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The dramatic shifts in health policy over the last several years have both resulted from and reinforced an equally dramatic shift on the part of policymakers, if not the general public, in their perception of hospitals. For a variety of reasons, hospitals, long viewed as among the most sacrosanct of community institutions, have increasingly become the object of hostility, suspicion, and even contempt on the part of legislators and executive branch officials alike. While public opinion data continue to suggest strong (if eroding) sympathy for hospitals in general, or at least for citizens’ own local hospitals, there has been a dramatic change in government and business circles. The loss in credibility created by the failure of the late 1970s “voluntary effort” to contain costs; reports of the profitability experienced by both for-profit and not-for-profit hospitals in an era of budget stringency; more anecdotal reports of excessive responses to governmental policy incentives in the form of premature discharges of patients or inappropriate care; and, perhaps especially, reports of increased “dumping” of seriously ill patients have all contributed to a climate in which hospitals have become the villains of contemporary health care melodrama. This villainization of the hospital permits a series of arbitrary and substantial reductions in public support for hospital expenditures after two decades of almost completely open-ended funding. Like all pendulums, this one has undoubtedly swung past a reasonable midpoint and will at some point begin to swing back. Certainly, any set of institutions which consume 4 percent of the gross national product, with half of that amount derived directly from public revenues, deserve more systematic and serious scrutiny and less unqualified approbation than was evident for much of the 1960s and 1970s. But as the public policy attack on hospitals proceeds beyond the point of defensible budget cutting or demands for rationalization, it is not inappropriate to leaven the current discussion with some consideration of what it is that hospitals do right. Just as hospitals in general should be no more immune from public scrutiny and public criticism than any other institutions in society, so too should they be compared to other institutions in terms of their relative accomplishments and relative success. Indeed, there is much that is right about America’s hospitals.
Some Basic Strengths

Most American hospitals do a pretty good job of those things that hospitals are supposed to do and do best. That’s far from a trivial or even redundant statement. What most of our hospitals were designed to do was to take care of relatively sick people with relatively well-defined medical conditions subject to relatively well-defined technological interventions. If you need multiple coronary artery bypass surgery, or even something less dramatic like a gall bladder removed or treatment of pneumonia, you are probably better off in an American hospital than just about any other place one could imagine. The odds are pretty good that the hospital, in conjunction with the medical staff for which it is legally and morally responsible, will adequately provide the nursing and other supportive services, technological equipment, and other preconditions necessary for producing outcomes about as good as the current state of scientific and medical knowledge permits.

Similarly, if you are hit by a car or suffer a heart attack, and (not insignificantly) survive to the point of reaching the hospital, the chances are overwhelmingly good that you will be discharged in a very much better condition sometime relatively soon thereafter. Hospitals are not even bad places in which to have babies, although there is increasing controversy as to whether or not they are the appropriate places for all mothers to give birth to all babies. Certainly, a significant, if small, subset of American hospitals are especially good places for the care of very small babies who would not have been expected to survive without the organizational, technological, and professional skills those institutions increasingly possess.

Not insignificantly, these things that hospitals do well are to a considerable extent the things that the public expects hospitals to do. In a society in which many institutions (one thinks, for example, of high schools or public transportation) have increasing difficulty meeting even minimal public expectations, the capacity of American hospitals to continually improve at their basic mission is worthy of some note.

It might also be noted that the things that hospitals do best are also those things that are most easily classified in, for instance, a diagnosis-related group (DRG) payment system. In fact, if you look at DRGs as a system of classification or pricing, they do work a lot better on gall bladders than on psychiatric cases, or very complicated medical cases, or on cases involving multiple, interactive chronic diseases in the very old. The statistical shortcomings of some DRGs are less a reflection of inadequacies in the classification process than of uncertainty and heterogeneity—qualitative as well as quantitative—in actual patterns of care.

To say, as a broad generalization, that most hospitals do a good job at many forms of medical treatment is not to gainsay the fact that a sizeable number of hospitals are not very good at much of anything, and that
most hospitals probably do not do as well as they might nearly as often as they should. Good inpatient hospital care is a complex, ever-changing, and surprisingly fragile phenomenon, and too many Americans must settle too often for the adequate as opposed to the optimal. We have a long way to go in improving both the quality of care and the quality of patient amenities in most hospitals, but in many considerable respects the current situation really is not so bad. Additionally, in contrast to many other contemporary American institutions, hospitals adopt and spread new technologies remarkably well. At a time when there is increasing legitimate concern about the technological innovativeness and adaptability of many sectors of the American economy, we persist in a continuing, and not entirely unjustified, anxiety that the hospital industry may overdo it in the other direction. But the extremely rapid adoption of intensive care units, of computerized tomography and other new imaging technologies, of new forms of cancer therapy, and now of procedures which increase the proportion of outpatient surgery have all produced considerable benefits for thousands of patients and their families.

The rate of technological diffusion within the American hospital industry is not entirely without problems. For many techniques and procedures, maintenance of optimal quality requires a certain minimal volume of activity; competitive pressures among hospitals and physicians have, in some instances, produced technological proliferation to the point where it became actually dangerous for patients. Conversely, one can raise serious questions about whether new incentives in the revolutionized world of health care financing will distort the process of technology diffusion in undesirable ways, retarding the adoption of promising new technologies in those institutions best equipped to make use of them, while encouraging their proliferation in inadequate or inappropriate freestanding sites. One might also debate at infinite length the extent to which government regulation of new technologies is either overly stringent or overly permissive, or the extent to which the subsidization of technological development through the public support of biomedical research has helped produce inappropriate windfalls for a relatively small number of entrepreneurs and firms. Nonetheless, the basic lesson is again clear: today’s American hospital industry insures that a high proportion of us will have reasonably easy and timely access to the most current and effective interventions for the problems they encounter. One need not live within walking distance of a major academic medical center to benefit from this rapid technological diffusion, although the uninsured and residents of rural areas are especially at risk for being left out.

Health care technology diffuses so rapidly through the American hospital industry, in part, because there are so many hospitals through which it can diffuse. As a society, we clearly have many more hospitals than we need, but in terms of the provision of a vital community service, it is
refreshing to find at least this one which is oversupplied rather than undersupplied. Relative to public libraries, day care centers, parks, or even such basic infrastructural public resources as adequate sewers, clean water supply, and low-income housing, hospitals are located in the great majority of communities, including a large number of rural communities, some of which do not even have physicians. In many inner city areas, the hospital is the last functioning community facility left.

We have, as a society, paid a substantial premium for the quantity of hospital capacity we have created. Obviously, an optimal supply of hospital capacity would be preferable to an excessive supply, especially if anyone could define what an optimum is. Given how expensive it is to maintain, let alone pay off the cost of creating, a hospital sector that is considerably larger than we need is hardly an unmixed blessing. However, it does speak importantly to two related issues.

First, we have so many hospitals in the United States, in large part, because people individually and in communities have been so eager to support their development and growth. Private ambition, in this case, does not always equate with public virtue, but the underlying reservoir of public concern and public support manifested by the number, diversity, and extent of hospital capacity is a phenomenon that must be reckoned with. Perhaps more importantly, we have in many communities both substantial reserves of unused inpatient hospital capacity, and a critical shortage of appropriate institutional services for groups in the population with serious chronic problems, including the chronic mentally ill, the chronic functionally impaired elderly, and perhaps even the homeless. At some point, we are going to figure out how little sense it makes to have all that excess institutional capacity on the one hand and a crying need for institutional services on the other. When we do, the capacity to build new and expanded services on the sunk costs associated with existing hospital “excess” should be the source of some very real comfort.

Hospitals And Communities

While we have not yet recognized, in most aspects of public policy, the availability of the physical plant of hospitals as a resource for helping to address other problems in the inadequate supply of institutional services in many communities, we do recognize, de facto, the value of the simple physical and professional presence of the hospital for a number of social purposes outside the narrow range of inpatient acute care. As the only care-giving institution in many communities whose doors are open twenty-four hours a day, seven days a week, the hospital takes on a number of additional, residual functions that are vital to community well-being. The paradigm is the emergency room of any large city hospital at two o’clock on a Sunday morning when it becomes, in essence, the reception point
for every social problem that no other institution can deal with. The emergency room is the receiving point for urgent, but not otherwise addressed, problems of mental health, substance abuse, social displacement, family violence, and criminal justice. Nowhere else are trained professionals and a relatively secure environment available around the clock.

The hospital as institution of last resort is not only a characteristic of emergency rooms in off hours; it also metaphorically describes the broader function of hospital capacity in the community. We have grown jaded about the phenomenon of “alternate care” patients—hospitalized persons defined as needing nursing home or home care for whom appropriate placements are not available—when in fact alternate care means that the hospital is serving as the institutional care-giver of last resort for patients for whom no other institutional care is available. Or to take a different example, as serious as the problem is, it is hard to imagine how as a society we would have responded to the acquired immunodeficiency syndrome (AIDS) epidemic if we did not have the capacity to treat 1,500 or 2,000 people at any one time in settings that are both technically competent and socially legitimate.

As we increasingly do less well at addressing a lot of social and human problems, the presence of hospitals, especially in inner city and rural areas, to serve as care-givers of last resort becomes more important, however inadequately or expensively hospitals might fulfill that role. The real irony here, as in other aspects of things that are right about America’s hospitals, is the way in which the people who run hospitals have inadequately understood this role—or shunned it.

Being the community resource of last resort is not very lucrative and not very attractive in a variety of other ways. It does not often get highlighted in marketing brochures. Many hospitals would just as soon do without it, although over time they, as well as we, would be the poorer.

Many hospital managers also fail to adequately recognize a related strength of our hospital system—the way it serves, in many areas, as both focal point and resource for community involvement, community commitment, and community concern. If we take seriously the contemporary rhetoric about the value of volunteering, of spontaneous community service activities, of private altruism and philanthropy, then we need to recognize the object of many of those impulses.

Volunteer service in hospitals continues to grow at a remarkable rate; contributions to hospitals have lagged behind hospital cost increases, but have continued to grow in real terms; the work of voluntary trustees has become increasingly burdensome, but trustees, by and large, have responded with increased energy, commitment, and creativity. The very powerful and widely spread instincts of Americans to help their neighbors can often be most effectively mobilized around and through hospitals.

As noted earlier, the willingness of communities to support their hos-
hitals can run counter to the efforts of bureaucrats and legislators to “rationalize” and shrink the hospital system. This phenomenon is also inadequately understood by many hospital administrators themselves, who can become so intoxicated by the symbols of the marketplace that they lose sight of their major sources of potential support. But the voluntary tradition, which has its ups and downs, retains considerable strength and continues to have a major influence on America’s hospitals.

Hospitals And Public Policy

The limited capacity of most hospitals to assure the quality of services they provide significantly exceeds the capacity for quality assurance in almost every other part of the health care system. In addition, it offers the best framework for the significant improvements in quality monitoring and quality assurance that are increasingly going to be demanded.

Quality assurance is not simply a question of data, of measuring and evaluating patterns of care. It also requires a set of institutional mechanisms to analyze the information, to draw conclusions from it, and to stimulate and enforce behavioral change. We are just learning how to do these things well in the hospital sector. At least in hospitals there exists the institutional capacity and obligation to do them. As health care delivery moves to freestanding sites, to the offices of private entrepreneurs, and back to patients’ homes, the comparative advantages of hospital structures will become more obvious. Policymakers are even now confounded by the problem of how to manage quality assurance for Medicare beneficiaries enrolled in health maintenance organizations (HMOs), just as they are beginning to see signs of real progress in hospital quality assurance.

The Health Care Financing Administration’s recent release of the so-called hospital “death list,” for all its technical and conceptual shortcomings, demonstrates at least that, with greater care and sophistication, it is now technically possible to systematically characterize and identify patterns of hospital care, and concentrate existing quality assurance mechanisms on suspected anomalies. Such information and analysis is not now possible for any other part of the health care system, and is likely to become less feasible still as increasing competition further fragments the delivery and insurance systems. The average freestanding surgicenter may provide lens extractions at the same level of quality as the average hospital-based day surgery unit, but the capacity to monitor and control quality is significantly greater in the latter than the former.

The current concern about quality of hospital care has arisen, to a considerable degree, of course, from the ways in which hospitals have responded to last year’s public policy priority—the need to reduce service intensity in order to control costs. Not so long ago, public policy students worried at great length about problems of implementation. Con-
gress would pass a law, the bureaucracy would issue regulations, and then nothing would happen because private actors in the community would just go on doing what they had been doing anyway. If anything, in the current climate hospitals have shown themselves to be overly responsive to the ebbs and flows of short-term policy priorities. Five or six years ago, they were told they would have to be more competitive in marketing and pricing, and they began competing like mad. Then Congress enacted the prospective payment system and told hospitals to control their costs and reduce lengths-of-stay; cost growth was cut in half, and lengths-of-stay plummeted. Now we worry that they might have overdone it.

With any set of institutions that respond so dramatically to external stimuli, one must question their internal gyroscopes, their sense of clarity about their own missions. Hospitals may have become too responsive to public concerns. Length-of-stay is an interesting example. As far as anyone can tell (given the vagaries of cross-national data), lengths-of-stay in the United States are already the lowest in the industrialized world. As a result of the tendency of policymakers to confuse marginal with average costs, public policy has nonetheless continued to emphasize length-of-stay reduction. With so much excess capacity in the hospital industry, and the patient population aging so dramatically, further reductions might not really be a very good idea, but they will probably continue to occur until someone tells hospitals they shouldn’t.

Finally, a minority of the nation’s hospitals, disproportionately those under public auspices (but including several hundred private voluntary institutions), take care of a large number of uninsured poor people without anyone adequately compensating them. In low-income communities, the supermarkets, drugstores, and furniture stores tend to charge more than their counterparts downtown, but the hospitals give 8 to 25 percent of their services away for nothing.

The reliance of the urban poor on hospitals for routine ambulatory as well as inpatient care has many undesirable characteristics, both qualitatively and economically. But that reliance emerges from the absence of anyone else to serve the need. Similarly, for all our current rhetoric about needing to find new revenue sources to subsidize the uninsured, the only practical systems of subsidies that have actually been put into effect are those in a handful of states that build on preexisting patterns of hospital services to the poor by redistributing revenues within the hospital sector. The average American corporation contributes something less than 1.5 percent of its after-tax profits to charity; the average hospital contributes 1 to 2 percent of its revenues to charity; the sizable minority of truly philanthropic hospitals have no profits because of the proportion of their revenues that they give away in uncompensated services.
Doing Better

For all the considerable strengths of America’s hospitals, however, the irritation felt toward them by many policymakers is far from entirely unfounded. Indeed, it mirrors a high degree of confusion, uncertainty, and anxiety among the people who run and govern hospitals. Better performance from the hospital sector will require, above all, greater clarity and commitment on the part of hospitals as to what they are supposed to be and do.

A generation of uncontrolled growth and unbridled expenditures, followed by the inevitable counterrevolution of the payers—in an industry and a culture with remarkably little sense of its own history—changed the rules of the game for a generation of administrators and trustees who never knew anything different. The current exaltation of business culture and entrepreneurial values furthers confusion in what is fundamentally an uneconomic enterprise. Even without these phenomena, the underlying dynamics of demographic change, physician supply, and a continuing technological revolution would be generating enormous pressures for change.

The people who run the nation’s hospitals need to define more clearly, for themselves and their institutions, just what it is hospitals are, or can become, good at—and what they are unlikely to ever be able to do as well as others. They need to find better ways to balance the seductions of new technologies with the qualitative and economic imperatives for regionalization and shared services. They need to figure out ways to put their excess capacity to use to meet other pressing human needs, even if the short-term economics appear discouraging. That must be part of a broader strategy to systematically rebuild hospitals’ implicit social contract with the communities that continue so emphatically to support them and their services. They need to give more life and force to the capacity they already possess to maintain and improve quality.

The environment for hospitals is almost certain to be less lucrative, less supportive, and more complicated in the future than it has been for the last generation. Running hospitals will be more difficult; the risks and uncertainties will be far greater, and the rewards nowhere near proportionate. Many relatively recent entrants to the business will turn around and leave, as they are already beginning to do, while some long-established institutions have become so far removed from their original missions that they too will see little point in maintaining the struggle.

One can readily imagine a world with fewer and smaller hospitals. But as the public still knows better than policymakers, none of us are really prepared to envision a society with too few. Holding those remaining hospitals to higher standards will, over time, provide the basis for a rebirth of the public policy support which they will by then so vitally deserve.