Approved March 3, 1983
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./~~p.m.~~ on February 28, 1983 in room 526-S of the Capitol.

All members were present except:

Senator Roitz, excused and Senator Bogina

Committee staff present:

Emalene Correll, Norman Furse, and Bill Wolff

Conferees appearing before the committee:

Ron Todd, Office of Commissioner of Insurance
Senator Jack Steineger
Dr. Robert Goolsbee, Mission Hills, Kansas
Dr. Joseph Hollowell, Department of Health and Environment
Lynelle King, Kansas State Nurses Association

Others present: see attached list

SB 87 - Hospital cost containment act
SB 285 - Creating a state health care commission

Ron Todd, office of Commissioner of Insurance, testified in support of SB 285. He stated that this bill was introduced at the request of Fletcher Bell, Insurance Commissioner, and that health care cost is one of the most critical issues we are facing and his office is directly involved. Mr. Todd declared they are trying to get a handle on rising health care costs, and they feel that SB 285 would best serve the state of Kansas by providing for a commission with some expertise and regulatory authority. This bill would create a health care commission; identify the charge of the commission; provide a funding mechanism; impose a deadline for the completion of its work; and would give this commission the authority to look into the key elements that are the cause of rising health care costs. Mr. Todd said they are setting up a commission with the expertise and legislative backing to provide the best possible working commission, and urges the committee to give serious consideration to this bill.

There were questions and discussion as to the staffing and cost of such a commission.

Senator Jack Steineger testified in support of SB 87 and 285, and distributed testimony stating that both bills address the problem of rising health care costs, but their approaches are different. SB 87 addresses the problem by establishing a Kansas Hospital Commission and providing for a uniform system of financial reporting by hospitals. SB 285 would create a "blue ribbon" state health care commission empowered to obtain the needed information from the health care industry and make appropriate recommendations. Senator Steineger suggested a third approach to the problem of health care cost, and requested that SB 285 be amended and the commission given the specific charge of examining the desirability of creating a regulatory commission and making a recommendation to the legislature. (Attachment #1).

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10 a.m./p.m. on February 28, 19 83

Dr. Robert Goolsbee, Mission Hills, Kansas, testified in support of SB 87, and said that a uniform system of cost accounting and reporting should be included in the bill, and a statewide prospective reimbursement system should be instituted. That is the only method that appears to be effective, according to Dr. Goolsbee, and would solve a great number of problems. He said there has been competition among hospitals to recruit physicians, but not to keep costs down. Dr. Goolsbee distributed to the committee an article entitled "Why Medical Costs Are Out of Control", taken from Forbes magazine, February 28, 1983. (Attachment #2).

Dr. Joseph Hollowell, DH&E, testified that this is a very important problem and it is time to start solving it. He said that SB 87 moves ahead and SB 285 re-studies the problem.

Lynelle King, Kansas State Nurses Association, testified in support of SB 285, with an amendment requested by KSNA which would place a representative of the State Nurses' Association on the Health Care Commission. (Attachment #3).

Senator Francisco moved that the minutes of February 25, 1983, be approved. Senator Morris seconded the motion and it carried.

Senator Meyers announced that the committee would meet again at 12:15 today.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-83 - 10 a.m.

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Lois Rick Scheitlin	KS K of Nursing
Dick Hummel	KS Health Care Assn. Topeka
Sheryl Jacobs	Business Men Assurance Co - KC Mo
Ron Todd	Dns. Dept.
KEITH K LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
JACK ROBERTS	BC-BS
Robert Grobbel M.D.	Free Standing Ambulatory Surgical Centers
Guillermo Bautista Vega	HSA NEK
Audrey Kennedy	HSANEK
Gary Petz	KDoA.
Nadine Burch	KC017
George B. Welch	D of A
HAROLD E. RIEHM	Ks Assn of OSTEOPATHIC MED.
Nickie Stein	KS St. Nurses' Assn.
Lynelle King	KSN " "
Ron Schmidt	KDH&E
Joe Holloway	"
Gary Robbins	Ks Opt. Assn
Ken Schatermeyer	Ks Pharmacists Assoc.
Rebecca Kupper	Ks. Hosp. Assoc.
Cheryl Jernigan	Ks. Hosp. Assc.
Donald A. Wilson	Ks. Hosp. Assoc.
Stanley	

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-83 - 10 a.m.

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Michele Hinds	Legislative Intern

1-9-m 2-28-83 #1

STATE OF KANSAS

JACK STEINEGER
MINORITY LEADER
SENATOR, SIXTH DISTRICT
STATE CAPITOL BLDG.
TOPEKA, KANSAS 66612
(913) 296-3245

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

WAYS AND MEANS
JUDICIARY
LEGISLATIVE AND CONGRESSIONAL APPORTIONMENT
COORDINATING COUNCIL
INTERSTATE COOPERATION
LEGISLATIVE BUDGET
POST AUDIT

REMARKS OF SENATOR JACK STEINEGER
FEBRUARY 28, 1983
S.B. 87 AND S.B. 285

IN THE PAST TEN YEARS, BOTH THE PRIVATE AND PUBLIC SECTORS HAVE SEARCHED FOR WAYS TO CONTROL OUR CONSTANTLY ESCALATING HEALTH CARE COSTS. ON THE NATIONAL LEVEL, THESE COSTS HAVE CONTINUED TO EAT UP MORE AND MORE OF OUR GROSS NATIONAL PRODUCT--- AND NO END APPEARS IN SIGHT.

IN 1980, THE LATEST YEAR FOR WHICH WE HAVE COMPLETE DATA, HEALTH CARE COSTS AMOUNTED TO 9.45% OF THE GROSS NATIONAL PRODUCT--AN INCREASE OF 15% OVER THE PREVIOUS YEAR AND THE HIGHEST ANNUAL INCREASE IN 15 YEARS. THE RATE OF INFLATION IN MEDICAL CARE COSTS HAS AVERAGED MORE THAN 10% SINCE 1974, WITH ANNUAL INCREASES ABOVE 15% FOR SOME MAJOR COST ITEMS SUCH AS HOSPITAL ROOM CHARGES, THESE ARE THE NATIONAL FIGURES. MUCH THE SAME IS TRUE FOR KANSAS,

Att. 1

ALTHOUGH THE HEALTH CARE PORTION OF OUR STATE'S ECONOMY HAS NOT GROWN AS FAST AS THE HEALTH CARE COMPONENT OF THE GROSS NATIONAL PRODUCT, OUR PER CAPITA HEALTH CARE EXPENDITURES HAVE GREATLY OUTSTRIPPED THE NATIONAL RATE OF INCREASE---15.5% OF KANSAS COMPARED WITH 12.3% FOR THE NATION, LET'S LOOK AT THE FIGURES.

IN 1980, KANSANS SPENT $2.3 BILLION FOR ALL HEALTH SERVICES AND SUPPLIES---A 13% INCREASE FROM 1979.

IN 1980, KANSANS SPENT $918 EACH FOR PERSONAL HEALTH CARE SERVICES COMPARED TO $941 NATIONALLY. KANSAS PER CAPITA SPENDING IS GROWING FASTER THAN THE NATIONAL RATE AND IS NOW 98% OF THE NATIONAL LEVEL COMPARED WITH 93% IN 1975.

IN 1980, KANSANS SPENT $428 EACH FOR HOSPITAL CARE COMPANRE WITH $430 NATIONALLY---JUST $2 BELOW THE NATIONAL AVERAGE. COMPARE THIS TO 1978 WHEN WE FELL $20 BELOW THE NATIONAL AVERAGE, AND YOU BEGIN TO GET A PICTURE OF HOW FAST OUR HOSPITAL COSTS ARE GROWING.

THESE INCREASED HOSPITAL COSTS SHOULDN'T SURPRISE ANYONE, THOUGH BECAUSE IT APPEARS KANSANS---AS A GROUP---HAVE ONE OF THE HIGHEST RATES FOR BOTH HOSPITAL ADMISSIONS AND LENGTH OF STAY FOR ANY GROUP IN THE NATION.

WHILE I DON'T HAVE ANY NEW FIGURES FOR KANSAS, WE CAN LOOK AT THE NATIONAL TRENDS, WHICH KANSAS FOLLOWS. THE AMERICAN MEDICAL ASSOCIATION'S CENTER FOR HEALTH POLICY RESEARCH PUBLISHES MONTHLY SUMMARIES OF MEDICAL CARE INFLATION RATES, AND I HAVE GIVEN YOU EXCERPTS FROM THE DECEMBER 1982 REPORT.

IF YOU LOOK AT THE FIRST PAGE, YOU WILL SEE THAT WHILE "ALL ITEMS" WERE DECLINING AT AN ANNUAL RATE OF -4.8% AND "ALL SERVICES" WERE DECLINING AT -10.1% BASED ON DECEMBER'S FIGURES, MEDICAL CARE COSTS CONTINUED THEIR UPWARD SPIRAL.

FOR EXAMPLE, MEDICAL CARE WAS UP 7.6%, DRUGS UP 11.3% AND HOSPITAL ROOMS UP 4%. IF YOU WILL LOOK AT TABLE ONE ON THE SECOND PAGE, YOU CAN SEE THE RATES FOR THE PAST 12 MONTHS.

WHILE "ALL ITEMS" AND "ALL SERVICES" WERE GOING UP AT ABOUT 4%, MEDICAL CARE'S INFLATION RATE WAS 11%. HOSPITAL ROOMS, WITH A RATE EXCEEDING 13%, MORE THAN TRIPLED THE RATE FOR THE NON-MEDICAL COMPONENTS OF THE CONSUMER PRICE INDEX.

FRANKLY, EVERYBODY KNOWS WE HAVE A PROBLEM, BUT WE CERTAINLY AREN'T REACHING A CONCENSUS ON WHAT NEEDS TO BE DONE. S.B. 87 AND S.B. 285 BOTH ADDRESS THE PROBLEM, BUT THEIR APPROACHES ARE DIFFERENT.

S.B. 87 ADDRESSES THE PROBLEM BY ESTABLISHING A KANSAS HOSPITAL COMMISSION AND PROVIDING FOR A UNIFORM SYSTEM OF FINANCIAL REPORTING BY HOSPITALS. THE COMMISSION WOULD REVIEW HOSPITAL RATES PROSPECTIVELY AND HAVE THE AUTHORITY TO APPROVE OR DISAPPROVE THE RATES.

THE COMMISSION ENVISIONED BY S.B. 87 WOULD DIRECTLY ADDRESS THE PROBLEM OF SKYROCKETING HEALTH CARE COSTS BY IMPLEMENTING DIRECT CONTROL OF THOSE RATES. AT THIS POINT, MORE THAN HALF THE STATES HAVE IMPLEMENTED HEALTH CARE COMMISSIONS OF ONE FORM OR ANOTHER. MOST HAVE PROSPECTIVE RATE REVIEW POWERS, BUT ONLY SEVEN CAN REQUIRE COMPLIANCE. (CONNECTICUT, MARYLAND, WASHINGTON, MASSACHUSETTS, NEW JERSEY, NEW YORK.) THESE SEVEN COMMISSIONS HAVE MET WITH VARYING DEGREES OF SUCCESS, BUT OVERALL, THEIR IMPACT ON HOLDING DOWN HOSPITAL COSTS HAS BEEN GOOD.

ANOTHER APPROACH, THE ONE CONTAINED IN S.B. 285 AS PROPOSED BY INSURANCE COMMISSIONER BELL, WOULD CREATE A "BLUE RIBBON" STATE HEALTH CARE COMMISSION EMPOWERED TO OBTAIN THE NEEDED INFORMATION FROM THE HEALTH CARE INDUSTRY AND MAKE APPROPRIATE RECOMMENDATIONS.

PRESIDENT REAGAN HAS POINTED OUT THAT HEALTH CARE COSTS ARE A NATIONAL PROBLEM WHICH SHOULD BE ADDRESSED AT BOTH THE STATE AND NATIONAL LEVEL WITHOUT DELAY. THIS LEGISLATURE HAS GRAPPLED WITH THE PROBLEM IN ONE FORM OR ANOTHER FOR A NUMBER OF YEARS, AS WE CONSIDER THESE TWO BILLS, AND THEIR DIFFERENT APPROACHES, I THINK THERE ARE THREE THINGS WE DHOULD REMEMBER:

FIRST, THERE'S ABSOLUTELY NO REASON FOR FURTHER DELAY. EVERY YEAR WE DELAY TAKING ACTION TO CONTROL HEALTH CARE COSTS IN KANSAS, THE PROBLEM ONLY GROWS WORSE, NOT BETTER.

SECOND, IT'S OBVIOUS TO EVERYONE THAT WE DO HAVE A PROBLEM. THE POINT IS NEARING WHEN HEALTH CARE OR HEALTH INSURANCE WILL BE PRICED OUT OF THE REACH OF MANY KANSANS.

AND,THIRD, THE LEGISLATURE IS ILL-EQUIPPED TO MAKE THE DETAILED DECISIONS NECESSARY TO BRING HEALTH CARE COSTS BACK UNDER CONTROL. WE DON'T HAVE THE STAFF. WE DON'T HAVE THE EXPERTISE. WE'RE POLICY MAKERS, NOT POLICY IMPLEMENTERS.

COMMISSIONER BELL AND I HAVE DISCUSSED THE PROBLEM OF HEALTH CARE COSTS FOR SEVERAL YEARS. WE AGREE THAT THERE'S A PROBLEM, BUT OUR APPROACHES TO THE SOLUTION ARE A LITTLE DIFFERENT. I CERTAINLY APPRECIATE THE COMMISSIONER'S COMMITMENT TO FINDING A SOLUTION, BUT I DON'T THINK S.B. 285 GOES FAR ENOUGH. I SAY THIS FOR TWO REASONS.

FIRST, I THINK ANOTHER STUDY, AS ENVISIONED BY S.B. 285, WOULD HAVE THE EFFECT OF DELAYING ANY MEANINGFUL SOLUTION TO THE PROBLEM OF HEALTH CARE COSTS.

SECOND, I'M UNSURE HOW EFFECTIVE OUR PART-TIME LEGISLATURE COULD BE IN REVIEWING AND TAKING ACTION ON THE COMMISSION'S RECOMMENDATIONS. EVEN WITH A STUDY, WE STILL LACK THE KNOWLEDGE, BACKGROUND AND INFORMATION TO MAKE THE KIND OF DETAILED, SPECIFIC DECISIONS WHICH WILL BE REQUIRED.

I AM A POLITICAL REALIST, HOWEVER, AND I RECOGNIZE THAT THE CHANCES FOR APPROVAL OF A S.B. 87 COMMISSION ARE NOT OVERWHELMING. SO, I WOULD ASK THE COMMITTEE TO CONSIDER A THIRD APPROACH TO THE PROBLEM.

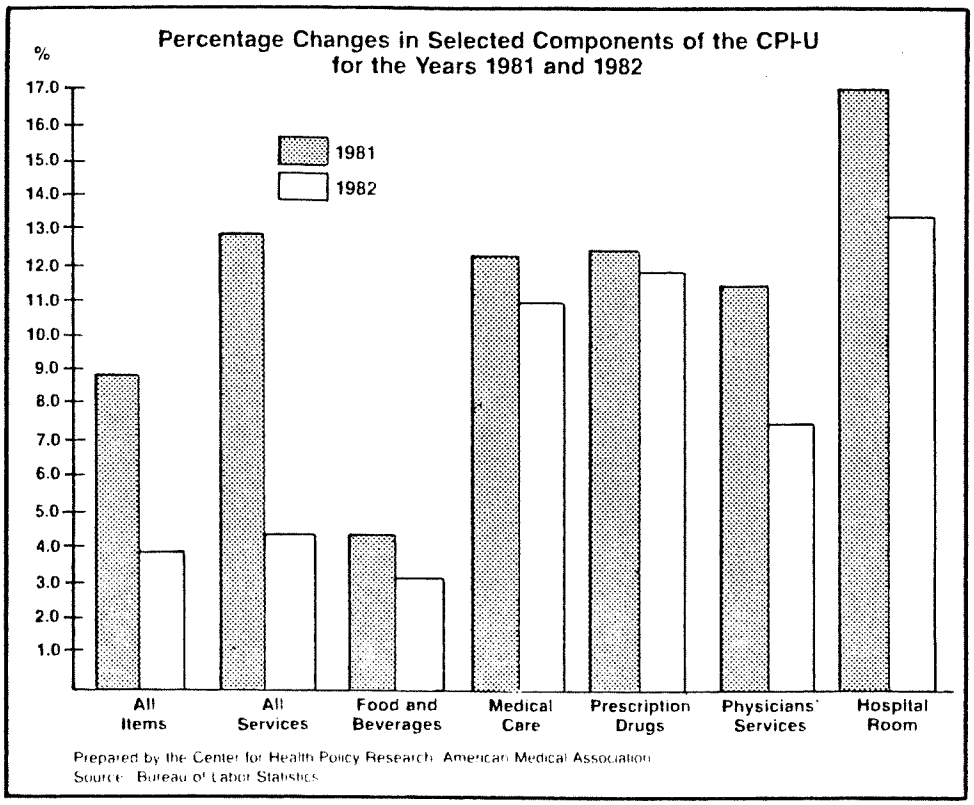
IF S.B. 87 DOESN'T RECEIVE YOUR APPROVAL, I WOULD REQUEST THAT S.B. 285 BE AMENDED AND THE COMMISSION GIVEN THE SPECIFIC CHARGE OF EXAMINING THE DESIRABILITY OF CREATING A REGULATORY COMMISSION AND MAKING A RECOMMENDATION TO THE LEGISLATURE.

WHILE THAT WON'T SOLVE THE PROBLEM OF RUNAWAY HEALTH CARE COSTS IN KANSAS, IT CERTAINLY WOULD BE A STEP IN THE RIGHT DIRECTION.

THANK YOU VERY MUCH.

CPI Report / Dec.'82
Center for Health Policy Research

January 21, 1983



OVERVIEW OF THE CPI

The consumer price index fell at an annualized rate of 4.8 percent during December 1982. This marked the second consecutive month during which overall prices fell. Lower gasoline prices were responsible for the decline in the transportation component, while lower interest rates were the principal reason for the decline in the housing component. For the entire year of 1982, the all items index rose by 3.9 percent. This figure is substantially less than half of the 8.9 percent increase registered in 1981. The three subcomponents of the medical care services price index reported here all rose at moderate rates during the month of December. Prices for physicians' services increased at an annualized rate of 4.8 percent, while the comparable figures for dental services and hospital room charges were 3.8 percent and 4.0 percent respectively.

Annualized Changes in CPI December 1982

All Items	-4.8
All Services	-10.1
Medical Care	7.6
Physicians' Services	4.8
Prescription Drugs	11.3
Hospital Room	4.0
Transportation	-4.0
Housing	-9.7

TABLE 1

PERCENTAGE CHANGES IN SELECTED COMPONENTS
OF THE CONSUMER PRICE INDEX (SERIES CPI-U)

Selected Items	Last Month (Nov. '82-Dec. '82)	Last 12 Months (Dec. '81-Dec. '82)	Annualized Change Last 5 Years (Dec. '77-Dec. '82)
All Items	-.4	3.9	9.5
All Services	-.9	4.3	10.9
Food and Beverages	.0	3.2	7.8
Housing	-.8	3.6	10.5
Transportation	-.3	1.7	10.5
Medical Care	.6	11.0	10.5
Medical Care Commodities	.4	9.6	N.A.
Prescription Drugs	.9	12.0	10.0
Medical Care Services	.6	11.2	N.A.
Physicians' Services	.4	7.5	9.5
Dental Services	.3	5.9	8.7
Hospital Room	.3	13.3	13.5

Source: CPI Detailed Report for December 1977, December 1981, November 1982. December 1982 figures derived from oral communication with Bureau of Labor Statistics, Washington, D.C., January 21, 1983. Because of the revision in the CPI in January 1978, figures are not available (N.A.) for some indexes. Figures are not seasonally adjusted.

Why is the cost of health care increasing three times as fast as inflation in general? Because there's no incentive for it not to.

Why medical costs are out of control

An interview with Michael Bromberg

By James Cook

OUTSIDE OF GOVERNMENT itself, America's largest public industry these days is health care. In 1982, it generated 10.5% of the U.S.' $3.1 trillion gross national product, and it is growing faster than virtually anything else save electronics and communications. But this is the kind of growth our economy could do without. With the Consumer Price Index up only 3.9% last year, health costs rose an alarming 11%.

If the nearly 30 million Americans who aren't covered by either private or government insurance aren't worried, they probably ought to be, and so should those who are covered, because, in the end, health insurance costs get passed on to the public in the form of higher prices for everything.

Is the situation hopeless? FORBES put that question to the knowledgeable Michael Bromberg, executive director of the Federation of American Hospitals, who says the heart of the problem is the physician. The FAH represents the 1,040 for-profit hospitals in the U.S.—and the one part of the medical industry that's produced demonstrable productivity gains.

Bromberg: I think the major problem is the way hospitals pay, and I don't think it really matters whether they're for-profit or nonprofit. The reimbursement system gives all the wrong incentives. It says we're going to give you your costs whatever they are. Blue Cross, Medicare, Medicaid—the more you spend, the more you get; the less you spend, the less you get; therefore, you might as well spend. If you have a 200-bed hospital and 50 of your beds are always empty, why bother firing the three employees you've got behind each of those empty beds. Their salaries are going to be reimbursed anyway. It's like 15 years ago, when the Pentagon used to reimburse all its contractors at cost plus.

There's also a demand-side question of no restraint on the part of anyone. The tax law says health insurance is free—it's not income to the employee, and business can write it off—so you might as well get a lot of first-dollar coverage and no copayment. There are no normal marketplace restraints on anyone. None on the doctor or the hospital, and none on the patients, because they're not even paying part of the bill.

How important has unionization been in the increase in health care costs?

Bromberg: It's been a major factor in places like New York, but nationwide not as important as we thought it was going to be. The shortage of nurses has been much more important in raising our costs. Over the last two years we've had a nurse shortage, and this has led to a price war as the easy answer to how to get all these nurses who aren't working back in the work place. This cost reimbursement system fuels that price war because, again, why not? So, in the last couple years, nurses' wages went up—and I may be off a point or two—at an annual rate of something around 15%, vs. 13% or 14% for all hospital workers. It has a ripple effect. You give nurses 16%, and you've got to give orderlies 14%. Payroll is half a hospital's operating costs, and with fringe benefits, you're up to about 60%.

So there's not much hope of getting costs under control unless you change the whole way in which Medicaid, Medicare and Blue Cross function.

Bromberg: I think you can make some gains in productivity. I once looked up 6,000 hospitals in the country, and basically the spread of workers to patients in hospitals goes from about 2½-to-1 to 5½-to-1, which is a tremendous range. The public hospitals are at the top end, and the for-profit hospitals at the bottom. The investor-run hospitals have a staffing pattern nearly a full point below all other hospitals. So you *can* have productivity. But once you get it, it's over, that's it. If you're going to have long-lasting, long-term cost savings in health care, you've got to change the system, but you won't do that until you get to the medical side. Physician-ordered tests are two-thirds of the hospital bill. When a patient gets a hospital bill in this country, between one-third and 40% is room and board. The rest, between 60% and 70% of that bill, is physician-ordered tests: X rays, lab.

Is this designed to protect the physician from malpractice suits?

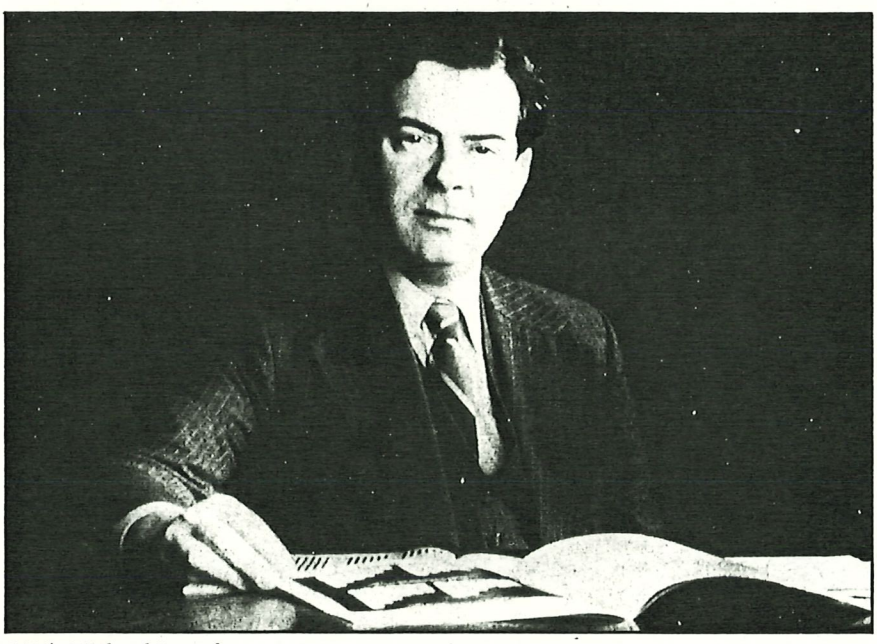
Bromberg: It may be quality of care, who am I to judge? Though labor is 50% of the cost, more than 60% of the cost, including labor, is attached to ancillary services—not room and board, but labs and X rays and equipment and capital expenditures. And that's ordered by a doctor. Not that the hospitals don't encourage it, but ultimately the authority—legal and moral and social, to say yes or no, the patient needs five X rays as opposed to six—belongs exclusively to the physician. And the only way to contain costs in the long-run is to get to the person who makes the whole system work, which is the physician.

And once again there's no incentive in the system for a physician to think twice. When in doubt, order. If I'm the patient, I may want that, I don't want some economic barrier. But if we want at least to put in an incentive to make the doctor and the patient think twice, we're going to have to change the system. I have never yet met a doctor who wouldn't tell me privately that, had he known that the patient was paying some significant part of the bill, he would have thought twice about some of the tests that he orders. Many times doctors put patients into the hospital overnight because they know insurance pays for it, whereas it would not if they did the same thing in their office. So why not? It's all

free—only it's not free; you and I are paying for it. If the patient were paying some small part of his bill I think doctors would act differently.

And I suppose part of the problem is that the price level is largely set by the cost of the difficult treatment. The simple high-volume ailments are used to subsidize the low-volume complicated ones. It's like asking a Chevette buyer to pay more so that Cadillacs will be cheaper.

Bromberg: It's a group-spreading-the-risk type of thing. If a burn patient—probably the most expensive there is—had to pay strictly out of pocket for that and not spread it over all the easy cases in the hospital, the whole theory of insurance would go out the window. For example, it generally costs two to three times as much per stay to take care of a patient over 65 as it does someone under 65. And yet Medicare doesn't pay very well. As a result, for a 40-year-old surgery patient who is in and out of the hospital in four days, about 25% of his bill really is nothing more than a subsidy for the 70-year-old patient.



FAH's Michael Bromberg
"The more you spend, the more you get, so you might as well spend."

Is the hospital system underutilized? Is that part of the problem?

Bromberg: We exaggerate this empty bed problem. What costs money in the hospital is people and equipment. And if you have 50 empty beds in a hospital and you don't staff them, they're not going to cost people much. More and more, the high-cost workers in a hospital are the people who work in the ancillary departments—people who run CAT scanners and coming NMR machines *(see story, p. 92)*, neonatal intensive-care units where nurses have to be used on a 1-to-1 ratio to patients. That's where the real costs are. So even if we can hold down the number of employees per patient to 3-to-1, say, the important thing would be what kind of workers.

Even so, the investor-owned hospitals have achieved at least some productivity improvements.

Bromberg: The profit motive gives you incentive to at least try. One of the questions the for-profit hospitals asked successfully about 12 years ago is: Wouldn't there be tremendous productivity gains and profit potential if we organized the hospitals into chains, multifacility systems? If we put 5 or 10 or 50 or 100 hospitals together, couldn't we share a lot of these high-cost items? Couldn't we share a computer in the admissions department and so cut the number of people working there? Maybe we could share accountants, save money there. Do the same thing with lawyers, with malpractice insurance. Maybe even form a captive insurance company. You go to General Electric and say, "Instead of buying a $1 million scanner, we're going to buy 10 or 20 scanners but only at a huge discount." There's a lot of money that can be saved.

But the biggest problem for hospitals in the next decade is access to capital; 40% of the hospitals in this country were built in the 1950s or early 1960s. That means that in this decade they're all going to reach 25 to 30 years of age, which means it's time for a total renovation. Well, the capital needs are going to be astronomical. Investor-owned hospitals opened a whole avenue of public finance—going to the stock market, equity capital—and a whole new source of capital that did not exist 12 years ago.

For all those economies of scale, for-profit operation hasn't produced lower prices, only more profitable operations.

Bromberg: I think so. Even though we pay taxes, we remain competitive in our prices. If we were absolutely equal, we'd be more expensive because we pay taxes. So I would say we're competitive. I don't make the claim that our prices are lower. However, I think we've upgraded quality and kept our prices competitive and costs down. The charge used to be made 10, 15 years ago that we weren't a full-service hospital, we just did easy cases. You look at all the capital we've pumped into these hospitals, and now the charge is we're doing too much.

How do you measure productivity in this business anyway?

Bromberg: It's hard because you can't define quality the way you can in others. The product changes every year. Ten years ago, you know, maybe 10% of the hospitals in America had intensive-care units. Today, 80% have them. Coronary-care units—same thing. So you have to adjust for quality, and nobody knows how to do that. What it comes down to in a service industry is what the consumer likes.

But to an extent, aren't a lot of health care expenditures a waste of economic resources? The quality of health care per se is not the driving force in lengthening the life span of the American people. That's come about through hygiene and a reduction in infant mortality.

Bromberg: I wouldn't discount it totally. Medical technology has played a role. The number of people who are living longer after their first and second heart attacks—some of that has to be attributed to the coronary care units and equipment, better diagnostic equipment and a lot of services that are done in a hospital. And you can't discount its impact on the quality of life, how much you're able to do, whether you live as a vegetable, how much pain is involved. What is it worth to a patient to be able to go through a ten-second scan at no pain on a million-dollar machine rather than have five very, very painful tests that may be a lot cheaper and aren't going to be as conclusive. You know that's worth something, too. ■

10 am 2-28-83 A3

KSNA

the voice of Nursing in Kansas

Statement of the Kansas State Nurses' Association
by Lynelle King, R.N., M.S. Executive Director
before the Senate Public Health and Welfare Committee
February 28, 1983

In Support of SB 285, Requesting an Amendment - State Health Care Commission

Madam Chairperson and members of the Committee, my name is Lynelle King and I am representing the Kansas Nurses' Association.

KSNA' Legislative Platform of 1980 through the present contains this plank: "KSNA supports efforts to contain health care costs while insuring a high quality of patient care." As a recent Salina Journal editorial said, everyone talks about keeping health care costs down but no one does anything about it. KSNA supports SB 285 because we believe the concept contained in the bill is a good first step to doing something about health care costs.

We believe there needs to be "review", evaluation, and the development of recommendation for action which fit the situations in Kansas, as provided by the Commission mandated in SB 285. We oppose the approach under SB 87 at this time until the type study proposed in SB 285.

We ask for an amendment to place a representative of the "state nurses' association" on the Commission. Note (lines 55 - 58) that health insurers are represented, non-profit service corporations and non-profit hospitals; "one shall represent the state hospital association and one shall represent the state medical society".

Rationale:

- professional nurses are the largest group of health care professionals
- they are the backbone of the health care system in all settings. They even are the only health care professionals in some settings.
- their orientation is more toward health promotion, wellness maintainence and rehabilitation, which has been shown to be much more cost-effective in the long run.
- nurses run the hospitals (and other institutions)

Att. 3

(over)

night and day, top to bottom, managing multi-million do budgets. They have expertise in cost-containment on a practical, everyday level. They have ideas about where else we might be saving.

- nurses have a great deal to lose from simplistic methods of cost-containment which have been instituted in several states. Quality care has been virtually destroyed in some states as a result of mandates of the state's rate review commission.
- expert nursing virtually is the only supportable reason for placing and keeping patients in hospitals. If they needed only an x-ray or other diagnostic test they could get this and then go home; if they needed only surgery they could get this and then go home - on an out-patient basis. The only reason for patients to be in hospitals is because they need the expert observation and care provided there by professional nurses.
- nurses and the ANA/KSNA have some new ideas about cost-containment. Nurses have been in the forefront of innovative, cost-effective ways of providing quality care yet at lower cost. For instance: (a) "primary nursing" - placing a professional nurse in charge of total care and planning for a group of patients from admission to discharge. Everyone has "my nurse". Only RNs and LPNs provide direct patient care. Studies have shown over an over that this approach saves money (or costs no more) yet the patient recuperates sooner - is able to leave the hospital sooner, patients, nurses and physicians like the system. (b) patient education - nurses have led out in demanding and getting hospitals and others to provide, through expert nurses, education to patients about how to prevent further illness, how to recuperate and so on. This has been shown to be particularly cost-effective in preventing recurrances of "heart attacks" and diabetic coma, for instance. (c) cost-effective use of nurse midwives, nurse practitioners and the like, (d) community nursing centers. (e) "It has been shown that a variety of predominently nursing interventions have low-cost-high-benefit results." Linda H. Aiken, R.N., Ph.D., Vice President for Research, Robt. Wood Johnson Foundation , Nursing in the 80's: Crises, Opportunities, Challenges, Lippencott, 1982 p. 470.

In summary, we believe that the state health care commission could benefit greatly from the balance and expertise of a representative of professional nursing serving on that commission. We feel most strongly that we must not be left outside knocking on the door of this body. We need to be on the inside probably more than any other named group, since we will be the group most affected (other than the patient/consumer) by any cost-containment proposal.

Thank you for the opportunity to comment. I will be happy to answer any questions.

LK/lw