Responsibility of the Board Member of Voluntary Health Agencies

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THE SPEAKER

IN A LONG and distinguished career, Marion Bayard Folsom has rendered outstanding service to his community, his state, the federal government, and the business organization (Eastman Kodak Company) of which he is a director. Mr. Folsom was Secretary of Health, Education, and Welfare in President Eisenhower's cabinet. He is chairman of the National Commission on Community Health Services; a member of the Federal Hospital Council; a director of the Rochester (New York) Council of Social Agencies, of the Rochester Community Chest, and of the Rochester Rehabilitation Center; chairman of the Patient Care Planning Council of Monroe County; and a director and chairman of the Planning Conference of the Rochester Regional Hospital Council. He was 1963 recipient of the Bronfman Prize, the nation's highest public health award. Mr. Folsom received an A.B. degree (with honors) from the University of Georgia and an M.B.A. (with distinction) from the Harvard Graduate School of Business Administration. He has been with the Eastman Kodak Company since 1914.

THE SERIES

The lecture series was established in the name of Dr. Michael M. Davis, medical care pioneer, by his friends and admirers. Dr. Davis opened the series in 1963 with an address entitled "America Challenges Medicine." Each year a distinguished authority is invited to address those interested in the improvement of medical services, to stimulate free and open discussion in a forum where medical care programs may be proposed, examined, and presented for public consideration.

THE OCCASION

Mr. Folsom delivered this talk at Billings Hospital, the University of Chicago, on May 14, 1964.

It is an unusual honor and a privilege to be invited to give the Michael M. Davis Lecture at this distinguished forum, and I consider it especially so in the first year following Dr. Davis' own initial presentation. For over a half-century Dr. Davis has made tremendous contributions to the science and art of medical administration. I am familiar with his words to you last year and am very much aware of the high precedent he set for those who follow him to the rostrum.

I wish to commend the University of Chicago's Graduate School of Business for sponsoring this lecture forum. The idea behind it is excellent indeed, and I am firmly convinced that much good will come of it.

I believe my subject today is a timely one, for hospitals and other voluntary health agencies have been important factors in the great progress made in health care in recent years, and they have added much to advances in medical science and practice.

Over 100,000 Agencies

Since World War II there has been a spectacular increase in the number of these voluntary agencies. Today, over 100,000 national, regional, and local health and welfare agencies, not including hospitals, solicit contributions from the general public—contributions which now amount to about two billion dollars a year. These voluntary agencies render invaluable service, and their combined effects, both direct and indirect, have been out of proportion to their expenditures.

Because of their rapid growth, a representative Ad Hoc Citizens Committee was brought together recently by the Rockefeller Foundation to study health and welfare organizations. After
commending these agencies for their services, the committee's report stated:

This remarkable growth could not have been achieved without creating major problems. Foremost among these is the fact that the proliferation of agencies and the expansion of their activities have not always paralleled the public need or interest. Furthermore, the machinery of many voluntary agencies has become antiquated, patched up, and at times jealously self-centered. This inefficient machinery impairs the capacity of the agencies to provide needed services. It unnecessarily diverts the dedicated efforts of contributors and volunteers. It threatens in time to undermine the valuable freedom of the agencies, as well as the devoted participation of millions of Americans.

A Nine-Times Growth

Behind statements of this nature is a concern about the rapid rise in expenditures for health, welfare, and medical care. In 1929 total expenditures for health and medical care, including health-facility construction and medical research, amounted to $3.6 billion and accounted for 3.6 per cent of the gross national product. By 1963 such expenditures came to over nine times this amount—some $33.8 billion—and represented 6.0 per cent of the gross national product. In only the last fifteen years, consumer expenditures for hospital services, for example, have jumped from $1.9 billion to $7 billion.

Much of the increase has been due to the great progress that has taken place in medical care, and for this reason, such expenditures and their proportion of our total income will probably continue to increase. There remains a question, however, as to whether some of this increase might not be held down through more effective use of these expenditures.

It is my purpose here to discuss the activities of the voluntary hospitals and other voluntary health agencies—both national and local. I shall give special emphasis to the responsibility of the individual board member of these agencies, with a view toward pointing out how he can make his agency more effective in achieving its desired goals.

Who Are the Trustees?

Voluntary non-profit organizations generally have boards of directors or trustees composed largely of outstanding lay members of the community—or of the nation, in the case of a national organization—with a few members who are well versed in the particular field of activity. Each board has the authority and responsibility for the operation of its organization, and the members are, in a real sense, trustees for the voluntary contributors and the general public.

In theory, since each agency was established to meet specific needs in its community (or the nation), the first consideration should be the needs of the community which the agency serves. In practice, however, many board members fail to carry out their basic responsibility; they delegate too much to the administrative staff. For example, the businessman on the board often confines his interest to financial matters; he seldom analyzes the operations of the agency as critically as he does his own business.

When it comes to accounting, the lack of information on the cost of specific services makes it difficult for board members to judge the need for continuing each one or the priority which should be given. The board is given a list of the various activities but no cost analysis for each service.

Competitive Attitude

If the agency or hospital is growing, has an energetic staff, and is receiving increasing support from the community, there soon develops a competitive attitude toward the other agencies or hospitals in the field. If it is an old institution, with a long record of family connections, the board member becomes particularly concerned
with building up his own organization. Thus the board and the staff often seem to be concerned primarily with their own institution rather than with the needs of the community as a whole.

Seldom do agencies make careful studies to evaluate their services. In the past, there has been very little real long-range planning by the individual agency.

Recently, however, questions have been raised by many outside groups, particularly larger contributors, about the need for some co-ordination of agencies to avoid duplication and overlapping and to meet gaps that might exist. As a result, steps are being taken by many agencies to make an objective evaluation of their own services, to set up their own long-range planning committees, and to co-operate with community planning groups. With this in mind, it is appropriate to consider in detail what part the individual board member should play in this process.

National Voluntary Agencies

Two principal recommendations were made by the Ad Hoc Citizens Committee in 1961—first, that a national commission be established to explore the important problems of voluntary agencies and, second, that a uniform accounting and reporting system be developed so that the public can be better informed about the activities and costs of the agencies.

Here are some of the questions the committee felt should be explored by the proposed commission (and these questions would apply to local as well as to national agencies):

Are there too many voluntary agencies? Need there be so many types with such specialized goals? How well do they adjust their programs to changing requirements? Can existing agencies be changed, combined, or terminated, and new agencies created to meet changing needs? What are the most appropriate fund-raising methods for voluntary agencies? How are they spending their funds? Are they using the best accounting and management practices?

Can the relative responsibilities of government and voluntary agencies be defined? What should be the relationship between government and voluntary agencies?

Why do voluntary agencies so often work in isolation and at cross-purposes? Why have they been unable to develop better means of co-operative action among themselves and within their communities?

What should be expected of them in the way of leadership in health and welfare activities at national, state, and local levels? How well do voluntary agencies fulfill their responsibility to the public?

On the subject of a uniform accounting system, the committee's report stated that "accurate data compiled on the basis of standard definitions, with allocations to program functions, would yield better information on the costs of specific activities and would identify weaknesses in administrative policies. Agency management could then make better decisions about programs and policies."

Improvement Noted

Since the report was issued, each member agency of the National Health Council has agreed to adopt an effective functional accounting system developed by the council, and each agency is now in the process of switching over. In addition, the National Social Welfare Assembly is now developing an accounting system based on the same principles.

These steps are encouraging, indeed. But much remains to be done, and it is definitely the responsibility of the individual lay board members of these national organizations to insist that their agencies co-operate in this program. The businessman can be especially helpful here. He should be very sure that his agency is determining the cost of each of its services and is giving complete information to the public.

Some progress is being made toward setting up a commission to study the various issues raised by the Ad Hoc Committee. In the meantime, the
individual board member should see what can be done in his own organization—particularly by looking into areas of overlapping and duplicated services, by considering the possibility of combining with other agencies in the same field, and by adjusting programs and services to meet changing needs.

While most of the administrative staff people are alert to these issues, it is only natural that they be concerned primarily with their own agency. It is up to the board to exercise a broader, more objective, and more critical analysis of the agency’s purposes and services.

Local Agencies

Through the growth of community chests, united funds, and councils of social agencies in most of the larger communities, great progress has been made in recent years in co-ordinating the efforts of the local voluntary health and welfare agencies. In this field of co-ordination and planning, however, there is still much to be done, and here again the lay board member can play the key role.

In many cases, the businessman on these boards is concerned with financial aspects—raising funds, avoiding deficits, and checking the accounts—and he provides little real analysis of the services rendered or the cost of each service. The usual financial statement of his agency will show the expenditures—salaries, expense items, maintenance of buildings, and so on—and then a separate statement listing the services rendered to the different groups with which the agency is concerned. But no information is given about the cost of rendering each service so that board members can judge whether the funds are being spent most wisely and effectively.

What businessman would think of operating his own company on this basis? It would be the same as having a factory simply keep a record of the total expenditures for wages, supplies, and expenses along with the quantity of the various products it manufactures, with no information as to the cost of each product or whether it is making or losing money on each product. While there is no question of profit involved in voluntary agencies, it is still important to know the actual cost of rendering each service so that the budget committee of the community chest, for instance, can determine how its funds should be allocated.

Business Budgeting

In an effort to provide this basic information, the Community Chest agencies of Rochester, New York, recently developed and applied a system of functional accounting and budgeting similar to that employed in business and industry. The system was devised with the aid of industrial cost accountants and social research workers. Under this system, the agency keeps not only the usual account of total income and total expense but also a separate account for each of its services. Thus, for each individual service, the agency knows not only the volume of service rendered but also the income derived from it, the expenditures related to it, and the resulting deficit incurred by the agency.

The plan has now been adopted by practically all agencies in Rochester, and a number of advantages have developed. First, because the plan gives the administrator and his staff the income and expenditures for each service, they have much closer control of the operations. And, second, because this information is available to each member of the board and of the chest budget committee, these people can do a better job of relating the budget to the program—a very difficult task under the usual accounting procedures of such agencies.
Determining Fees

The system also has special value in determining the fees to be charged. Fee-charging is becoming more and more common. It stretches the welfare dollar and encourages independence and self-reliance in those receiving the service. A common difficulty is lack of information on the cost of the service so the fee scale can provide a maximum charge equal to the cost for those able to pay. For years, the community has been subsidizing services for people who have been willing and able to pay the cost. Several agencies have already increased their fees to those who are able to pay.

The functional accounting system also is helpful to boards and other planning councils in their continuing study of current programs, in eliminating those no longer needed, in strengthening those where the needs are greatest, and in developing long-range plans.

The benefits of knowing the comparative cost of services provided by different agencies were illustrated recently when an organized home-care program was established in Rochester. Previously, homemaker service had been provided by four family agencies, and more of this service would be needed under the home-care program. As a result of functional accounting, it was found that this service could be better provided by the Visiting Nurse Service at little more than half the cost.

The Rochester agencies that have adopted the functional accounting system seem well pleased with it. Very little progress has been made, however, in applying this type of system widely throughout the country. Board members with business experience should encourage and assist their organizations in adopting such systems. They should also encourage closer co-operation with other agencies in the community.

Need for Co-ordination

As an illustration of the need to co-ordinate a community's health agencies, for example, the Patient Care Planning Council in Rochester found, upon looking into the area's mental health services, that there were more than forty agencies engaged in one way or another in this field. We asked Dr. Robert Felix, head of the National Institute of Mental Health, to look into our situation. At a meeting where representatives of the various agencies were present, he pointed out that, while each agency probably was doing a good job, there was very little communication between them, very little co-ordination, and probably quite a lot of overlapping. He suggested that a co-ordinating agency be established so that each agency would know what the others were doing and could ascertain where the overlapping and gaps were.

Accordingly, a council has now been organized under the Council of Social Agencies. It will also help to co-ordinate the work of these local agencies with that of the state mental hospital—for instance, to devise a system for the follow-up of discharges from the state mental hospital, since the state provides no money for this service.

In a community that has a united fund or community chest, its council of social agencies generally does a good job in co-ordinating services of the various health and welfare agencies. Often, however, not enough attention is given to long-range planning, to objective evaluation of the services of the agencies, to whether services are being adapted to changing conditions, and to the advisability of consolidating some of the agencies. Lay board members with a more objective point of view could be instrumental in having such studies and broad community surveys made periodically.

Hospitals

Not nearly so much progress has been made by
hospitals in co-ordinating programs with one another and in long-range planning. As a general rule, each hospital is so concerned with its own institution that it generally expands its facilities and services without first giving careful study to the needs of the community as a whole and without co-ordinating its plans with other hospitals. Probably the greatest need in the whole health field today is for sound community planning of hospitals and other health facilities. Much attention is now being given to this problem because of the rapid rise in the cost of hospital services. Average daily service charges by hospitals nationwide have increased 138 per cent from 1950 to 1963. This compares with an increase of 59 per cent in total medical costs and of 27 per cent in the over-all cost-of-living index during the same period.

There are a number of reasons for this rapid increase: Wages and salaries have risen to a level more nearly approaching other fields. The great advances in the science and practice of medicine have naturally resulted in the need for more professional and technical personnel, for more laboratory facilities, and for more expensive equipment of all types.

**Haphazard Planning**

Another important factor, however, has been the haphazard planning that has preceded the construction of acute general hospitals—planning that has resulted in overexpansion of acute beds and duplication of expensive equipment and services. The maintenance of more empty beds than needed can be a heavy charge on the community. Many hospitals now consider 90–100 per cent occupancy as standard rather than 80–90 per cent, as formerly.

In many cases, the most expensive types of facilities have been built when more economical ones would be adequate and perhaps even fit the needs of the patient better. Numerous surveys have shown that pressure for additional acute general beds could be relieved if there were more minimal care and long-term care facilities, which can be built and operated at lower cost. The surveys also show that greater use can be made of outpatient services and organized home-care services.

The board member, especially the business and professional man, can render a great service by insisting that, before his hospital expands, a careful study be made of the actual needs of the whole community. The survey should determine how well existing services and facilities fit these needs; and, if additional units are needed, what kinds of units these should be, and which of the community’s hospitals might best provide them.

It is only natural that a hospital’s administrative staff be concerned primarily with building up its own institution. In a recent survey of fifty hospital administrators in Massachusetts, not one listed the need for community planning as among the important problems facing hospitals. All too often, however, the board member becomes just as much imbued with this desire to build up his own institution and fails to give adequate consideration to the actual needs of the community.

**Businessman’s Contributions**

Because of his experience and training, the businessman on the boards of hospitals can contribute greatly to more effective operation. Here are a few examples of areas where he can be particularly helpful:

Wages, salaries, and benefits of hospital personnel undoubtedly will continue to climb further. Hospitals must find ways to reduce costs just as industry has been able to prevent unit costs from rising as fast as wages. Many hospitals have started, for example, by subdividing the duties of registered nurses. There can also be better channels of communication between the
top administrative staff and the medical and other staff. Larger hospitals can make good use of computers. It is up to the board member to raise questions frequently as to whether the hospital is following the lead provided by the best-run hospitals in the country. After all, is this not the same critical approach the board member applies in his own business?

In the matter of nursing, the board member could very well raise the question as to whether the cost of training nurses should be borne by the hospital or whether nurses should not be trained by the educational system. In Rochester, for instance, the first-year training of all nurses under the diploma system run by the hospitals is now taken care of by the Community College. Beginning last year, the Community College inaugurated a two-year certificate program, under which nurses will be given complete training, with the clinical work done in co-operation with the hospitals. As a result, one of the hospitals has discontinued its diploma program entirely, and, when the Community College program gets into full operation, the other hospitals will probably do likewise.

Co-operating Economies

The business member of a hospital board should also take the initiative in seeing whether the cost of some services might not be reduced through closer co-operation with other hospitals. For some years, the hospitals of the Rochester area have benefited by centralizing some of their purchases through the Rochester Regional Hospital Council. Recently, the hospitals in Rochester set up an organization to construct and operate a centralized laundry, with the cost of amortizing the building and equipment included in the charges. We believe that this will result in savings, both in capital equipment and in operating costs. Efforts will be made to have the hospitals agree on standardized linen so that additional savings can result.

The Rochester hospitals have engaged a firm of management engineers to study the feasibility of centralizing specialized laboratory services, but with basic services still maintained in each hospital. Because of the increasing need for highly trained personnel and for high-priced special equipment that is used infrequently, centralization could lead to substantial savings. Even for equipment used more frequently, centralization might result in less idle time of both equipment and personnel. In view of the shortage of trained personnel in this field, the quality of service would probably be improved too. The management firm feels that consolidation is feasible, and it is now developing the detailed plan.

Use of Equipment

Rapid progress in medical science and in methods of treatment have presented hospitals with a serious problem as to what expensive equipment and which specialized services each should provide. If every medium-sized hospital attempts to have complete equipment and to provide complete services in every respect, the cost to the community would be excessive indeed. In many cases, one unit may be sufficient for the whole community. If there is a large university-teaching hospital in the community, many of the special units located in that center could serve the other hospitals if the proper relationships are developed.

This, again, is a field in which the lay board member must take an active part. It is only natural for the administrator and the medical staff to want their hospital complete in every respect. The board member should check closely on the actual need for an expensive unit, and, if it is vital, he should see why it might not be obtained on a co-operative basis with other hospitals. The scarcity of skilled personnel and the cost of oper-
ation and maintenance are often more important considerations than the initial cost.

Utilization Committees

The board member should also stimulate the use of utilization committees. While the admission of a patient and the time of his discharge are primarily in the hands of the patient’s physician, it has been found that utilization committees, composed of physicians, can help to speed up the discharges and to cut down the unnecessary admissions. As a rule, the administrative staff is not much concerned with this problem until there is a tight bed situation, since high occupancy results in a better financial showing. The Massachusetts survey of hospital administrators stated:

The problem of overutilization of hospitals does not appear to loom large in the minds of these administrators. Only one mentioned it as a “major problem” for hospitals in the future. There is acknowledgment that some overutilization occurs, but its importance to the administrator appears minimal.

This should be a matter of serious concern to board members, for with overutilization there is continuous pressure to add more beds in the acute general hospitals when there might not be an actual need, or else a greater need for less costly types of facilities.

The over-all value of utilization committees is pointed out in the following quotation from a speech by Dr. Russell A. Nelson, director of Johns Hopkins Hospital and past president of the American Hospital Association. “In the long run,” he said, “this utilization-committee idea and its effect by education of the medical staff, in my judgment, will be the most important factor in the control of utilization. It will also have a very useful effect in bringing the medical staff closer to the financial and management side of hospital operation.”

Most utilization committees function by reviewing discharge records on a sampling basis and by studying the cases questioned by Blue Cross. A more effective and scientific approach is to study patients while they are in the hospital.

Study of Patient Needs

Such a study of 1,100 medical and surgical patients, selected on a statistical sampling basis among six hospitals in Rochester, was conducted by a group of twenty-eight physicians, half from the community and half from outside. Each patient was visited by a team of two doctors—an internist and a surgeon. The patient’s records were examined. Nurses and, where possible, the physicians were consulted. The team then filled out a form indicating their judgment as to what type of facility the patient needed at that time—an acute general-hospital bed, a long-term care facility, a self-care unit, outpatient care, organized home care, or other care.

The result of the study indicated that 11 per cent of the surgical patients should not have been in the hospital for medical reasons and, in the case of medical patients, that 23 per cent should not have been in acute general hospitals for medical reasons. The study teams also indicated that an additional 5 per cent could be cared for in other facilities—if ideal facilities were available in the community.

This study resulted in a radical change in the plans for expansion of hospital facilities in the community. The increase in acute beds requested by the hospitals was reduced from 500 to 140; and 140 additional beds are to be provided in extended-care units in three hospitals. These units are for patients who are recovering from a serious illness and do not require the ordinary services of acute beds but do require rehabilitation services. It is expected that these beds will better fit the needs of these patients and can be constructed and operated at a cost considerably below the
cost of acute beds. The stay in these units will be limited to a maximum of sixty days, since the units are not intended for chronic cases.

More for the Dollar

Thus, the hard look at actual needs is enabling us to use a higher proportion of our funds for modernization and to get more and better hospital facilities for the dollar.

The County Medical Society and the University of Rochester Medical Center are now engaged in developing a program for an ongoing utilization study on a sampling basis of the patients in the Rochester hospitals, using the techniques followed in the other study. This program will go further to include an analysis of the reasons other than medical for the patient's being in the acute bed and also the extent of underutilization.

Here is another illustration of the value of a careful study of patients: One of the Rochester hospitals discontinued its pediatric service. To decide what to do with the vacated space, the hospital administrator had a team of nurses and a team of physicians make independent studies, over a three-month period, of the medical and surgical patients occupying 210 beds. All together, over 3,000 patients were classified in four categories—self-care, intermediate care, special care, and long-term care. There was 80 per cent agreement by the nurses and physicians as to patient needs and classification. The study showed that about 30 per cent of these patients could be taken care of in a self-care unit and 10 per cent in a long-term care unit. As a result, the hospital decided to set up a 24-28 bed self-care or minimal-care unit. This unit is designed for ambulatory patients who may require diagnostic study not feasible on an outpatient basis or who need certain specialized treatment or brief convalescence. Careful estimates were made of the cost of operation, and, because of reduced need for nursing and other services, the operating cost is estimated to be 36 per cent less than for acute general beds.

Social, Economic Factors

Much of the so-called overutilization in the general acute hospitals is due to the lack of other, less expensive facilities or to the failure to use such facilities if they do exist in the community. Of course, there are many social or economic factors, too, that are responsible for the high occupancy of the acute hospitals—for example, widespread use of hospital insurance, the failure of insurance policies to cover for other type facilities, the lack sometimes of even minimum care at a patient's home, convenience for the family, convenience for the physician, and the desire of administrators and boards to avoid deficits from lower occupancy.

The several levels of care available in a community should include self-care or minimum-care facilities, extended-care units for those recovering from serious illness where rehabilitation is needed; long-term care facilities for those with chronic illness; outpatient clinics; and well-organized home care. Under programs of home care, the nurses and physicians are organized in such a way as to give adequate care to patients at home, before or after they leave the hospital. A program of this type should preferably be connected with the general hospital and administered in close touch with the medical social workers.

Home Care Experience

A home-care organization was set up in Rochester two years ago. In 1963, up to 100 patients were being cared for daily at a cost of $8.53 per day—less than one-fourth the cost of an acute hospital bed. It was estimated that, without this service, half of these patients would have been occupying the expensive acute beds.
Local studies indicate that in the typical general hospital about 10 per cent of the patients could be transferred to long-term care units. In most communities, there is a shortage of desirable facilities of this type for the family of average income. When any proposal is brought to a board of a general hospital to increase its bed capacity, the members should insist on a thorough study to ascertain whether it would not be better for the hospitals in the community to add a long-term care unit. The trend now is to have such a unit closely connected with the hospital.

Some larger hospitals are finding it very helpful to have medical social workers on their staffs to ascertain the needs of patients, both private and those on welfare, aside from their health condition. They can assist the patient and his family in making adjustments when he returns home. They can determine, particularly in the case of long-term care patients, the type of facility to which the patient should be transferred and can assist in the transfer. Sometimes this service is under the control of a team of a physician, nurse, and social worker. It has been found that such services often reduce unnecessarily long stays in the general hospital and can result in care better suited to the patient’s needs. The board member should ask whether his hospital should not provide such services.

If adequate facilities and services of these various types can be made available in a community, the load on the acute hospital units will be gradually reduced. Ultimately, only the very sick will be in the acute units, and the per-diem cost will rise because of the concentration of services. But there will be an over-all saving to the community because of the low per-diem cost of the other facilities and services.

**Community Health Planning**

Throughout my remarks I have been trying to point up the need for better community-wide planning of health facilities and services. The first step is for each hospital and other health agency to set up its own long-range planning committee, with representatives of the board and administrative and medical staffs. The community planning agency should be established to co-ordinate existing health facilities—both governmental and voluntary. It should study the actual needs in order to prevent duplication. It should study future needs in order to fill any gaps. And it should obtain community agreement on the facilities that are needed and should study methods of financing.

There should be broad representation on such a committee, including officials from all the community’s health agencies and hospitals. If the committee is to succeed, it must have the active cooperation of the community’s leaders—those who make the decisions for their organizations and who will be in a position to put the committee’s recommendations into effect.

For example, the Patient Care Planning Council of Rochester and Monroe County, which was established in 1960, is composed of the county health and welfare officers, the mayor of the city, the presidents of the medical and dental societies, the dean of the medical school, the president of the hospital council, and top officials of the Hospital Fund, the Community Chest, social agencies, the state welfare, health, and mental health departments, employer organizations, labor, and Blue Cross and Blue Shield, plus two or three other leaders from the public at large.

The Rochester council was asked by the Hospital Fund to study the needs of the community and to recommend how the funds, which were obtained in a hospital fund campaign in 1962, should be allocated to the different hospitals. After a careful study of the facilities and needs (including the bed survey described above) and with the advice of officials of the State Health Department and the United States Public Health
Service, the council agreed upon a definite program. The Hospital Fund officials adopted the program and the council's recommendations on allocations to the several hospitals.

Study Brings Savings

The city and county have since asked the council to investigate problems relating to the municipal hospital, the county tuberculosis hospital, and the county infirmary. The council's recommendations, made after considerable study, have resulted in substantial savings to the city and county and have provided the opportunity for improved medical care.

The council has standing committees studying the problems of short-term care, long-term care, and long-range planning. The council attempts to bring current critical problems to the attention of individual agencies and helps to get action on recommendations. It is also attempting to prepare a co-ordinated long-range plan for future health facilities.

The initiative to organize a health planning agency must come from the influential board members of the hospitals and health agencies—usually the business and professional members. Their companies, employees, and clients furnish a large part of the funds for building and operating the health facilities; the funds of the community are entrusted to them for the most effective use. They should readily see that the only way to carry out this trust is to look at problems from the needs of the community as a whole.

Must Test New Methods

Also, there should be ample opportunity for trying out new methods and new types of facilities and for setting up demonstration projects. In other words, businessmen who realize the value of research and development in their own businesses should stimulate similar activity on the part of the administrative staffs of health agencies.

The wide expansion of hospital insurance through Blue Cross has had a marked effect on the greater utilization of hospitals. The board members of Blue Cross and Blue Shield agencies have a direct interest and responsibility in the expansion of bed capacities. These agencies should exert their influence in the community to see that thorough studies are made of the actual needs before expansions are started.

The board member of the Blue Cross agency should keep in mind the need for extending coverage to facilities and services that are designed to keep people from occupying the most expensive beds. For if the insurance does not cover these facilities, patients will naturally continue to use the general hospital.

Service-Type Contracts

The lay members of the Blue Shield agencies should continue to press for service-type contracts and for broader conditions under which subscribers can receive complete service without additional fees. As an illustration of the value of an objective approach to such problems, I recall that in the early days of the Blue Shield organization in Rochester the industrial relations people of local companies urged that a service-type contract be adopted rather than an indemnity type. They thought there would be a bad reaction from employee subscribers if many were charged additional fees. But the initial plan provided an indemnity insurance just the same as under a commercial insurance company plan. Because of the lack of interest from the larger companies, the plan did not go very well. Later, it was converted to a service-type contract, and the number of subscribers increased substantially.

Now, approximately 80 per cent of the population in Monroe County, New York (including Rochester), is covered. The agency has been very
progressive in raising the maximum limits and now provides generally complete service, with no additional fees for people whose incomes are below $7,200. With this wide coverage and with no credit losses or collection expense, physicians rarely find it necessary to charge additional fees for people above the maximum. In fact, 98 percent of all surgical bills are paid without any additional fees. Both physicians and subscribers seem satisfied with the plan. Since 1952 there has been only one increase in premiums—in 1962.

Area-Wide Planning

There are a few demonstrations now under way in the field of area-wide health planning as a supplement to local health planning. Under a grant from the United States Public Health Service, the Rochester Regional Hospital Council is now attempting to see what can be done to coordinate planning in the eleven-county area surrounding Rochester. A broadly representative committee and a small steering committee have been working about a year.

The Patient Care Planning Council in Rochester was well under way before this demonstration commenced. A similar planning unit has now been established in an adjacent county and a third group in a three-county area. Plans are under way for a fourth unit covering four counties. A survey is now being conducted of patients in all the area’s hospitals to obtain pertinent data, particularly as to each patient’s residence.

For some time, the Rochester Regional Hospital Council has been the designated agency to request Hill-Burton federal funds for the area. In conducting the demonstration project, this council stated that, if there was more than one hospital in a community, the planning group would not approve requests for expansion until a co-ordinated community plan had been developed.

Later, a request for expansion was received from a general hospital in a city where there were two hospitals of long standing. A study indicated that there were enough acute beds in the community but a shortage of long-term care beds; also there was unnecessary duplication of facilities in the two hospitals. The request was turned down, with the suggestion that efforts be made to work out a co-ordinated plan for the other hospital on how the two hospitals could better fit the needs of the community. Fortunately, the physicians in the community had access to both hospitals, and there was co-operation between the administrative staffs. With the help of one of the members of our planning group, the key board members of the two hospitals were brought together, and these community leaders are now developing a co-ordinated plan.

Task Forces in Study

Because of the compelling need for better community planning and for bringing to the people more quickly the many benefits of advances in medical science and practice, the United States Public Health Service and the Kellogg and other foundations have made substantial grants for a four-year study of these problems by the National Commission on Community Health Services.

This commission, established in 1962, is composed of highly qualified representatives in the public health, medical, and hospital fields. Seven task forces are working in the following areas: community assessment, planning, and action; environmental health; organization of community services; financing health services and facilities; health service manpower; health facilities; and comprehensive health care.

In addition, the commission has selected twenty-two communities, in different geographic areas and of different sizes. These communities have agreed to organize groups to develop programs for co-ordinating their various health agencies and
to develop long-range plans. Assistance will be provided by the National Commission.

After the task forces have completed their studies and have benefited by the experience of the communities, one or more conferences of experts will be called to discuss the findings. Later, probably in 1966, the final results will be published. We expect that this study will stimulate the organization of community planning groups throughout the country and that they will benefit from the findings of the study. In the meantime, there is no reason why interested leaders in a community cannot organize such planning groups immediately.

Board is Responsible

Great, continuing progress has been made in medical science and practice, but there has often been a lag in bringing the benefits of the advances to the people. Some communities are planning their facilities and services to take quick advantage of these advances and thereby improve their health services and provide better quality of care.

The effectiveness of the individual hospital or other health agency rests, ultimately, with its board. To meet his personal obligation, each board member will have to show the same interest and leadership in the operation of the agency as he does in his own business or profession. Furthermore, in every situation, he will have to see the need of providing high quality, comprehensive health care to the entire community as the overriding consideration. For the hospital or other voluntary agency belongs—in a very real sense—to the entire community.