hospital construction where it was needed, linking the amount of federal aid to providing free services could have induced overinvestment in capital intensive facilities. These could then be offered free of charge to indigents to fulfill the requirements of the law. These possible incentives to overbuild did not exist before the 1972 regulations and therefore could have affected only those projects built after this date. Since then, only ambulatory facilities have been funded, minimizing its potential impact on the supply of medical facilities. By not specifying the distribution or kinds of services to be delivered, the regulation could have also induced hospitals to provide intensive care to few patients (such as numerous lab tests, hospitalization when outpatient services could suffice). This is particularly of interest for facilities located in relatively affluent communities where there are few eligible indigents. It has been speculated that hospitals in these areas provide free care to individuals who technically do not qualify, due to the lack of indigents.

In many states, the major problem of the Hill-Burton amendments has been the minimal efforts to enforce the community service requirements. Ineffective implementation has resulted in the lack of provision of free care in many Hill-Burton funded facilities. In addition, due to the scarcity of resources to monitor and enforce compliance, the state agencies lack the ability to effectively enforce these requirements. Essentially there was no regulatory stick. The cutoff of funds (the only federal sanction) was two steps removed from the regulated facility, in that the Surgeon General does not regulate the hospitals but rather regulates the state agencies. The state agencies in turn regulate the facilities. This made the regulation difficult to enforce.

The Massachusetts Experience

As in other areas of health care regulation, Massachusetts seems to be ahead of most states in the regulatory role assumed by the state Hill-Burton office. Responding to Federal mandate to develop free care regulations, the Department of Public Health passed "Minimum Level of Uncompensated Medical Services" Regulations in 1974, "Community Service" Regulations in 1975, and Amendments in 1976. They defined medical indigents as persons with a family income of less than $4,000 per year plus $600 per dependent. Exceptions can be made if the extent of third party coverage size of family, or other financial obligations and resources would impose an unreasonable financial burden. This allows each facility considerable discretion in determining each applicant's eligibility. The services which are to be provided include all services normally delivered by that facility (or that unit if only a specific unit of a larger facility was funded). The state regulations also mandated that signs be posted in-

dicating the availability of uncompensated services and a notice be included with the first bill for emergency visits.

The State Hill-Burton Office set more enforceable and tangible sanctions on hospitals found to be out of compliance. The first step towards using sanctions is simply to ask the hospital to deliver the services in question or to deliver a greater volume of free care. If this tactic fails, sanctions which can be used include: 1) publicizing non-compliance in the local newspaper; 2) notifying HEW which can affect other funds of the hospital: 3) delicensing the hospital, thereby eliminating its Medicaid and Medicare reimbursements (and effectively reducing its daily census); 4) initiating a court case; and 5) notifying the Department of Public Health, who reviews all Determination of Need applications. The potential impact non-compliance can have on Certificate of Need and on community relations has promoted compliance in many hospitals.

The Office has also outlined specific annual reporting procedures required of every funded facility. The reporting form calculates the cost of the uncompensated services (not the charges) and requires that the following documents accompany the form: the annual financial statement required by the Rate Setting Commission; the written procedure for determining free care also filed with the Rate Setting Commission; the notice of the Hill-Burton regulation and its translations; the Community Services Admissions statement; and the Community Services notice as it appears in the newspaper.

While all of these requirements attempt to improve compliance, it is still difficult for the office to evaluate its success. Some hospitals do not file complete reports (or a report at all) and the accuracy of these reports is not checked. In addition, no one in the office is an

accountant so that spot audits would have limited ability to uncover non-compliance. They do, however, bring the results of non-compliance closer to home and this acts as an effective deterrent. Not only are hospital administrators prone to obey the law, but the last thing most of them want is bad publicity.

New Proposed Regulations

Serious concern over the degree of non-compliance and problems of enforcement are not limited to this state--clearly they are widespread, for in October 1978 proposed regulations appeared in the Federal Register for comment. These new regulations attempt to ensure that: 1) all facilities which received Hill-Burton funds are providing the required amount of uncompensated services; 2) services are provided to those who should get them; and 3) services are distributed in a fair manner. The proposed changes include eliminating the state role (to be taken over by the DHEW), which it is argued, has been ineffective as both evaluator and monitorer. Moreover, it makes eligibility requirements uniform throughout the country, thereby removing the facility's and state's discretion as to who can receive free care. It also reduces the options by which a facility can determine how it will met the "reasonable volume of free care" by eliminating the "open door" option. It was argued that this has been a source of improper policy implementation because it is practically impossible to monitor, particularly since financial records are not required to be kept in most states. The proposal also addresses criticisms made regarding the lack of publicity of the Hill-Burton assistance and requires that notices be given to all individuals seeking services and that multi-lingual signs be visibly posted.

The hearings for these proposed regulations were held on December 5-6 and no final regulations have been issued. It is very likely that the hearings will yield modifications given that the hospital industry was against such "arbitrary" regulatory "overkill" which "seeks to expand the hospital's contractual obligations and impose unnecessary administrative burdens . . . ignoring their voluntary compliance efforts."[12] The American Hospital Association argued that hospitals have been meeting their obligations, that such proposals are unlawful and that their burdens could damage the hospitals' ability to deliver quality care. However, consumer representatives alleged that hospitals have failed to offer information on the availabilty of free care, that posted signs often were absent or inaccessible to patients, that physicians refused to treat charity patients, that hospitals have initiated collection proceedings against individuals who claimed to be eligible for free care, and that both federal and state agencies failed to enforce Hill-Burton regulations.

Purpose of the Regulation

It should be clear from this brief account of the regulation's history that the purpose of the Hill-Burton has evolved with each of its amendments. In 1946, its intent was to increase the supply of general hospitals, to plan such construction, and thereby improve the distribution of health facilities. This purpose expanded to include more specialized services, ambulatory facilities, modernizations, and facilities in urban poverty areas. In general, these goals shifted with the adoption of amendments. For example, in 1948 7% of the Hill-Burton funds went for new

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[12] American Hospital Association, Health Law Vigil. December 15, 1978, AHA Testimony, p. 1.

construction. One year after the goal of modernization was instituted (1965) 15% of the funds went for new construction, while the remaining 85% went for modernization. This trend continued as emphasis on new construction shifted to other priority areas and in 1974 only 3% of the funds went for such projects.[13]

Until 1972 the reasonable volume of uncompensated services remained ambiguous and unquestioned. However, increasing pressures from court cases demanded that a working definition be established. This indicates that the Hill-Burton, whether originally intended as such or not, has become a source of community charity in the form of free services. This purpose may not have been emphasized in its original regulations due to the fact that hospitals have always given a certain amount of free care, incurred as bad debts, and a further elaboration of commitment was unnecessary. However, escalating health care costs and the proliferation of social services in the 'sixties may have served as impetus for more specific (and, in many cases, expanded) obligations. Thus, implicitly, a goal of accessibility has been established. The measure of accessibilty (amount of free care) is very sloppy, probably because it was a secondary goal. By specifying a dollar amount or "open door" policy, rather than number of persons treated or some measure of the distribution of benefits, the policy is open to numerous implementations with varying results.

Impact of the Regulation

With respect to the initial goals of the Hill-Burton Act, the regula-

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[13] "Legislative History on National Health Planning and Resources Development Act," U.S. Congressional and Administrative News, Vol. 4, 1974, p. 7863.

tion has been widely viewed as successful. Between 1947 and 1974 almost 500,000 beds have been constructed or modernized at a cost of $14.5 million. For the same time period, it was responsible for an average of 8% of the total health construction costs. Though seemingly insignificant, these improvements have significantly reduced the imbalances between states and between rural and urban areas. The development of rural facilities has also helped to attract physicians to these regions. Much of the success has been due to the programs' adaptability to changing needs and the recognition of the limitations of the original act. Many of the amendments try to compensate for these omissions by categorically setting aside special grants. Although much less successful, the program did help in health planning efforts by both raising licensing standards and improving the design and operation of health facilities.

However, not all reports are so positive. The Committee Report prepared to the Subcommittee on Health had the following criticisms:

1) lack of planning had resulted in too many facilities with duplication;

2) rural migration had resulted in overbedding in some areas;

3) the need for Hill-Burton loans and grants had decreased due to the availability of other, equally attractive options for financing costs.[14]

The resultant overbedding tends to be overemphasized. The Hill-Burton favored funding small, community hospitals which normally have lower occupancy rates. Despite these and other criticisms the hospitals have been candidates for refunding because of the lack of ambulatory ser-

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[14] U.S. Senate, Committee Report prepared for the Subcommittee on Health of the Committee on Labor and Public Welfare, "Hill-Burton Hospital Survey and Construction Act: History and Current Problems and Issues," 1973.

vices and gaps existing in third party financing of health care for the poor. This recognition of the program's shortcomings, yet consistent refunding and justification, seemed typical of the debate surrounding extensions of the program, particularly since 1970. The conflict seems to stem from varying conceptions of the program's objectives. Opponents saw the program as a construction act whose goal had been met. On the other hand, proponents saw it as having multiple goals which had evolved with the numerous amendments.

The extent to which the Hill-Burton Act provided uncompensated services is difficult to determine. Many hospitals (65%)[15] chose to comply via the "open door" policy which does not require financial reporting (many critics claim that this is why this option is so popular). The state agencies have not monitored or enforced compliance in part due to a lack of personnel (which may reflect a lack of priority--these offices probably see their primary role as securing Hill-Burton funds, not guaranteeing access for the poor). Generally, they rely on complaints to monitor compliance. In a GAO report issued in 1974 which reviewed the implementation of the Hill-Burton free service policy, it concluded that most hospitals were indeed complying with the regulations. However, the accuracy of these findings can be questioned. Due to "time constraints" the reporters relied on the records at state agencies and did not verify any information. Of their sample of 20 facilities, only six kept financial records, which were not checked for their validity. The report's accuracy essentially depends on the assumed accuracy of the records and

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[15] Testimony of Mr. Ahart, GAO Office, before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, "Implementation of the Hill-Burton Amendments, 1974," Hearings, November 25, 1974, p. 89.

oral comments, which as other testimonies indicated, are highly suspect.

At the 1974 hearings there were other highly critical testimonies which recounted the following:

1) Some facilities use loopholes to avoid accountability for specific dollar amounts of free service.
2) Highly questionable expenses are accounted for in such a way that hospitals appear to be in compliance.
3) Public notification of the availability of free service is a farce.
4) Eligible people are turned away from service due to arbitrary geographic restrictions and limitations on the types of medical care given to indigents. Often, individuals who are eligible for other types of coverage benefit at the expense of those who are not eligible for other programs, the target population.
5) State agencies do not perform adequate evaluations and often take the facilities at word for compliance.
6) Regional HEW offices condone this lack of effective evaluation and enforcement by approving inadequate State Plans and overlooking the states' failure to file annual reports.[16] This is probably because they see their primary mission as dispensing Hill-Burton funds, not monitoring compliance and thus attach little importance to this function.

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[16] Testimony of Allan Crimm, Southern Governmental Monitoring Project, before the Health Subcommittee of the Senate Committee on Labor and Public Welfare, November 25, 1974. This project investigated the compliance of 44 hospitals in eleven states.

In summary, the impact of the Hill-Burton has been to increase and improve the supply of health care facilities and in this sense has been a positive impact. Recent amendments to improve and enforce accessibility have, at best, mixed evaluations. Some facilities have conformed to this regulation with little difficulty. Others have, at least, been attempting to comply, while still others have done little except avoid compliance. As mentioned previously, the way in which this policy of uncompensated services is actually implemented and its distributive effects can vary significantly. This, coupled with various degrees of compliance, make the impacts of this policy difficult to estimate. It is clear that many of the intended beneficiaries are still excluded from medical care.

Summary

It is difficult to assess some of the impacts of the regulation because the State is not rigorous in its monitoring and it lacks complete and accurate financial reports. Certainly part of the problem lies in the design of the regulation and regulatory process--the State Office does not have any incentives to monitor compliance and therefore it enforces the regulations so infrequently that the sanctions lose their effectiveness. My sense is that the State Office tries to maximize the amount of Federal funds coming into the state. Enforcing the uncompensated services requirement and uncovering non-compliance is inconsistent with this objective. In addition, the goals of improving the access of hospital services and providing free care may not be seen by the State Office workers as either appropriate or realistic. These two goals may be perceived as inappropriate because they were never formalized, but rather, evolved into implicit objectives, and therefore workers are not

evaluated with respect to these goals. Moreover, the goals may be unrealistic, given the overwhelming institutional barriers. Thus, the State workers choose other more obtainable goals to achieve. Moreover, since the Federal government does not encourage monitoring or enforcement, the State Office may simply reflect the low priority attached to these functions. Although implicitly established as a goal, accessibility is still not seriously considered in the evaluation of the regulation. The only figure of concern to the State Office is dollars expended, a poor proxy for patients treated and for accessibility. Because questions of implementation are not addressed in the regulation, institutions have considerable flexibility in adapting their own procedures for compliance.

The next chapter analyzes how one facility has implemented this regulation and the kinds of results policies have had.

Hypotheses about the Impact of the Regulation on the Hospital

This section reviews the hypotheses about the effects of the regulation on the hospital. They are based on the history and purpose of the Act, the characteristics of the hospital, and the shortcomings of the regulation.

The first hypothesis is that the hospital acts to minimize its financial burdens and therefore it selects the least expensive compliance option. If the hospital is located in a poor, urban area we would expect it to select a minimum volume requirement to limit its obligation. Conversely, a hospital in an affluent suburb would select an "open door" policy to treat all indigents, and assuming that there would be few indigents to treat, the hospital would bear a minimal burden. The hospital which is very community- or patient-oriented may be unaffected by the

regulations and carry on business as it always has done.

It is also hypothesized that the regulation may have produced dysfunctional consequences. For example, once it was clear that facilities would have to provide free care, a potential recipient of funds may have inflated the anticipated demand figures to accomodate serving the indigent population. Or, the hospital staff would be encouraged to provide intensive care (high technology and expensive services) to few patients to use up its required amount of free care and ease its administration. Conversely, under the open door option, if the hospital is paying the costs of care, it may monitor more closely free care patients to "process" them as quickly as possible, thereby minimizing the hospital's losses.

There is considerable room for interpretation in the state and Federal guidelines, leading to many possible hypotheses about their exact implementation in the hospitals. A hospital may want to keep the eligibility guidelines vague, to ensure its own discretion in decision-making. On the other hand, hospitals may use this imprecision to tighten its own policies and institute arbitrary restrictions on service areas or procedures excluded from coverage. Given that the distinction between a bad debt and free care is ambiguous the hospital may juggle these figures to its advantage if there is a difference in reimbursement.

There are three hypotheses about the actions of the Chief Executive Officer. First, he will try to keep losses at a minimum, thus minimizing the amount of free care given out. Second, he will try to avoid bad publicity that may jeopardize any pending Certificate of Need applications or future funding. This fundamental concern with stability leads him to comply with the regulations when the costs of non-compliance are

too great. Complaints filed with the State Office will induce compliance and serve as a monitoring mechanism. Last, the retroactive nature of the regulation will have produced many feelings of distrust and resentment towards the government by the hospital administration.

The last two hypotheses focus on the behavior of physicians. On the one hand, physicians will feel an instinctive professionalism which will circumscribe their behavior and they will treat free care individuals no differently than other patients. This could significantly limit the effectiveness of cost controls by administration, since most hospital costs are doctor prescribed. On the other hand, some physicians will resent treating free care individuals knowing that it is unlikely that they will ever receive payment for services rendered. Eventually, these physicians will refuse to treat indigents leaving this burden to fall on fewer physicians.

These hypotheses and themes structured my interviewing and data analysis. Throughout the data gathering phase many themes were developed and refined or discarded. One of the beauties of a case study is that such refinement is possible and improves the research. For example, data may collected, analyzed, and spur the collection of new data or the development of new interview topics.

CHAPTER TWO

THE IMPLEMENTATION OF THE HILL-BURTON REGULATIONS AT THE HOSPITAL

Introduction

Massachusetts regulations require each facility that has received Hill-Burton funding to annually select a compliance option. The three options, as specified in the Federal Regulations, are:

a) an amount of free care equal to 3% of its operating costs excluding Medicaid and Medicare reimbursements;

b) an amount of free care equal to 10% of the total federal assistance received;

c) the "open door" option, where a hospital ensures that no individual will be refused admission because of their inability to pay.

Based on a recommendation made by the Chief Fiscal Officer the Board of Trustees determined that Prescott Hospital would operate under option C, the "open door" policy. This option has been selected every year because it is the cheapest option for the hospital.[1] Until option C is eliminated or the volume of free care given out exceeds a minimum volume alternative the hospital will continue to elect the cheapest option. As many interviewed admitted, this decision is strictly a financial one, and is divorced from any social responsibility rationale or community service obligation.

This chapter examines how Prescott Hospital implemented the Hill-Burton requirements to provide uncompensated services. First, it describes the policies and procedures adopted by the hospital: the

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[1] Under option A the hospital would have to provide $631,758 of free care, and under option B $700,000. Last year the hospital provided only $453,372 worth of free care.

application process; the eligibility criteria; and the decision-making process. Second, it analyzes the free care process in terms of: 1) the timing required to make the entire process successful; 2) the impact of the policies on accountability; 3) the leniency of the eligibility requirements; and 4) the discretion of the decision-making body. Third, the outcomes of the process are described and new policies and efforts to "tighten up" are examined to evaluate their effect on the amount of free care given out, the hospital losses, and accessibility of care. We will see that although the dollar amount and the number of individuals receiving free care have both increased, these do not necessarily improve the accessibility of care to indigents. Given that one of the goals of the uncompensated services requirement was to provide hospital care to individuals who normally fall between the cracks of other existing payment systems, the regulation is not effective.

The Application Process

There are several different ways in which patients find out about the availability of free care. For example, some patients acquire this information at the time of admission, others find out during their stay at the hospital, while still others discover free care sometime during the dunning cycle. These methods accomodate for various circumstances of the individual case such as whether the admission was emergency or elective, whether the person is overly concerned about the financing of the hospital bill, and the completeness and accuracy of the admission forms' information. The entrees into the system occur at different times in the free care application process, with the later applications being more difficult to administer. These methods are described in

chronological order of the application process.

All patients are interviewed and questioned about their finances at the time of admission. Here the application form can identify the patients who qualify for free care. In such cases, the admitting person is instructed to provide the patient or guarantor with an application for uncompensated services and may also help the individual complete the form. (See Appendix A for a sample application form.) Note that already there are three possible ways for this relatively straightforward procedure to fail. The admitting desk may fail to give out the uncompensated services form, the form may never be completed or returned, or the patient may give inaccurate information and hence delay the entire application process until the accounts department has checked out the insurance number and discovered its validity.

The admitting office serves as an initial screen for the medically indigent[2] for all but emergency cases. However, for emergency admissions, the admitting office route does not work. Not only are many patients unable to complete the necessary forms but admission is basically granted with no questions asked. These patients (and persons not picked up during admitting) are not identified as medically indigent until services have been rendered or while the patient is still in the hospital. This occurs in one of four ways:

1) The nurse on the floor senses the patient's anxiety about the costs and will notify social services.

2) Social services, in planning discharges, will discover medical indigents.

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[2] Medically indigent is defined as those persons needing medical attention but who cannot afford to pay for services.

3) Patient accounts may uncover invalid or poor insurance policies and contact the patient, who then may express concern about his or her lack of funds.

4) In the dunning cycle an ex-patient may contact patient accounts about his or her inability to pay the bill. An application will then be sent to the patient.

Invariably the system of informing patients about the availability of free care is ineffective for many reasons: a) the patient did not see or understand the posted signs; b) his insurance policy is invalid but only discovered as such months after services are rendered; c) the policy is valid but incomplete in terms of his coverage; or d) he slips through the system unnoticed. The free care application can be filed at any time before collection efforts begin.[3]

The dunning cycle at the hospital is fairly lengthy and provides a considerable time for an indigent to mention that he or she does not have the finances. It consists of the first itemized bill, two reminders, and a pre-collection letter (essentially a not-so-nasty letter). At this point uncollected accounts are turned over to a collection agency.[4] The pre-collection letter is effective for about 30% of the accounts; for the remaining 70% the collection agency collects on 20-22% of these accounts. If collection efforts fail, the amount is counted as a bad debt.[5]

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[3] By law, accounts which have already gone to a collection agency cannot be included in the category of "free care." Although these accounts are uncompensated services, if the hospital goes to the extent of sending them to a collection agency, it is argued that the intent of providing free care has been invalidated.

[4] The collection agency receives a percentage of the accounts turned over to them.

[5] The distinction between bad debt and free care is as follows: "free care" is uncompensated services rendered to a patient who has

Once an application is filed by the patient it is sent either to the inpatient or outpatient accounts manager. The outpatient accounts manager makes all decisions about free care himself, for bills under $100, due to the small size of most bills (average bill is $48 volume of applications (about five to ten per day). He reviews the applications and renders free care based on the guidelines established by the Free Care Committee (FCC). Approximately 75% of these applications are accepted--this high acceptance ratio is a function of the large proportion of the applicants that are either low-income (many poor individuals use the outpatient department as their only source of medical care and in place of a doctor visit) or transient. If the accounts manager is unsure whether a patient qualifies for free care, if the bill is in excess of $100 he presents the case to the Free Care Committee.

The decision process for inpatient accounts is much more complex. All inpatient applications are presented to the Free Care Committee which meets once a week to discuss and vote on applications. Although

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applied for free care via the Hill-Burton application process. An application may be filed at any time before collection action has been taken. "Bad debt" are uncompensated services for which collection efforts have been unsuccessful and thus the hospital is forced to incur a loss.

Note that the amount actually lost by a hospital by incurring bad debt or providing free care varies substantially as the following example will illustrate. Assume there is $100,000 worth of uncompensated services.

Free Care:	$100,000	uncompensated services
	- 30,000	reimbursed by Blue Cross at 30%
	$ 70,000	LOSS
Bad Debt:	$100,000	uncompensated services
	- 30,000	receipts from collection efforts
	- 2,000	fees for collection agency
	$ 68,000	
	- 20,400	reimbursed by Blue Cross
	$ 47,600	LOSS

its decision is officially a recommendation to the chief fiscal officer, it is not rigorously monitored. Essentially, the chief fiscal officer has delegated total responsibility for the implementation of the Hill-Burton to the FCC. Within a week, the decision has been sent to the applicant unless it has been deferred due to a lack of information.

The Free Care Committee is an innovative response to the Hill-Burton regulation. Most hospitals simply have a fiscal accounts person review applicants and make determinations. At first this was the process at this hospital but the director for fiscal affairs was so uncomfortable making these important (at least to the individuals involved) decisions and was aware of his own biases in making them that he initiated a Free Care Committee to review the applications. To reduce the biases (or at least balance them), the committee has a wide cross-section of members from nursing (1), fiscal services (2), social services (3), psychiatry (1), quality assurance (1), continuing care (1), controller's office (1), and physical therapy (1).

Another important innovation at this hospital, which was a direct result of the Hill-Burton requirement, was the establishment of governmental program coordinators in social services. Two individuals (one for inpatients and one for outpatients) review free care applications for potential eligibility for other programs such as workingman's compensation, Medicaid, Medicare, social security, and other discharge services like food stamps, AFDC, and general relief. The inpatient coordinator in Fiscal Year 1978 saved the hospital over $173,000 by transferring free care individuals to other government programs. In fact, this has been so successful that the hospital recently hired an outpatient coordinator to try to find alternative programs to bill for

outpatients.

Individuals who apply for free care and who are not eligible for other programs are reviewed and decided upon by the FCC. Any decision may be appealed to the Free Care Committee for reconsideration based on additional information. The guidelines which the committee uses to determine eligibility are based on financial and medical need of patients who live in the hospital's service area. The guidelines are listed below.

I. Financial Eligibility
   - A. Income of $5,000 per year for an individual, plus $1,000 per year per dependent.
   - B. Other assets--$2,000 for an individual, $3,000 for a couple. Assets include savings, trust funds, stocks, property other than residence, etc.
   - C. A persons' car and home are not considered in assessing eligibility.
   - D. For patients temporarily unemployed, work potential is considered (i.e. educational level attained, usual income when working, whether part-time, or unemployment is voluntary).

II. Service Area
   - A. Service area is defined as Cambridge, Somerville, Belmont, Watertown, Arlington, and Lexington.
   - B. Patients who apply should be permanent residents of one of the above towns.
   - C. Exemptions to service area criteria:
     1. Emergency admissions where patient comes to the hospital as the closest facility.
     2. Persons recently moved out of our service area (3-6 months ago) who were residents and have ties to the hospital.
   - D. Patients from out of the service area who come to doctors on the staff are not exempted from the policy.

III. Medical Need
   - A. Service must be medically necessary at the time rendered.
   - B. Services not covered include:
     1. Cosmetic surgery.
     2. Procedures that can safely be deferred.
     3. In-hospital services that can be done on an outpatient basis.
   - C. Whenever possible, eligibility is determined prior to the rendering of services.

IV. Students
   A. Students must meet service area requirements.
   B. Students claimed by parents for tax purposes must provide families' financial information for consideration.

ANALYSIS OF THE PROCESS

The complete application process is outlined in Figure 1. This diagram highlights the numerous steps involved in making uncompensated services decisions. Needless to say there are many points at which the process does break down. Even at the admitting desk, presumed to have adopted a straightforward process, eligible patients are overlooked.

Timing

Ideally the hospital would like to consider applications either before admission or during the stay for two reasons. First, it is required by law (eligibiity should be determined before the rendering of services except in emergencies), and second, early consideration permits monitoring of free care cases more closely while in the hospital. Monitoring rarely happens for several reasons: few people know about free care to apply for it ahead of admission; the length of stay is too short; emergency admissions are admitted without financial information and hence do not enter into the application process until either the patient is well into his or her stay or already discharged; and many admissions appear to have coverage and when checked into actually do not. The invalidity is not discoverd until after admission (for Blue Cross policy holders) or long after discharge for all others (private insurance companies, Medicaid, Medicare, and self-paying patients). And finally, people for no apparent reason slip through the admitting desk

Figure 1.
The Application Process

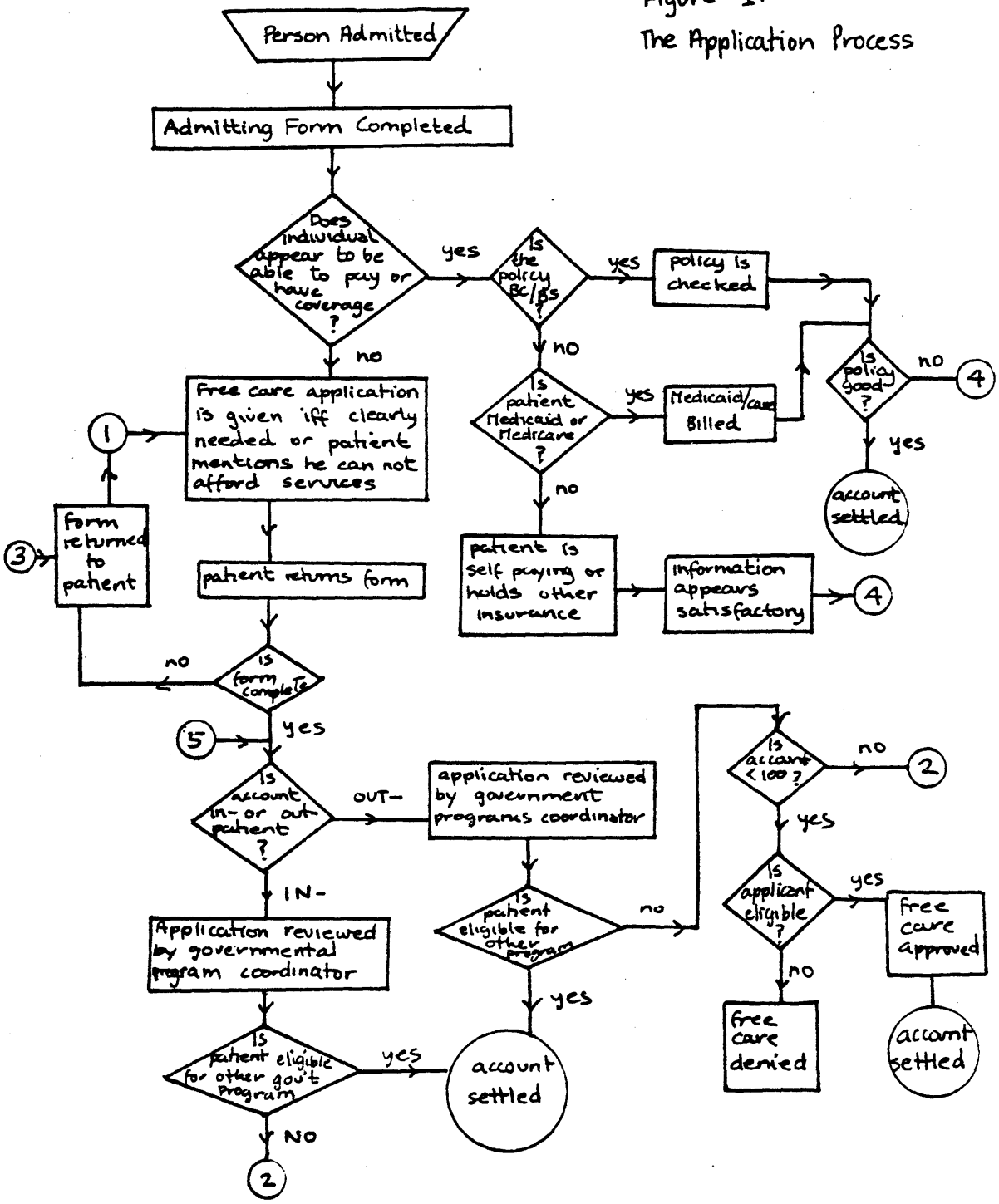
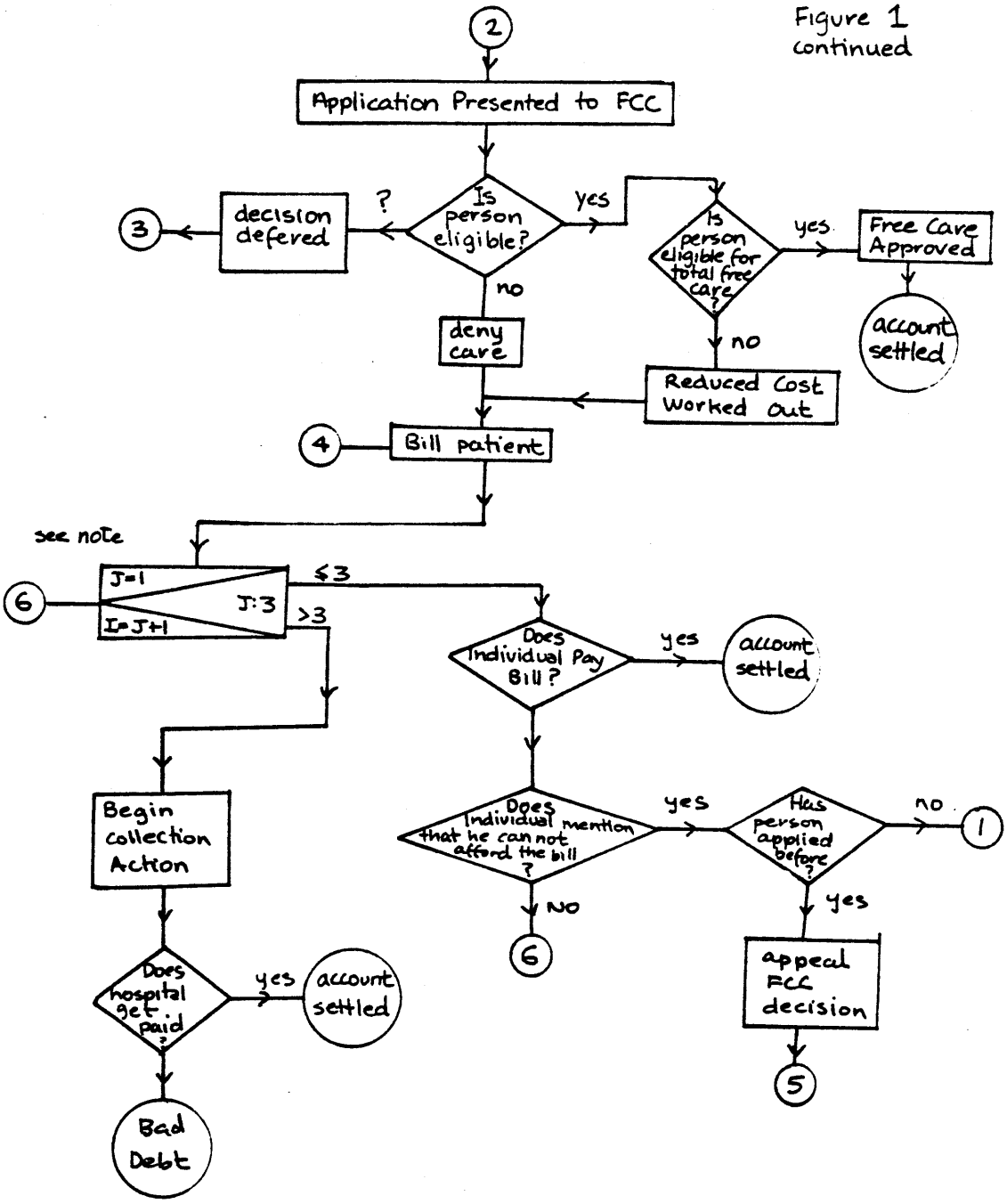


Figure 1
continued



Note: Dunning Cycle is comprised of 2 reminders and 1 precollection letter.

screen. This lag time is very costly for the hospital. It requires excessive paperwork, and results in avoidable debts (for elective admissions only).

In addition to the legal reasons for wanting to identify indigents before providing services, the hospital would like to monitor the cases of free care recipients. Ideally, this would ensure that all services rendered would be necessary expenditures for the hospital, but not affect the quality of care received.[6] Given that the preadmissions are a small percentage of the total recipients of free care (about 13%) and that presently there is no special monitoring of these cases, this form of "tightening up" is overly optimistic. This example illustrates the ongoing problem of the quality assurance program in most hospitals--the incentives for the hospital simply are in direct conflict with the PSRO's and quality assurance. To compound this problem, these programs have very little clout with physicians and generally have limited impact on altering behavior except in infrequent, blatant cases.

Persistent Inaccessibility

It is important to note that no matter how long the dunning cycle is, once the patient is past the admitting desk, dissemination of the information about the availability of free care is totally dependent on the patient's initiative. If the patient does not mention that he or she cannot pay the bill, there is no way to identify potentially eligible patients. From the growing size of bad debts, it is very possible that potentially eligible individuals are not aware of the availability of

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[6] For example, free care patients could be excluded from testing done for education purposes by the house staff.

free care and do not ever enter the free care process.

This complaint about the lack of information is common. Although the Massachusetts regulations as amended in February 1976 require that the first emergency bill have a notice indicating the availability of Hill-Burton uncompensated services, most hospitals do not comply with this requirement and it is not presently enforced by the State Office. Such a notice could significantly improve the knowledge and accessibility of uncompensated services. From the hospital perspective, increased access is more costly and would have serious financial implications for the rate of increase in the hospital losses. Losses are of grave importance to the hospital which experienced its first deficit last year in over 20 years. I am certain that this hospital, like many hospitals, will not comply with this regulation until it absolutely has to, i.e., when the costs of non-compliance outweigh the costs of providing free care either in terms of dollars, jeopardizing Certificate of Need application, publicity, or delicensure. One can only wonder why such an easily administered enforcement has not been done by the state, assuming an honest concern for accessibility.

The Eligibility Guidelines

The guidelines which the Free Care Committee follows were outlined previously. There are several points worth making about these criteria. First, the Committee's guidelines are more lenient than required by law. The Massachusetts Regulations defining eligibility criteria ($4,000 and $600 per dependent for income and $1,000 of assets and up to $2,000 assets in the case of a married couple) were adopted by the FCC and approved by the Board of Trustees on March 26, 1975. These policies

were in effect for almost three years, and in February 1978 new eligibility criteria were developed and agreed upon. These new criteria were more lenient: $5,000 income plus $1,000 per dependent and $2,000 personal assets plus $1,000 for a spouse and $500 per dependent. There are several possible explanations for this.

First, the FCC's composition probably favors more lenient criteria than those set by only financial administrators. The guidelines are partly derived from the poverty line guidelines which have higher income cutoffs. Second, the Board may have seen this generosity as an important gesture to make to the community. Third, the hospital is not an urban hospital per se and its service area (Cambridge, Somerville, Arlington, Watertown, Lexington, and Belmont), while having numerous pockets of poverty is not a poor area generally. This situation may have influenced the guidelines' upper limits. Fourth, the guidelines set by the state were over three years old and inflation combined with the escalated costs of medical care may have warranted a reasonable increase. Last, many members of the FCC mentioned that they were disgusted with the minimal allowances given by the state and wanted to make their guidelines more realistic and reasonable.

The eligiibilty criteria are less flexible with respect to service area and students than income. By limiting its service area to six towns the hospital has significantly reduced the number of potentially eligible persons and successfully excluded large poor sections of Boston. The administrator responsible for deciding the service area at the time of applying for Hill-Burton funds must have had considerable foresight (or luck) in strictly defining its service area as such and not including "greater Boston vicinity" as many other hospitals did. These other

hospitals currently must provide uncompensated services for the majority of metropolitan Boston.

Similarly, the hospital has excluded students who are not permanent residents of the service area. Given the composition of Cambridge, this has excluded a large number of the low-income persons who otherwise would be potentially eligible. Some of the hospital staff I interviewed criticized the exclusion of students, saying that the hospital should accept the community composition as given but this position has not been formally presented to the FCC.

While the guidelines may appear rather straightforward and easy to apply, they actually permit the exercise of a considerable amount of discretion. For example, work potential can be a criterion used for assessing an applicant. The weight that is attached to this criterion varies considerably from case to case depending on many circumstances. In some cases, the weighting appears to reflect the Committee's attitude towards an individual's lifestyle. The FCC is sensitive to this issue and tries not to be too judgemental but the distinctions between acceptable and unacceptable unemployment or underemployment are difficult ones to make.

The service area as defined also appears more straightforward than it actually is in practice. Although its use in limiting the amount of free care provided to non-emergency admissions has increased, exceptions are still made. Such factors as location of relatives, past residencies, and past hospitalization at the hospital are sometimes used to waive this criterion.

Finally, considerable judgement is required in determining that services rendered are truely medically necessary. This is clear-cut in

some cases but certainly questionable in others, especially when the patient suffers from psychological problems. Although the FCC does include people who have sophisticated knowledge it does not have a physician who regularly attends meetings. The FCC has debated including a physician in its composition but has decided against it, arguing that the physician would often be asked to review work of his peers. Such peer review may result in too much pressure on the individual. However, the arguments for a physician are convincing--he would improve their ability to discern "medically necessary" services and would improve the committee's impact on quality assurance of care rendered.

The Free Care Committee

By law, the Free Care Committee (FCC) can determine eligibility for either free care or reduced costs. Some people have found the name of the committee misleading inferring that approvals will mean free care, not reduced cost care. When challenged, individuals from the FCC argued that "Uncompensated Services Committee" or "Hill-Burton Committee" does not easily convey its purpose and may discourage applicants. Regardless of its title, the FCC has rendered reduced cost services to a small proportion of inpatient applicants (9% in Fiscal Year 1978 and 13% in Fiscal Year 1977). These decisions are made in the following way: the amount of income the individual is over the guidelines is subtracted from the total amount of the bill. If there is a positive difference the person receives that amount as free care. For example, suppose an individual with dependents is allowed an income of $10,000, yet he or she makes $11,000. The bill has amounted to $2,400. The $1,000 difference between the actual income and the individual's income is put

towards the payment of the account. This person would therefore owe $1,000 while the hospital would supply $1,400 of free care.

The small proportion of reduced cost care is only partially explained by this methodology--that is, income over an individual's allotment may pay for the hospital bills in most cases. An additional explanation is that the FCC until about one and a half years ago was very liberal in its dispensing of free care. If an individual was indigent, chances were the total hospital bill would be covered.

In my interviews, the outpatient accounts maanger was criticized by some hospital staff for not awarding any reduced cost care. While the average size of the bill is generally small, the critics claim that there are borderline individuals who are rejected from total free care yet should receive reduced cost care.[7] Given the average size of the bills and the financial pressure the manager must feel, this may be the easiest policy for him to administer. He simply approves clear-cut cases and avoids the substantive issues raised by borderline cases.

Besides reduced cost or total free care, the FCC has the power to make unofficial decisions such as deferred payments. This option is used for potential workers who are only temporarily out of the job market. The FCC may delay billing until a job is resumed or permit installment payments, thereby spreading the bill over one or more years. The accounts managers are agreeable to this arrangement because they would much rather get a small monthly check than put the bill into bad debts.

Another option used by the FCC is to ignore an account and let it

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[7] These critical remarks came from within a unit of the hospital which is currently experiencing low census and may be losing patients to other hospitals which have better "deals." Their concern for their own viability may in fact be coloring their perception of the FCC decisions.

go bad without sending it to a collection agency. This strategy gives the individual free care, while the hospital incurs bad debt (rather than counting it as free care, which has a lower reimbursement rate), yet the individual does not receive a bad credit rating in the process. This approach is used for individuals who are unemployed but previously held good jobs, have assets which are tied up, and have a good credit rating which would significantly harm their current financial situation. The account is ignored and no one loses in the process, since the hospital could not have collected on the account in any event.

One final action which the FCC can take is contacting the patient's physician about reducing the physician fees included in the medical bill.[8] This is only done with the individual's permission since otherwise a patient's pride or relationship with his or her physician may be damaged in the process. Upon consent, usually a social service worker will contact the physician and simply inform the doctor that the hospital is providing free care. The social worker may then ask if the doctor could at least reduce the fee and generally the doctor agrees to also provide free care.

One interesting and counterintuitive finding is that the FCC is much more likely to approve free care for a large hospital bill than for a small one. Their rationale is that a small bill can be more easily budget paid or deferred and covered by the individual. A large bill is more likely to end up as an uncollectable or produce unreasonable financial burdens and therefore should be covered by the hospital. Moreover,

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[8] Free care includes hospital costs and ancillary charges, and does not cover physician fees.

large bills generally mean that the individual has gone through a more traumatic medical experience, which the FCC would like to minimize.

The four options (deferred payment, installment plans, ignoring the bill but not sending it to a collection agency, and attempting to get free care for the physician fees) are discretionary decisions which the FCC has used in the past to respond to individual cases. In summary, each case warrants a close examination of its circumstances and appropriate action is then taken. These adjustments reflect the general style of the FCC--it is flexible, it treats each case individually, and it has a genuine concern for the patients involved.

OUTCOMES OF THE PROCESS

How have the application process and the set of eligibility criteria affected implementation of the Hill-Burton regulations? Figure 2 shows the overall percentage and number of applications which were accepted for either free or reduced cost care since February 1976. Figure 3 displays the breakdown of the decisions made by the Free Care Committee since February 1976. Acceptances for total free care and partial pay (reduced cost care) are shown separately. Denials are categorized into several groups: work potential; outside service area; not a permanent resident; over income; and other. Figure 4 further analyzes denials. It depicts the total percentage of the applications which were denied and then subdivides this percentage according to the reason for denial.

At first, the acceptance rate of applications was very high and the only rejections were due to "other reasons," usually incomplete applications (see Figures 3 and 4). It was not until December 1976 that anyone was rejected due to ineligibility and then for the next year only

Figure 2. Percent and Number of Applications Accepted 3/76 - 3/79

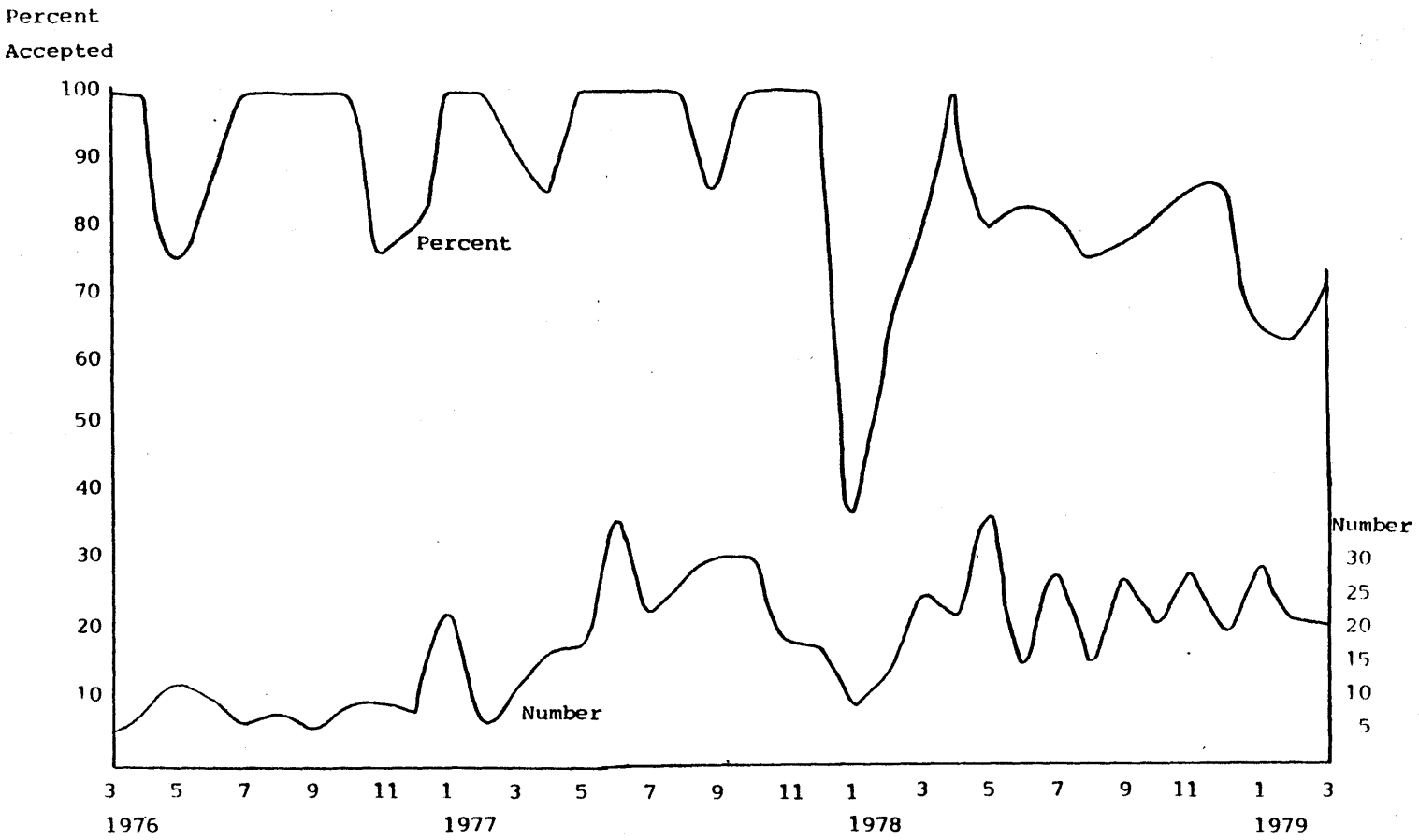


Figure 3. Breakdown of Free Care Committee Decisions for Hill-Burton Applications 3/76 - 3/79

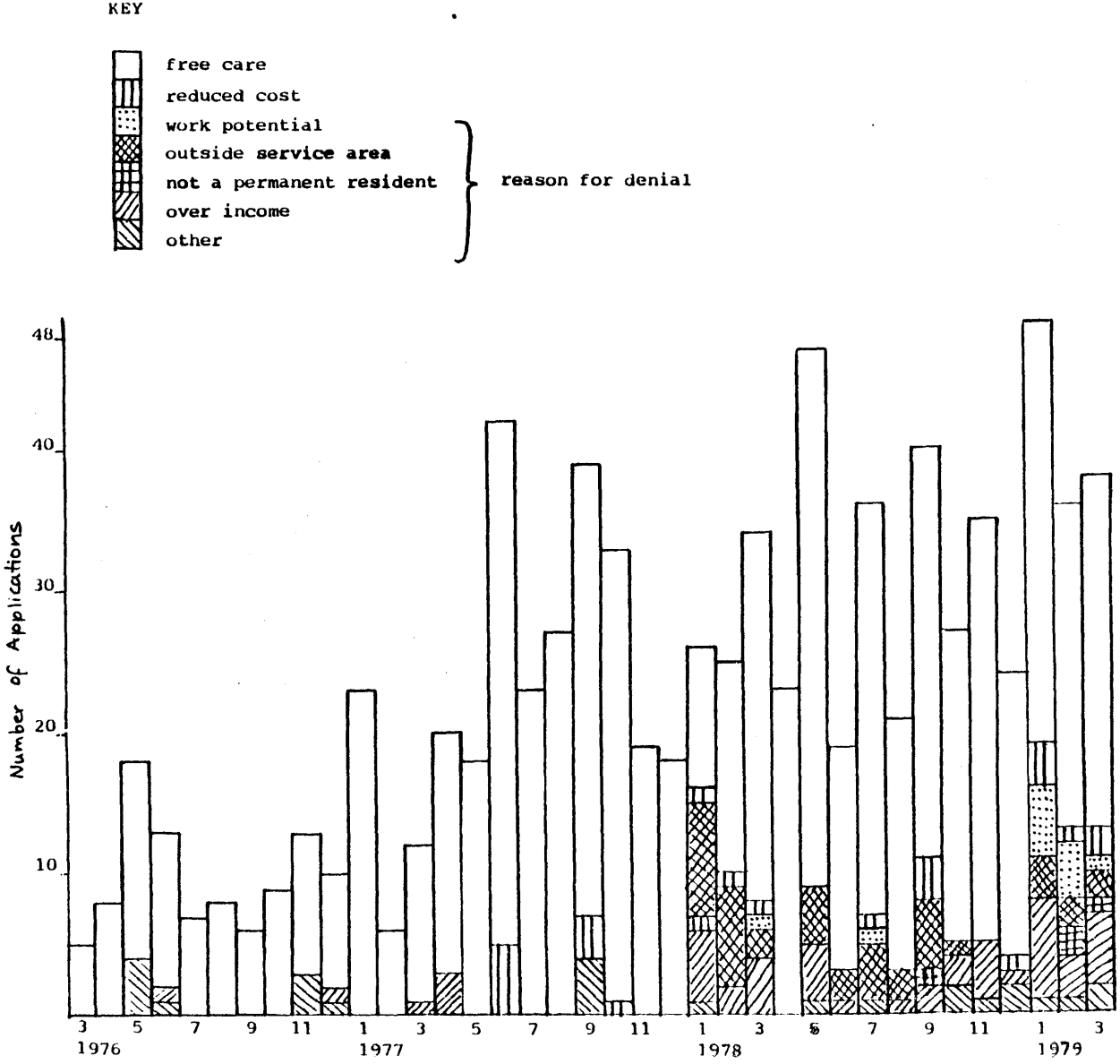
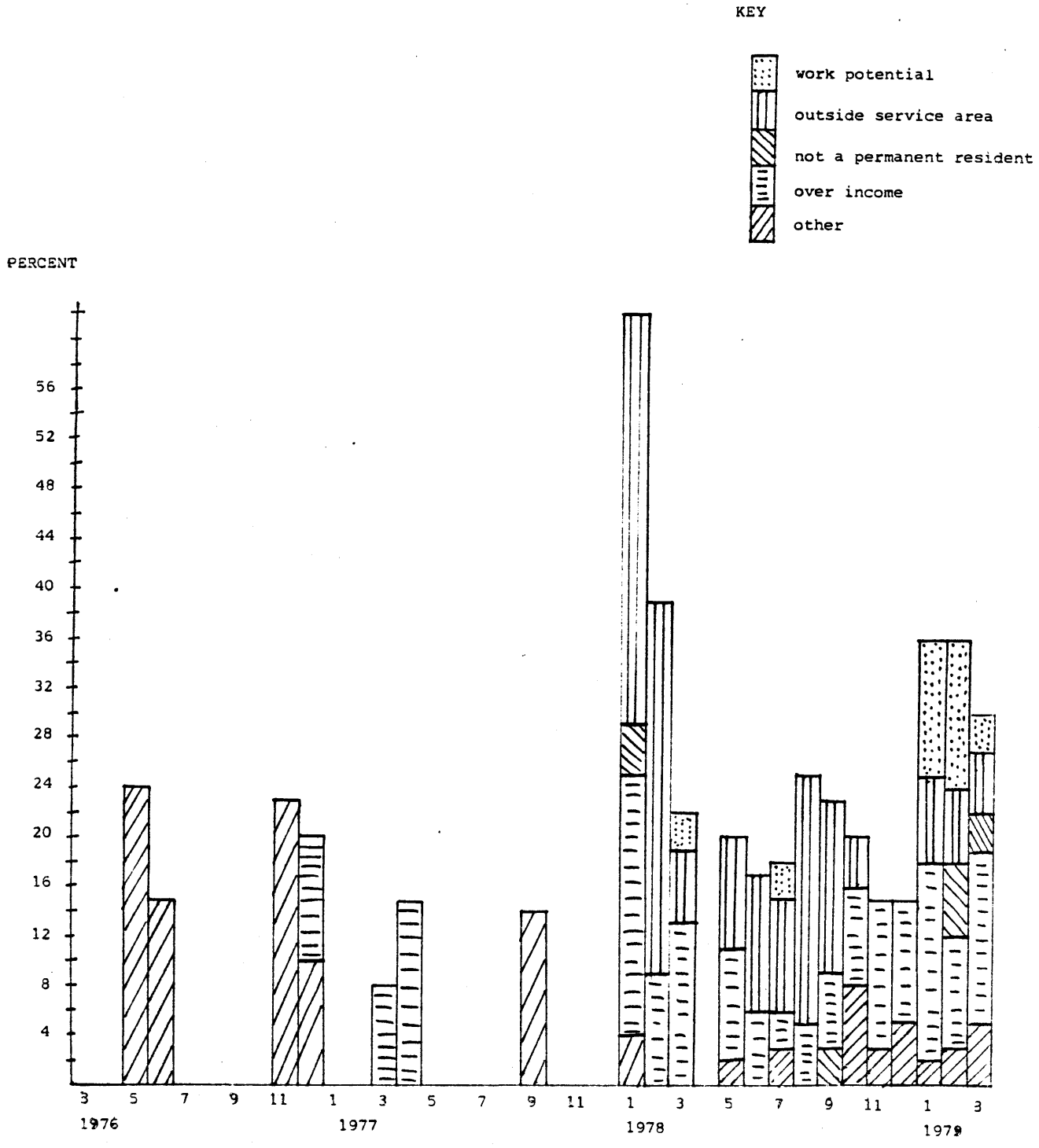


Figure 4. Percent of Denials Made By the Free Care Committee
Percentage Broken Down According to Reason



"over income" was used to reject applications. The other criterion, "service area," was not used to reject patients, even though through 1976 and 1977 the FCC did approve free care to patients who resided outside the service area (see Table 1). It was not until January 1978, one month before new FCC procedures and policies were adopted, that other reasons began to rule out applicants. Service area was particularly used, although not being a permanent resident and work potential of the patient were also included. Recently, work potential has increasingly disqualified several individuals.

Limitations of the Data

Any discussion of data must begin with a few qualifiers to outline some of the problems with using simple statistics. First, Figures 3 and 4 categorize the denials according to the reasons stated in the minutes of the FCC meeting. It is unknown what degree of consistency there is in the listing of these reasons. The first reason listed may not always be the most important. Second, the category of "other reasons" included applications which were denied due to their incompletion. These may have been completed and resubmitted, and it is unclear if these are included in the records. Third, none of the records include any of the informal forms of decisions which the FCC makes, as described earlier. Last, records, while conscientiously kept, are subject to considerable sources of error.[9]

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[9] For example, in the Hill-Burton annual report in 1977 the number of accepted applicants is not consistent from one page to another.

TABLE 1. ACCEPTED APPLICATIONS FROM INSIDE AND OUTSIDE SERVICE AREA, Fiscal Year 1976 - Present.

	Fiscal 1976		Fiscal 1977		Fiscal 1978		Fiscal 1979	
Month	Inside	Outside	Inside	Outside	Inside	Outside	Inside	Outside
1	0	0	7	2	23	7	21	0
2	0	0	9	1	16	3	25	4
3	0	0	7	0	10	0	15	4
4	3	0	2	1	7	1	20	1
5	4	2	6	2	12	0	17	6
6	5	0	5	6	16	5		
7	7	1	11	6	16	8		
8	10	3	15	3	26	6		
9	9	2	22	14	12	3		
10	7	1	12	6	16	4		
11	4	3	20	7	13	2		
12	5	1	16	10	18	4		

Percentage outside the Service Area, by Quarter

	1st	2nd	3rd	4th
FY 1976	0	14	19	24
FY 1977	12	41	32	32
FY 1978	17	15	24	18
FY 1979	12	16		

Increase in Applications

The number of applicants and recipients of free care is increasing. In FY 1976, 155 persons received free care; in FY 1977 the number went up to 466, and in FY 1978 it was 1,997. The number of applicants accepted per month is depicted in Figure 2. There are several reasons for this upward trend. For one, the availabiity of free care was more clearly posted within the hospital and printed notices in the local newspaper may have increased community awareness. Last summer, the regulation requiring visible and translated signs in numerous locations was enforced by the Attorney General's Office and this may have resulted in an increase in applications. In addition, the admitting desk began checking for insurance information and immediately giving out applications in their admissions process and this significantly improved patient awareness of the program.

Second, there have been substantial cutbacks in Medicaid 04 General Relief funding, which increases the potential eligible population. This decrease in other governmental program benefits has forced the hospital to absorb the costs of providing free care. Essentially, this represents a redistribution of costs from the general public to paying patients hospitalized at this facility.

Third, the revision of the policies and procedures (adopted in February 1978) significantly changed the free care application process. The old policies and procedures were less accessible to applicants in the following ways:

- free care application forms were located in one office and applications were not given out at the admissions desk;
- this office was only open during normal business hours (not in the evenings or on the weekends);

- the posted signs advertising free care were fairly cryptic;
- the applications were supposed to be filed within three days of the receipt of services.

The present policies have been improved greatly. Applications are available and can be returned at numerous offices throughout the hospital, including the admitting room, ambulatory care offices, patient accounts, and social services. The policy of asking for applications within three days has been dropped either because it was unfair or unrealistic. The signs are much more coherent and explicit about the availability of free care. (A copy of the present posted text is found in Appendix B.)

Last, the number of applicants for free care coincides with two recent development in the attitudes and behavior of the general public towards health care. The first is the dramatic growth in the utilization of outpatient services. Apparently, these services are now replacing doctor visits, especially for lower income persons. The huge rise in outpatients applying and receiving free care is in part due to the expansion of both the women's clinic and outpatient psychiatry services. The second trend is the increasing acceptance of the attitude that health care is a right and not a privilege. This observation is probably more applicable to outpatient visits, since most inpatient applicants were acute or emergency admissions (only about 11% of inpatient recipients are pre-admission determined).

Figure 2 also illustrates that although the acceptance process appears to be more strict, in general the number of applicants receiving free or reduced cost care has increased. This is in large part due to the greater volume of applicants, particular outpatient.

Monthly Variations

The second point that should be made about this data is that the number of applications fluctuates considerably each month. For instance, in Figure 4, the considerable dip in accepted applications in January 1978 is mainly due to the large number of applications in that month that were over income and outside the service area. Similarly, back in 1976 and 1977, most of the rejections were generally dependent on the number of incomplete applications. This stochastic nature makes it difficult to project the trends in the FCC decisions, since their decisions are often a direct function of the actual applicants. Moreover, we do not know if the application pool has changed or if the FCC, in fact, applied different criteria.

Impacts of the New Policies

The revised policies and procedures appear to have had a significant impact upon the Free Care Committee decisions. Once these new policies were adopted (February 1978) the decisions to reject applicants were based on a variety of reasons. The concept of work potential was introduced, and although not significant until recent months, represents a new departure for the FCC. Work potential allows the FCC the right to base decisions on a patient's potential or past lifestyle and provides ample opportunity for the FCC to abuse this policy. The FCC realizes this danger and honestly tries to exclude personal values of committee members from their decisions. However, just the fact of its existence implicitly indicates a trend towards "tightening up" the allocation of free care.

Figure 4 indicates that "outside service area" has also been used

more strictly since January 1978. Table 1 supports this trend, at least when 1978 and 1979 figures are compared with 1977 figures. This requirement is somewhat more difficult to enforce due to: 1) emergencies and acute admissions regardless of residence; 2) a person may have a past connection with the hospital in which case the rules are bent; and 3) a patient may normally visit Dr. X who works out of the hospital--therefore the rule is not strictly enforced.

Although the new policies and procedures have increased the variety of reasons for denial and reduced the percentage of applications accepted by the Free Care Committee, they have had no impact on the overall number of acceptances and dollar amount given out. This is due to the large volume of applications which are processed by the outpatients accounts manager alone.[10] Because the proportion of the total number of applicants which he processes for free care is increasing, stricter policies on the part of the FCC have not reduced the overall acceptance rate.[11]

Although obviously influenced by policies adopted by the FCC, the accounts manager still makes a majority of the decisions regarding free care. Therefore, despite stricter policies and the fact that the FCC is "tightening up" and rejecting a larger proportion of their applicants, it has not reduced the overall percentage of the total number of applicants receiving care. This discussion refers to the number of applicants;

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[10] The outpatient accounts manager can approve applications for accounts under $100. Because the majority of his accounts are under $100 and outpatient accounts constitute over 85% (FY 1978) of the free care patients, the outpatient accounts manager effectively controls the majority of the total number of applications.

[11] One other possible explanation is that the outpatient accounts manager is becoming more lenient than in the past, which certain interviewees indicated.

in terms of the dollar amount of care given out the FCC has probably had a more significant impact since inpatient accounts are much larger (in FY 1978, the average inpatient bill receiving some kind of free care was $1,652, while the outpatient bill was $43).

The Summary Statistics

Table 2 summarizes the hospital outputs regarding compliance with the Hill-Burton regulations. The total amount of free care given (both in terms of dollars and patients), the number of applications denied, the average amount of free care received, and the amount of free care awarded by quarter are displayed for FY 1977 and FY 1978. This data (with all of its problems) indicates numerous trends:

1) The amount of free care awarded annually is increasing (even accounting for inflation of around 7%).
2) The number of applicants applying and being accepted for free care is increasing. This is almost exclusively due to the increase in outpatient visits, previously mentioned.
3) The number of individuals receiving reduced cost care is decreasing. This is probably, again, due to the number outpatient visits, which do not receive reduced cost care, generally because the size of the bill is small.
4) The number of prior determinations of eligibility is decreasing.
5) The average amount of assistance is decreasing due to the dramatic increase in outpatient visits and the reduction in the average size of the bill. The average inpatient assistance also decreased during this period.

TABLE 2. SUMMARY STATISTICS ON THE PROVISION OF FREE CARE, Fiscal Years 1977 and 1978[1]

	Fiscal 1977	Fiscal 1978[2]
Applications for Free Care		
Total received	544	2,143
Accepted	462 (85%)	1,997 (93%)
Free care	432	1,977
Reduced cost	30	20
Denied	82 (15%)	146 (7%)
Prior determination made		
Inpatient	23 (12%)	24 (11%)
Outpatient	90 (32%)	177 (10%)
Number of Patients		
Total number	476	1,997
Inpatient	198 (42%)	228 (11%)
Free care	163	208
Reduced cost	35	20
Outpatient	278 (58%)	1,769 (89%)
Free care	278	1,769
Reduced cost	0	0
Total Dollar Amount Provided	$394,728.04	$453,372.
Inpatient	342,180.00 (87%)	376,733. (83%)
12.1[3] Free care	299.852.56	331,525.
Reduced cost	13,581.58	15,069.
12.2 Free care	0.00	0.
Reduced cost	28,745.89	30,139.
Outpatient	52,548.94 (13%)	76,639. (17%)
12.1 Free care	52,548.94	76,639.
Reduced cost	0.00	0.
12.2 Free care	0.00	0.
Reduced cost	0.00	0.

[1] Figures are compiled from the annual compliance report filed by the hospital.

[2] For comparison with Fiscal Year 1977, charges (not costs) are used.

[3] 12.1 clause refers to care provided to individuals with income under $5,000. 12.2 clause refers to individuals who earn over $5,000.

TABLE 2. SUMMARY STATISTICS ON THE PROVISION OF FREE CARE, continued.

	Fiscal 1977	Fiscal 1978
Average Amount of Assistance		
Total average	$ 829.	$ 227.
Inpatient average	1,728.	1,652.
Free care	1,840.	1,594.
Reduced cost	1,209.	2,260.
Outpatient average	189.	43.
Amount of Care Given Out, by Quarter (% of the Annual Total)		
Dollar Amount		
1st Quarter	12%	28%
2nd Quarter	16	10
3rd Quarter	34	29
4th Quarter	38	33
Number of Patients		
1st Quarter	11	27
2nd Quarter	19	27
3rd Quarter	34	23
4th Quarter	35	23

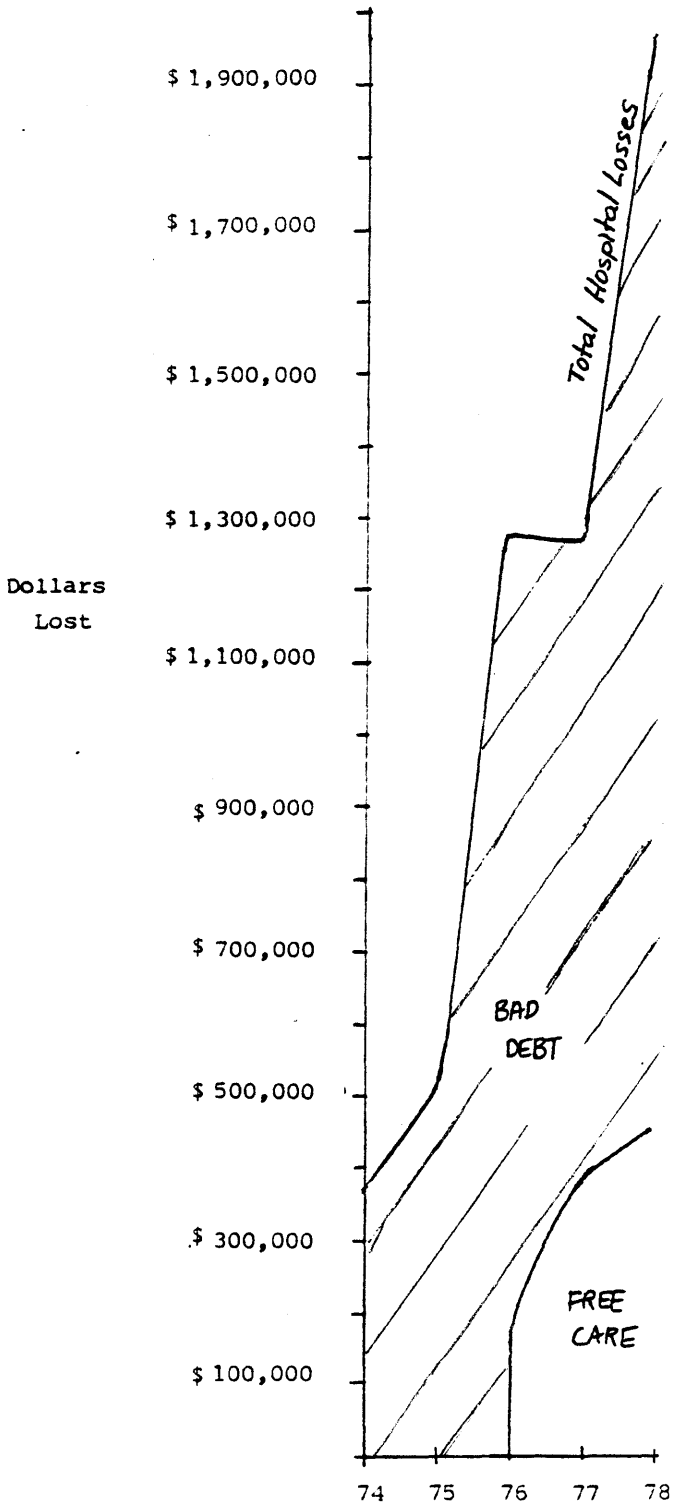
6) The hypothesis that the amount of free care (either in terms of the number of individuals receiving free care or in the dollar amounts) declines in the later half of the year, due to pressure mounting on the FCC to keep the amount low and the knowledge of how much care has been given out already for the fiscal year, is rejected. The quarterly figures do not support this reasoning.

7) It appears that the FCC adheres to its policy about reducing the cost of care to individuals over income. That is, over income individuals do not receive free care but rather have their bill reduced by that amount by which they are over income. This presumes that any amount of "excess" income is available to go towards the hospital bill.

Impact of Free Care on Hospital Losses

Figure 5 displays the amount of bad debt and free care for 1974-1978, and provokes only one comment: while it is true that free care is increasing, this cannot be used to explain the enormous increases in the bad debts. The chief administrator has implicitly told the hospital staff that the growth in the bad debt is attributable to the increasing amount of free care given out. The statistics do not support this accusation--the hospital losses are rising too fast to be solely due to the provision of free care. It may be that although the chief administrator knows this, it is one of the few leverage points he has without interfering with the medical staff or the board of directors.

Figure 5. Hospital Losses 1974-1978



Impact on Accessibility

By law, the hospital cannot refuse admission to any individual on the basis of race, creed, color, third party payor, ability to pay.[12] This requirement appears to be carefully observed by the hospital, except for elective admissions (when the hospital may require a deposit if insurance coverage is not evident). In theory, the Hill-Burton was to improve access to hospitals. However, it appears that the experience has not significantly increased accessibility. The social workers mentioned that the availability of free care did ease the burdens of many patients and induce a few individuals to receive care who otherwise would have been too proud to have come to the hospital. Given the public's ignorance about Hill-Burton, the individuals who were actually induced to receive care must be limited. In addition, the number of preadmission determinations of eligibility (10% each for inpatient and outpatient visits which received free care) is small, inferring that those who came to the hospital generally would have come regardless of the financial circumstances.

For acute admissions I would conclude that care is no more accessible than before Hill-Burton, although it eases financial burdens and for this reason is very important. The experience for outpatient visits is significantly different, however. The number of outpatient visits receiving care is rapidly increasing, particularly due to the expansion of the outpatient clinics. These two departments are known to the financial administrators as "losers" and actually were advertised in The Real Paper as "bargains." The outpatient accounts manager is certain that word is getting around that this hospital will provide free care and that

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[12] This is specified in the Community Service requirement of the Hill-Burton Act.

they are receiving patients who come specifically for this reason. In terms of numbers of patients this care is probably becoming more accessible due to the large number of outpatient visits which receive free care (over 1,700 per year). As in the past, the emergency or acute patient is admitted with relatively few questions asked, care is rendered, and the issue of financing comes up after the fact. This process has not been altered (except to hand out a free care application when insurance coverage is lacking) and therefore cannot claim to be more accessible.

CHAPTER THREE

THE IMPACT OF THE REGULATION ON THE HOSPITAL

The previous chapter described the application process for free care, the eligibility criteria, and the decision-making process. This process was then analyzed in terms of the timing required for the approval of care, its failures to improve accessibility, and the discretion and leniency of the criteria and the Free Care Committee. Finally, the outcomes of the process were outlined, i.e. what kinds of decisions were actually made and how did these affect the financial status of the hospital and the accessibility of both inpatient and outpatient care.

The outcomes described in Chapter Two do not fully explain the effects which the regulation has had on the hospital. The regulation has affected many of the hospital staff and their jobs. This chapter takes the analysis of the regulation one step further to focus on the impacts of the regulation on the organization. Before the regulation, there were hospital staff doing their respective jobs, responding to various incentives. How did the regulation change the jobs and the incentive systems at work? In analyzing the effects on the organization, the long-term impacts and success of the regulation can be fully evaluated.

The organization of this chapter follows its logical argument. The first section describes the informal goals of the actors in the free care decision-making process. These goals circumscribe the major concerns of the various actors and help to explain the impacts of the regulation on them, also outlined. However, these goals only go so far in explaining the unexpected behavior of the Free Care Committee. Two

elements are useful in completing the explanation: 1) the incentives which the various actors respond to; and 2) the organizational norms of the FCC. Finally, due to the numerous goals in operation, the incentive systems, and the norms of the FCC, the Hill-Burton regulation has had unintended consequences. These consequences are analyzed as to whether they are functional or dysfunctional according to the original objectives of the regulation. In the end, we will see that the sub-organizational goals and needs are very powerful and can, in fact, have goals which diverge from those of the main organization. Therefore, in order to ensure maximum effectiveness at the policy level, it may be necessary to translate these sub-organizational goals into incentives to modify their behavior and thereby change the overall organizational responses to the imposed regulation.

The Goals of the Major Actors in the Free Care Process

The key actors in the free care process each have their own set of goals and purposes which delineate the actions that they can and will take. In this sense, many actions and decisions are predictable and are limited in their scope. Below, the goals of the major actors in the decision-making process for free care are summarized. These goals were surmised from the numerous interviews I conducted.

Patient Accounts and Fiscal Officers. Their sole purpose is to ensure the financial viability of the hospital and to minimize losses. This may induce the accountants to minimize the amount of free care given out and increase bad debts due to the higher reimbursement rate for bad debts. Ideally, the patient accountants want to have complete information about any account because uncertainty is very costly. This

preference for settled accounts may counteract the financial preference for bad debts, since establishing which accounts will receive free care reduces the uncertainty and its related costs.

Social Services. Their primary objective is to provide high quality social services in the form of eligibility for government programs, continued care, and provision of free care. They also try to ensure that all eligibles apply for free care and that all legitimate applicants receive free care.

Administration. The main goal of the Chief Executive Officer is the perpetuation of the hospital and its reputation. This necessitates a constant concern for hospital losses which threaten the fiscal integrity of the budget. Therefore, he would prefer providing a minimally acceptable amount of free care and limit the risk of his institution. In many ways, his perspective is probably the most utilitarian in that he sees managing the hospital as many business people see running businesses, given the distinct characteristics of hospitals. Knowing about last year's deficit, he tries to pressure those who make decisions about free care to minimize their awards.

The Physicians. The doctors have one chief purpose--to provide the best medical care they can, irregardless of cost. This position is supported by their profession and efforts to instill a sense of cost consciousness are slow to have a noticeable impact on the physician's behavior. Thus, the doctors are generally unconcerned about the financial aspects of the delivery of care. Indeed, most physicians are ignorant of how the hospital care delivered to indigents is paid for.

The Board of Trustees. The greatest concern of the Board is the permanence and viability of the institution and this directly translates

into fiscal responsibility. Given the small (miniscule) impact of free care on the hospital budget, their interest in negligible.

Thus, there are two major goals in opposition, each with its own support. On the one hand, fiscal responsibility is central to the values and roles of the patient accounts managers, the fiscal officers, the administration, and the Board of Trustees. On the other hand, the physicians and social service workers are primarily concerned with providing quality care. Given this brief outline of the general goals of the key actors, let us now turn to the actual impacts of the regulation.

Impacts of the Regulation on the Key Actors

How were the vaious actors in the free care process affected by the provision of uncompensated services? To what extent did their goals shape the actions that each actor took? Several actors are analyzed in this section to explain the actions taken and the outcomes of the free care application process.

The Admitting Desk. The provision of free care has probably had the most significant impact on the workers at the admitting desk, at least in altering their daily routine. The desk is now required to complete the cover sheet of the medical record, check for insurance coverage, and if there is none, it is instructed to hand out free care applications. Depending on the time of day, the interviewer at the admitting desk may help the patient fill out the form, answer any questions or explain the application process. The consistency with which this is done is questionable, particularly given the large number of applicants who slip through the process. The admitting desk is a crucial source of information about the free care program; it is probably the most important poten-

tial contact for an ignorant patient. This responsibility has forced the admitting desk to ask more questions of admitted patients and to be more aware of the financial arrangements of the admissions. Given the historical predisposition of the hospital to serving a middle class population and not to inquire about such issues, this is a major change in their orientation.

The Social Service Workers. With the implementation of free care services, the social services workers have had much more work to do besides planning for discharges and continuing care. The delivery of free care has increased patient contacts and diversified the types of patients which the social service department handles. This new type of patient (simply poor, not chronically ill or elderly) may give the workers a different sense of reward since their work efforts have immediate and final payoffs--sick people are treated, get discharged, and yet do not incur financial burdens.

In addition, the free care program has expanded the responsibilities of social service workers to include working with many different groups. The department not only identifies and processes free care applicants, but it also investigates alternative government program options for which the applicant may be eligible. This role as a liaison between the hospital and outside agencies increases their contacts and knowledge about outside reousrces and issues. By increasing the social services provided, improving the worker's knowledge, and locating alternative funding (thereby saving the hospital money), the worker has many more opportunities for self-satisfaction. The social service department also has an increased responsibility at the Free Care Committee meetings for presenting cases which they are working on. This responsibility

gives them considerable power in affecting the outcome of the FCC decision. Last, the workers often negotiate the reduction or elimination of doctor bills with physicians. These responsibilities, while offering many opportunities for significant benefits, also impose some costs to the workers. For example, contacting a physician about the reduction of a patient bill may not be rewarding in itself, but does improve the workers' access to the physician in other contexts, and therefore can be beneficial.

The Patient Accounts Managers. The workload of the patient accounts managers has increased substantially with the provision of free care; the equivalent of two full-time people are required to administer the program. But this work does not go unrewarded. The patient accounts managers present all cases to the FCC, except those currently being worked on by social services for alternative funding, and can heavily influence the FCC decisions with their impressions. The job also is very rewarding in the personal satisfaction gained by helping indigents. This process has made the accounts managers much more sympathetic to indigents and more patient oriented. In addition, it has made them more aware of the multi-faceted aspects of health care delivery problems, an outcome that is particularly valuable for fiscal officers whose training probably did not emphasize this approach. At the same time, however, the accounts managers have become collectively more skeptical of two actors in this process: physicians and the government. Some accounts managers did not appreciate the entrepreneurial nature of medical practice until they had to address the social problems created by large physician fees. Similarly, intimate knowledge of a federal regulatory program 1) made them doubt the government's ability to implement any program fairly, 2) created resentment about the state's change in the rules of the program after the

fact, and 3) disapproved of the state's cutbacks in government program benefits which directly increase their role as a welfare provider.[1]

The Physicians. The impact on physicians is more difficult to assess because physicians fall into two categories--those who have heard about free care and those who have not. Although the chief administrator has sent around a memo to the physicians informing them about the availability of free care, many physicians do not know of its existence. This significantly affects the medical staff's ability to serve as a source of information for potentially eligible patients. Despite the overal ignorance about the free care program, the regulation has had two indirect effects on changing physician attitudes. First, the overall consciousness about medical costs is increasing, in part due to the contact of the social workers with physicians about reducing the cost of the doctor fees. Often times the physicians will not have realized the total cost of the treatment. Whether this awareness gets translated into modified physician behavior is open to debate. Second, treating indigents with no compensation can, and has, created a backlash of physicians who refuse to treat any patients who cannot pay cash. In addition, these physicians have self selected themselves out of emergency room duty to eliminate their chances of having to take indigents, thereby reducing the number of physicians on call to serve in emergencies.

One physician told me that he knew a fellow doctor was telling his patients to come specifically to Prescott Hospital because of the free care policies. He felt this was taking advantage of the hospital. I am not sure how this "takes advantage" of the hospital if the patients were

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[1] For example, the cutback in Medicaid 04 General Relief in 1975.

truly medically indigent. This seems to be an indication of how well the hospital is doing its job relative to other facilities.

At a more theoretical and long term level, the availability of free care could reduce the power of the physicians by having their practice scrutinized by Quality Assurance or the FCC for patients who are receiving free care. Although presently ineffective, this surveillance could create pressure to ensure the provision of cost-effective hospital services. Moreover, the FCC can and sometimes does question "medically necessary" or the appropriateness of certain procedures and length of stay. For the present, however, because 1) many patients have not applied for free care before they are discharged, and 2) most physicians are unaware of the availability of free care, it is difficult for the regulation to affect the behavior of physicians.

In addition to these two constraints on affecting physician behavior, there is an overriding professional bias against using economic rationales to determine medical decisions. In general, physicians' primary concern, as professionally prescribed and constantly reinforced, is quality medicine, not cost-effective practice. This attitude is slowly changing as the younger physicians are slightly more aware of issues of cost. To underscore the difficulty of influencing physicians to provide cost-effective care, it is worth noting that the chief of medicine will not speak out on the issue of providing free or reduced cost care--this would be interfering with the physicians' practices. Such notions of independence and professionalism are very strong and severly limit the impact that any free care regulations might have on physician behavior.

The Chief Executive Officer (CEO). Absolutely no visions of "charity" or "community service" are conjured up with the mention of

free care to the CEO, only skepticism and resentment. The CEO is very skeptical about government's ability to implement fair and reasonable programs, and this is only worsened by his experience with Hill-Burton. He resents having the terms of a loan changed midway through the payback period and this lack of trust seems to pervade this impressions about any government regulation.

The delivery of free care has also threatened his most important goal--the financial security of his institution. He has let his growing concern be known at general staff meetings and has implied that much of the loss is attributable to the provision of free care. Realistically, to harp on free care would be inappropriate given the amount provided versus the size of the bad debts. However, it may be one of his few points where he feels he has any control and tries to use this to its fullest extent. Although when examining his influence in trying to reduce hospital losses, statistics do not indicate much success.[2] This lack of effectiveness may serve to emphasize his vulnerability and lack of control over the dominant forces shaping the financial picture of his institution.

The Board of Trustees. Much to my surprise, the Board is only minimally affected or interested in the provision of free care. Apparently, this board is not very community oriented. Thus, the Board does not choose to advertise its goodwill to the community and does not play up its public relations. (It probably does not have to sell "charity," just good health care.) Therefore, free care is of minimal interest to the Board since it constitutes only a minor fraction of the annual budget

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[2] See Figure 5. The amounts of free care and bad debts are both increasing.

(about 1%). The board members I interviewed thought the amount was "trivial" and probably should be larger. They also felt that they should spend their time worrying about the real money losers and sources of loss. This disinterest is reflected in the fact that this topic came up maybe twice last year and was never discussed separately but under the heading of "uncollectables." The only other effect that free care may have had is that the Board quietly appreciates the relatively nearby urban hospital which acts as a buffer for this hospital--they know that without this other institution demand for free care at their hospital would be several times greater.

The Free Care Committee Members. The Hill-Burton has affected the members of the FCC in several ways. The provision of free care and the FCC meetings have improved the individuals' senses of accomplishment and productivity. This has spillovers into other, unrelated working relationships with the member departments and has improved their ability to communicate and get other jobs done--"it greases the wheels," someone said. In addition, by having members from a cross-section of departments, the FCC meetings often digress into a forum for discussion of general health care issues and greatly improves communication with other departments. Lastly, the provision of free care improves the hospital's accountability (it has a better sense of where its losses are) and allows the hospital to take some credit for the public services that it does provide in the form of free care.

Given the prevailing cost consciousness of the administration, it is surprising that the FCC has developed such lenient (and patient-oriented) policies and can derive such satisfaction from administering this regulation. While the goals of the various actors help in explaining

some of their actions, they do not capture all of the dynamics. What is missing from this explanation is an analysis of the incentive systems to which the various actors respond. In addition, if the committee members come from various departments each with their own set of goals, how is it that the FCC can overlook many fundamental differences and operate in such a productive and consensual way? The examination of these two issues is important in understanding how free care actually gets decided and the way in which the regulation has affected the inner workings of the organization.

Incentives

The two basic incentives which aid in explaining the behavior of the actors involved in free care decision-making include solidary and purposive incentives.[3] These incentives result in a high degree of cohesion between certain groups within the organization, whose goals are otherwise incompatible. Solidary incentives are intangible rewards derived from associating with the other members involved, such as socializing, sense of group membership, and identification. This status is achieved regardless of the precise ends of the association. For example, several members of the Free Care Committee talked to me about how much they enjoyed the meetings themselves--they were "fun" and the "best committee in the hospital." Indeed, their meeting reflected this in the socializing beforehand, the story-telling, and the general sense of comraderie. It was clear that the members, regardless of their beliefs in the purpose of the committee, enjoyed the association.

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[3] This section is based on the categorization outlined in Peter B. Clark and James Q. Wilson, "Incentive Systems: A Theory of Organizations," Administrative Science Quarterly, Vol. 6, September 1961, pp. 129-166.

The other relevant incentives are purposive. These are intangible incentives which are related to the stated ends of the association. The members of the committee do not personally benefit from their actions but are induced to expend their personal energies because they believe in the function they are performing--it is a good and worthy cause. All of the committee members interviewed mentioned how satisfying the FCC meetings were for this reason. In fact, to underline their sense of purpose, "thank you" letters from individuals having received free care are read aloud at meetings. This and other forms of acknowledgements occur frequently.

The self-satisfaction and sense of success that the committee members feel are explained by the solidary and purposive incentives provided by the committee. Although not formally acknowledged by any group (either within the hospital or in the community) or rewarded materially, these two incentives are strong and promote a sense of commitment to providing free care in the best possible manner. In addition, for members of the committee who do not have much patient contact, the relationships with patients provided through committee work are valued. Perhaps, upon coming to the hospital certain workers may have been slightly disappointed with the utilitarian aspects of the hospital (which, in many ways, is run like a business) and the FCC may be an important vehicle for them to feel like they are doing something which has broader social implications than, say, the perpetuation of the institution. In Schein's terms, it may be a re-establishment of a psychological contract that may have been violated with the ordinary tasks of their job.[4]

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[4] Edgar H. Schein, Organizational Psychology (Englewood Cliffs: Prentice-Hall, 1965), p. 45.

The Free Care Committee as an Organization

One question still unanswered is how the FCC can work successfully, given that all of its members have both personal and departmental goals which conflict. The most probably explanation is that the FCC acts as its own organization complete with its own set of policies, operating procedures, and expected behavior. Rules and expectations delineate authority and decision-making. These operating procedures enhance clarity and continuity, and minimize the personal and material consequences.[5] As we have already noted, the rules and decision-making are not unambiguous or predictable as they may seem, but part of this is due to the type of decisions which are being made (each with its own set of circumstances) and the hospital environment.[6]

As an organization, the FCC has devised its own set of rules (the policies, eligibility criteria, and their procedures) with which to handle the weekly applications. Since it has been in operation for about three years, it has its own past decisions and policies which prescribe much of its current activities and decisions. Through the development and adoption of its norms and policies, its members generally leave behind their "home" departments' perspectives and mold to the accepted and ex-

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[5] The FCC exhibits many qualities of a bureaucracy. These characteristics are discussed in H. H. Gerth and C. Wright Mills, From Max Weber: Essays in Sociology (New York: Oxford University Press, 1946).

[6] Important elements of the hospital environment include the undefined nature of the products, lack of clear lines of authority, formally organized yet requiring considerable flexibility, and a unique combination of autonomy and coordination of highly specialized care. For a complete discussion see Basil S. Georgopoulos and Floyd C. Mann, "Hospitals as an Organization" in Jonathan S. Rakich and Kurt Darr, eds., Hospital Organization and Management (New York: Spectrum Publications, 1978).

pected behavior of the FCC. For example, in reviewing an application the case presenter may begin to tell about the interview or personal contact with the individual. Such anecdotal information is expected and enjoyed, and in fact a certain amount of joking around is acceptable. However, at some implicitly agreed upon limit, the joking and story-telling halts and the case is invariably brought to the established criteria and guidelines. Past decisions and behavior act as checks for consistency and acceptability of decision-making.

Further support for the existence of FCC standards and norms of behavior was uncovered when I asked about block voting. I had hypothesized that committee members from the same department would tend to vote together in conformance with their department perspective. All members I interviewed rejected this reasoning and meetings I attended did not reveal any distinct patterns in voting. In fact, quite often two members from the same department would take opposite views on a case only to be reconciled with a compromise solution or the reaffirmation of a piece of decisive information. These indicate that the FCC has developed into an organization unto itself and accountable essentially only to itself.

These organizational tendencies are reinforced by the lack of supervision from outside or higher up influences. The CEO and the Board do not have any direct control over free care decisions (except the Board which must approve their policies) and basically have delegated the total responsibility for providing free care to the Free Care Committee. Nominally the FCC is accountable to the Chief Fiscal Officer but he does not review its work. Thus, not only does the FCC act as an organization with its own accepted standards of behavior but its formal authority has it quite insulated from outside influences.

In summary, although not formally investigated, there is probably widespread agreement among the hospital administration as to the general goals of the hospital and the delivery of free care. For example, everyone on the staff would agree that patients should not be denied admission or receive inferior medical care because of an inability to pay the hospital bill. Similarly, the hospital should provide "quality medicine," serve the community, and advance medical knowledge.

Beyond the ambiguities of the general goals there seems to be considerable disagreement and uncertainty surrounding the numerous sub-organizational goals. As pointed out, these sub-unit goals often do not necessarily coincide with the general goals and, in fact, become the primary goals of each sub-unit. That is, each group in performing its purpose has its own functional requirements that it must meet before the overall goals of the organization can be met.[7] Each department plays a role in the total operation of the hospital but it has its own needs and goals to be met first before it can meet the higher level goals of the hospital. The hospital, in its delivery of free care must be seen as a social system, shaped by the numerous sub-organizational goals and purposes which, as they interact, force adjustments to be made and determine the final form of the hospital organization.

Functional and Dysfunctional Consequences of the Regulation

The Hill-Burton regulation has had many unintended consequences due to the various departmental goals, the incentive systems, and the norms of the FCC. The fulfillment of some of the department goals will be achieved

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[7] For a discussion of functionalism see Nicos Mouzelis, Organization and Bureaucracy (Chicago: Aldine Publishing, 1969).

to the detriment of the overall goal of providing free care. When such a function of a part hinders the goals of the whole, it is known as a dysfunctional consequence. Note that a single action may be viewed as functional by one group and dysfunctional by another. For example, the provision of free care is dysfunctional for the CEO and the fiscal accountant who are trying to meet their primary goals of financial viability and minimizing hospital losses. Yet the same provision of care is seen by the social services, the community, and the recipients of the care as functional since it serves their primary goals.

Other functional consequences ("functional" from my perspective or in relation to the objectives of the regulation) of the regulation include:

- the admitting desk is more careful about completing its admitting forms;
- the hospital has a better knowledge of its losses;
- the hospital has saved some money by hiring governmental program coordinators to check applicants' eligibility for other programs;
- improved patient contact for patient accounts managers;
- the FCC members have a deeper understanding of health care issues and a forum for their discussion;
- the FCC has improved the working relations with the departments represented;
- some physicians have a better knowledge of the costs of hospital care;
- the hospital has contacts with several governmental agencies;
- physicians' power in the long run decreases if their practices are increasingly scrutinized.

However, these functional aspects have not been without accompanying dysfunctions. These are less numerous and probably are outweighed by their beneficial counterparts. They include:

- increased skepticism and distrust of the government;
- increased resentment towards the government;
- doctors can look more concerned with profits than with health;
- doctors may grow impatient with free care and not serve indigents at all, but only those patients who can pay cash, and may take themselves out of serving in the emergency room;
- the availability of free care at this hospital may have distributional effects on other hospitals in the area.

Most of these effects were unanticipated--all except those specific to providing free care, and many may be latent, in that the hospital administrator or the regulator may not have realized these impacts.

CHAPTER FOUR

CONCLUSION

Having outlined the application process in detail, analyzed its outcomes, and described the effects of the regulation on the organization, I would like to make some concluding remarks about the success of this policy at Prescott Hospital. As previously stated, certain aspects of the Hill-Burton Act were very successful. For example, it increased the supply of uncompensated services, improved interdepartmental communication, and saved the hospital thousands of dollars by transfering patients to other governmental programs. The first section of this chapter analyzes the characteristics of the implementation which made the delivery of free care successful.

The second section highlights those characteristics which have contributed to the regulation not being totally successful. Although the program may be deemed successful relative to other hospitals' experiences or to what existed before at Prescott, it failed in one important respect: it did not improve significantly the accessibility of health care to poor people. Although the financial burdens for those individuals receiving free care or reduced cost care have been relieved, the regulation has not induced indigents, who otherwise would go untreated, to receive medical care. The second section of this chapter investigates what elements of the regulation, as implemented, have inhibited the achievement of this objective. The chapter concludes with three suggestions for improving the regulation: 1) increase accessibility of hospital care; 2) ensure fairness of the decisions and policies; and 3) simultaneously meet the goals of cost reduction. Several of these suggestions

came from the staff interviewed and are their views of where the system can be "tightened up." Others represent my outside perspective on where the provision of uncompensated services can be improved. Finally, alternative ways of achieving the same objectives of the regulation are discussed. If one of the goals of the Hill-Burton Act is to provide uncompensated services to indigents, there may well be better approaches for achieving redistribution.

What Makes the Regulation Successful?

The most important factor in making this regulation successful at Prescott is the institution of the Free Care Committee. Because the membership is structured to be diverse, the decisions it makes and policies it sets are more patient-oriented and responsive to individual circumstances than in other hospitals. In addition, since it has been in operation for almost three years, it has developed its own bureaucratic characteristics through the past decisions it has made. The FCC is an unusual innovation which has served the patients and social workers well. The outcomes of such a committee are very different (and much more lenient) than if a single fiscal administrator were making decisions about applicants. In the present process, many factors are considered in each final decision made, not simply its impact on hospital losses.

The establishment of the FCC has been directly or indirectly responsible for 1) the development of more lenient guidelines than those minimally required by law, 2) the improved communication between departments within the hospital and between the hospital and outside governmental agencies, and 3) the use of unofficial decisions which significantly improve the situations for many individuals (for example, deferred pay-

ments, reduction of the physician bill).

What Factors Inhibit the Regulation's Success?

The most important reason why the regulation has not been totally successful is that it does not specify exactly how the regulation will be implemented. In providing this flexibility, the regulators have accepted a continuum of outcomes which will be "successful" to varying degrees. For example, a hospital under one option may have to provide $700,000 worth of uncompensated services, while another hospital may operate under the open door option and give out $40,000. Both may be in compliance yet the amounts of service provided vary considerably. By giving the hospitals a choice of compliance options, the regulation allows the hospitals to select the cheapest option, not necessarily the most beneficial one.

Another source of failure is the regulation itself. Any required dollar amount immediately becomes a minimum and will not be exceeded. In addition, a dollar figure is no measure of the distribution of the uncompensated services or of service accessibility. The regulation does not specifically address these two critical issues and consequently fails with respect to them.

A third problem is that the regulation does not require the State Office to evaluate facilities on the basis of accessbility or distribution of benefits. Therefore, the Office does not place much importance on these considerations. Moreover, the funding available for monitoring facility compliance is minimal if at all existent. The State Office is limited in terms of its personnel, expertise, and funds to be able to carry out an effective enforcement and monitoring program.

In addition to the unsupportive environment for the State Office

to enforce the regulation, there is a similar discouraging atmosphere within the hospital. Both the administration and the physicians in general are not enthusiastic about the provision of free care, although for very different reasons. On the one hand the administration is cost conscious and has difficulty in seeing beyond the dollars lost in the process. Most physicians, on the other hand, are ignorant about the availability of free care and therefore are limited in their ability to improve accessibility. Consequently, the two most powerful and visible groups, the administration and the medical staff, do not encourage improving the availability and accessibility of free care. Given the ineffective enforcement by the State and the lack of commitment by the hospital, it is little wonder that the regulation is not as successful as it could be.

Improvements

The improvements suggested by the hospital and myself center on three issues: 1) improving accessibility; 2) improving the decisions made; and 3) decreasing the overall operating costs for the hospital at the same time as meeting the uncompensated services requirement.

Improving Accessibility. More patients will learn about the availability of free care if it were posted on all hospital bills. While such a notice is presently required for emergency accounts, it is not observed by the hospitals or enforced by the State. Another tactic could be to make the notice in the paper more visible and more comprehendable. The State Office could draw up standard formats for the hospitals to use. Similar formats could also be used for the posted signs within the hospital. Prescott recently changed its signs to ones that

are comprehendable but individuals still have to track down what the eligibility requirements are, since they are not included in the sign (see Appendix B). This information barrier may easily deter eligible people from applying. Another way to improve awareness is to include information on free care in the admissions package given to all inpatients. It could simply state the availability of free care, the eligibility requirements, and outline the application process. It is also advised that this section highlight the limitations of many insurance policies and state that free care can be awarded to cover the difference between coverage and the actual hospital bill.

A different approach focuses its efforts on the awareness of the physicians, who could, but presently do not, play an important role in the dissemination of information. Physicians could be informed at a general medical staff meeting of the entire free care process. This would dispel the myth that some physicians have that the hospital has to "use up" a certain minimum volume of free care after which the hospital has no obligations. In addition, the physicians could be encouraged to use the social services. Since the social service workers are more aware of free care, this could increase accessibility.

Improving the Decisions Made. Putting a physician on the FCC would also improve the quality of the decisions that it made. That is, the decisions would be more "fair" or appropriate (say in terms of the medical necessity of a procedure for an individual). The physician, at times, would assume the role of an advocate for the patient, making the care more accessible. At other times, the physician would give the FCC the credibility it needs in some situations.

Decreasing Unnecessary Hospital Costs. Although this is not a

goal of the Hill-Burton Act, there are a couple of suggestions which could improve the efficiency of the administration of the uncompensated services requirement. First, the hospital could develop a better screening process to check the validity of the application. This could be done in two ways. The hospital could buy the available computer linkages with Blue Cross in order to immediately obtain the status of the alleged policy holders. In addition, the patient accounts managers or social service workers could attempt to verify the information on the application. The easiest items to check are the person's address (to ensure that the applicant meets the residency requirement) and the present employment. While obviously not thorough, these two checks would help to weed out "chistlers" of the system and could significantly reduce costly administrative inefficiencies. Second, the FCC could make it its policy to send a copy of the hospital bill for each free care patient to the attending physician. This would increase physician awareness about the total costs of hospital care and may, in the long run, affect their behavior. If lag time was reduced and more admissions were monitored, the costs could be reduced.

Improvements at the State Office. Most of the previously mentioned suggestions center on improvements the hospital could make. As already noted, the State Office does a poor job of monitoring compliance and essentially relies on the honesty of the facility report and complaints to police the regulation. One suggestion was for the State to improve its enforcement and monitoring functions by having specific funds allocated for these purposes. In addition, the State could hire an accountant so that it could be capable of monitoring compliance reports. More personnel would also allow them to do more than process complaints, and to be more

aggressive in its monitoring efforts. Another tactic the State could take would be to change what it monitored from only checking outcome measures to including process measures. This would enable the State to learn much more about developing effective policies by studying how organizations implement and adapt to regulations.[1] Investigations into the processes within hospitals could yield useful information about possible regulations regarding implementation. In addition, analyzing processes would allow the State to do much more meaningful evaluations. For example, last year in reviewing Prescott Hospital the State Office discovered that the hospital signs were not translated into Armenian. The State Office immediately attacked the hospital and spent considerable time haggling over the sign's text and translation. Yet, if the State Office had investigated the process of free care at Prescott, it would have realized that despite superficial appearances (a lack of proper signs), in fact the hospital was meeting the intent of the law. Rather than expend limited resources on this case, the State Office should have been investigating one of the other hospitals where the objectives of the regulation are clearly and consistently not met. It is important to note that while process evaluations would yield more complete information about a hospital's compliance, it would also increase the State's discretion to determine what constituted compliance.

In conclusion, it is recommended that the regulations be kept general, emphasizing their intent rather than the details of implementation. This flexibility allows the facility to adopt procedures which best suit its circumstances. What has made the regulation successful at

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[1] For a clear description of how government agencies can develop learning capacities see Donald Schon, Beyond the Stable State (New York: Random House, 1971).

this hospital is precisely this independence. The FCC is successful because it wants to do a good job, the incentives at work being purposive and solidary ones. Increased supervision and detailed implementation guidelines would destroy the most effective monitoring devices the regulation currently has: conscientious workers. Moreover, the flexible approach minimizes the negative and dysfunctional consequences of the regulation.

Summary

Based on the experience at Prescott, it would seem that benefits from the flexibility and independence of the Free Care Committee outweigh the negative aspects. Therefore, changes to improve the regulation should center on other aspects such as the State's lack of enforcement or monitoring efforts. An easily administered change would be to have hospital bills have a notice about the availability of free care. This would significantly improve awareness and therefore accessibility. The Committee should also include a physician to increase its visibility and credibility. In addition, the State should begin to enforce non-compliance and utilize the sanctions at its disposal. Otherwise, these tools lose their effectiveness because they are not taken seriously. The establishment of a committee to make policies and process applications has been effective at this hospital and should be instituted at other hospitals to investigate the degree to which this can be generalized. The effectiveness of this innovation may be applicable to other facilities and enhance the accessibility of medical care to indigents who are not covered by other government programs.

The Distribution of Costs within the Health Care System

The question of the distribution of costs often came up in discussions with various hospital staff. All of the staff recognized the importance of cross-subsidization of care by insurance policy holders to non-policy holders. For example, no one seemed surprised that Blue Cross reimburses the hospital's bad debt at 30%--such redistribution is expected. Yet many members commented that it did not seem fair that Prescott was singled out as having an increased obligation to treat indigents because of some loan it had taken out years ago. This criticism is well taken--if the point of the regulation is to make medical care accessible to indigents then there is no rationale for singling out specific institutions. Rather, all facilities should contribute towards achieving this goal and the costs of treating indigents should be distributed evenly. Given that the principle objective of the uncompensated services requirement is to assure care to indigents, there are more equitable ways to achieve this goal.

Although it is beyond the scope of this paper to evaluate the alternative forms of redistribution, let me briefly outline the form which an analysis might take. The government presently uses many mechanisms to redistribute income and provide services to indigents, including vouchers, taxes, direct cash payments, cross-subsidization through reimbursement, and government-financed clinics. None of these alternatives were considered by the government when it developed the community services requirement. However, any one of these mechanisms could be used to redistribute income and provide health services.

Each method has its own set of dysfunctional characteristics--government-run facilities would promote a dual class system of care,

voucher systems and subsidies often result in scandals, and direct cash payments cannot be targeted to have specific outcomes. The trick then is to devise a program which minimizes the dysfunctional consequences while still managing to be an effective method of redistribution. It may be that the present cross-subsidization should be expanded such that free care provided is reimbursed at a rate which does not penalize the provider. While this method would distribute costs more evenly, it does not address questions of persistent inaccessibility and regional imbalances.

A careful analysis of each alternative considering 1) the functional consequences, 2) the dysfunctional impacts, 3) the costs of implementation and administration, 4) technical problems, and 5) political considerations needs to be done before any recommendations can be made.

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Appendix B

IN COMPLIANCE WITH STATE AND FEDERAL REGULATIONS,
WILL GIVE A REASONABLE AMOUNT OF SERVICE AT NO COST OR LESS THAN FULL COST TO PATIENTS WHO MEET ELIGIBILITY REQUIREMENTS. GUIDELINES AND APPLICATION FORMS MAY BE OBTAINED AT THIS DESK. IF YOU THINK THAT YOU ARE ELIGIBLE, PLEASE CONTACT OUR PATIENT ACCOUNTS OFFICE AND ASK FOR ASSISTANCE.

IF YOU ARE NOT SATISFIED WITH RESULTS, YOU MAY APPEAL THE DECISION AND/OR CONTACT THE STATE HILL—BURTON OFFICE, DEPARTMENT OF PUBLIC HEALTH, 80 BOYLSTON STREET, 726-7623.

PATIENT ACCOUNTS OFFICE EXTENSIONS: IN-PATIENT 1607
OUT-PATIENT 1680

Appendix A

☐ In-Patient Date of Admission:

Note: Separate application necessary for each admission

☐ Outpatient Balance of Bill:

Application for Uncompensated Services as Provided Under G.L. Mass. Chapter 30A

Patient Name			Age	Street Address	
City	State	Zip Code	Phone	Occupation (even if not currently employed)	
Name of Person Responsible for Bill			Street Address	City	Phone
Dependents: Names, Relationship and Ages					

SOURCES OF INCOME

Name of Employer of Patient or Responsible Person			Address	If temporarily unemployed, anticipated date of employment:
City	State	Zip Code	Phone	Employment is: ☐ Part-Time ☐ Full-Time
How Long Employed			Income After Taxes: $ per week / month / year (Circle One)	
Any income / support from spouse, dependents, parents, etc.			Name of Person with income	Address
Relationship to Patient			Amount of income after taxes $ per week / month / year (Circle One)	

Misc. income from Rent, Pensions, Social Security, Veterans, Unemployment Compensation, Trust Funds, Welfare, etc.

Names or Sources: Amount: $ per week / month / year (Circle One)

PERSONAL ASSETS	AMOUNT
Checking Account	
Savings Account	
Stocks, Bonds, etc.	
Other	
Total	

Do you own any Real Estate other than the house in which you live? ☐ Yes ☐ No If yes, explain below.

Health Insurance: Name of Carrier:

Amount Paid (if individual contract):

INDEBTEDNESS	TO WHOM OWED	MO. PAYMENT	BALANCE
Rent or Mortgage			
Banks, etc.			
Charge Accounts			
Auto Loan			
Auto, Life, Health & Home Owners Insurance			
Medical Bills			
Other			

Only applications which are complete will be considered.

I certify under penalty of perjury that the information I have given is correct, true and complete.

Signature of Patient or Responsible Person _____ Date _____

Please note that this application for "Free Care" is for hospital charges only, we are unable to consider private physician/anesthesia charge.

If you have any questions, please call our Patient Accounts Office – Inpatient, ext. 1607 - Outpatient, ext. 1680.

For Hospital Use Only:

Recommended by: Date _____ Approved by: Date: _____

Hospital Financial No. Amount Approved:

Unit Record No. **Additional information can be supplied on reverse side.**

Form 447-D Rev. 9/78 MAH