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THE BUSINESS COMMUNITY LOOKS AT DRG-BASED HOSPITAL REIMBURSEMENT

by Robert R. Henderson, M.D. and J. Joel May

Prologue:
One of the most promising developments in the health sphere to emerge from the 1970s was the more active participation of large corporations in decisions revolving around medical care. This more active role is reflected in the creation of some 100 private sector coalitions that now exist around the United States. Many involve only coalitions of private business representatives, but another prevalent model features participation by all of the major interests with an important stake in the future of medical care. One of these coalitions is the New Jersey Business Group on Health, Inc., which was formed several years ago with the expressed purpose of participating actively within the existing health care system to control inappropriate health care costs while continuing to promote quality health care. Once the New Jersey business group formed, it became readily apparent that among its first tasks was to learn the details of the Diagnosis-Related Group (DRGs) reimbursement system used there to pay hospitals. During the course of this educational effort a predictable phenomenon occurred given the complex nature of hospital reimbursement and government regulation: their research produced more questions than answers. Secondly, Dr. Robert R. Henderson, who directed the educational effort for New Jersey’s business community, concluded that further study of the DRG system by an independent party must be undertaken. The long saga that led New Jersey to implement a hospital payment plan based on a patient’s diagnosis has become important nationally because the Reagan administration is proposing, at the strong suggestion of Congress, that Medicare adopt a prospective hospital payment scheme based in large part on the DRG model. J. Joel May, a respected figure in the health services research community, is president of the Health Research and Educational Trust, once an arm of the New Jersey Hospital Association but now an independent, Princeton-based health policy research firm engaged in evaluating the state’s DRG-based payment system. To provide some perspective on the questions of New Jersey business as it applies to DRGs, we invited Henderson and May to engage in a dialogue, the results of which follow.
Dr. Henderson: Why do you believe the Diagnosis-Related Group (DRG) system is looked upon so favorably by individuals in the New Jersey State Department of Health and others involved in the process?

Mr. May: The Department of Health has a contract with the Health Care Financing Administration to implement this program in New Jersey. Several millions of dollars are involved and, naturally, the Department of Health is interested in making the program work and is scarcely likely to say anything critical about it in public. At another level, however, there is a firm belief that prospective payment on a per case basis creates a far superior set of incentives for hospitals than does retrospective per diem-based payment. The prospective per case payment mechanism causes hospitals to scrutinize the amount of resources they are devoting to each case, to attempt to discharge patients as early as feasible, and, in general, to reduce the total quantity of resources consumed by each patient. If we believe that in-patient admission rates are not likely to fall greatly in the near future, this payment mechanism may be the only effective way of controlling total health care costs.

Dr. Henderson: In terms of a thorough evaluation of the DRG system, it would seem necessary to continue it as an experiment until sufficient data has been accumulated for the experience to be studied over time. When will sufficient data be available for this experiment to be studied? How many of the hospitals reimbursed by the DRG methodology have actually received final reconciliation payments? For what years?

Mr. May: Let me start with the last two questions. Only six of the hospitals have actually received final reconciliation payments and those only for the year 1980, the first year the system was in operation. This is the result of a combination of a serious bottleneck in the data processing activities at the state level and maneuvering by third-party payers to ensure that they are each fairly treated. As you know, the DRG-based reimbursement system is not a purely prospective reimbursement system. Following the close of the year, a reconciliation takes place which takes into account changes in volume by payer, the amount of uncompensated care provided by the hospital (which must be built into future rates), the timing of payment from payers, and other factors. It is a complex process and, unfortunately, has been seriously delayed. This, coupled with the fact that the period required for hospitals to fully adjust to the new incentive systems and to change their managerial behavior accordingly is a lengthy one, causes me to believe that only now can we begin to answer the questions raised concerning cost containment and financial impact on the institutions from a firm empirical basis. It may be several more years before we can confidently answer questions about changes in the
quantity and quality of care delivered, access, and other questions. We are well aware of the urgency with which these answers are sought, but feel that decisions based on anecdotal information and assertions can only lead to knee-jerk reactions which may or may not be for the good of the patients and the health care provider community in New Jersey. Incidentally, it follows that the question of whether or not it is a good idea for HCFA to use the DRG system for reimbursement for Medicare patients cannot be unambiguously answered at this time based on the New Jersey experience.

Dr. Henderson: The New Jersey Business Group on Health (NJBGH) members are clearly interested in the effect of the DRG system on the cost of their hospital benefits and on taxes they pay to support programs such as Medicare and Medicaid. They are also interested in maintaining quality. Some companies are self-insured and have been comparing DRG and itemized bills and believe they have found that the DRG charges are much higher. Has the DRG system, or will it, decrease the cost of hospital care in the state of New Jersey? By this I do not mean the financial position of the hospitals but rather the cost to the purchaser. Will it at least control the escalation of costs?

Mr. May: The system, as designed by the Department of Health, has the potential for reducing the rate of cost increase in hospitals. Specifically, it is capable of providing incentives to decrease the cost per admission of hospital care (rewarding the hospital for doing so). Whether it will or not depends upon how the Department of Health manages it. To date, it is my judgment that it has not. In the first year of the system, under the terms of Chapter 83 of the New Jersey code—the law which implemented the system—hospitals received more money than they otherwise would have and hence had little incentive to reduce costs. Our analysis shows that the rate of increase in costs for all New Jersey hospitals was approximately 5 percent below the rate of increase for all hospitals in the country, although it should be pointed out that this was true in years preceding the implementation of the DRG system as well. The twenty-six hospitals which were paid on the basis of DRGs for at least part of that year increased their costs 13.2 percent, as contrasted to a rate of increase for the other hospitals in New Jersey of 13.8 percent. This is not a statistically significant difference. Perhaps more interestingly, of the hospitals being paid under the DRG system in 1980, those that had made money in 1979 had a rate of increase of 14.1 percent and those that had lost money in 1979 increased their costs only 10.1 percent in 1980. Our tentative conclusion from this is that while the DRG system does contain incentives for cost cutting at the hospital level, the incentives operate much more strongly in hospitals experiencing financial problems than in those that are not.
There are two reasons why more money was paid out to hospitals in the early years of the system. One is purely political— in order to “sweeten the pot,” the Department of Health deliberately made the rate appealing to hospitals. This was to avoid opposition to the implementation of the system on the part of the hospital association and also to give the Department the necessary leeway to tinker with the system as it was implemented. There is some evidence that while in 1980 and 1981 hospitals participating in the system did quite well, the current situation is beginning to pinch them somewhat more. The reasons for this are quite complicated but essentially revolve around the fact that the rates hospitals are receiving in 1982 and 1983 are a function of their 1979 case mix and actual incurred costs, adjusted for inflation in each of the intervening years, then retroactively adjusted for changes in volume and case mix. No effort has been made to take into account in these rates any changes in technology which might have occurred during that three-year period, unless that change was brought about by an approved certificate of need. Thus, any differences in how hospitals treat patients today as contrasted to three years ago are not included in the rates for this year, even though many such changes (for example, the use of hyperalimentation) do incur additional costs. As a result, in the current year hospitals are, or at least claim to be, suffering financially. Whether or not this is desirable depends upon how one chooses to think about the technological advances which are occurring, that is, are they frills which are unnecessary and even perhaps self-serving to physicians and hospitals, or are they real advances which make the care provided to patients superior to that which might otherwise be provided?

The second reason for more money being infused into the system in the early years is associated with the law itself. It provides for the inclusion in the rates of a “working cash infusion” to hospitals which have an inordinately high accounts payable or low cash holdings in the first year of their participation. It also, on an ongoing basis, provides for payment of “uncompensated care” which hospitals were not previously able to collect through the rates. Finally, the “capital facilities allowance” in some hospitals provides more money in the rates than in the previously used depreciation calculation.

As a result of the confluence of all these factors, the system has not yet decreased the costs of hospital care in the state of New Jersey to any significant degree, though it has had a differential effect on the hospitals which were losing money as opposed to those making money prior to the implementation of the system. Yet it has within it the seeds of the ability to control the escalation of costs.

Dr. Henderson: The Department of Health uses the term “ratcheting down” to describe the use of the rate-making process to reduce costs. When will ratcheting down take place, or will it ever?
Mr. May: As indicated above, in 1982 there was apparently some ratcheting down taking place as a result of the lack of inclusion of the costs of new technology in the current rates. This, however, is indiscriminate ratcheting down and therefore not the kind contemplated originally by the developers of the DRG Reimbursement System at the Department of Health. Truly effective ratcheting down would selectively reward and penalize individual institutions for efficiencies or inefficiencies on a DRG-specific basis. Whether or not this will ever take place is a question which revolves around its political feasibility as contrasted to the rationality which underlies it. The ways in which it could take place center on the ability of the state to modify the rate-making formula, including a greater or lesser percentage of the state average in the formula, and creatively relating that included percentage to the distribution of costs across hospitals for each DRG. This is a complicated technical process as well as a delicate political one. In my view, it will never take place to the extent originally contemplated by the Department. In fact, my sense is that the true cost-saving incentives in the system lie in the increased visibility of the costs incurred on the part of both the hospitals and physicians involved, the increased sensitivity of individual institutions to the "profitability" of various "product lines," and the resultant sound business decisions which can be made on the basis of this information. Hospitals, after all, have in the past had an incentive to keep patients as long as possible in order to maximize per diem reimbursement and did not even know how much the cost of keeping those patients longer was since it didn’t matter to them. Under the DRG Reimbursement System it matters a lot. The incentives are now to discharge patients as early as possible, preferably before the point where the costs incurred in caring for those patients exceed the rates which they will receive. Further, hospitals have information as to how well they are doing on this basis. It is these features of the system which will ultimately ratchet down hospital costs and not, in my view, the actions of the regulators.

Dr. Henderson: Other questions of data availability, for example, to the business payer, have arisen. HRET is the key data intermediary (of three) for hospital submission of the Uniform Bill-Patient Summary (UB-PS) data to the New Jersey Department of Health in support of DRG rate reimbursement. HRET is directly responsible for eighty-three hospitals' nonfederal patient UB-PS data and has also signed agreements to receive all UB-PS data from the other data intermediaries. The Trust is responsible for producing all the required reports for both the hospitals and Department of Health based on 100 percent of UB-PS data.

As the result of its efforts in the collection of these and other hospital data, HRET says it is "in a position of having a unique Master Data Base of health-related data which can be made available to hospital administrators, policy makers, planners, researchers, and regulators. With strict
adherence to necessary constraints on the release of certain confidential patient and provider data, the combined data bases can be shared by all users . . . . Each user will have access to all data pertinent to his institution and certain nonconfidential data relating to other institutions. Confidential/sensitive data will not be available except by special permission from the individual provider and then only as permitted under current federal and state guidelines. Clearly, present delineated policies for obtaining information regarding the use and costs of health care services (particularly hospitals) in New Jersey appear to be quite stringent.

The major purchasers of health care are very interested in being able to directly monitor what they are buying. They are not simply interested in comparing their cost in New Jersey to other portions of the country. They are interested in comparing costs by individual provider and related to the services performed. This interest, together with the above DRG program characteristics (nonitemized bill and tight control of DRG-generated data) raises several questions. Unless major purchasers of health care (either self-insured or through their carrier) have access to the details of utilization the costs, who will monitor the regulator?

Mr. May: You indeed raise a number of important questions here. First of all, efforts to monitor the system are underway by the Department of Health, which is itself a major payer into the system, both through its Department of Economic Services and through the PSROs which in New Jersey are being preserved for the primary purpose of monitoring utilization and costs under the system. Nevertheless, it is easy to understand and empathize with the interests of employers and others in participating in this monitoring process from their own economic perspectives. In 1914, Dr. E. H. Codman wrote: “We must formulate some method of hospital report showing as nearly as possible what are the results of the treatment obtained at different institutions. This report must be made out and published by each hospital in a uniform manner, so that comparisons will be possible. With such a report as a starting point, those interested can begin to ask questions as to management and efficiency.”

In 1914 such reports were not possible simply because the data were not available. Today in New Jersey they are. However, during the years which have elapsed since 1914, two chains of events have occurred which militate against it. The first is that the hospital industry itself has become much more complex in its organizational structure, the regulatory influences it works under, and the patterns of services it provides. This complexity has made comparisons across hospitals much more difficult to do than when Dr. Codman made his plea. Casual, statistically unrefined, and simplistic comparisons across hospitals (or across payers, or across employee groups) can be at best uninformative and at worst totally misleading. The spirit in which I believe industry, hospitals, insurance companies, and others interested in this data should proceed is the same
spirit as that implicit in Dr. Codman’s remark. But there are serious hurdles to be overcome and caveats to be observed before the kinds of analyses contemplated can be successfully completed.

## DRGs and Cost Shifting

### Dr. Henderson:
Under the DRG reimbursement process, all payers share equally in paying for hospital care received by uninsureds not eligible for Medicaid and unable to pay out-of-pocket. Thus a cost shift to the insurance carrier and out-of-pocket payer has occurred. More subtle shifts also exist between commercial carriers and Blue Cross. To some, this cost shift represents a legislated hidden tax on all those who pay for hospital bills directly or through insurance. While this may represent a meritorious social policy, some institutions which benefit most from this program are located in central cities where outward population shifts have been experienced. What is the effect of this equal sharing on total New Jersey hospital costs and how can we be certain that DRG does not maintain unnecessary beds or support inefficient institutions?

### Mr. May:
The hidden tax involved is the cost of the care which is rendered by the hospital to people who have no source of payment, principally those whose income level is too high for Medicaid benefits but who do not have sufficient capital to pay large hospital bills and are otherwise uninsured, and the unemployed who have lost their company-provided health benefits. This is a population which has always been with us and hospitals have always collected this hidden tax from somewhere. Under the reimbursement system that existed in New Jersey prior to the DRG system, the hidden tax was paid by the people who were covered by commercial insurance companies (that is, those other than Blue Cross) and by those who were uninsured but paid their bills in full. Blue Cross, Medicare, and Medicaid—which in the past negotiated an average per diem payment to hospitals that excluded the costs of providing this care and incorporated only the true costs of providing care to the people whom they insured—avoided this hidden tax in the past. Hospitals responded by overpricing their services to the people who were paying the billed charges in order to make up the difference. Under the current system, all payers for hospital care share equally in paying this “tax.”

Thus, firms who are insured through Blue Cross are paying more than they otherwise would and firms insured by commercial insurers pay less. In fact, during 1980, the twenty-six hospitals in the DRG system reduced their charges, on average, by 10.09 percent from what they had been in 1979 because the cross-subsidy between payers was no longer required. This has the effect of removing the responsibility for playing Robin Hood from the hospital itself and placing the burden on state government; in particular on the Department of Insurance and the Department of Health.
It will differentially affect employers depending upon whom their insurance carrier is. It does not generate additional revenues for the hospitals in and of itself, but it does redistribute the burden across employers. Additionally, it may serve to make the health insurance market somewhat more competitive.

The answer to your other question dealing with the maintenance of unnecessary beds or the support of inefficient institutions is that certainly any system which supports an inefficient operation or maintains unnecessary facilities is not in the best interests of payers, the industry, or society. The problem is figuring out which are unnecessary or inefficient and which are not, and who should decide the question. In fact, since the DRG-based reimbursement system is based on payment by the case, a hospital located in an area from which population is shifting would experience a fall in the rate of admissions and of occupancy. It would thus bear a financial burden greater than had been true in the past, and may, in fact, be identified as unnecessary or inefficient de facto.

**DRGs and Innovation**

*Dr. Henderson:* In some respects, the total hospital regulatory program of New Jersey may negate innovation. For example, during one discussion with a representative of the New Jersey State Health Coordinating Council (SHCC) the question was asked, “Why cannot free-standing ambulatory surgical centers be approved and developed in New Jersey?” The response was, “Under our total regulatory program, we consider the hospitals as similar to public utilities and therefore we have to protect their turf.” Representatives of the HMO industry in New Jersey have also complained that under the DRG system their hospital costs have increased even though they use less hospitalization than the usual health care programs. What do you believe is the effect on HMOs and on innovation in general of the DRG system?

*Mr. May:* There are many ways in which the DRG system does, indeed, discourage innovation. The fact that the law which implements the DRG program requires equal payment from all payers in some sense discriminates against those payers who, either because of the nature of their insured group or because of the way they function, tend to purchase less hospital care per stay than others. Thus, for example, one would expect that HMOs and the typically healthy populations of many Blue Cross and commercially insured employee groups would pay more than their “fair share” while, for example, Medicare may be paying less simply because of the averaging process. Further, innovative efforts such as preferred provider organizations (PPOs) are discouraged in New Jersey because of the requirement for equal payment from all payers.

In addition, innovation at the hospital level may very well be discour-
aged. Suppose that a new technique was developed for the treatment of a particular kind of patient which, while costly and effective, does not reduce length of stay. Under a retrospective cost-based per diem reimbursement, the hospital would be encouraged to adopt such a technology. Under the DRG system, it would not since the total reimbursement to the hospital would remain the same as it had been previous to the adoption of the technology. There is great concern among New Jersey hospital administrators about the negative incentives to adopt new technologies under the system.

Dr. Henderson: Your response seems to further add to the need to monitor various aspects of health care delivery in New Jersey. Have analyses been done on the effect of the DRG system on the use, by hospital, of ambulatory surgery (percentage of ambulatory to total); analyses, by hospital, of preoperative hospital stays and postoperative stays; hospital utilization, such as days of care per 1,000 insured; the average length of stay by major category; the use of preadmission testing by hospital; comparison of total average dollar cost of selected medical/surgical procedures before and after DRG by hospital; and the number of inpatient admissions by diagnostic groups, pre- and post-DRG, by hospital?

Mr. May: Such analyses can certainly be done. In fact, as part of the HRET Evaluation of the Economic and Financial Impact which will be reported in Volume 2 of our findings, we are simulating the revenues on a DRG-by-DRG basis which the original twenty-six hospitals would have received in 1980 and comparing them to the revenues actually received. While not actually comparing dollar costs of selected procedures before and after DRGs, we will be obtaining a proxy for that result and will thus provide some information on that question. The problem of comparing actual costs is that while costs are indeed allocated to specific procedures under the DRG system, they were never previously so allocated. Instead, they were allocated to the departments that produce the procedures (along with many others).

The Uniform Bill-Patient Summary form which is filled out for every patient discharged from hospitals in New Jersey contains information about the patient’s residence, insurance coverage, physician or physicians, diagnoses, procedures and treatments performed, charges incurred, actual amount paid on the bill, and by whom. With this data, all the items on the list above can be addressed though no work has been done in this area as yet. The problem is not one of inability but rather of cost and difficulty of interpretation. Interpreting the results can be very difficult. When and what kinds of surgery can or should be done on an ambulatory basis rather than an inpatient basis is a question not agreed upon by physicians. Also, the availability or unavailability of facilities at a particular hospital may cloud the issue. Thus, the analysis is scarcely as straight-
forward as running cross-tabs and looking at the results. The data, while available, may be insufficient to answer the question accurately and completely, however, a pass could be made at it. Taking those results and comparing hospitals based on them becomes even more tricky in a methodological sense. It is fairly simple to tabulate the number of ambulatory surgery procedures of certain kinds which are performed hospital by hospital, but it is somewhat more difficult to know whether you should be pleased with or frightened by the results of that analysis.

One of the general problems with this is the quality of data. A simple example is that of identifying the primary, secondary, and tertiary payer in a particular hospital admission. Is the primary payer the one who picks up the first dollars of cost during the stay or is it the one who pays the largest amount for the total stay? Some hospitals answer one way and some the other, and, when comparisons across hospitals are attempted, it makes for major problems in the interpretation of the data. Even worse is the problem of the accuracy of the diagnostic data on the medical chart and on the Uniform Bill-Patient Summary. A study some three years ago found a 30 percent error rate in transferring the diagnostic information from the chart itself to the fact sheet and subsequently in coded form to the medical record abstract. An analysis done two years ago in the Maryland reimbursement system attempted to estimate the impact of such a coding error on total hospital reimbursement. It concluded that since the errors were not systematic but random, the net dollar effect was small. The number of cases which were paid for at too high a rate was approximately balanced by the number of cases that were paid for at too low a rate because of these errors.

Dr. Henderson: During the 1960s the suggestion was made to representatives of the New Jersey hospital community that a standardized accounting system be developed for New Jersey hospitals. This would have allowed various internal and comparative studies of New Jersey hospitals, including their degree of productivity. Has the DRG program improved hospital productivity or does it allow for the analysis of individual hospital productivity?

Mr. May: In response to the recommendations you referred to, a standardized accounting system was indeed developed. Standard Hospital Accounting and Rate Evaluation (SHARE) was instituted in the mid-1970s. Unfortunately, the accounting system allocated costs to producing departments rather than to units of output of those departments. It is essential, as you know, to assign cost to units of output in order to measure the relative efficiency and productivity of an organization. In fact, the question of whether the DRG program has improved hospital productivity is currently impossible to answer. In the literature on hospital production functions and costs, many attempts have been made to measure
hospital productivity and all have fallen short for purely technical reasons. There has not, in the past, been available an unambiguous, easily obtainable, mutually agreed upon measure of hospital product until the case-mix classification methodologies were developed. Though we cannot say what has happened to hospital productivity as a result of the DRG system, it must be noted that the very existence of the DRG classification system will enable us in the future to improve our techniques in measuring hospital productivity.

That is the technical answer. At a more gut level, I believe that, as mentioned above, the presence of information concerning how individual patients, classified into homogeneous groups, were treated by individual physicians highlights the question of productivity in the hospital setting; and, for the first time, provides management with a tool and an incentive to do something about it.

Is The DRG System Working?

Dr. Henderson: Published information from HRET indicates that the net revenues of hospitals in the DRG system during its first year of operation increased at a greater rate than those not in the system. How could a program such as DRG, which would not be in effect without a need to contain costs, be called successful if the financial position of those institutions in the program has improved so dramatically?

Mr. May: Our findings are that the profitability of hospitals in the DRG system increased more than did the profitability of those not in the system. In fact, between 1979 and 1980, the hospitals not in the DRG system increased their profit as a percent of total revenue from 1.44 percent to 1.85 percent; those in the DRG system experienced a .06 percent loss in 1979 and 3.49 percent profit in 1980. Because, under the DRG system, hospitals are not paid a retrospective cost-based amount but rather a prospective price for each type of case, they function much more like typical businesses than they did under the previous system. The net revenues of hospitals are affected by the prices set by the Department of Health for individual DRGs, the volumes of patients in each of those DRGs, and the costs which the hospitals incur in caring for them. In such a situation, successful cost-containment efforts at the individual hospital level, combined with known fixed prices for various cases, could indeed lead to improved net revenues. While I believe that a good portion of the improvement in net revenues of DRG hospitals is due to the attributes of the enabling legislation and the sweetening of the pot phenomenon discussed above, I must point out that one way for a hospital to improve its bottom line under the DRG reimbursement system is to engage in cost-containment efforts in the face of known per case prices. This option is not available to hospitals under a per diem-based reimburse-
ment system but it is under the DRG system. Such behavior on the part of hospitals would, in turn, reduce the rate of cost escalation and thus the expenditures by payers for hospital bills.

**Dr. Henderson:** Finally, there is some concern, particularly among New Jersey physicians, that the DRG process will decrease the quality of care by shortening the lengths of stay or decreasing the frequency of needed laboratory tests. Conversely it should be noted that the New Jersey regulatory process mandates utilization review of all hospitalized patients performed by the various PSROs. Theoretically this review should see that the quantity of hospital care is maintained at a reasonable level in spite of the DRG pressure to reduce lengths of stay. Has the DRG program affected the quality of hospital care in the state? Have specific studies been performed or are data available (for example, on short-stay cases and the rate of readmissions) to assure that the DRG process does not have an inappropriate impact? Will there in fact be a balance between pressure to reduce service levels and the need for quality care?

**Mr. May:** The DRG system has most probably reduced the quantity of care provided to individual patients in hospitals in the state of New Jersey. The reason for this is encapsulated in the incentives which the DRG system provides. Whether the reduction in the quantity of services provided represents a reduction or an increase in the quality of care, I do not know—neither can physicians agree on this question. There is some concern that hospitals are discharging people before they are fully recovered in order to shorten the length of stay and increase revenues and, thereby, putting the patient at risk for a readmission for the same condition. Based on the data available to date, there is no evidence to support this. AHA Annual Survey Data report a reduction of only 0.1 day in length of stay in New Jersey community hospitals between 1979 and 1981. As mentioned above, definitive answers to these questions must await data which will become available only after the adjustment process to the new system has taken place.

As to the question of achieving a balance between pressure to reduce service levels and assuring appropriate quality, I must again emphasize the importance of the in-hospital availability of data and information on care of individual patients as the central factor. The more the colleagues of a physician, the administrator of the hospital, and the trustees of the hospital know about what individual physicians are doing for individual patients, the more visible and, therefore, the more manageable becomes the question of whether or not quality care is being provided.

**NOTES**