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# The process of implementation of a city-wide HMO- Newark, New Jersey experience.

J. Pernell Parker

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THE PROCESS OF IMPLEMENTATION OF A CITY-WIDE HMO-  
NEWARK, NEW JERSEY EXPERIENCE

A Dissertation Presented

By

J. PERNELL PARKER

Submitted to the Graduate School of the  
University of Massachusetts/Amherst in partial fulfillment  
of the requirements for the degree of

DOCTOR OF EDUCATION

September

1977

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## Preface

The debt of gratitude incurred by the author in the course of developing and completing this study can never be repaid. It would be difficult to acknowledge the multiple contributions and to adequately thank faculty members, friends, colleagues and family members who helped at various points in the study. My gratitude to those not explicitly named here is no less than to the following persons without whose assistance this study could not have been completed:

Dr. Ernest Washington who served as friend, advisor, chairman of my doctoral committee and perfectionist who demanded excellence, but without failure offered the interest, enthusiasm and perserverance which is part of his lifestyle.

My Advisory Committee: Dr. Donald Carew provided invaluable assistance during the entry level of my graduate studies and served as a resource throughout my graduate work. Dr. Norma Jean Anderson served as the warm, understanding, sensitive dean of administration who leaves an indelible impression on the minds of those she encounters and finally Dr. A. Fahar Moustafa who skillfully challenged many of my statements and each detail of my study served as the impetus for me reading twice as many materials than would ordinarily be my choice.

Apart from my academic advisors, my family has my complete gratitude for tolerating my behavior during the entire project. My wife, Gladys

provided continuous moral support and became a professional critic that was always right in her analysis of each chapter. Our daughters, Jackie and Sabrina served as a resource for relaxation from the pressures and stress of completing this work. I thank my mother for her prayers for my perseverance.

None of this group is responsible for the inadequacies which remain within the following pages.

## ABSTRACT

### THE PROCESS OF IMPLEMENTATION OF A CITY-WIDE HMO-THE NEWARK, NEW JERSEY EXPERIENCE (September 1977)

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The objective of this study is to report on the Newark project which is designed to develop a health care delivery system which will overcome the deficiencies of the present system. Six general goals will serve as a summary of these objectives: effective cost efficiencies in health care, improvement of the health status of Newark residents, expand the city's health delivery system, insure a high quality of health care, improve the effectiveness of the Newark health care delivery system, and provide a model health indigency program for possible statewide use.

This study explores an alternative method of delivering health care services to the total population of a major inner city community. Although there are a host of different approaches to the traditional fee-for-service system of health care delivery. This study was directed toward the process of implementation of a ciety-wide health maintenance organization. The study highlights social, financial, and political issues associated with health care in general and specifically as they relate to the process of installing a new system to provide health services

to a total community of 260,000 residents. One significance of the study is that while there is a broad base of data and materials which describe the health maintenance organization concept, history, development and current status, few studies have researched and documented the actual process of implementation of a city-wide HMO.

One concern of the study was centered around information derived from questions in the following broad areas:

- Are there an adequate number of physicians in Newark and its contiguous areas to implement a city-wide health network (HMO)?
- Are there enough physicians practicing medicine in certain medical categories such as General/Family Practice; Obstetrics-Gynecology; Ophthalmology; Orthopedics; Urology; Pediatrics; Internal Medicine-Cardiology and General Surgery to provide an acceptable health care delivery system?
- Why was Newark, New Jersey chosen as the site for the nation's first city-wide health maintenance organization?

The second major direction of the study was its discussion of the glaring defects in the traditional health systems especially as they relate to the matter of physician shortage being a problem of distribution. Other defects highlighted were problems of inadequate health records and related problems along with inappropriate hospitalization.

Another focus of the study was the target population that would be potentially serviced by the city-wide HMO. This population included:



- Medically Indigents which are often referred to as the working poor or those persons who currently work at full time jobs. In spite of gainful employment, these individuals do not earn sufficient income to pay the cost of their basic health care needs.
- Medicaid Transfers are described as those individuals who are currently eligible for health care services under the state wide medicaid program. Those persons who live in Newark may elect to become members of the city-wide HMO by transferring from the state Medicaid program to the city-wide HMO.
- Medicare recipients are those persons who are currently eligible for the Medicare program and they may elect to join the city-wide HMO.
- Self-Paying Population are those persons who pay the cost of their health care out of their own pockets or have their employers pay for their health care. Payment by employers would be part of the individuals employment benefits.

This was an exploratory study in a relatively uncharted area which produced information valuable to medical staffs and health care executives in improving the utilization of services and in controlling health care costs.

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C H A P T E R I  
BACKGROUND AND GENERAL OVERVIEW OF  
HEALTH CARE

Introduction

The thoughtful voluntary actions of people make it possible to better the human condition. In essence, the quality of life can be improved through human ingenuity. Yet, when the issue of providing quality health care is raised, it must be viewed as a laudable goal, while at the same time, reviewed in the context of its complexities involving racial, political, social and economic influences which often have failed to respond to conventional, short-term, impetuses.

The provision of quality health care or its absence presents different problems requiring new approaches and revised values suitable to accomplish this task in a pluralistic democratic society.

In one part of the American socio-economic system, persons are rewarded with money, status and power, with their related advantages, for personal achievements and health care services is an essential component of that reward system. Conversely, another part of the socio-economic system which responds to the needs of those who must contend with less money, status and power, the related advantages are far less. Consequently, the availability

of health care services are lessened to the point of almost total nonexistence.

In many instances, the decrease in money, status, power and the availability of social services, particularly health care services are directly related to political and racial problems of twentieth century America. Health care services should be ranked among the most important of the rewards available to mankind without reference or influence to racial or economic status since a lack of health adversely affects access to the socio-economic reward system.

It is appropriate to define the issues clearly, in that *without* the basic foundation of good health:

- Can a child develop and grow in the most desirable fashion and is this factor essential for all children without reference to insignificant factors such as one's race.
- Can persons of school age--at whatever level--be expected to succeed if that person carries the burden of unattended health care problems?
- Can an adult person hold gainful employment, support a family, contribute to society in a productive useful fashion if that person carries the burden of unattended and inadequate health care needs.

If answers to these problems are negative ones, then it is urgent that the dual system of health care and services be discarded and a new

equitable system substituted and implemented. The new system would serve as an alternative to this problem and ensure American citizens that basic, comprehensive health care would be available.

Within the national hierarchy of priorities, health care services that are essential to sustain basic health are often relegated to a secondary position which is unfortunate, especially since good health is now viewed as a basic human right.

Accordingly, a paradox exists, in that, on one hand, all citizens are guaranteed free and equal access to the reward system. While on the other hand, "some 30 million Americans, for a variety of reasons, are denied the rewards available to other citizens by the absence of free and equal access to health care service systems essential to assure health."<sup>1</sup>

With the magnitude and complexity of problems associated with the delivery of health care, it is increasingly clear that such problems reach beyond the boundaries of city and state governments.

"Major efforts by the federal government to help preserve the people's health have occurred since World War II. Illuminated against the backdrop of national war needs, U.S. health problems stood out dramatically. Government officials were troubled deeply by the fact that one out of every three young men called for military service in the early 1940's was found physically or

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<sup>1</sup>Urban Health, the Journal of Health Care in the Cities, Atlanta, Georgia, 1974, p. 3.

mentally unfit."<sup>2</sup>

After World War II the federal government's thrust in the health field focused basically in two areas, namely, Public Health--the effort to prevent communicable diseases through research, training of medical professionals, and national public programs. The second thrust was support for biomedical research.

While the support for research continues and is clearly needed to foster adequate advancements in medical science, it proposes a barrier to good health care for certain consumers. Segments of the minority community have been used--unwillingly--as part of the biomedical research effort. Blacks in particular have been used as "teaching material" in hospital settings, while experimental drugs and medications have been key elements of theoretical approaches. Whispers about this type of health care tends to spread rapidly throughout a community, thus a barrier is created, because few people want to be "teaching material."

One alternative to this approach is that drugs could be adequately tested in the laboratories before they are used on humans, particularly if certain drugs are rushed on the market to get them there before the competing drug firms put a similar product on the market. In the instances where the medically indigent patient is used as "teaching material," it would seem more appropriate

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<sup>2</sup>Health Maintenance Organization, Medical Group Management, Proceedings of a Conference, 1972, p. 7.

if medical students in training were allowed to see patients on all socio-economic levels without the identification of a specific ethnic group.

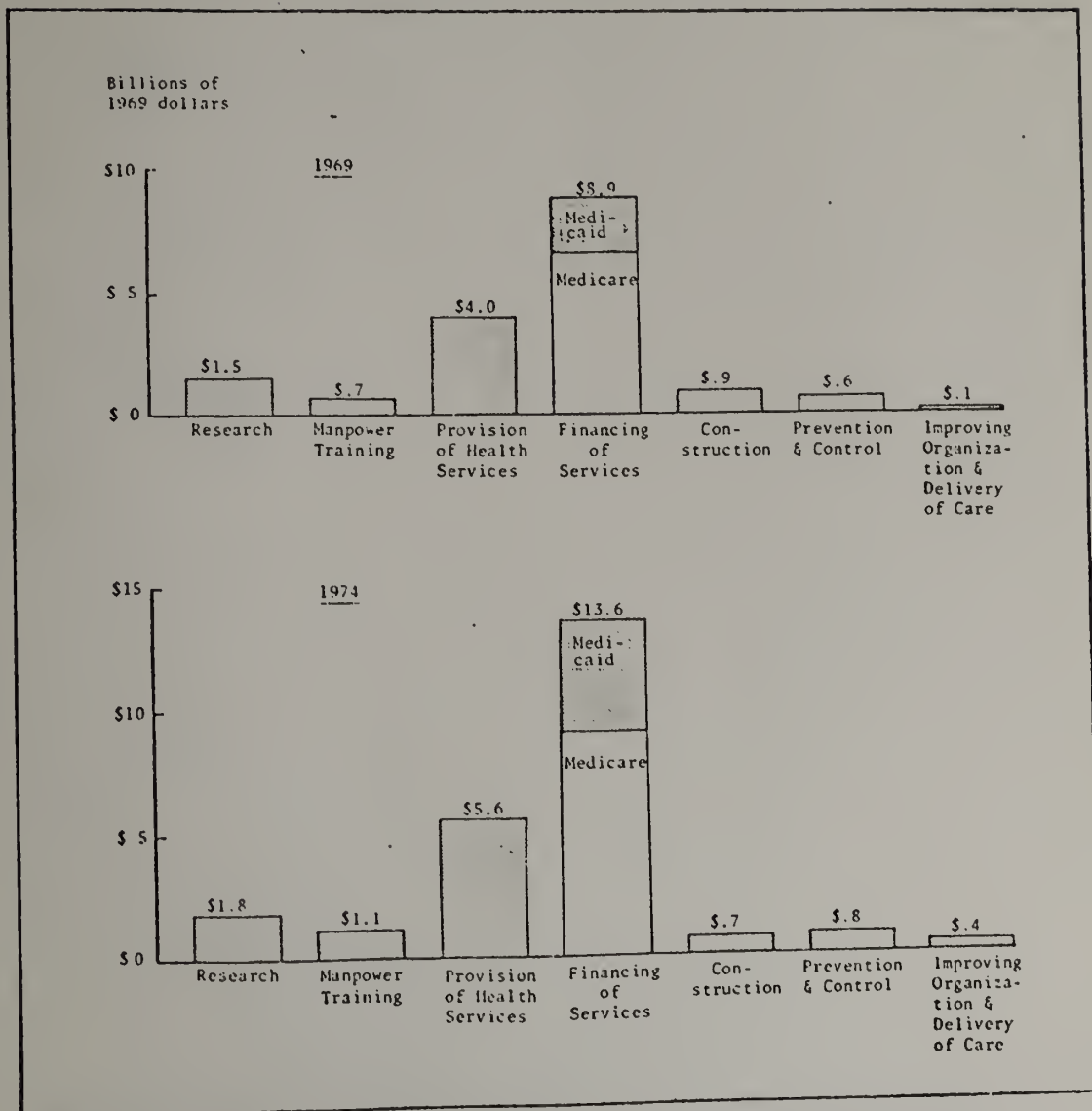
The governments' role in financing certain health care has enabled it to exercise some controls over providers, but these controls have been designed primarily to curb rapid escalations in the cost of health care but not to change appreciably the manner in which the care is delivered. The problem is highlighted by Table 1 which indicates the small amount of funding spent by the government for improving the organization and delivery of health care.

After years of experience with the Medicaid and Medicare programs it is clear that costs have not been contained or reduced. The alternative approach that could have been taken to correct the global problem with health care is to focus attention and money on correcting the ills of the delivery system itself. In short, the Medicaid program provides a "card" to eligible person by which care can be provided. It is the responsibility of the consumer to find adequate health care, which is the major problem because there is no systematic, organized, fraud free health care delivery system available for a person to get health care. This problem exists for the affluent as well.

"Our national system for the delivery of health care has changed little for most Americans since the end of World War II. Most people go to doctors, if at all, only when they are sick, or when their health needs have become acute. Most medical care is provided, in hospitals, clinics, or offices, by doctors who practice medicine privately and charge a fee for each specific service

TABLE 1

Federal Health Care Expenditures:  
1969 and 1974  
(Billions of 1969 dollars)



Source: National Planning Association, Center for Health Policy Studies, Charthook of Federal Health Spending: 1969-74 (Washington, D.C.: 1974).

they render."<sup>3</sup>

### Summary of Alleged Defects in Health Care

It is appropriate, at this point, to briefly review and summarize the current status of health care delivery, at least, as it is perceived at present. Perhaps little objective data support the forthcoming summary, but public opinion, political action and social concern suggests that the alleged defects have fairly strong basis for reality.

#### 1. Double standards and Two Systems of Health Care Services

As the American public becomes better educated, it becomes more knowledgeable about medical care, more demanding of good care, less awed by the medical profession, more inclined to view the hospital care system with a critical eye, and more articulate in expressing criticism and in pressing for reform.

Individualized, personal health care services are frequently not available on a continuous basis, to all segments of the population except at emergency rooms of hospitals, or through telephone answering services. In general, it is the consensus of both the consumer and the provider that the general health care available at hospital emergency rooms is inappropriate and inadequate. Perhaps the one exception is during life-threatening conditions. "Doctors clearly believe that the American health system works best in

---

<sup>3</sup> Anne R. Somers, The Kaiser-Permanente Medical Care Program, A Symposium, The Commonwealth Fund, New York, 1971.

providing care in emergency situations. Their high confidence on this point probably reflected both physicians' awareness of the demonstrable technical capacity of American medicine and their realization that, in emergency situations, ability to pay is less important than in non-emergency situations."<sup>4</sup>

Equally important to this analysis is the notion that as incomes rise and as the percentage of the population living in poverty declines, some of the diseases and social attitudes associated with poverty should decline. At present, the wide array of gaps between health care for the affluent and care for the poor are extremely broad and depressing.

"A poor child has half the chance of a more affluent child to live to his first birthday. The poor child's chances of contracting communicable diseases are far greater; for example, only half of all poor children are now immunized against polio. Poor children have five times more mental illness, seven times more visual impairment, six times more hearing defects, and three times more heart disease than their more affluent contemporaries."<sup>5</sup>

Tuberculosis, venereal disease, heart disease, hypertension, arthritis, mental disease, visual impairment, and orthopedic disability are far more common among the poor.<sup>6</sup>

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<sup>4</sup>Stephen Strickland, Ph.D., U.S. Health Care--What's Wrong and What's Right, A Potomac Associates Books, 1972, p. 13.

<sup>5</sup>"HEW's Child Health Failure," Congressional Record 120:S12574, July 16, 1974, quoted in Medical Care Review, September, 1974, p. 825.

<sup>6</sup>Charles Greene, "Medical Care of Underprivileged Populations," New England Journal of Medicine, May 21, 1970, p. 1187. Also Mary Herman, "The Poor: Their Medical Needs and the Health Services Supplied Them," The Annals of The American Academy of Political and Social Science, January 1972, pp. 12-21.



The poor are hospitalized far more often than more prosperous citizens and for several reasons. One element of this problem is a reflection of difficulty the poor encounter in getting preventive and ambulatory health services. A second element of this problem is that poverty seems to be more of a barrier to ambulatory care than to hospital care, so the poor find it easier to get expensive hospital care than the simple care that often might have made hospitalization unnecessary. A close review of this issue makes the solution understandable but difficult to accept.

The practicing physician will hospitalize a patient--particularly an indigent one--because through hospitalization, the physician is virtually assured that he will get paid. Health insurances, in this country, are designated to defray the cost of health care only if it is done in a hospital setting and not on an ambulatory or preventive approach basis.

Inadequacies in the medical care received by the poor are not due solely to the financial barriers to care encountered by the poor. Ignorance of where care can be obtained can be a problem in our scatter-site, atomistic, fee-for-service health care system.

Finally, the question of what impact new technology has had on this problem suggests a twofold answer: In one instance new techniques have helped transform the American health care system into one that emphasizes sophisticated technology. In another instance it gives lower priority to simple, basic health care. Often, large sums of funds are invested in radiation therapy

equipment, while ghetto children continue to get contagious diseases that could have been avoided by relatively inexpensive inoculation programs. Hospitals are frequently eager to add open heart surgery facilities, for which there is a limited need, but are less enthusiastic about expanding their outpatient clinics to meet the health needs of parts of its communities.

Clearly, the need for open heart surgery and other medical advancements are essential to the survival of an industrialized and modern society. With modernization and its sophisticated approach to problem solving it would seem that one of the countries top priorities would be to find a solution to humanities basic and most dreadful problem, which is inadequate health care.

The issue of the poor not being able to get preventive and ambulatory care is incredible especially when it has become common knowledge that it is easier and less costly to address a health care problem before it reaches its advance stages. One answer would be to reorganize the health care delivery system the same as the HMO concept or a similar organized delivery system that addresses the need of the affluent and the poor alike.

## 2. Lack of Trained Medical Generalists

The medically trained generalists in health care are declining and the super-specialists are increasing. An appropriate question is whether the generalists have sufficient competence to manage certain problems that require a thorough knowledge of contemporary scientific medicine and whether the super-specialists have the "Interest" in early, non-specific and undifferentiated complaints.

From a socio-economic viewpoint the American specialist finds it far more prestigious and socially acceptable to be identified as a surgeon or a medical specialist of some type. Financially, these physicians command higher fees while probably spending less actual time at their practice of medicine. At a minimum, weekends and holidays would be spent away from the practice while a family practitioner or pediatrician may be on call from patients.

More important than the prestige of a medical title is the need to identify with the need to keep a society well and healthy. An organized system of health care would address the problem of training adequate manpower to provide services to communities based on that particular communities needs. Each geographical area would have to be supplied with an acceptable number of medical and dental providers. Using this approach would not solve the problem of stratification among physicians but at a minimum people would be getting better and more comprehensive services.

"The American 'specialist' is virtually unknown in other countries; he frequently confuses himself both with 'consultants' and 'generalists.' He is perhaps best described as a 'consultoid' since he is apt to have the training and aspirations of the former but does the work of the latter."<sup>7</sup>

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<sup>7</sup>John B. McKinley, Politics and Law in Health Care Policy, Millbank Fund, 1971.

### 3. Inappropriate Employment of Scarce Manpower

The training and talents of many health professionals are wasted by inappropriate employment thus scarce human resources are wasted. It appears that the health care industry tends to use its skills and knowledge in conjunction with selective individual utilization of services than with the collective perceived needs and requests of the community.

An example that brings this problem closer in view is the Pediatrician who is taught by training to manage complex medical problems, but in actuality spend much of his time providing well-child care to "private" patients in their offices and to "public patients in health departments."

Perhaps the paradox is that responsibility for coordinating the care of "public" patients seen in the health department clinics is often delegated to a public health nurse, with the rotating physician advising only on medical problems. The same rotating physician, in a private practice setting may spend much of his professional time coordinating the care of his patient in the absence of skilled public health nursing services.

It is easily concluded that "nurses could undertake many tasks currently done by doctors, including the administration of screening questionnaires and tests, instruction and health education, certain treatments and domicillary visiting and care."<sup>8</sup>

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<sup>8</sup>  
Ibid., p. 7.

Licensing plays a positive and a negative role in the problem of adequate manpower. In theory, licensing protects consumers by ensuring that health professionals are properly qualified. It also protects health professionals from competition that might save consumers money. "It isn't uncommon for licensing boards to try to limit access to a given occupation in apparent disregard of the public interest. In Arkansas, discount drugstore operators say the pharmacy board's regulations subtly discriminate against discount drugstores, making it difficult for them to operate competitively."<sup>9</sup>

In one sense, it appears that medical licensing boards and medical societies can be viewed as coalitions of monopolists whose purposes in coming together include protection and strengthening of their individual market power.

With the growth of consumerism, it would appear licensing is an area in which consumers could have a profound impact. Consumers placed appropriately on licensing boards, health planning boards and Health Systems Agency boards could begin to question the need for more extensive use of certain paraprofessionals. Two questions as a beginning need to be addressed and resolved:

Could the nurse practitioner be used more extensively, and second could dental hygienist be used more extensively? Wouldn't the quality of care be equal or better than is currently provided and wouldn't the cost be equal to current cost or less?

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<sup>9</sup> Jim Montgomery, "Far-Reaching Reform of Licensing Boards Urged in Many States," Wall Street Journal, January 8, 1975, p. 1.

#### 4. Inadequate Health Records

Historical and contemporary reviews indicate that the different levels and sources of communication related to health care services are inadequate. Health records information is appalling when it is viewed from the standpoint of how it is recorded, stored, retrieved and transmitted. Frequently, information about patient's prior or existing health problems, their treatment, referrals, consultations and results are too often not transmitted between professions and institutions in a rapid, reliable, responsible fashion.

Many health institutions that provide health care have not designed adequate internal systems that allow for medical records to follow patients in an acceptable fashion. The outgrowth of the problem is that expensive diagnostic tests are often repeated unnecessarily, hence direct patient care specifically is escalated as the cost of health care in general continues its skyrocketing climb.

This condition does not need to exist especially in a highly computerized society. The availability of computerized services are plentiful at minimum costs. Computer service bureaus are readily available to provide the expertise to help change and modernize outdated hospital systems.

When the cost of a newly developed and implemented system is compared with the old outdated ones and the quality of care under one system is measured against quality of care under a new one, the cost of the systems development will probably be determined to be well worth it.

Dr. Lawrence L. Weed, originator of the problem-oriented record system has often discussed communications problems and is obviously concerned about record keeping. "Watergate pales beside the 'cover-up' of medical practice. . . American medicine 'is a lousy system'. . . If NASA ran rockets the way most physicians run clinical records, 'nobody would get in those ships'. . . Medical knowledge is passed along like Norwegian songs. . . doctors singing ballads to each other in the hospital lobby and in those show-and-tell rounds. . . they believe what they want to believe; nowhere else is there more hallucinatory fulfillment than in medicine."<sup>10</sup>

Dr. Weed's comments continue, ". . . Our data are so poor, we don't even know our care is bad. You have to build the system in order to audit performance. . . The information system must become automatic-like turning on a light switch or flushing the john, we cannot go on with these scribbles. . . There is no point in spending all this money on Professional Standards Review Organizations (PSRO's) and audit to find out that many medical practices with improper records are no good---we know that now."<sup>11</sup>

##### 5. Inappropriate Institutionalization of Patients

Health care consumer's financial problems and health care institution's financial problems have been widely discussed. One factor contributing to the discussion is the inappropriate institutionalization of patients which not only

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<sup>10</sup> Medical Care Review, Vol. 31, No. 8, August 1974, Bureau of Public Health, University of Michigan, p. 949.

<sup>11</sup> Ibid., p. 7.

increases the cost of the whole health care system, but it also may be harmful and even life-threatening because of the confinement. Other apparent hazards center around medication errors, adverse reaction to diagnostic reagent and injury caused by the strange environment of the hospital.

Primary focus of this problem seems to be the results of a combined political and financial impetuses. Should a physician determined that his patient needs an electrocardiogram, there are many instances in which that patient would have to be hospitalized and put through an extensive work-up before the health insurance would pay for these health services. Clearly, the same electrocardiogram could be administered in the physicians office and requiring probably less than one hour's work. The expense for this care in the doctors office is greatly reduced over the expense for the same treatment in a hospital setting. But the physician would like to get paid and often the patient may not have the money; the health insurance coverage will not pay for office visits to the family doctor; the end results is that the patient is inappropriately hospitalized.

A review of this problem from a political standpoint would suggest that hospital administrators are interested in keeping their hospital beds filled. The usual method of filling beds is to have doctors with hospital privileges to hospitalize patients. As hospital census start to get too low a hint to the various hospital departmental chiefs may serve to solve the low census problem fairly swiftly.



This is an example of how the hospital keeps its doors open; how the doctor is paid an unnecessarily high fee; how the patient lose unnecessary time from their families and employment and worst of all, this is one reason for the increasing cost of health care.

Based on this example, too much emphasis is placed on hospitalization rather than keeping people well. As opposed to using this approach, hospitals could develop their ambulatory centers in a way that they could provide a comprehensive range of health care services to a wide array on consumers.

#### 6. Lack of Accountability

There is a three-fold division of medicine, namely, (a) academic medicine, (b) community medicine (the new public health) and (c) private medicine. Responsibility and accountability is perhaps equally confusing for members of the professions and the public.

Specifically, if personal health services of a community are inadequate or inappropriate, with whom does the citizen get in touch? Skepticism is growing that these three groups always act either alone or collectively in the public interest.

It is uncertain who is "in charge" of seeing that society has available personal health services. Who is responsible for developing the information, providing the leadership, convening the committees, proposing the alternative solutions, implementing programs, providing and coordinating services and evaluating them?

The lack of accountability touches one of the basic and essential faults in the American health care delivery system. Brief reference can be made to the government of Denmark in Europe as a comparison which is responsible and accountable to its citizens for all of their health needs from the cradle to the grave.

In contrast to the health care delivery system in Denmark is the system of health care in the United States where the physician is not unlike the American businessman. As such the American physician can and often does move his business of practicing medicine any place in the United States. The physician is the sole decision maker about the geographical location of his practice.

The problems with this "freedom of choice" are many but certainly several of the pressing problems are that certain rural areas have no health care services for its entire population. Certain inner city communities have one doctor for twenty thousand persons which is clearly undesirable.

There is probably no other industrialized nation in the world that allows this sloppy approach to mankind's most basic need. Instead some countries will pay for the medical students' education but when the student is chosen for medical school he must make a commitment to return to his own home community and spend his career practicing in that community.

Maybe the United States does not need to adapt measures as strict as other countries, but clearly the present system must be adjusted as a minimum measure.

This researcher believes that the alternative or solution to this problem is fairly simple in that those medical students requesting scholarship funds would be required to practice medicine in a specific scarcity area of their choice.

It is also suggested that Health Maintenance Organizations and other organized systems of health care delivery will address these problems properly and offer a better solution than currently exist.

#### 7. Responsiveness To the Needs of Minorities

In the effort to resolve major health care problems, there is a point where the status of medically indigency and race come together, particularly in the inner city communities. This encounter creates a problem which is significantly different from the usual and customary issues encountered during normal attempts to address and resolve health problems.

The issues of race complicates the ability to organize and deliver health care in a community which has a minority black population. Most of the population in Newark is black and poor, but beyond the issue of poverty is the issue of race which brings with it prejudices, racism and the added issues unrelated to poverty.

## C H A P T E R I I

## MANPOWER NEEDS AND DISTRIBUTION PROBLEMS

The physician continues to be the major element in the process of health care delivery. "Sometimes we speak loosely of hospital-bed utilization by the population, giving the impression that patients utilize the beds; when, in fact, the physicians utilize the beds; patients lie in them. A patient cannot even have the privilege of lying in a hospital bed unless ordered to by a physician, who has the extremely valuable privilege of giving this order. Patients can bring pressure on physicians to admit them to hospital beds, but the decision rests with the physician. Similarly with discharge, the physician makes the decision that determines the end of the bed-utilization episode. Patients can, of course, discharge themselves against the physician's advice, but this right is rarely exercised. Patients can also bring pressure on physicians to delay discharge, but again, the decision rests with the physician. The patient plays a part in the utilization experience only insofar as he influences the physician. The physician's judgment is the crucial factor."<sup>1</sup>

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<sup>1</sup>Robert M. Sigmond, Controlling Hospital Use Through Medical Staff Utilization Committees. Proceedings of the Fifth Annual Symposium on Hospital Affairs. Chicago, Illinois: University of Chicago Press, 1962.

While many documents are written about the importance of the physician and the essential need for his participation in health care delivery, few researchers seem to have defined or measured the key factors which will make his participation easily acceptable, uncomplicated and perhaps a long-lasting relationship. Paradoxically, researchers have acknowledged the critically important role of the physician, but few have constructed an analytical framework within which his motives and influences can be tested.

### Doctor Shortage Problem

"Although the United States has a higher physician to population ratio than either the United Kingdom or Sweden, the uneven geographic distribution of physicians and the decline of primary care practitioners have made it increasingly difficult for some sectors of the American population to obtain the medical attention they need and want."<sup>2</sup> Aggravating this problem is the apparent increase in the demand for health services as the general population becomes better educated and more aware of what health care can accomplish.

The critical shortage of doctors, of any kind in rural areas and in our congested central cities, is a reflection of general shortage of primary care physicians. It appears that physicians tend to locate in fairly prosperous medium-sized cities and in suburbs of big cities, which means that the rest of the country is left with inadequate medical attention.

"Of the 311,342 active non-federal physicians in 1973, nearly 87% were

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<sup>2</sup>U. S. Department of Health, Education, and Welfare, Trends Affecting the U. S. Health Care System, October, 1975.

located in metropolitan areas, while only about 75% of the population lived in such areas. As a result, while there were about 172 physicians per 100,000 population in metropolitan areas, there were only 79 doctors per 100,000 population in non-metropolitan areas. Furthermore, the large number of doctors in our urban areas are not distributed evenly: Urban physicians tend to cluster in the wealthier districts, leaving very few to provide medical care in the ghettos. In Chicago, for example, poverty areas have a ratio of 26 physicians per 100,000 population, while affluent areas of the city have 210 physicians per 100,000 population, a variation of more than 800%.<sup>3</sup> Similarly, doctors tend to flock to our wealthier states: New York state, for example, has about 244 non-federal physicians per 100,000 population, while Mississippi has only about a third that number."<sup>4</sup>

It is clear that geographical locations such as the state of Mississippi are not properly served by physicians. This is particularly true when compared with the affluent areas of New York city with 250 physicians per 100,000 population which is far more than the 154-167 ratio of physicians to 100,000 population thought to be necessary for good health care. The ongoing perplexity appears to be that doctors clustered in prosperous areas have an abundance of patients and thus no incentive to move elsewhere.

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<sup>3</sup>"Health Services," Congressional Record, 120: H3270, April 25, 1974 cited by Medical Care Review, 1974, p. 560.

<sup>4</sup>American Medical Association, Distribution Physicians, 1973, pp. 20-21.

### Maldistribution and Foreign Medical Graduates

There are probably many who believe that migration is a human phenomenon which may be forced or voluntary. While it may involve educated and talented individuals or those who are mostly uneducated, it is probably fair to assume that, overall, the migration of educated manpower involves scientists, engineers, physicians and other health personnel. The reasons for migration can range from individual decisions, moral and ethical issues which are deeply embedded in national cultures and attitudes to national interest and the interest of the individual and his or her personal development.

"According to the World Health Organization's 1970 World Director of Medical Schools, which does not include data from the People's Republic of China, 111,142 physicians graduated from medical schools in 1970. During that same year, 313,378 medical students were enrolled in first-year classes. Of these individuals, the United States graduated approximately 11,000 and acquired another 12,000 through permanent or temporary immigration, mainly for training purposes. Assuming a population of 203 million in 1970, the United States thus added one new domestic or foreign medical graduate per 8,830 people, while on a global scale the incremental increase was one medical graduate per 22,500."<sup>5</sup>

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<sup>5</sup> Medical Care Review--Bureau of Public Health Economics, School of Public Health, The University of Michigan, Vol. 33, No. 6, June, 1976, p. 660.

From this illustration there appears to be a lack of coordination among physician manpower needs, career opportunities, and educational capacity. The result is an imbalance between physician production and utilization with two examples to illustrate this point. Our statistics above indicate that the United States has a negative balance, with underproduction and overutilization and thus requiring large numbers of physicians from abroad. On the other hand, India, with a positive balance caused by overproduction and underutilization, sends many of its own graduates abroad.

In general, society must accept and even support individuals who seek the best opportunities to fulfill their professional capacity. At the same time, there are two impressive views that should be considered before a fair assessment of the problem can be made. The first view is that "countries receiving physicians from other countries, particularly the United States, should: (a) reassess their position relative to manpower policy and the right to the liberal utilization of world resources; (b) accept foreign graduates only if their institutions are willing to provide an educational experience equal to that offered their own students and only if that training is suitable to the foreign graduate as well as to the needs of his or her country; (c) for that purpose, enter, if necessary, into bilateral agreements between institutions and governments; (d) encourage and support graduate education programs in developing countries which harmonize with health services development; (e) discourage or prohibit the recruitment of physicians from other countries,



while developing opportunities for medical education sufficient to satisfy domestic demand."<sup>6</sup>

This approach implies a certain level of idealism and perhaps a degree of wishful thinking to assume that these guidelines will be followed and hence a fairly reasonable solution has been offered for the problem. Another view that offers a proposal closer to the legal and legislative approach is embodied in what is called a "Health Manpower Bill."

"Basically, the legislation (H. R. 5546, approved by the House during the year 1975, and S. 3239, passed July 1, 1976 addresses the maldistribution of physicians and other health professionals and the increase in foreign medical graduates (FMGs) immigrating to this country."<sup>7</sup> One provision in the senate bill proposes establishment of federal controls over the type, number and location of medical residency training programs.

As an alternative, another proposal in the legislation would cause the creation of a 24-member national council to study postgraduate training, to make recommendations to the Secretary of the Department of Health, Education, and Welfare, and to advise and assist institutions.

Perhaps the most controversial section of the bill lies in the House version which would require medical students in schools receiving capitation grants to "repay" the grants, upon the completion of their training, by practicing

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<sup>6</sup>Ibid., p. 661.

<sup>7</sup>Hospitals--Journal of the American Hospital Association, July 16, 1976, Vol. 60, No. 14, p. 24.

in a medically underserved area on a year-for-year basis. Equally interesting in the senate bill is a provision that seeks to substantially strengthen immigration laws and would make it more difficult for foreign medical graduates to immigrate to the United States. ". . . Provision would require that the alien physicians meet new, more stringent requirements and take the same entrance examination for residency (or an equivalent prescribed by HEW) as American medical school graduates."<sup>8</sup>

In the final portion of the legislation, there is an essential and vital component which would probably make an important contribution to the solution of the shortage of certain medical specialties. This provision would make it clear that schools must have certain percentages of their residencies in family practice, general internal medicine, general pediatrics, and general obstetrics and gynecology.

#### Growth in the Number of Doctors and Medical Students

An adverse position to the one previously discussed is that instead of a shortage, the total number of physicians in the United States increased about 67% during the period 1950 to 1973. This increase caused the total number of physicians per 100,000 population to increase from 141 per 100,000 in 1950 to 171 per 100,000 in 1973.

"In 1973-74, there were 114 medical schools with 50,886 students, of which 11,613 graduated that year, thus the number graduating from medical

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<sup>8</sup>Ibid., p. 16.

school each year climbed 89% during that 23-year period. . . Pressure and financial inducements from the federal government have not only stimulated the expansion of our medical schools, they have also changed the character of the students enrolled in them. Traditionally, medical students have been white males from upper income families. With scholarship and loan funds, supplied primarily by the federal government but also by foundations and the school's own endowments, the schools have increased their enrollment of blacks from 2.7% in 1969-70 to 5.9% in 1973-74, and their total minority enrollment (Blacks, Mexican Americans, Puerto Ricans, American Indians, and Orientals) has grown from 5.0% in 1969-70 to 9.2% in 1973-74. There has also been a substantial increase in the number of women enrolled in medical schools: Women comprised 5.7% of medical students in 1959-60, 9.0% in 1969-70, and 15.4% in 1973-74."<sup>9</sup>

Apart from efforts to increase enrollment, a number of medical schools have attempted to hasten the medical student through school and into the health care system by taking off up to one year from the traditional four-year program. Reduction in the length of the educational program serves a useful purpose of offsetting the rising costs of medical education and allows schools to accommodate more trainees over a period of years. Another approach is to allow certain students to enter medical school without the traditional four years of under-

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<sup>9</sup>Trends Affecting the U.S. Health Care Systems, cited by Cambridge Research Institute for U.S. Department of Health, Education, and Welfare under contract No. 230-75-0072.

graduate college. And some medical schools, by closely meshing premedical education in their parent universities with their own programs, are graduating doctors six years after high school graduation.

Within the last decade the use of paraprofessional personnel has had significant growth and active participation in the delivery of health care services. This development has been applied successfully in physician scarcity areas where professionals such as the nurse practitioners have made commendable contributions in providing high quality health care.

#### Discussion of General Problems and Basic Assumptions About the Health Care Delivery System

It is commonly known and accepted that the health care delivery system in America has problems. Accordingly, "In over 130 rural counties throughout the country and in some inner city neighborhoods, thousands of American citizens live where no doctors practice medicine. And many thousands more go without needed medical attention because the doctor won't or can't come, or because they can't pay for his services or for hospital care, having little income and inadequate insurance coverage. In fact, high cost seems to be the most pernicious problem in American health care."<sup>10</sup> This problem has obviously caused great concern, hence, between 1960 and 1970 estimations are that national health expenditures increased from \$25 billion to \$70 billion for a wide range of health programs including biomedical research to hospitalization.

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<sup>10</sup>Stephen Strickland, Ph.D., U. S. Health Care--What's Wrong and What's Right, A Potomac Associates Book, 1972, p. 13.

One major health care program had a significant effect on the vast increase in health expenditures, and that was the enactment and implementation of Medicare and Medicaid. Prior to the development of these programs in 1965 the Department of Health, Education, and Welfare's budget was approximately \$2.8 billion. It was estimated that five years later, in 1970, that \$2.8 billion would increase to \$15.8 billion. The enormous expenditures are impressive but they have not solved the problem. "A central problem, however, is that the recent large additional expenditures have not bought unqualifiedly better health for all the people, but have largely gone to keep pace with price inflation. Medical costs have gone up twice as fast as the overall cost of living in the last decade."<sup>11</sup>

Other problems in American health care is the infant mortality rate which takes a high annual total of the population and the destruction of a family's savings when a catastrophic illness such as cancer strikes the average family. To alienate parts of these problems, probably 87 percent of the American people are estimated to be covered by medical insurance as opposed to 50 percent twenty years ago. In spite of this, often only hospital-related costs are covered by health insurance, which obviously leaves the individual to cope with doctor's bills. An additional problem is related to the difficulty encountered by consumers in finding a competent physician to handle these problems.

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<sup>11</sup>The Law and Health Personnel, Comprehensive Health Planning Program, Minnesota State Planning Agency, St. Paul, Minnesota, April, 1970.

## Problems in Health Care Delivery

Health care in this country is scarce and expensive. It is dangerously fragmented, and many times it is offered in an atmosphere of mystery and unaccountability. These predicaments account for some of the major problems in Health Care Delivery. It would be helpful to review four basic elements of these problems for clarity:

### Problem One: Finding Appropriate Health Care at a Reasonable Price

In the past, it was generally assumed that the distance from doctors offices or hospital clinics was a problem only in rural areas. The literature indicates that large inner cities share the same problem as rural communities. "One region of Bedford-Stuyvesant contains only one practicing physician for a population of one hundred thousand. Milwaukee County Hospital, the sole source of medical care for tens of thousands of poor and working-class people, is sixteen miles outside the city, an hour-and-a-half bus ride for many."<sup>12</sup>

Apart from the problem of locating the building or office where health care is offered, some citizens must then address the problem of paying for their care. While insurance plans such as Blue Cross, Medicare and Medicaid help pay for some of the costs, many people are too poor to afford Blue Cross, too young for Medicare, and perhaps too rich for Medicaid. "Even for those

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<sup>12</sup>B. Ehrenreich and J. Ehrenreich, The American Health Empire: Power, Profits, and Politics--A Health-Pac Book, Random House, New York, 1970, p. 4.

who are insured, costs remain a major problem; first, there is the cost of the insurance itself, then there is the cost of all those services which are not covered by insurance. One hundred and two million Americans have no insurance coverage for visits to the doctor, as opposed to hospital stays. They spend about ten dollars just to see a doctor; more, if laboratory tests or specialists are needed. Otherwise, they wait for an illness to become serious enough to warrant hospitalization. Hardly anyone, of course, has insurance for such everyday needs as dental care or prenatal care."<sup>13</sup>

Some observers believe that the average or routine medical problem is often left to wait for hours in a hospital setting whereas the dramatic and exotic cases which excite professional interest are reviewed with greater interest and care.

#### Problem Two: Finding One's Way Amidst the Many Available Types of Medical Care

American health services are arranged according to the various specialties and subspecialties that doctors study, not according to the problems and symptoms of patients. The middle-class patient usually has a private doctor who can serve as a kind of guide as the patient visits the list of specialists--hematologist, allergist, cardiologist, endocrinologist and maybe a urologist. The hospital clinic patient often must find his own way through this same group of specialists. "Until human physiology adapts itself to the fragmentation of modern medical

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<sup>13</sup>Ibid., p. 5.

practice, it is up to the patient himself to integrate his medical problems, and to integrate them with the rest of his life."<sup>14</sup>

### Problem Three: Figuring Out What They Are Doing to You

Finding the proper doctor or clinic is the solution to one part of the health care problem, but many people also want to know what is being done to their bodies as health care is provided. When expensive medical bills must be paid, the obvious concern from the consumer is whether the same or similar care could be provided at less expensive costs. Even when confronted with what seems to be irrational therapy, most patients feel helpless to question or complain so the dilemma remains, the consumer can only pay the price and hope the product works.

### Problem Four: Getting a Hearing if Things Don't go Right

Many aspects of the American medical system seems designed to maintain the dependent, childlike and depersonalized condition of the consumer. "Doctors and hospitals have turned patients into 'consumers' but patients have none of the rights or protection which consumers of other goods and services expect. People in search of medical care cannot very easily do comparative shopping . . . Health consumers know what they'd like--good health--but they have no way of knowing what this should entail in terms of services...And, if they

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<sup>14</sup> Ibid., p. 9.



suspect that the price was unduly high, the treatment unnecessarily complicated or drastic, there is no one to turn to--no Better Business Bureau or Department of Consumer Protection."<sup>15</sup>

The second major problem in Health Care Delivery is the critical need for primary care doctors. This need is particularly important with the growing complexity of medical technology and the increasing specialization among doctors. "Even among physicians in office-based practice, the percentage of General Practitioners has declined precipitously. . . the percentage of General Practitioners is even lower in urban areas, for nearly a third of our remaining general practitioners are practicing in non-metropolitan communities. In such communities, GP's comprise 44% of the few doctors still providing office-based care."<sup>16</sup> Table 2 illustrates this finding.

Another view of this problem is that perhaps the number of primary care physicians has not shrunk as much as the statistics would suggest, in that certain specialists focus their practice on primary care. These specialists include internists, pediatricians, family medicine practitioners and specialists in Obstetrics and Gynecology. "However, even if one adds to the GP's these other primary care providers, only 47% of U.S. doctors are focusing on primary care. In contrast, in U.S. prepaid group practices, the percentage of primary care

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<sup>15</sup> Ibid., p. 12.

<sup>16</sup> American Medical Association, Center for Health Services Research and Development, Distribution of Physicians in the U.S., C1973, Chicago, Illinois, 1974, p. 15.

TABLE 2

DISTRIBUTION OF PHYSICIANS BY ACTIVITY: SELECTED YEARS 1963-1973

Physician Activity	1963		1970		1972		1973	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Total	261,722	100.0%	311,243	100.0%	331,259	100.0%	313,111	100.0%
Patient Care	246,951	94.3%	273,555	88.5%	292,210	88.2%	265,257	84.7%
Office-based Practice <sup>1</sup>	179,443	68.6	192,439	61.8	201,352	60.4	201,435	64.3
Hospital-based Practice	67,502	25.6	86,096	27.7	90,858	27.3	93,822	29.9
Interns	9,517	3.6	11,449	3.7	12,456	3.7	11,953	3.8
Residents and Fellows	28,989	11.1	39,779	12.8	42,055	12.7	46,299	14.8
Physician Staff	28,596	11.1	34,652	11.2	37,357	11.3	35,570	11.4
Medical Teaching	8,190	3.1	5,583	1.8	5,636	1.7	6,183	1.9
Research	3,255	1.2	11,029	3.5	9,299	2.8	11,959	3.8
Administration	3,332	1.3	12,152	3.9	11,074	3.3	8,332	2.7
Other	—	—	2,635	0.8	2,603	0.8	2,635	0.8
Not Classified	—	—	358	0.1	12,356	3.7	13,744	4.4

Sources: American Medical Association, Distribution of Physicians in the United States, 1970 (Chicago, Ill.: 1971), p. 3.

American Medical Association, Distribution of Physicians in the U.S., 1972: Volume 1/Regional, State, County (Chicago, Ill.: 1973), p. 21.

American Medical Association, Distribution of Physicians in the U.S., 1973 (Chicago, Ill.: 1974), p. 33.

Note: These data do not include physicians who are inactive or whose address is unknown.

— = Not Applicable.

<sup>1</sup>Physicians in "office-based practice" include doctors in solo practice, doctors practicing in groups, and those practicing in clinics.

doctors is 69%, and in the British National Health Service the figure is 74%. Not only are primary care providers underrepresented in our health care system, but there is every prospect that this underrepresentation will grow worse rather than better: While 47% of all U.S. physicians are now in primary care, only 37% of physicians now in the residency training are in primary care specialties. In the United States today the primary physician ratio is 60 per 100,000 population, but a study by Schonfeld and others at Yale University estimates that a primary physician ratio of 133 per 100,000 population is necessary to provide adequate primary care."<sup>17</sup> Table 3 illustrates this finding.

#### Physician Shortage is Problem of Distribution

According to projections based on national data there should be at least one physician for every 1800 members of the population. Many cities and towns of this nation fall far short of reaching this goal. An example of this shortage manifests itself in the state of New Jersey where even though there are more than 10,000 practicing physicians registered in the state, it is still faced with an acute shortage of primary care physicians in certain areas.

"Efforts have been under way during the past several years to alleviate the shortage, but there remains a 'critical' maldistribution of primary health care manpower in many of the state's central cities and rural areas, according to general health care officials."<sup>18</sup> For the majority of state residents to receive

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<sup>17</sup> Health Services, Congressional Record 120: H3270, April 25, 1974, cited in Medical Care Review, p. 561.

<sup>18</sup> E. Roberson, Health and Medicine, Section One, The Sunday Star Ledger, February 27, 1977, p. 43.

TABLE 3

DISTRIBUTION OF NON-FEDERAL PHYSICIANS BY SPECIALTY:  
SELECTED YEARS 1963-1973

Specialty	1963		1967		1969		1973	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	253,226	100.0%	279,418	100.0%	293,397	100.0%	297,598	100.0%
General Practice	70,405	27.8	65,430	23.4	55,341	18.9	51,653	17.4
Medical Specialties	50,846	20.1	61,115	21.9	64,322	21.9	78,708	26.4
Surgical Specialties	65,017	25.7	75,286	26.9	76,303	26.0	85,343	28.7
Other Specialties <sup>a</sup>	66,958	26.4	77,587	27.8	97,431	33.2	81,894	27.5

Sources: American Medical Association, Department of Survey Research, Center for Health Services Research and Development, Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., 1969, Vols. I and II (Chicago, Ill.: 1970); Selected Characteristics of the Physician Population, 1963 and 1967 (Chicago, Ill.: 1968), and Distribution of Physicians in the U.S., 1973 (Chicago, Ill.: 1974), p. 76.

<sup>a</sup>In 1963, 1967 and 1969, includes inactive physicians as well as specialists in psychiatry, radiology, pathology, etc. In 1973, inactive and not classified physicians are excluded.

adequate health care, the distribution and availability of primary care physicians must be altered.

The doctor shortage has not escaped the concerns of the New Jersey State Assembly and Senate where they are considering pending bills to help alleviate the shortage problems. These bills include a Loan Forgiveness program for medical school students, a Graduate Medical Education bill and a Physician's Assistance bill that would provide additional health manpower in areas designated as "medically underserved" throughout the state.

On the federal level, there is the Urban Health Strategy bill before Congress which would provide aid for additional health manpower for New Jersey and other states. Under this legislation, areas designated as "Critical Manpower Shortage Areas" (CMSA), would be eligible for federal aid to increase the supply of health manpower in the area.

Since there is a new administration in Washington, D. C., an assortment of projections and speculations appear to be forthcoming. Since the President appears to be taking a major interest in health care, it may be safe to assume that the budget of the National Health Service Corps, in which students promise to serve in areas with shortages of health professionals after they graduate, could possibly be increased. Grants for special projects to increase the number of residency positions in family medicine and family dentistry may also increase.

### Distribution of Physicians by Activity

The effort to find a physician to properly take care of a persons health problem has become more of a problem in the last decade because of the decline in the percentage of physicians in office-based practice: "Such physicians comprised 68.6% of the total in 1963, but only 59.6% a decade later. The percentage of physicians in all types of patient care fell. . . In 1967, of the doctors who had earned their degrees in 1955-59, 17.8% were on a hospital's full-time physician staff, while only 9.9% of the 1945-59 graduates were working full-time on a hospital staff. Thus, the growing emphasis on hospital rather than office-based practice is particularly marked among younger doctors."<sup>19</sup> The percentage of doctors in administration has grown as the management of health care delivery has grown more complex. Part of this shift is due to the government's fairly recent shift from research to the provision of care.

### Four Basic Assumptions Pertaining to Health Care

Clearly, efforts are needed to design and develop a functional health care delivery system that will address itself to the elimination of sporadic, crisis oriented, hospital emergency room, uncoordinated and the lack of continuity of health care. Such efforts can take many forms, medical foundations, prepaid private practices, a group of physicians using the same building but providing individual private practice, and perhaps a host of other ideas and

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<sup>19</sup> Trends Affecting the U.S. Health Care System, cited by Cambridge Research Institute for U.S. Department of Health, Education, and Welfare under Contract No. 230-75-0072, p. 357.

organizational arrangements not mentioned here.

In fairness to these concepts, methods of health care delivery and any discussion of possible changes in the organization and delivery of personal health care services necessitate basic assumptions. Although some assumptions will be widely held and accepted, others maybe personal and restricted, it is appropriate to make suppositions in the process of limiting the breadth and scope of this project.

#### Assumption Number 1

Physicians will continue to be the primary care professionals responsible for the provision of personal health services. It is essential that they be provided the advice and counsel obtainable from a variety of other professions, such as lay groups, scientific groups, allied health professions and other professional groups. With this assistance, it is fairly safe to assume that medicine will be the profession finally accountable for the personal health care of society.

#### Assumption Number 2

It is thought that health services and the organization of health services are too important to be left entirely to the "experts" who constitute the medical profession. Appropriately, the accountability of physicians is determined by a social contract of greater and wider applicability than the Hippocratic Oath. This contract between society and medicine is an ongoing negotiation conducted on the continuing basis at the various levels of society. The profile and

expression of these negotiations are often seen through legislation, rules, regulations, accreditation, licensing, fiscal controls and professional standards. In these arrangements, medicine need to be sensitive to the notion that it is only one part of a two-party contract which means that in the final analysis the consumer has the upper hand.

#### Assumption Number 3

A National Health Services Policy will most likely be developed in this country, within the next decade. Accordingly, a clear definition must be drawn between a health policy and a health service. When the health policy is finally developed it will most certainly not advocate a statutory service under which all doctors are paid salaries by the federal government or its agencies. Nor will their total annual income be determined by a uniform formula applicable to all physicians.

#### Assumption Number 4

The medical care profession will no longer be able to resort to authoritarian pronouncements as acceptable and total justification for increasing allocations of scarce resources. It appears that a twofold approach will be primary target, that is, the overall allocation of manpower, facilities and money will be requested and continued. Second, it appears that pressures for increased efficiency and effectiveness in the use of resources society currently allocates to medical care will intensify.



Impetus for this focus stems from other service industries such as transportation, communication, inn-keeping, education and national defense.

C H A P T E R   I I I  
DEVELOPMENT OF HEALTH MAINTENANCE  
ORGANIZATION CONCEPT

"Every month, 750 out of 1,000 Americans suffer some ailment; 250 seek a physician's help, and about 100 are hospitalized. Americans consult doctors an average of 4.5 times per year."<sup>1</sup>

During the past two and one half decades a growing number of American citizens have been purchasing their medical care outside the regular channels of the traditional health care industry. As members of a comprehensive, prepaid health care delivery system, certain consumers have, in effect, contracted with groups of doctors to furnish them with the level of health care they need, both in and out of a hospital, for a fixed annual cost. The doctors within this system are paid a flat retainer. Instead of earning a fee for each service rendered, they are usually paid by straight salary or by a pre-arranged formula, divide among themselves the money the group is paid collectively for its services.

"Arrangements of this kind have been made under a variety of auspices. Some plans are cooperative ventures, organized by groups of people who have

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<sup>1</sup> Arthur S. Freese, Managing your Doctor--How to Get the Best Possible Health Care, Stein and Day Publishers, New York, 1974, p. 10.

chipped in to build a clinic and to hire doctors to staff it. Others have been organized by labor unions to care for their own members. The two largest plans--Kaiser-Permanente, with more than 2,700,000 members, and Health Insurance Plan of Greater New York (known as HIP), with 750,000--are both, like Blue Cross, run by not-for-profit corporations. These corporations act as middle-men, enrolling subscribers, collecting money from them and their employers, and contracting with groups of doctors to take care of the subscribers at a certain dollar rate per subscriber."<sup>2</sup>

These descriptions describe some of the basic elements of a Health Maintenance Organization (HMO) which take many forms, but they have certain common characteristics: They are organized systems that provide a comprehensive range of health maintenance and treatment services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.

Some HMO's are called "closed panel" HMO's by the federal government which means that the medical professionals work entirely on a base salary. There is also the "individual practice" HMO's within which doctors treat clients in their private offices but they consult with other physicians within the HMO group by sending the patient to consultant services under contract to handle the enrolled members of the HMO.

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<sup>2</sup>S. Klan, The Great American Medicine Show, The Unhealthy State of U. S. Medical Care, and What Can Be Done About It, The Viking Press, New York, 1975.

1. How much will the HMO cost?

Answer:

An HMO promotes many economies. The fixed method of prepayment provides an incentive for health care providers to minimize expenses and avoid unnecessary services which is quite different from the traditional system where each service is a means of increasing the income of providers in a fee-for-service health system.

"When a study was made comparing the health care provided Medicaid recipients in an HMO and those using the fee-for-service system, analysis showed the HMO enrollees used 30% fewer hospital visits, 15% fewer physician visits, and 18% fewer prescription drugs. As a consequence, the cost saving per Medicaid patient in the HMO versus those in the fee-for-service system averaged 21% during fiscal 1972, 1973, and 1974."<sup>3</sup>

Apart from the economies that can accrue from health care service areas, other cost-saving factors often surface from equipment utilization, routine business administration, and manpower utilization.

2. How does an HMO differ from regular health insurance?

Answer:

HMO's are different in many ways than health insurance in that patients are encouraged to seek care in the early stages of an illness. This approach is unlike ordinary health insurance which does not cover routine medical care until

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<sup>3</sup>U. S. Department of Health, Education, and Welfare Press Release, March 9, 1975, quoted in Medical Care Review, April 1975, p. 376.

the patient's illness becomes sufficiently serious to require hospitalization which is then covered by insurance.

The HMO member or consumer has no financial barrier that prevents him from seeking early preventive care or treatment. Membership fees are paid on a monthly basis and covers routine care as well as hospital and specialist's care. In an HMO, greater emphasis is placed on ambulatory care than with traditional health care.

The HMO's emphasis on ambulatory care serve as evidence that the differences in cost of health care in the HMO is due to treatment on an out-patient basis thus causing shorter hospital stays. Cost reduction is usually not due to better preventive care alone rather it is that HMO's treat patients in proper facilities with proper personnel. Table 4 illustrates this issue.

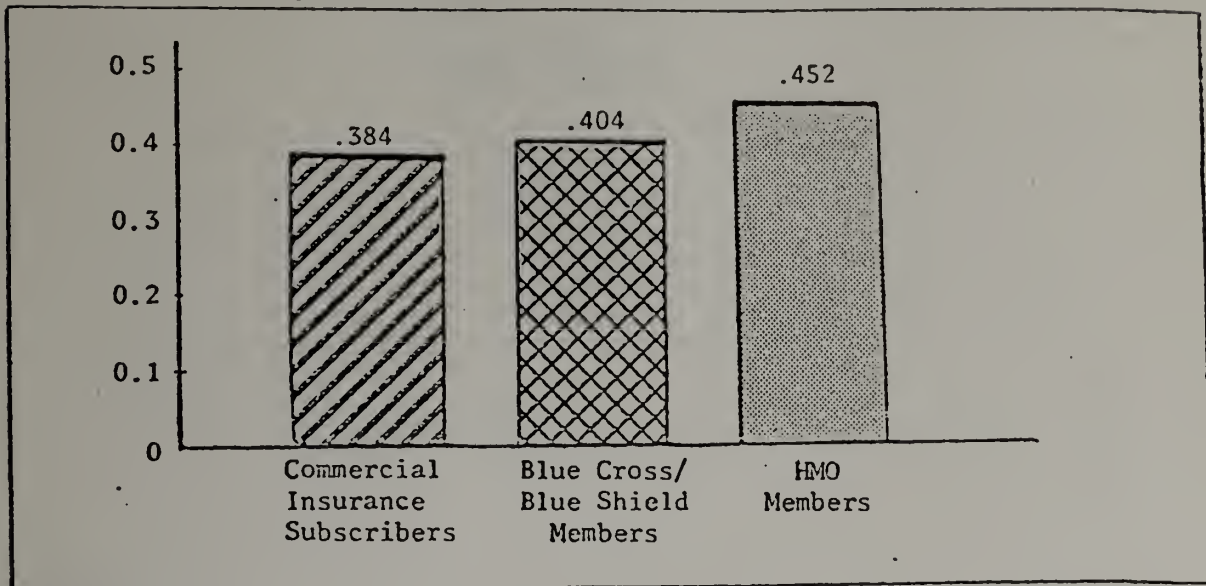
3. How does the HMO arrange to provide its members with comprehensive health care?

Answer:

There are several different ways of organizing a prepaid group practice or delivery system. The most common way is for the plan to contract with a group of physicians who are paid on the basis of the premiums received from members. The physicians are accountable to the membership for the quality, availability and cost of the care rendered. When needed, the plan also arranges for specialty care that may not be available within the group practice as well as hospital care, 24-hour emergency care and other needed services. Specialists

TABLE 4

## HMO EMPHASIS ON AMBULATORY AND PREVENTIVE CARE

A. Amount of Preventive Care Received  
By Subscribers to Three Types of Health Care Plans

The University of California School of Public Health compiled a "preventive service index" accounting for such services as Pap smears, chest X-rays, blood tests, routine rectal examinations, and immunizations. The results were placed on a range of zero to one, and are illustrated above.

Source: Cited in Steven Aaronson, "Can the HMOs Make It?," Medical Dimensions, April 1975, p. 3.

B. Doctor Visits Versus Hospital Days  
with Three Types of Health Care Plans

Health Care Plan	Doctor Visits Per 1,000 Per Year (a)	Hospital Days Per 1,000 Per Year (b)	Ratio (a):(b)
Commercial Insurance	3,104	864	3.6
Blue Cross/Blue Shield Prepaid Group	3,984	1,109	3.6
Practice (HMO)	3,324	526	6.3

Source: Milton Roemer and William Shonick, "HMO Performance: The Recent Evidence," Health and Society (Milbank Memorial Fund Quarterly), Summer 1973, p. 291.

can readily refer patients back to primary care physicians to insure that basic medical needs are not overlooked.

A system of comprehensive care that is offered by HMO's serves a vital function in easing the problems consumers often encounter in their attempt to seek health care from an array of providers in the U.S. health care system. One major feature of HMO's is that they offer their members easy access to health care and steers them to the different levels of care.

"In a few cases, an HMO has been organized around a hospital outpatient clinic. Such a step is designed to increase the efficiency with which the clinic operates, to improve the quality of care delivered, and to increase revenues by attracting a wider range of patients."<sup>4</sup> (See Table 5.)

4. How are high standards and excellent quality of care maintained in HMO's?

Answer:

Several methods are used to maintain quality and high standards in HMO's. In a group practice setting doctors often serve on a panel to choose or recruit new doctors to their staff after which continuous review and evaluation of the doctors performance is conducted. The invaluable part of this work environment is that in instances where a doctor may need assistance or additional consultation from another physician, the close working relationships provides for easy access for quick and frequent communications.

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<sup>4</sup>Health Planning Information Series, Trends Affecting U.S. Health Care System, U.S. Department of Health, Education, and Welfare, October 1975, p. 228.

TABLE 5

## Hospital Use in HMO's Versus the Traditional System

Hospital Use	HMO	Other	HMO as % Of Other
Number of Hospital Days Per 1000 Persons per Year	744	955	78
Number of Hospital Admissions Per 1000 Persons per Year	70	88	79
Hospitalized Surgical Cases Per 1000 Persons per Year	49	69	71
Tonsillectomies Per 1000 Persons per Year	47	94	50

Source: Paul Densen, et al., "Prepaid Medical Care and Hospital Utilization in a Dual Choice Situation," American Journal of Public Health, November 1960, cited in Paul Ellwood, "The Health Maintenance Organization Approach," Realigning the Health Care Delivery System, 1971.

Note: Data standardized for age, sex, income, residence, and, expecting tonsillectomy rates, for out-of-plan services.



Another valuable element in the control of standards and quality is the use of certain drugs and if it appears from medical audit that the drug is ineffective, its use can be discontinued by all doctors within the group practice immediately. Then there is the strongest weapon of all in that if high standards are not maintained the consumer can use his option and leave the HMO. Such competition not only can insure that quality will remain at a high level but will also serve as impetus for private physicians to upgrade quality to compete with the prepaid system. (See Tables 6 and 7.)

5. Has the past record of HMO's been good or bad?

Answer:

"Overall, . . . the record of HMO's established before 1970 was an exceptionally good one and was an important factor in the generation of enthusiasm and support for their large-scale growth. Ross-Loos Medical Group of Los Angeles (founded in 1929), Group Health Association, Inc. of Washington, D.C. (1937), Group Health Cooperative of Puget Sound (1947), and Kaiser Foundation Health Plan (1942) are among the highly successful HMO's noted for their efficient operations, their low hospital utilization, their patient satisfaction and their consistently high quality of care."<sup>5</sup>

On the other hand, there have been problems as HMO's have developed and there is evidence that between January and March, 1975, nine new HMO's came into being with eleven going out of business because of either the loss of

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<sup>5</sup>B. Ehrenreich and J. Ehrenreich, The American Health Empire: Power, Profits, and Politics, A Health Pac Book, Random House, New York, 1970, p. 231.

TABLE 6

Effect of HMO Performance on Health Status  
(Prematurity and Mortality)

Health Status	HMO	Traditional Mode	HMO as % of Traditional Mode
Premature Births per 100 Live Births:			
White	5.5	6.0	92
Non-white	8.8	10.8	81
Infant Mortality per 1000 Births:			
White	22.7	27.3	83
Non-white	33.7	43.8	77
Annual Mortality of Elderly Population: (18 Months or More after Plan Membership)			
	7.8%	8.8%	89

Source: Sam Shapiro, Harold Jacobjiner, et al., "Further Observations on Prematurity and Prenatal Mortality in a General Population of a Prepaid Group Practice Medical Care Plan," American Journal of Public Health, September 1960, pp. 1304-1317; and Sam Shapiro, Josephine Williams et al., "Patterns of Medical Use by the Indigent Aged Under Two Systems of Medical Care," American Journal of Public Health, May 1967.

Note: Data standardized for age, sex, income, residence and, where appropriate, age of mother.

TABLE 7

Kaiser-Foundation Health Plan, Portland Region: Utilization by OEO Membership and Remainder of Portland Kaiser Membership (Under 65), 1970

Utilization Indicator	OEO <sup>a</sup> Membership	Remainder of Membership (under 65)	OEO versus Remainder
Doctor office visits per 1000 members	3,645	3,270	+11.5%
Hospital days per 1000 members	428	375	+14.1%
Average length of stay in hospital	4.5	4.8	- 6.3%
X-ray procedures per 1000 members	743	794	- 6.4%
Laboratory procedures per 1000 members	3,444	3,673	-10.0%
Average population during year	6,802	123,613	N.A.

Source: Anne R. Somers, ed., The Kaiser-Permanente Medical Care Program, Proceedings of a Symposium Sponsored by the Kaiser-Permanente Medical Care Program, the Commonwealth Fund, and the Association of American Medical Colleges, Oakland, California, March 1971 (New York, N. Y.: The Commonwealth Fund, 1971), p. 143.

<sup>a</sup>OEO = Office of Economic Opportunity, which contracted with Kaiser to care for a medically indigent population.

a medicaid contract or other financial problems.

6. What is meant by "comprehensive" health care?

Answer:

Services ranging from preventive care before the consumer gets sick, such as check ups and immunizations, to specialty care, complete hospital treatment and post-hospital care. Many prepaid group health plans offer mental health and dental care.

7. Where will a consumer go to get health care?

Answer:

Most of the care needed by the consumer will be available at the HMO's Health Center, which will be a facility that houses doctors' offices and usually a laboratory and x-ray equipment services on site. The Health Center may not have hospital beds although hospitalization and extended care will be arranged by the plan.

8. Who will provide health care to consumer?

Answer:

A personal physician will be chosen by a consumer from among the group practice, and will supervise total care. For their children, consumers will choose a pediatrician from among the group. A prepaid group practice HMO normally provides all the basic health care in one facility.

9. What does prepayment mean?

Answer:

Each family or individual who chooses to join the health plan pays a fixed amount of money on a periodic basis. If the consumers employer already provides health insurance, he may provide the option of choosing the HMO. Membership entitles the consumer to comprehensive health care which is provided by the plan.

10. What is a group practice?

Answer:

A group of doctors practice together in one Health Center. These physicians represent many specialties; they share their skills and knowledge; they pool their resources; they share space and equipment.

11. Are members covered when they are out of town, or in the event of an emergency?

Answer:

Yes. The HMO will provide coverage when a consumer is away from home. If an emergency arises while a consumer is near home, that person may be taken to a non-plan physician or hospital.

12. Will the HMO's services cost remain the same?

Answer:

No. It is reasonable to expect that the plan's premiums will change, depending on inflationary factors and the economy in general. It is expected,

however, that at any given time, a consumer will be getting more medical care for each dollar paid.

13. What are the main advantages of a prepaid group practice HMO?

Answer:

It eliminates most, if not all, out-of-pocket expense that a consumer could expect to pay under other plans. Table 8 illustrates this issue. High quality health services are more accessible, appointments are easy to get, services are available under one roof, and continuity of care is assured by assigning the responsibility of your health to the physician of your choice. The consumer's personal physician coordinates all of his health care and maintains a single health record for the consumer.

#### Health Maintenance Organization Objectives

Implicit in the discussion of HMO's is the notion that private practice, fee-for-service medical services must be discarded. Probably no one envisions a monolithic system of health care. A complete replacement overnight or in the future of the existing, traditional fee-for-service, private practice system is unthinkable, undesirable and unplanned. Instead, the objective and intent is to promote some alternatives to the existing methods which offer certain different advantages within which health care consumers can choose the system thought best for them.

A second objective is to make concerted efforts to reform and update the delivery of health care while at the same time, bring about greater

TABLE 8

Medical Care Expenditures Under HMO's Versus  
Other Health Insurance Plans

Type of Plan	Average Premium	Out-of-Pocket Expenditures	Total Cost
Commercial Insurance	\$208	\$156	\$364
Blue Cross/Blue Shield	257	190	447
Prepaid Group Insurance	271	52	323

Source: M.I. Roemer, R.W. Hetherington, C.E. Hopkins, et al., Health Insurance Effects: Service Under Three Types of Plans, Bureau of Public Health Economics, Research Series No. 16 (Ann Arbor, Mich.: University of Michigan School of Public Health, 1972).

organizational efficiency along with more effective control of quality or care.

A third objective is to develop and support the impetus for cost control.

A fourth objective could easily be cited as providing incentives for health maintenance for each consumer rather than crisis-oriented medical care.

In addition to the importance of the first three objectives, equally important is the objective to serve as a mechanism to correct the maldistribution of health services. Understandably, certain priorities should be given to supporting a developing HMO in medically underserved areas which does not abort the need for HMO's to serve the affluent population. Three reasons support this argument.

"(a) The entire population should have the HMO alternative which it does not have now, (b) the HMO is not necessarily designed to create new health services, but represents reorganization of those that already exist and (c) most people are beginning to accept the judgement that the poor should not bear the brunt of supporting innovation in health care delivery. For years new demonstrations--new kinds of health manpower, delivery systems, and technological developments--have been tried out on populations that do not have much choice whether or not they want to participate. The poor either have had to accept being experimented on by physician assistants, or by neighborhood health centers, or with new techniques, or they went without care."<sup>6</sup>

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<sup>6</sup> A. Myers Beverlee, M. P. H., Health Maintenance Organizations: Objectives and Issues, U. S. Department of Health, Education, and Welfare, Health Services and Mental Health Administration, DHEW Publication No. HSM 73-13002, p. 5.



## C H A P T E R I V

## HMO LEGISLATION AND THE LONG STRUGGLE FOR ACCEPTANCE

Prepaid group practice is an idea which should gain further exploration according to the view of--perhaps many--health care experts. This innovative method of health care has obviously experienced a long struggle for acceptance. "The current official popularity represents a remarkable change from the preceding four decades when both organized medicine and local governments fought the fledgling organizations with numerous potent weapons: state laws outlawing 'lay controlled' medical care plans, invocation of the common law against 'the corporate practice of medicine,' professional boycotts and expulsion of affiliated doctors from medical societies, refusal to extend hospital privileges to these doctors, refusal to make available Hill-Burton funds and other aids to facilities construction."<sup>1</sup>

Despite the many obstacles--often thought overwhelming--that faced prepaid group practice decades ago, several plans did survive. Gradually the basic principle upon which prepaid group practice is based has won increasing acceptance, especially among consumers and providers.

Evolutionary developments which influenced a change of attitude can be contributed to a series of landmark decisions by the United States and state

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<sup>1</sup> Anne R. Somers, The Kaiser-Permanente Medical Care Program, A Symposium, The Commonwealth Fund, New York, 1971.

Supreme Court decisions, in which medical societies were found guilty of restraint of trade and ordered to stop boycotting the innovative organizations. Specifically, there is New York State law which prohibits denial of hospital privileges to doctors because of affiliation with a group practice plan.

As a result of these and closely related legal developments, prepaid group practice gradually shook off its professional stigma. Over the years, additional plans were started and the membership gradually increased to several million. The exact figure varies, but according to a recent document entitled, "A Census of HMO's,"<sup>2</sup> there has been significant enrollment, in general, in HMO's across the nation and an apparent steady increase in that enrollment. (See Table 9.)

#### Legal Obstacles and the Need for Legislation

The legal environment affecting the creation and operation of HMO's is primarily a matter of individual state laws. The principal state legal barriers fall into several categories:

1. State laws affecting the control and form of organizations offering health care services.
2. Applicable state insurance laws and regulations.
3. Common law restrictions on the corporate practice of medicine.
4. Health professional licensure laws.

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<sup>2</sup> Rhona L. Wetheville and Jean M. Nordley, A Census of HMO's (Including further HMO Act Survey Results and HMO Enrollment Estimates), Interstudy, Minneapolis, Minnesota, October, 1974.

TABLE 9

Enrollment Growth for States, July 1973 to July 1974

State:	July 1973 Enrollment	July 1974 Enrollment	Percent Increase	No. of HMO's in Sample	No. of of HMO's Responding
Alaska	---	---	---	1	0
Arizona	25,797	47,752	85.1	5	5
California	2,536,959	2,732,069	7.7	65	41
Colorado	46,248	61,310	32.6	4	3
Connecticut	29,189	33,572	15.0	2	2
Florida	0	415	---	3	1
Hawaii	99,253	111,273	12.1	3	3
Illinois	25,699	40,245	56.6	5	5
Kansas	0	250	---	1	1
Kentucky	9,300	15,021	61.5	3	3
Maine	4,511	6,363	41.1	2	2
Maryland	17,017	23,661	39.0	2	2
Massachusetts	35,898	45,128	25.7	3	3
Michigan	78,000	92,862	19.1	4	3
Minnesota	67,211	82,059	22.1	7	6
Missouri	33,850	38,186	12.8	3	3
Nevada	---	---	---	1	0
New Hampshire	0	580	---	1	1
New Mexico	14,000	14,300	2.1	2	2
New York*	0	14,708	---	3	3
Ohio	91,735	110,883	20.9	3	3
Oregon	199,494	212,950	6.7	3	3
Pennsylvania	11,819	38,295	224.0	6	5
Rhode Island	13,632	14,309	5.0	2	2
Texas	625	3,500	460.0	1	1
Utah	193,433	214,726	38.1	1	1
Washington	193,433	214,726	11.0	4	3
West Virginia	5,200	8,122	56.2	1	1
Wisconsin	21,585	24,040	11.4	4	2
D. C.	88,596	99,655	12.5	3	2
TOTAL	3,658,631	4,099,462	12.0	148	112

\*Health Insurance Plan of New York, with an enrollment of approximately 760,000 is considered a "quasi" HMO in our census since it is not at risk for hospital costs. Therefore, the enrollment figure for New York does not include enrollment for HIP.

Knowing that these laws constitute barriers to establishing health maintenance organizations and that these barriers can be removed with varying degrees of difficulty, ample time should be devoted to the examination of these laws.

#### Laws Affecting the Control and Form of Organizations Offering Health Care Services

Few state laws other than state enabling legislation affect the organization of the health care system. The vast majority of states have varying forms of enabling acts that affect the formation and operation of certain types of organizations, including prepaid group practice plans. Enabling acts can be grouped in two categories, first is laws relating to the control of an organization and second, is laws relating to the form of the organization which provides care.

#### Laws Relating to the Control of an Organization

In some states it is required that a majority of the board of directors of the corporation be members of the medical profession. In some instances there may also be a requirement that every practicing physician in the immediate geographic location have the opportunity to join the plan if he desires. Such requirements are "restrictive" in nature because the operation of the organization is required to be under the control of representatives of the medical profession. Other states have laws often referred to as "open" that allow control and operation of the organization to be nested with consumer or lay groups as well as health professionals.

"As of mid-1969, there were 22 states or jurisdictions which had restrictive, and only restrictive, enabling acts. In other jurisdictions the enabling acts were open. There were 4 jurisdictions which had enacted both restrictive acts as well as separate open acts. The net effect of such combinations is to render the state "open" for health maintenance organizations."<sup>3</sup>

#### Laws Relating to the Form of the Organization Which Provides Care

Several states have enabling legislation acts which requires the organization to assume a corporate form. In these states an organization cannot be established without following the procedures set forth in the statute.

Enabling legislation which requires the organization to follow the form specified by statute is "mandatory"; legislation which permits other forms of organization to operate is permissive.

The mandatory laws constitute barriers to the formation of health maintenance organizations in that the law prescribes the form and prescribes other possible configurations for an organization. For example, if the form required is a non-profit corporation, a profit corporation or a partnership would not be allowed.

#### Insurance Laws and Regulations

Many states apply insurance laws to health maintenance organizations,

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<sup>3</sup>State Laws Affecting the Establishment of Health Maintenance Organizations, Institute for Interdisciplinary Studies, American Rehabilitation Foundation, Minneapolis, Minnesota, May 1971.

assuming such organizations are not otherwise prohibited by restrictive state legislation. Specifically, these laws usually call for establishment of reserves, contingency funds, and other such requirements to make sure the dollars available exceed potential claims for those dollars. Rate controls, too, are usually called for in insurance regulations. Although the application of these laws obviously does not prohibit establishing health maintenance organizations, it makes it extremely difficult for them to operate efficiently and economically.

While there are similarities, of course, between health maintenance organizations and insurance companies, there are basic differences, in that, health maintenance organizations provide services, not dollars.

#### Common Law Restrictions on the Corporate Practice of Medicine

The "corporate practice rule" prohibits a corporation from furnishing health care services for compensation through physicians engaged and paid by it. The rule is followed in a majority of the states. It is usually based upon the desire to protect the public from an organization which may cause the professionals employed by it to compromise their professional judgment to some organizational goals. The rule, however, developed from cases involving corporations which sold physicians' services to the public for a profit.

"The corporate practice rule is not a statutory law, but rather a legal fiction which the courts have adopted to proscribe profit-making schemes that might adversely affect the health of those who subscribe to it. Since there is no

legislation to control commercialization of medicine, courts have apparently justified the creation of the rule in the interest of protecting the public health. However, when non-profit plans were established, a distinction was drawn: organizations which provide services to members on a nonprofit basis are distinguished in the rule in most jurisdictions, and no decision has been rendered where the rule has been applied against a nonprofit, prepayment corporation (often known as a group health plan). Health maintenance organizations established as nonprofit corporations should enjoy a similar immunity, but those seeking to establish themselves as profit-making corporations would be barred from doing so, if the rule is applied.<sup>4</sup>

There are, of course, statutes which permit physicians and other licensed professional persons to form corporations or associations to provide professional services to the public. While these laws were enacted primarily to allow self-employed professional persons to take advantage of certain benefits under the Internal Revenue Code, the language used in the statutes is broad enough to allow the group to create corporations or associations which may provide advantages other than those related to matters of taxation and the creation of favorable annuity plans.

#### Health Professional Licensure Laws

Licensure laws were originally designed to assure the public that

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<sup>4</sup>A. Myers Beverlee, Health Maintenance Organizations Objectives and Issues, U.S. Department of Health, Education, and Welfare, Health Services and Mental Health Administration, DHEW Publication No. HSM 73-13002, p. 4.

practitioners met certain standards. In this sense, they were a response to potential exploitation of the public by diverse quacks providing diverse services, seldom based upon scientifically acceptable theory and practice.

Licensure practices vary among the states. No one state licenses all identified health care practitioners. Licensure serves as an "entry barrier," however, to insure a minimum degree of competence by those practitioners who are licensed. The rationale for licensure, in other words, is that the public has to be protected from the ministrations of individual practitioners about whom little, if anything, would be known otherwise.



C H A P T E R V

WHY WAS THE CITY-WIDE HEALTH MAINTENANCE ORGANIZATION  
CREATED IN NEWARK, NEW JERSEY AND WHAT ARE SOME  
OF ITS PROBLEMS?

A noted physician, Dr. Martland, practiced medicine in the City of Newark about thirty years ago. During his medical practice, Dr. Martland decided to develop a hospital and the City of Newark became a major financial supporter. "City hospitals" are not usually great profit making centers and the "Martland" hospital was no different.

As the years passed, the debts at the Martland continued to escalate and finally the cost reached the point where the City of Newark felt that it could no longer be responsible for its operational cost. The City of Newark's financial problems were particularly acute since its population and tax base was beginning to erode with the outward migration of its affluent population.

The City of Newark's administration asked the state of New Jersey to take over the financial and operational responsibility for the hospital.

While the state did assume responsibility for the Martland Hospital, it had the idea of getting the federal government to supplement this financial burden. With this in mind, the governor of New Jersey went to Washington, D.C. to meet with the Secretary of the Department of Health, Education, and

Welfare (HEW) to make a formal request for financial aid.

While the Secretary of H. E. W. could readily understand the Newark Health problem, he believed that any federal aid would set a dangerous precedent which would serve as impetus for many other similar requests from other states. Instead of approving this approach, the Secretary of H. E. W. suggested that the governor develop a proposal which would address the general health care needs of the entire City of Newark. A brief "Demographic Profile" of Newark is illustrated in Table 10.

The Washington decision set the stage for the creation of a community advisory group and a Board of Trustees by the governor to develop a proposal for the solution to Newark's health care problems. Although the politicians knew that the basic intent of the proposal was to attract federal funds to satisfy the indebtedness of the Martland Hospital, the creation of the Board of Trustees and the Community Advisory group was to camouflage the actual purpose of the entire project.

Composition of the Board of Trustees was carefully orchestrated from a political viewpoint, in that, members of the Board of Trustees were made up of members of the governors own cabinet:

Commissioner of Health

Commissioner of Human Services

Commissioner of Insurance

Commissioner of Community Affairs

TABLE 10

## DEMOGRAPHIC INFORMATION

	Essex County (Excluding Newark)	City of Newark	Morris County	Sussex County	Union County	Warren County	Total Area II	State of New Jersey
Males Percent	256,179 47%	181,026 47%	187,109 49%	38,100 49%	260,348 48%	35,411 48%	958,173 48%	3,467,373 48%
Females Percent	291,426 53%	201,391 53%	196,345 51%	39,428 51%	282,768 52%	38,468 52%	1,049,790 52%	3,700,791 52%
White and Other Percent	475,891 87%	174,959 46%	374,971 98%	72,217 99.6%	482,393 89%	73,084 99%	1,653,515 82.5%	6,397,872 89.3%
Negro Percent	71,714 13%	207,458 54%	8,483 2%	311 .4%	60,723 11%	795 1%	349,448 17.5%	776,292 10.7%
Total Population	547,605	382,417	383,454	77,528	543,116	73,879	2,007,963	7,168,104
Median Age (1)	30.6	25.9	28.1	28.2	33.0	30.5	29.7	30.1
Percent over 64	10.6%	7.9%	7.4%	9.3%	10.1%	11.3%	9.8%	9.7%
Net Effective Buying Income By Household	\$14,088	\$7,204(2)	\$15,458	\$11,145	\$15,133	\$9,377	\$13,223	\$12,509
Average Family Size	3.0	3.7	3.4	3.4	3.1	3.1	3.2	3.0
Percent Receiving Public Assistance	10.0%	18.5%	2.8%	5.5%	4.5%	5.2%	8.4%	6.6%

(1) Not Average

(2) Mean income in this case. Based on 1970 data.

Treasurers Office for the State of New Jersey

Representative from the Governor's Office  
(This person served as Chairman of the Board)

Additionally, several community persons were appointed to the board and were the only members who actually lived in Newark and had fairly substantial knowledge about its health problems. In conjunction with the same issue the community advisory board was quite different from the Board of Trustees in that it was composed entirely of community residents and its function was strictly "advisory" when they were needed. The advisory board did not have any decision making powers.

With the Board of Trustees and the Community Advisory Board established, meetings were held to set in place plans for developing ideas and writing the actual grant proposal for submission to HEW in Washington. As these meetings progressed it became clear to other hospital administrators in Newark that this proposal was a thin disguise to satisfy the financial needs of Martland. After forming that conclusion the hospitals formed a coalition and demanded that the proposal be expanded to include all Newark hospitals as part of the health care delivery system. The hospitals also demanded representation on the Board of Trustees.

Once the hospitals were successful in their demand for inclusion in the proposal as part of the health care delivery system, the six neighborhood health centers made the same demands, and finally the same demand was made by the individual practicing physicians. It was concluded that the physicians would

have to work within a Physicians Foundation which would be designed similar to the San Joquin Physicians Foundation in the State of Washington. The dental, mental health, pharmacy and vision care people made the same demand but were rejected by the board and told that they would have to work within the physicians foundation.

By this time the Community Advisory Board had realized its true worth and soon disbanded. The Board of Trustees' membership, by now, had increased to twenty-six members.

Close analysis of the board composition would expose several important factors with the potential for a serious impact on social, political and financial issues:

1. Political Issues:

- A. The governor of the state maintained control of the proposal because members of the board had to be appointed by him. And as added political insurance, members of the governors cabinet made up the "majority" of the voting power on the board so the governor could pass or defeat any motion being voted on by the Board. Unfortunately, the local community did not have very much clout on the board although by this time the Mayor's office and the City of Newark's Department of Health and Welfare was part of the board composition.
- B. The health grant proposal was being developed for the largest and most populated city in New Jersey. Clearly, this would have excellent potential for producing "votes" during a

gubernatorial election.

- C. While the basic thrust of the grant proposal was to address the health needs of the entire population of the City of Newark including the waiver group or those persons who earned incomes of  $133\frac{1}{3}$  above the AFDC guidelines, (Aid for Families of Dependent Children), another large group being denied health care under this proposal would be those who earn from fifty cents to fifty dollars above the AFDC guidelines. This population group would continue to be ineligible for health care. Yet the law relating to this issue seems clear.

"The basic purpose of Title XIX (Medicaid), as outlined in the 1965 legislation, was comprehensive and far-reaching. Each state was to be encouraged "as far as practicable under the conditions in such state" to provide medical assistance to families with dependent children and to aged, blind, or permanently and totally disabled individuals 'whose income and resources are insufficient to meet the costs of necessary medical services."<sup>1</sup>

In summary, the health grant proposal was a bold new innovative approach to total health care while on the other hand, it probably could have been designed to include a broader base of consumers. One reason for this

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<sup>1</sup>R. Stevens and R. Stevens, Welfare Medicine in America, A Case Study of Medicaid, The Free Press, Collier Macmillan Publishers, London, 1974, p. 57.

statement is that there is a major question currently unanswered. How many persons will fit into the category of income levels that are between 100 and 133-1/3 percent above the AFDC guidelines? If this number turns out to be 10,000 people out of a potential population base of roughly 100,000 then the impact is almost insignificant.

If this line of thinking is continued it becomes fairly obvious that the grant proposal will probably satisfy the needs of the local health institutions and the politician on a statewide basis rather than the health needs of the community.

## 2. Financial Issues

- A. The current Medicaid program for Newark is running a fifty million dollars deficit. It is estimated that next year it will be roughly double that or a one hundred million dollar deficit.
- B. It is evident that a solution must be found to contain the cost of health care. This health grant proposal will seek to provide funds for a comprehensive approach to health care based on prepayment, which is intended to erase the cash flow problems of many providers;  
Prevention, which is intended to catch illness in their very infant stages thus requiring less cost to cure; and capitation, which is intended to involve the health provide in the financial risk of taking care of members of a health plan within a fixed number of dollars.

Provided that the approach and the design is successful, local officials will become national heroes, the institutions will survive and the governor will probably be re-elected.

### 3. Social Issues

A. In one sense, Medicaid is an extension of Welfare. In that regard, this health proposal would be providing additional health care for poor people. Many exceptions should be taken with this statement that Medicaid is an extension of Welfare especially since it is clear to the Welfare recipients and to those persons responsible for administering the welfare system that it is grossly inadequate for the needs of a contemporary society. The defaults of the welfare system have been researched and studied repeatedly without impressive improvements which brings about the question of whether the entire system should not be discarded with an entirely new approach developed.

B. In another view, this health proposal could easily help get recipients off welfare roles--because of health reasons--and back into the labor market.

Being back on the labor market helps provide a better tax base for Newark.



Apart from these issues, the health grant proposal was finally completed and submitted to the secretary of the Department of Health Education and Welfare. By this time, a new Secretary had been named and he had to be briefed on the political deal that was made. After one year, the project received conditional approval, one of which included the establishment of a private non-profit Corporation to manage the project and to hire an Executive Director to operate the project on a daily basis.

The same board of trustees that had responsibility for the development of the proposal assumed responsibility for the new private corporation. The next major task was to locate and hire an Executive Director and this process involved the time span of one year and included the review of over two hundred resume's. The problem that caused the delay was easy to understand, in that, each faction on the board of trustees wanted someone who would favor their thinking and support their cause.

When this research was interviewed for this position, there were a minimum of thirty five people in the room and the interview lasted for over two hours.

Once the Project staff was hired and started making recommendations to the board for policy decisions, the conflict of interest issues that were directly related to boards composition became readily apparent.

### Conflict of Interest Within the Board of Trustees

Perhaps many boards of trustees have factions within it with a variety of interests, but the Newark project board may have set a record by its uniqueness. One obvious faction on the board was the "state" representation who were going to be certain that the health proposal maintained key components that were in their best interest. The second faction was the representatives for the medical and dental societies who usually voted in a "block" until issues arose that questioned whether a particular medical service would be provided versus a dental service. At this point, the support and voting would be based on "each man or profession must fight for himself."

The third faction on the board was what could be called the consumer group and its composition included laymen consumer representatives from the local community; the Mayor's Office; the City Department of Health and Welfare and representation from the Neighborhood Health Centers. The fourth group was the representatives from the major hospitals in the Newark community.

The issues that fostered the conflict of interest were easily apparent in that:

- The State Department of Insurance would have to review and approve the rates established by the new health plan before it could market its benefits package. The crux of the problem was that if the Commissioner or his designee on the board was unhappy with any parts of the rate structure and the

board somehow approved the rates without modification, the Commissioner could simply decide not to approve the rates once they reach his office as a state official.

-The State Department of Health has responsibility for review and approval of the certificate of authority. Without this certificate, a health plan, can not legally conduct its marketing effort to get members enrolled in the health plan. Again the conflict is clearly evident.

-The State Treasurers Office not only had responsibility for the state's share of the projects funds but also controlled the monthly cash flow of funds to the project. (The State's share of the fund was matched by the federal health grant.)

-The State Department of Human Services was responsible for the greatest conflict in that this department was directly responsible for the general supervision of the prospect on behalf of the state. This responsibility includes budget review and review and approval of the eligibility criteria's for plan membership.

The next major conflict of interest came from the potential providers of health care, physicians, dentists, hospitals and neighborhood health centers. As board members, they voted on policy issues that had direct effect on many substantive issues which involved; the content of the benefits package;

who would be allowed to deliver specific aspects of the package, and equally important who would deliver such services in that, can 24-hour services be provided by the hospital in their regular emergency room or must there be a separate system. Clearly, the separate system is mandatory to relieve the burden of episodic uncoordinated, lack of continuity "medical" care instead of an organized comprehensive health care approach.

The providers, as board members decide how much the benefits package would cost which in essence determined how much money will ultimately go into their own institution's pockets.

After these issues and many others were discussed and approved at the board of trustees level, it then became the responsibility of the project staff to negotiate contracts and other arrangements for health care with these same providers who serve on the board of trustees. The "impossible" nature of this arrangement was that often when a provider could not win his point during direct negotiations with project staff they would simply wait until a board meeting was held and use other sympathetic members of the board to vote approval of what they wanted contractually in the first instance.

This farce is another example of how the institutions, the medical and dental societies and the politicians can manipulate propositions into certain postures to satisfy their needs. But haven't the needs of the consumer been overlooked?

Internal Conflict Within DHEW that was Caused  
By the Newark Project

The U.S. Department of Health, Education, and Welfare has control over a budget that ranges well over one hundred billion dollars annually. Management of these expenditures and programs are often uncoordinated, overlapping and sometimes the goals of one program financed by DHEW seems to be in conflict with the goals of another program financed by DHEW.

To avoid some of these problems relative to the Newark project, it was decided that a Policy Board should be established to provide broad supervision and advice to the Newark project. Membership composition of the Washington Policy Board would be from essential program areas within DHEW and namely; Public Health Services; Social and Rehabilitation Services; Planning and Evaluation; HMOS who had responsibility for the development and funding of Health Maintenance Organizations nationally and finally the New York Regional Administrator and the New York Regional Commissioner.

As the Washington Policy Board met and the breadth and scope of the Newark Project became known the internal conflicts were quickly highlighted. Probably the first clear issue that surfaced came from the HMOS office with responsibility for traditional Health Maintenance Organizations. Representatives from this department expressed strong reservations about the need for the Newark Project and suggested that it should be abandoned. To address this problem "eye ball to eye ball" management of the Newark Project staff had to travel to Washington and make a full presentation to the management staff of HMOS.

The second major issue within DHEW came with the request from other organizations within Newark and its surrounding communities to establish their own Health Maintenance Organizations. The issues involved in this matter were basically financial in that if other HMO's were allowed to develop in the immediate Newark area they would have the great potential of attracting the self paying population thus leaving the Newark Project as a poor peoples or poverty program. Should that be allowed to happen it would be extremely difficult to attract well qualified physicians, which means that the level of health care would be questionable. The most complex issue was that if this were allowed to happen the financial base that could be gained, from persons who pay out of their own pockets or who have their employers pay for their health care, would be lost.

The self paying populations are one of the most essential factors in the Newark Project Program because, in addition to the financial concerns, it is important if this country is going to have one class and one level of health care in the American society.

To solve this problem, intense lobbying was conducted within DHEW and finally a policy decision was approved and issued by the Washington Policy Board. In summary the policy stated that the local "B" agencies and the "A" agencies, which were responsible at that time for approving HMO applications before they were reviewed for possible funding by regional DHEW offices, were not to approve HMO applications for the Newark Community. The policy also stated

that HMO's located in the surrounding Newark Community could not market within the city limits of Newark.

Without this policy it would seem that in one way DHEW would be spending a large sum of money to finance a health care delivery system and in another way creating other HMO programs to assure that it would be unsuccessful.

#### The Newark Plan (Compre Health)

The Newark Plan is a demonstration project designed to bring together by contract all of Newark's health resources for cost effective quality care in the open market. This project mobilizes available health resources in the City into an HMO structure. It is the premise of this major demonstration project that better usage of the health care dollars can be gained if all of the City's health providers are organized into a citywide network implemented through primary care contracts and subcontracts. In this way, there will be greatly increased access to health services which are for the first time both comprehensive and coordinated to insure quality and continuity of care with strong ambulatory components. The plan's design will lead to early diagnosis and treatment, a reduction in in-patient usage and ultimately to prevention. The greater use of ambulatory services also will reflect the higher productive and lower cost rate of out-patient resources. This network will replace the current fragmented, inadequate system with its fee-for-service, episodic and crisis care, emphasis on expensive in-patient usage, and severely limited entry points into primary and secondary health care.

## 1. Key Components

- Waivers of Medicaid regulations to permit delivery of health services to various segments of the population classed as medically indigent especially since the state of New Jersey does not have a medically indigent program. Once the previously used income levels had been changed or waived figures in Table 11 indicate the new income levels that are used in determining if the individual is eligible for health care services under Compre Health.
- Enrollment of waived Medicaid groups--medically indigent--by the Plan's staff at various sites throughout the City. The first year's target is 20,000 enrollees, with 75,000 by the end of the 27 month project.
- Provision of a comprehensive package of services by prepaid capitation contracts with the three primary health care providers: the neighborhood health centers, the hospitals, and the physicians foundation.  
The facilities include hospitals (Martland, St. Michael's, Beth Israel, Columbus, St. James, and United) and neighborhood health centers (Timothy Still, Bessie Smith, Lyons Avenue, North Jersey Community Union, and Gladys Dickinson).
- Organization of health care groups to allow for the participation in the Plan by other private practitioners: dentists, optometrists, podiatrists and pharmacists. These groups will contract for services but receive referral of patients only through the primary health providers.
- Options for partial and full-pay enrollees, whether as individuals or



TABLE 11

Compre Health Income Limits for Title XIX Waiver Eligibility Only

Family Size	Weekly		Monthly		Annual		Allowable Assets
	Gross	Net	Gross	Net *	Gross	Net	
1	79.84	61.53	346.00	266.66	4152.00	3199.92	2076
2	107.30	95.23	465.00	369.33	5580.00	4431.96	2790
3	118.07	95.30	511.66	413.00	6140.00	4956.00	3070
4	133.36	109.61	577.91	475.00	6935.00	5700.00	3467
5	151.05	124.84	654.58	541.00	7855.00	6492.00	3927
6	167.69	141.23	726.66	612.00	8720.00	7344.00	4360
7	184.13	155.76	797.91	675.00	9575.00	8100.00	4787
8	201.15	170.76	871.66	740.00	10460.00	8880.00	5230
9	214.23	183.92	923.33	797.00	11140.00	9564.00	5570
10	226.25	195.92	980.41	849.00	11765.00	10188.00	5882

- groups, to join the Plan, so that there is one citywide system providing quality care, not one for the poor and another for "paying" patients.
- . Patient information and record system;; registration and enrollment forms and provider contracts and subcontracts will be standardized.
  - . Planned and aggressive patient management by the primary provider--the patient's primary physician--coupled with a computerized health monitoring system.
  - . Financial incentives to the primary providers to reduce costly in-patient usage, emphasize ambulatory care, and to plan all health care on the most efficient, cost-effective basis.
  - . A financial management system to identify cost centers, and develop the mechanisms to contain costs and reduce the rate of increase.
  - . A peer review and medical audits at several levels and standardized treatment programs for selected major diseases to insure improvement in the quality of care as well as earlier and more effective preventive care.

## 2. Organization

The Newark Plan will be implemented under the name of the--New Jersey State Health Services Corporation and will be known as Compre Health. As an independent corporation entity, it will have the permanency, strength and flexibility to successfully conduct this broad-scale demonstration project.

The Corporation's trustees will direct and operate the Plan through contracts with

primary providers and through an Executive Director and management staff for day-to-day administration. The new Corporation will be empowered and funded to implement and direct the Plan through the State Department of Institutions and Agencies, which has responsibility for the New Jersey Medicaid Program.

### Waivers

One of the most unique features of this Plan is the series of waivers of Medicaid regulations. These waivers are essential to the establishment of a citywide demonstration representative of the various categories of population in Newark.

Only through the waivers can a large enough economically viable membership base be created to test the hypothesis of a citywide health maintenance system. Only with participation of the various waived groups will there be a valid productive demonstration.

### Planned Improvements in Newark Health Care

In comparison with present random fragmented and uncoordinated health service in Newark, Compre Health should accomplish the following major improvements:

1. City-wide organization of health care resources in Newark into a coordinated system of patient-oriented care.
2. Removal of financial obstacles to health care for low-income working poor and increased access to more health providers.

3. Planned therapy and health management for enrolled membership.

4. Comprehensive benefits:

Periodic physical examinations

- laboratory tests
- specific disease screening

Dental care

Referrals to specialized services

- medical and dental specialties
- vision examination and correction
- pharmacy services
- podiatry
- skilled nursing services
  - in patient
  - at home

5. Outreach and Follow Up:

- notification of appointments
- calls and visits when required
- health education
  - through school systems
  - through publicity and scheduled events

6. Preventive Care through

- immunization
- education
- specific screening programs

7. Health Monitoring System--including coordination with school health services.

8. Primary Health Care Teams including paraprofessionals.

9. Home care and skilled nursing service through hospitals.

10. Concurrent and pre-certification for in-patient care.

11. Standardized patient encounter records.
12. Open hospital privileges for all physicians in the Plan.
13. Primary physician control of patient care management for all types of health services.
14. Reduction in the utilization of in-patient services through prevention, health maintenance and expanded ambulatory care.
15. Cost containment system to identify cost centers, promote cost-effective care and to reduce the total rate of increase.
16. A capitated health care system which will serve not only the medically indigent but will attract other residents who can afford to contribute for their health care.

C H A P T E R V I  
CONSUMER INVOLVEMENT

While the participation of physicians in a city-wide HMO is an essential ingredient in the success of that HMO, it appears that it constitutes only half of the solution to the physicians manpower shortage in a scarcity area or an inner city community. The second component of the problem includes organized factions within the local communities, individual consumers and the medical community.

For greater clarity, it may be helpful to examine briefly the important role each of these elements contribute to the total health care delivery system.

Patients can Protect Themselves Against  
Incompetent and Negligent Medical Care

It is believed by some health care experts that an informed and inquisitive consumer can often foster better health care for themselves and their families. "The informed consumer can be the most powerful force for bettering the caliber of health care indicates Dr. Arthur Levin, a New York City pediatrician who is the author of the recently published book, "Talk Back to Your Doctor." . . . Doctors, like everyone else, perform better when their performance is being scrutinized," he says.<sup>1</sup>

An informed consumer of health care should know how and when to choose

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<sup>1</sup>J. E. Brody, How Educated Patients Get Proper Health Care, The New York Times, Friday, January 30, 1976, p. 9.

a physician as well as what questions to ask to assure adequate preventive care and treatment of illnesses. Since the choice of a doctor is a life-and-death decision, the informed consumer should know what to tell the doctor about himself, how to identify a good hospital, how to find out if surgery is needed and how generally to act in his own interests as a patient.

"In 1958 Dr. Donald Munro, a Massachusetts surgeon advocating better consumer education in medicine, outlined four case histories in the New England Journal of Medicine. One case resulted in needless death, another in blindness, a third in the loss of a career and the fourth in unnecessary hospitalization and great emotional trauma. . . These cases had one thing in common. . . in every one. . . the patients chose or permitted a doctor to treat their varied and serious complaints without actually knowing anything about the doctors capabilities."<sup>2</sup>

There are firm and strongly held beliefs supporting the notion that a patient does not have to be a physician to evaluate the care a doctor gives him any more than he has to be a mechanic to appreciate the difference between a Model T and a Cadillac. One advocate of this approach was documented in the book entitled "How to Choose and Use Your Doctor" which was written by Dr. Marvin S. Belsky, a New York internist.

Many health care experts, including Dr. Belsky, maintain that the first requirement is to destroy the God-like image that many laymen have of physicians.

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<sup>2</sup>Ibid., p. 10.

Dr. Belsky tells patients, "Get off your knees." The unquestioning belief that "doctor knows best," . . . can lull patients into accepting false reassurance and inadequate care.

Once patients emerge from the "thrall of the medical mystique," Dr. Belsky says they are in a far better position to evaluate rationally their physicians and the care they give."<sup>3</sup> Dr. Belsky, along with other health care experts, have developed guidelines and suggestions to help consumers to choose a good doctor:

-Select a doctor while you are healthy, when you can think clearly and have the time to evaluate his competence, rather than when you are sick or faced with a medical emergency. The first visit to a new doctor should be for a routine check-up.

-Choose a family doctor to be your regular physician--an internist or specialist in family practice (and a pediatrician or family practitioner for children). Do not choose as your family doctor a surgeon, gynecologist or other specialist who focuses on only one aspect of medical care.

-It is usually unwise to refer yourself to a specialist without first seeking the advice of your family doctor. The eye problem you take to an ophthalmologist could be a result of diabetes.

-In general, avoid doctors without any hospital affiliation or doctors who only have appointments at small, private, profit-making hospitals. "Dr.

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<sup>3</sup>J. E. Brody, How Educated Patients Get Proper Health Care, The New York Times, Friday, January 30, 1976, p. 10.



Levin says that hospitals with fewer than 100 beds and there are more than 3,000 of them in the country, have death rates 40 percent higher than other hospitals when the severity of their cases is taken in account."<sup>4</sup>

-Consider choosing a doctor in a medical group or large partnership. Such doctors are more likely to have screened one another for quality and are inclined to consult with one another in difficult cases.

-If you have no regular doctor and you are suddenly faced with an illness that requires immediate care, it is better to go to the outpatient department of a teaching hospital than to rely on picking a name out of the Yellow Pages or soliciting the advice of a friend.

Once a physician has been chosen, the next step is to evaluate the care he gives to the consumer. There are a host of questions that should be answered including: Does the doctor treat the consumer as a rightful participant in his health care; Does the doctor spend enough time with the consumer; and does the doctor emphasize preventive medicine?

One essential and significant part of this evaluation is whether the doctor did a thorough "work-up" during the consumers first office visit. At a minimum, it is believed that a work-up should include a complete personal and family medical history with precise questions (not, "How are your bowels?" but, "Have you had any recent diarrhea, constipation, blood in your stool?"). A careful physical examination with the consumers clothes off, checking all parts

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<sup>4</sup>J. E. Brody, How Educated Patients Get Proper Health Care, The New York Times, Friday, January 30, 1976, p. 9.

of your body (including the inside of your mouth), and routine laboratory tests of blood and urine, plus any special tests the individual's history may suggest.

The physical also should include a digital rectal examination for men, and a pap smear and manual pelvic examination for women unless they are regularly examined by a gynecologist.

### Publicity Has Become Strong Medicine for Public Health

The ability of radio, television and the press to sell almost anything it chooses to advertise is well known to the American public, but the unanswered question is whether people can be sold things that really are good for them-- such as good health habits. Publicity sharply focused on the swine flu program-- both intentional and inadvertent--suggest that publicity may have more of an impact on the public health than either doctors or laymen had ever thought possible.

While the swine flu episode certainly has shown that public awareness can dramatically change the course of a public health program, in other cases, publicity has led to small but significant public health successes. Perhaps the most dramatic demonstration of the potential impact of publicity on health followed the discovery within a three-week period in the fall of 1974 that the wives of both the President and the Vice President of the United States had breast cancer, the leading cancer killer of American women.

With the anxiety and concern of women everywhere aroused by the news

that two such seemingly healthy and well-cared-for women could be almost simultaneously struck by this dread disease, the press responded with a massive amount of information about how women can protect themselves through early detection and proper treatment.

"Thousands upon thousands of women descended on breast cancer detection centers, thousands more visited their doctors for breast examinations they had long put off. . . while some deplored the detailed publicity given to the medical lives of Betty Ford and Happy Rockefeller, the results of this press-created consciousness raising were life-saving, to judge from a study done in one city."<sup>5</sup>

"Statistics gathered from four hospitals in Nashville showed that in the three months following the surgery on Mrs. Ford and Mrs. Rockefeller, there was a 100 percent increase in the number of patients found to have breast cancer compared to the same three-months period the year before. But while the number of cancers found increased dramatically, a larger proportion of the cases were early, presumably more curable cancers."<sup>6</sup>

Apart from the publicity about cancers, it is thought that the recent decline in deaths from cardiovascular diseases provides another illustration of the effect of the press on health. More specifically, deaths from this cause

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<sup>5</sup>J. E. Brody, *Publicity has Become Strong Medicine for Public Health*, *The New York Times*, Sunday, November 28, 1976, p. 8.

<sup>6</sup>*Ibid.*

declined below the one million mark for the first time since 1967. With consumption of dairy products and eggs now far below pre-world war II levels, with cigarette smoking by adult Americans far less common than when the Surgeon General's report on smoking was released in 1964, and with a sizable proportion of the population now jogging, biking or otherwise moving muscles, there is little doubt that the decline in cardiovascular deaths is largely the result of relentless publicity about the hazards of dietary fats and cholesterol, smoking and sedentary living.

An experiment in California showed that a publicity campaign--including television and radio spots, newspaper columns and personal mailings--could get people to lower their risk of developing cardiovascular diseases.

Residents of the towns of Watsonville and Gilroy responded to the publicity blitz by lowering their egg consumption, blood cholesterol and the number of cigarettes they smoked. In Tracy, a comparable town that was spared the publicity, egg consumption dropped slightly, cigarette consumption was unchanged and blood pressure and cholesterol levels rose.

#### Active Involvement of the Medical Community

With the increasing participation of individual consumers and consumer groups, it is thought that professionals in every endeavor must actively and accurately police themselves. Failing this, it is fairly clear that certain consumer groups will become sufficiently strong to make significant impacts upon certain industries. There is no reason to believe that the health care

industry which governs life and death will escape the influence of consumers. With this, it is certain that the medical community must become more active in reviewing its own activities. An example of the need is obvious when more than 250,000 of the approximately 18 million Americans who underwent surgery last year died during or shortly after their operations, according to figures from the National Center for Health Statistics. That represents one death for every 72 surgical procedures.

"Many of these patients were critically ill before surgery and most probably would have died had they not had an operation. For other patients, however, it was the operation itself that ended their lives. Approximately 80 percent of surgery in the United States is elective. . . one in 200 persons who undergoes an elective operation dies as a result. An unknown percentage of these deaths occurs despite the best medical care, representing the risks inherent in any surgery. But many other deaths are the direct result of careless errors made by doctors or others involved in the patient's care."<sup>7</sup>

A two-year study recently completed by the surgical profession of 1,493 patients who suffered complications during or after surgery found that almost half the 1,451 non-fatal complications and a third of the 245 deaths that resulted were preventable. The need to combat this problem is clear but what is encouraging is that the study was part of a massive five-year self-examination of surgery by the American College of Surgeons and the American Surgical

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<sup>7</sup> J. E. Brody, *Incompetent Surgery is Found not Isolated*, The New York Times, Tuesday, January 26, 1976, p. 24.

Association. "The study, which examined data about patients treated at 95 hospitals in seven states, found that 78 percent of the preventable complications were due to surgeons' errors, with one-half resulting from faulty surgical techniques."<sup>8</sup>

Dr. John Bunker, a Stanford University anesthesiologist, published findings in 1970 in the New England Journal of Medicine where he said that "The surgeon's bias toward performing an operation is matched by the patient's eagerness to have one. Dr. Bunker was one of the early researchers who documented that the amount of surgery done is directly proportional to the number of surgeons available and to whether they receive a fee for each operation they do. It appears that at least some American surgeon's conduct their practice under the principle of "When in doubt, take it out" which accounts for why the rate of elective surgery in the United States is the highest in the world. In 1970, there were 70 operations per 1,000 persons but this increased in 1974 to 78 operations per 1,000 persons.

It is estimated that the most serious surgical risks are those associated with anesthesia. "No anesthesia is minor" according to Dr. Marcell Willock, Director of obstetrical anesthesia at Roosevelt Hospital in New York City and a special investigator of anesthesia-related deaths for the New York City office of the Medical Examiner. Dr. Willock further indicates that an adverse anesthesia reaction may mean permanent brain damage, leaving the person

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<sup>8</sup>Ibid.

# Deaths During Surgery in U.S., 1975

## Cholecystectomy

(Gall bladder removal)

Operations.....472,000  
 Deaths.....6,700  
 Surgery not recommended.....14%  
 Avoidable deaths.....938

## Appendectomy

Operations.....784,000  
 Deaths.....3,000  
 All operations are considered emergency procedures

## Hysterectomy

Operations.....787,000  
 Deaths.....1,700  
 Surgery not recommended.....22%  
 Avoidable deaths.....374

## Tonsillectomy

Operations.....724,000  
 Deaths.....150  
 Surgery not recommended.....70%  
 Avoidable deaths.....105

## Prostatectomy

Operations.....223,000  
 Deaths.....2,700  
 Surgery not recommended.....29%  
 Avoidable deaths.....783

## Hemorrhoidectomy

Operations.....200,000  
 Deaths statistically insignificant  
 Surgery not recommended.....17%

## Herniorrhaphy

(Hernia repair)

Operations.....508,000  
 Deaths.....2,000  
 Surgery not recommended.....2%  
 Avoidable deaths.....40



Operations, deaths: Commission on Hospital and Professional Activities  
 Surgery. Dr. Eugene McCarthy, Cornell University Medical College

Avoidable deaths: U.S. projections of avoidable surgical deaths based on percent of operations not recommended by consultants, Cornell study and The New York Times projections.

\* Estimate of various experts, not reflected in Cornell study.

crippled for life or doomed to a negative existence.

Despite the hazards of anesthesia, Dr. John Bunker's findings indicate that less than half of anesthetic administrations are handled by anesthesiologists or physicians in specialty training. By this he means those considered most qualified to give anesthesia properly and to cope with related emergencies. According to Dr. Bunker, the majority of anesthesia is administered by nurse anesthetists or nurses with no special training.

The preponderance of surgery is a significant contributor to the total cost of health care and further adds to the question about what can be done to adequately control it and to reduce its cost. To start its search for an answer, the United States Department of Health, Education, and Welfare conducted a study in which it compared federal employees covered by Blue Cross (where doctors receive a fee for service) and those employees enrolled in a prepaid group health plan (where the physicians are paid the same amount whether they operate or not). The study showed that surgery rates were 44 to 54 percent higher among the Blue Cross participants.

#### Prepaid Versus Fee-For-Service

"A recently completed study by the social security administration found that medicaid patients who are members of prepaid plans underwent half the number of operations performed on patients who were cared for by independent fee-for-service physicians. While it is sometimes argued by physicians that



perhaps participants in prepaid plans do not undergo as much surgery as they should, a national study headed by Dr. Paul Ellwood, a Minneapolis medical administrator, suggested that members of such plans, where the emphasis is on preventing illness, may, in fact, be healthier.

Dr. Ellwood's study found that they were hospitalized one-third as often and spent more time at work than comparable Americans receiving regular fee-for-service, illness-oriented medical care.<sup>9</sup>

With these findings, we assumed a high level of confidence in identifying certain specific problems while at the same time proposing certain specific correctives. The attached chart illustrates this approach.

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<sup>9</sup>J. E. Brody, Incompetent Surgery is Found not Isolated, The New York Times, Tuesday, January 27, 1976, p. 24.

Problems and Proposed Correctives

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Newark's Major Problems	Related To	Proposed City-Wide Health Plan Correctives
<b>1. POVERTY</b>		
Many low income families lack money for health care		Remove financial obstacles to care
Low Income families have poor nutrition		Coordinate food stamp, school lunch, and other programs with health education
Health providers carry many unable to pay, lack funds for improved facilities and services		Provide fair payment for services to medically indigent
<b>2. PREDISPOSED POPULATION</b>		
High rates of under-20 and over-55 groups require higher rates of utilization		Organize medical plan to serve local population
Demographic composition heavily weighted toward poverty and ill health		Build health system capable of interacting with unusual challenge in constructive, forward-looking manner
Educational lags		Improve health education
Low-level skills, mobility		Plan for individual care, follow-up outreach
<b>3. PREVALENT ILL HEALTH</b>		
High morbidity and mortality TB, VD, infant and maternal mortality, heart disease, hypertension		Early detection Screening Preventive Programs Health Education Outreach

#### 4. DECLINING HEALTH SERVICES

Physicians and hospitals leave

Incentive for more providers  
to come or return to  
Newark

Bias toward high-cost hospital  
care

Develop network of primary  
ambulatory care units

Fragmented, uncoordinated, non-  
integrated services

Develop planned, compre-  
hensive care with patient-  
oriented care and sophisti-  
cated record and information  
systems

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Source: Part of unpublished proposal to the Department of Health, Education, and Welfare. Proposal addressed Newark's major health problems in an effort to secure federal funding with which these health issues could be properly addressed and solved.

## C H A P T E R V I I

### THE COLLECTION OF RELEVANT DATA

Outward migration of local physicians has not only been a concern but a fear of urban communities for perhaps over a decade. As the middle-class population start to leave inner cities, it is often clear that vital services will quickly follow.

Planning toward the implementation of the Compre Health project provided fairly strong concerns about the actual number of physicians practicing medicine in the Newark community and its contiguous areas. Based on this concern and uncertainty, we decided that it would be a prudent decision to conduct a physicians manpower survey. The primary purpose of the survey was to more accurately assess the complement and category of physician specialties within the Newark community. We also wanted to know the willingness of these physicians to have an association with a city-wide Health Maintenance Organization.

In addition to answering these questions, the study has other inter-related objectives. One was to gain systematic information about physicians attitude and behavior as it relates to Health Maintenance Organizations (HMO) in general and a city-wide HMO specifically. Another goal was to gain

sufficient information which might assist in the control of health care utilization and hospital costs.

The primary objective was achieved by developing several areas of inquiry which represent the basis for formulating specific questions to be answered by the study:

1. Are there an adequate number of practicing physicians in a particular inner city to form the basis for a citywide Health Maintenance Organization?
2. To what extent are there sufficient numbers of specialty and super specialty physicians?
3. What is the level of interest, by physicians, in a citywide Health Maintenance Organization?

To our knowledge, there have been no major studies in which the primary purpose was to examine physicians participation as a major element in the implementation of a city-wide health maintenance organization. Thus, this study investigates a relatively unknown area.

In an initial investigation of this type, concentrated efforts were made in offering a certain level of financial incentive and motivation, to serve as impetus for a positive response from the medical community. This need served as the basis for the initial covering letter to the physicians to indicate the level of funding available to the city-wide health maintenance organization (see Appendix A).

As part of this approach it was hypothesized that a physician's patient represents influences on the geographical location of his medical practice. Second, if a physician is dedicated to the practice of medicine, where else can he be more challenged than in the general community that has been described as the sickest city in the nation?

In this study, the traditional approach, conventionally used by other investigators, was rejected. Instead this research became a twofold effort. One objective was to actually encourage and motivate physicians to become active and practicing members of a city-wide Health Maintenance Organization. A second effort was focused on the collection of relevant data that would assist this exploration.

Further, this is a cross-sectional study; that is, it attempts to question physicians at a certain point in time based on a series of questionnaires and telephone calls over a period of four months. Some might suggest that a longitudinal study, in which physicians were questioned at regular intervals over a number of years, would have been a more dynamic measure of physicians willingness for active participation in the implementation of a city-wide Health Maintenance Organization (HMO). Arguments, such as this, may be fairly significant when considered in conjunction with the rapid increase in the cost of medical malpractice insurances. Often, if a physician joins an organization, as opposed to a solo practice, the organization normally assumes responsibility for paying for the malpractice insurance as part of the physicians fringe benefits.

While the advantages of a longitudinal study are acknowledged, the cost in time and resources made this approach unrealistic for the present study. Moreover, a cross-sectional study more than adequately achieves the objectives of this study which is addressed to a relatively unexplored area.

### Initial Planning of the Study

Finding a field laboratory in which to carry out the study posed one of the early planning tasks.

Geographical convenience was a major factor in that there are few city-wide Health Maintenance Organizations in this country. A general concept of this type does exist within the Rochester Health Network which reportedly address the health needs of a fairly large portion of the population in the city of Rochester, New York.

In addition to the Rochester network, the Department of Health, Education, and Welfare had provided the largest single health grant to develop, plan and implement a city-wide Health Maintenance Organization in the city of Newark, New Jersey. This city has an estimated population of 383,417 residents and a medical community reportedly made up of approximately 300 physicians and with that number slowly decreasing.

The next major planning test involved obtaining permission to carry out the study. This problem was greatly reduced when this researcher was asked, by the Board of Trustees of the Newark Project, to take responsibility

for management and implementation of the health plan. After accepting that responsibility and pursuing the tasks of hiring staff, a series of interviews were conducted with representatives of the dental and medical communities. These interviews facilitated developing uniform sources of physician data and drafting preliminary schedules for collecting information.

Preliminary schedules starting with the one shown in Appendix C were pretested using the projects Medical Director and other physicians throughout the Newark Community and contiguous areas.

Two issues became clear and obvious during the pretesting experiences. One was that physicians were being approached during the period prior to the time when many of them take their annual vacations. This factor accounted for additional scheduling pressures and lead to the second major problem. According to physicians used in the pretest, the original survey instrument was simply too much to read, digest and then answer adequately in the short time they could devote to this document. During the pretest, it was the concensus of those persons spoken to that the questionnaire should be revised and simplified. With this advice the second instrument was designed and prepared for use on the actual study. The revised schedule is reproduced as Appendix D.

#### Creating a Physician Sample

The City of Newark, New Jersey and its contiguous areas including: East Orange, West Orange, South Orange, Hillside, Belleville, Maplewood,



Bloomfield and Elizabeth, New Jersey served as the target population resource for developing a physician population.

All practitioners were listed as members of the Essex County Medical Society or the National Medical Society. The Essex County Medical Society includes a membership of white and black physicians while the National Medical Society includes membership of basically black physicians. In this project, the interest was in attracting physicians from both medical societies.

In one sense, the target population and sample was established by the Board of Trustees of the Newark project in that they mandated that to participate in the project, a doctor would have to be currently practicing medicine in Newark or its contiguous areas. This provision further indicated that if the physician practiced medicine in a contiguous area, he would have to move his offices into the actual Newark Community within one year after the project started delivering health services.

Using this approach, every individual physician meeting the sample criteria had an equal and independent chance of being chosen. It was found that actually 272 physicians suited the established criteria and the data collected on these physicians form the basis of this report.

### Research Method

In June, 1976, letters were sent to 272 physicians which introduced Compre Health (The Newark Project) and informing them that they would be

contacted in the near future concerning their participation in the city-wide HMO. A copy of that correspondence is shown in Appendix A. As a financial incentive, the letter indicated that the project had received a substantial amount of funding from the state of New Jersey (\$9,000,000) with the understanding that this level of funding would be equally matched by the federal government's Department of Health, Education, and Welfare.

A second financial incentive was also mentioned in the letter in that \$15,000 was available to the physicians to defray the cost of a management consultant service to develop and finalize a central administrative structure for the physicians. This organizational structure would be designed to allow physicians to continue to practice medicine in their individual offices but through the central organizational structure could make use of certain commonly used services such as laboratory and x-ray.

On August 2, 1976 a second letter was sent to the same group of physicians. A copy of that document is shown in Appendix B. This second letter announced forthcoming individual and group meetings intended to explain the concept of the city-wide health maintenance program and to answer relative questions about the Newark project. The telephone number was included so that individual questions, from physicians, could be answered prior to the group meetings.

Two other documents were attached to the second letter to the physicians-- shown in Appendix D and E and reflects a brief and general fact sheet of interest

to physicians. The intent of the general facts sheets was to briefly address several questions that appeared to be a primary concern from those physicians who telephone the Newark project offices. Finally, the second document, and perhaps the most important one, was the questionnaire- survey which would provide essential data for the study. Appendix D illustrates this document. Basically, the question was whether a sufficient number of individual physicians could be attracted to formulate a physicians foundation.

In addition to the question of adequate numbers of primary care physicians is the need to insure that this group includes general practitioners, internists, obstetricians and gynecologists, and pediatricians. Essential to this grouping is the need for general surgeons, ophthalmologists, orthopedists and other specialty doctors. With these needs in mind, the second question on the questionnaire was perhaps the most important to the study.

With both letters sent to the physicians, a self-addressed envelope was enclosed along with a request that the questionnaire be answered and returned to Compre Health. Three weeks later telephone calls were made to those physicians who did not respond to the questionnaire. The responses to the telephone calls were recorded.

Response to the Questionnaire

There was no significant differences ( $Z=1.62$ )<sup>1</sup> between the proportions of physicians who responded to the questionnaire and those who did not respond. Among the responding physicians, a significant difference existed between the proportion of physicians who were available<sup>2</sup> and those who were unavailable<sup>3</sup> for participation in Compre Health ( $Z=2.1$ ).

Among the total number of physicians contacted, the proportion of available physicians was significantly smaller ( $Z=5.7$ ) than those who were unavailable (Table 11).

Apparently, the type of practice (specialty or general) did not influence whether or not the physicians responded to the questionnaire or were willing to participate in the Foundation. The differences in the proportions of specialists to generalists among the four groups of physicians, according to their response to the questionnaire and their availability, were statistically insignificant.

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<sup>1</sup> Statistical significance of differences between percentages was determined by Statistical Inference Analysis at the 5 percent confidence level ( $Z=1.96$ ). Helen M. Walker and Joseph Lev. Statistical Inference (United States: Holt, Rinehart and Winston, 1953), p. 78.

<sup>2</sup> Available--willing to participate in the Physicians Foundation.

<sup>3</sup> Unavailable--not willing to participate in the Physicians Foundation.

TABLE 11

## Physicians' Response to the Questionnaire

Physicians Response	Number of Physicians	Percent of Physicians
<u>Available</u>	<u>62</u>	<u>23</u>
<u>Unavailable</u>	<u>88</u>	<u>32</u>
Not interested	24	
Moved out of Area	29	
Retired or Semi-Retired	8	
Deceased	3	
Interested in Additional Information only	24	
<u>No Response</u>	<u>122</u>	<u>45</u>
Total	272	100

The percentages of physicians in the various areas<sup>4</sup> who responded to the questionnaire ranged from 100 percent in Millburn to 48 percent in East Orange, but the differences between the percentages were statistically insignificant.

#### Available Physicians

The available physicians were located in fourteen different areas with the majority in Health Districts I, I I, and IV, and East Orange (Table 12).

Among the sixty-two available physicians, twenty were willing to participate in other capacities in addition to providing medical care--four physicians in the administration of the Foundation, 7 physicians on a working committee of the Foundation and 9 physicians in both activities.

The participation of the available physicians in the Physicians Foundation would make primary care and most specialty services more accessible to Compre Health members.

#### Unavailable Physicians

Forty-two physicians stated that they did not want to participate in the Physicians Foundation. Some of the physicians gave one or more reasons for their non-participation while others did not give any reasons (Table 14). The reasons most often cited were retirement or semi-retirement, the Plan represents socialized medicine, and a desire to avoid government bureaucracy.

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<sup>4</sup>The Physicians (to whom questionnaires were sent) were located in the following areas: Newark, East Orange, West Orange, Irvington, Maplewood, Belleville, Bloomfield, Elizabeth, Livingston, Kearny, Millburn, Orange, Springfield, Hillside, Nutley, Watchung and Harrison.

TABLE 12

Proportions of Specialists and Generalists Among the Four  
Groups of Physicians, by Response and Availability

Physician Group	Specialists <sup>1</sup>		Generalists <sup>1</sup>		Total*	
	No.	%	No.	%	No.	%
(A) Responded to Questionnaire	88	83	18	17	106	100
(B) No Response to Questionnaire	104	77	29	23	135	100
(C) Available	44	77	13	23	57	100
(D) Unavailable	147	82	32	18	179	100

\*These totals represent only a part of the actual total for each group because information was not available for every physician (Group A - 87%; Group B - 90%; Group C - 90%; Group D - 85%).

TABLE 13

Geographic Distribution of Physicians Expressing Willingness  
to Participate in the City-Wide  
HMO

Area	Number of Physicians	Percent
Newark Health District I	13	20.9
Newark Health District II	10	16.0
Newark Health District III	3	4.8
Newark Health District IV	8	12.9
East Orange	9	15.0
South Orange	1	1.6
Irvington	6	9.6
Maplewood	4	6.4
Belleville	3	4.8
Bloomfield	1	1.6
Elizabeth	1	1.6
Orange	1	1.6
Springfield	1	1.6
Millburn	1	1.6
Total	62	100.0



TABLE 14

Potential Health Coverage by Medical Specialties According  
to Physicians who Indicated Their  
Availability

Specialty	Number of M. D. 's	Population Covered by M. D.	Total Population Covered
OB/GYN	6	11,000	66,000
Internal Medicine	4	5,000	20,000
Dermatology	1	40,000	40,000
Pediatrics	3	10,000	10,000
Urology	3	30,000	90,000
Ophthalmology	2	20,000	40,000
Radiology	5	15,000	75,000
Orthopedic Surgery	1	25,000	25,000
Gastroenterology	2	50,000	100,000
Cardiology	1	25,000	25,000
General/Family Practice	14	2,000	28,000
Proctology	2	unknown	---
Anesthesiology	2	14,000	28,000
Plastic Surgery	1	50,000	50,000
General Surgery	2	10,000	20,000
Vascular Surgery			
Pathology	1	unknown	---
Neurology	2	60,000	120,000
Neurosurgery	1	100,000	100,000
Unknown	8	---	---

TABLE 15

## Physicians' Reasons For Not Participating in the Foundation

Reasons	Physicians <sup>1</sup>	
	<u>Number</u>	<u>Percent</u>
Total	42	100
Retired or Semi-Retired	8	19
Plan Represents Socialized Medicine	8	19
Possibility of Undesirable Patients	2	5
Lack of Time	3	7
Involves too much paper work	2	5
Desire to avoid government bureaucracy	6	14
Illness	2	5
Uncertainty about capitation rates	3	7
Practicing out of state	2	5
Insufficient Information Concerning Peer Review	1	2
None	21	50

<sup>1</sup>The sum of the individual numbers and percentages are greater than the totals because some physicians gave more than one reason for not participating in the Foundation.

Among the 88 physicians who responded to the questionnaire but were unavailable for participation in the Foundation, 26 of them requested additional information through future mailings, individual meetings, small group meetings and telephone calls.

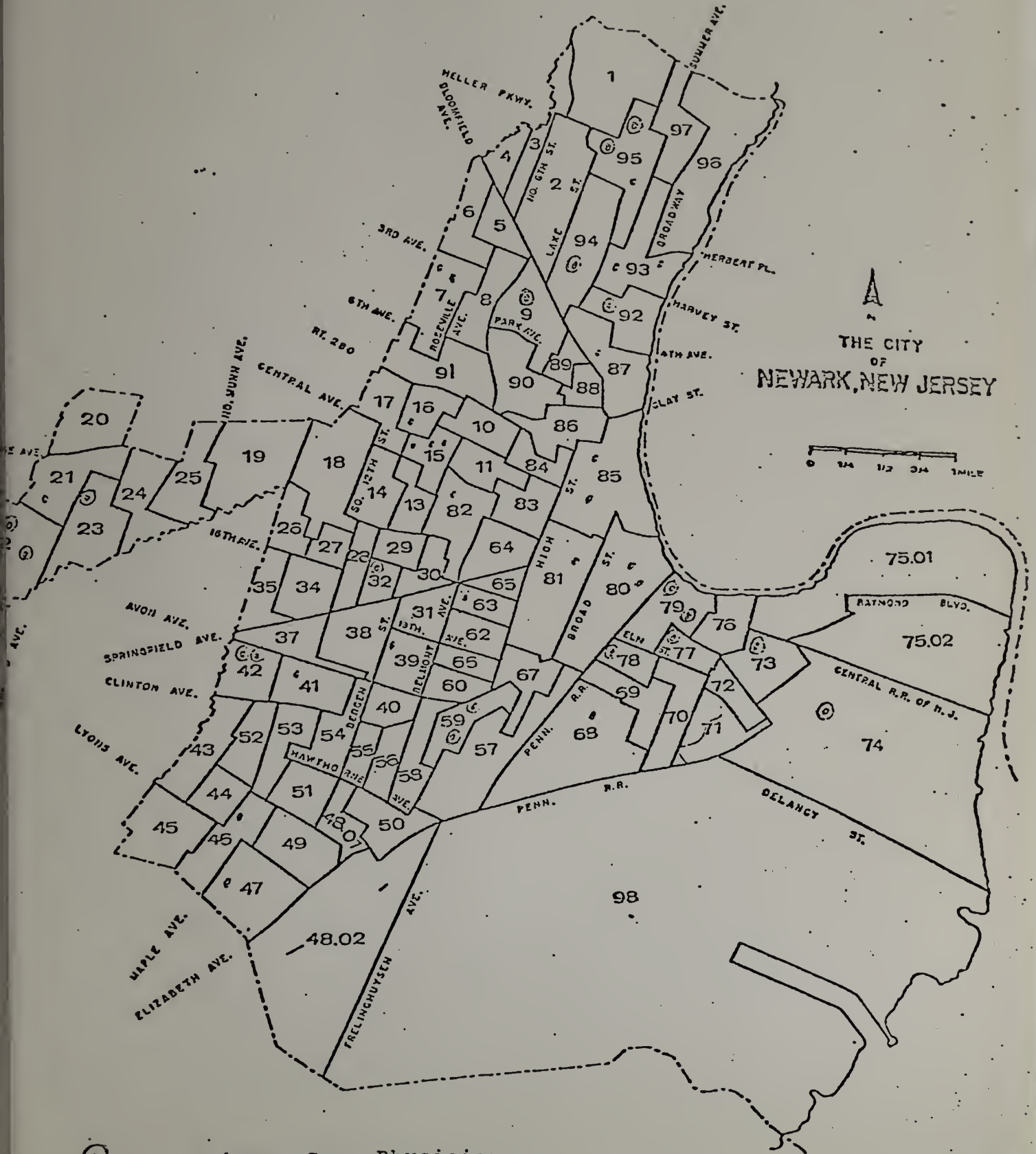
TABLE 16

Physicians Requesting Additional Information  
About Compre Health, by Type of Request

Type of Request	Number of Physicians 26
Future Mailings	25
Individual Meetings	2
Small Group Meetings	5
Telephone Calls	2

MAP III

DISTRIBUTION OF NEWARK PHYSICIANS WILLING TO PARTICIPATE IN COMPRE HEALTH



SPECIALITIES BY CENSUS TRACTSCensus Tracts:Specialties:

7	Urology
7	Proctology
9	Pediatrics
15	Internal Medicine--Cardiology
15	Pediatric Surgery
15	Plastic Surgery
16	General Surgery
21	General Surgery
22	Osteopathy
22	Osteopathy
23	General Practice
32	General Practice
39	Unknown
41	Orthopedics
42	Pediatrics
42	General Practice
46	Pathology
47	Anaesthesiology
59	Internal Medicine
59	Internal Medicine
63	Internal Medicine
68	Unknown
73	General Practice--Chest Diseases
74	General Practice
77	General Practice
78	General Practice
79	Obstetrics--Gynecology
79	Obstetrics--Gynecology
80	Ophthalmology
80	Orthopedics
81	Radiology
82	Unknown
85	Psychiatry
87	Unknown
92	General Practice
93	Gastro-Enterology
93	Gastro-Enterology
94	Obstetrics--Gynecology
95	General Practice
95	Anaesthesiology
95	General Practice

C H A P T E R V I I I  
RESULTS AND DISCUSSION

In spite of the unavailability of a significant proportion of the surveyed physicians for participation in Compre Health, the number of available physicians is adequate for the establishment of a viable "Physicians Foundation." There is also a possibility that other physicians will become interested in the Foundation once it is functional and an integral part of Compre Health's network of providers. This is probably true of those physicians who want to be kept informed of Compre Health's progress.

Generally, the physicians' reasons for non-participation in Compre Health does not connote hostility to the idea of a "Physicians Foundation" although there are some concerns over the effects of a government sponsored, prepaid delivery system based on the capitation approach. These fears will probably dissipate once Compre Health becomes operational and the physicians are convinced that the Plan's intent is in agreement with their basic philosophy of providing the best possible care to the residents of Newark.

It is clear from the review and analysis of this data that the result is not overwhelming nor is it strongly impressive. To the Compre Health management it does mean that an adequate number of physicians are willing

to cooperate with the citywide HMO to allow the health plan to move forward.

Other considerations are also pertinent to this discussion, in that in making a decision to locate in a specific geographic area a health practitioner, or any other professional for that matter, will base their decision on a number of economic and sociological characteristics of a location. Each person will place different importance on these characteristics depending on their particular "value" system.

The issues of individual value systems is particularly important to this discussion especially as this researcher recalls the subjective data gathered in the doctors survey. In an attempt to make an assessment of the "real" reasons that physicians were showing reluctance to work with Compre Health, certain "frank" discussions were held with many physicians who were friendly with Compre Health.

Information obtained from these conversations indicated that:

-Physicians would rather be paid their usual and customary fees for seeing patients and not be paid state of New Jersey Medicaid rates which are lower fees. Knowing that Compre Health would be negotiating Medicaid rates, many physicians were not anxious to participate in the Plan.

This problem is magnified by the affluent communities surrounding Newark, which means that patients who are capable of paying the usual and customary fees are readily available.

Two options are frequently available to physicians. One is to practice in an affluent community with many "well worried" patients who are basically not very sick and who pay fees that are often very high. Part of the alternatives is to practice medicine in the inner City of Newark where the physicians life is quite different.

The Newark patient is often very ill with a history of poor medical care. His health habits are undesirable in that the patient will often not take the medication prescribed by the doctor.

The follow-up visits to the doctor are often infrequent, if at all.

Personal hygiene is neglected which causes great difficulty in medical problem assessments and, therefore, medical treatment becomes a problem. With the possibility of extremely high jury awards for malpractice many white doctors believe they could not get a fair trial in Newark if a black patient brought a malpractice suit against him. Since Newark is a town with a 52% black population the general thinking is that any jury would be predominately black.

-Physicians complain that the Medicaid fees they are paid for providing health care to many Newark residents are inadequate fees. Additionally, they cite the heavy load of "paper work" that has become an essential part of the process in taking care of the Medicaid patient.



When the physicians compare the low Medicaid fees and the paper-work load associated with treating Medicaid patients with their experience of treating the affluent or suburban patient, there are a wide array of differences. The preferential practice becomes an easy selection to make.

-The Compré Health board has several influential and vocal, consumer representatives on its Board of Trustees. Many physicians believe that the control of health organizations should be in the hand of physicians and not laymen.

While this idea of physician control and domination is probably beginning to change, many of the Newark physicians are fifty and sixty years old. These physicians are not too willing to change their behavior patterns at this stage of their lives by having to follow the policies established by a board of trustees particularly one with a fair number of consumers.

#### Physician Shortage is Problem of Distribution

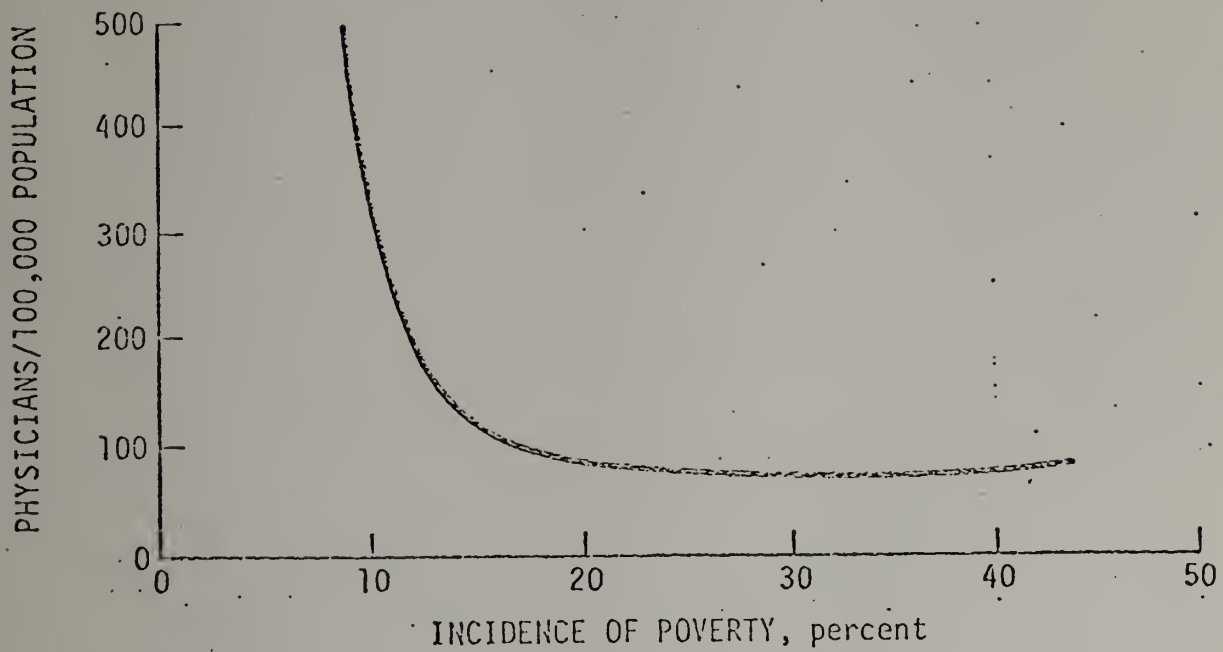
Alleviating the geographical mal-distribution of physicians and other health practitioners requires either a change in one or more characteristics of the medically underserved areas or a change in the value system of the health practitioners. Compré Health has little control over the values of

the health practitioner, but can be effective in changing certain elements of a region to make it a more attractive place to locate. The Compre Health plan addresses one particular characteristic by increasing the financial attractiveness of the Newark community.

Table 16 shows a curve that was fit to some preliminary National Center for Health Statistics data on physician density and census income data. The model postulates a hyperbolic relationship between per capita income and physicians density. This, of course, does not imply that all low income areas are medically underserved or that all high-income areas have an abundance of health practitioners. Rather, this is one of the characteristics of an area that affects the location decision. "All other factors being equal," the higher the income in an area the more likely a health practitioner will choose to locate in that area.

According to projections based on national data there should be at least one physician for every 1800 members of the population. Many cities and towns of this nation fall far short of reaching this goal. An example of this shortage manifests itself in the state of New Jersey where even though there are more than 10,000 practicing physicians registered in the state, it is still faced with an acute shortage of primary care physicians in certain areas.

TABLE 16



Trends in Data on Proportions of Physicians Related to Incidence of Poverty in Region

Source: Curves Fit to National Center for Health Statistics and Office of Economic Opportunity Data

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"Efforts have been under way during the past several years to alleviate the shortage, but there remains a 'critical' maldistribution of primary health care manpower in many of the state's central cities and rural areas, according to general health care officials."<sup>1</sup> For the majority of state residents to receive adequate health care, the distribution and availability of primary care physicians must be altered.

The doctor shortage has not escaped the concerns of the state of New Jersey Assembly and Senate where they are considering pending bills to help alleviate the shortage problems. These bills include a Loan Forgiveness program for medical school students, a Graduate Medical Education bill and a Physician's Assistants bill that would provide additional health manpower in areas designated as "medically underserved" throughout the state.

On the federal level, there is the Urban Health Strategy bill before Congress which would provide aid for additional health manpower for New Jersey and other states. Under this legislation, areas designated as "Critical Manpower Shortage Areas" (CMSA), would be eligible for federal aid to increase the supply of health manpower in the area.

Since there is a new administration in Washington, D. C., an assertion of projections and speculations appear to be forthcoming. Specially, it has been suggested that "President Carter would increase, from \$35 million to

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<sup>1</sup>E. Roberson, Health and Medicine, Section One, The Sunday Star Ledger, February 27, 1977, p. 43.

\$40 million, the budget of the National Health Service Corps, in which students promise to serve in areas with shortages of health professionals after they graduate. Grants for special projects to increase the number of residency positions in family medicine and family dentistry would increase from \$9 million to \$45 million under the Carter budget."<sup>2</sup>

### Health Systems Agency Involvement

To further address the problem of physician availability we found a fair amount of encouragement in the federal legislation passed in 1975 and called the National Health Planning and Resource Development Act, PL 93-641. This act serves as impetus for a five year plan to be entitled, "The Health Systems Plan" to be developed by each Health Systems Agency (HSA).

"The primary responsibility for planning the state's health manpower needs lies with five area health systems agencies (HSA) established under federal legislation in 1975. . . the associate director of the Newark agency said. . . we have attempted to increase the number of primary care physicians for every 1,800 people in the population. In our area, which comprises Essex, Morris, Union, Sussex and Warren counties, this goal has largely been met. However, the problem is now clearly distribution, as evidenced by Newark, East Orange and Plainfield, where shortages still exist."<sup>3</sup>

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<sup>2</sup>The Chronicle of Higher Education, February 28, 1977, Vol. XIV, No. I, p. 5.

<sup>3</sup>E. Roberson, Health and Medicine, Section One, The Sunday Star Ledger, February 27, 1977, p. 43.

In the search to find a solution to the physicians participation problem, local HSA officials were questioned about what work they had been engaged in to help resolve the problem of attracting physicians to the local community. It was found that the state department of health had designated Area II of their five health services areas to include:

- Essex County,
- Morris County,
- Union County,
- Sussex County,
- Warren County.

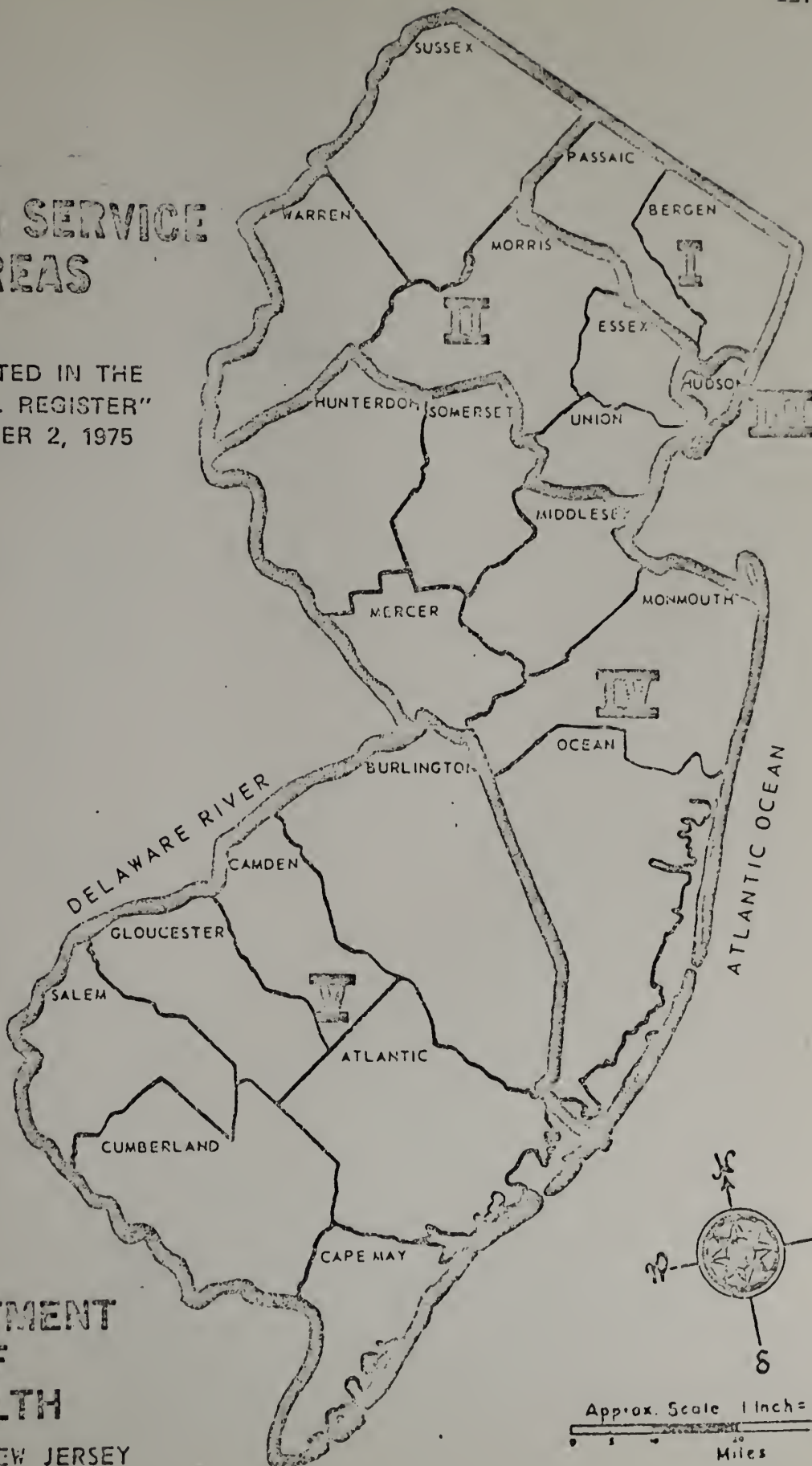
Based on this finding, efforts were centered on Essex County since Newark is located there, and is the state's largest city. The five health service areas are shown on the following page along with significant demographic information.

### Health Characteristics

When looking at Area II in terms of the characteristics that relate to health care, several points need to be kept in mind. First of all, Newark is located in Area II and is recognized as the center of the state. Its immediate proximity to New York City, its metropolitan status, and its teaching facilities are all reasons why Newark is also the center for the most sophisticated medicine in New Jersey. Area II maintains roughly one-half of the hospital

# HEALTH SERVICE AREAS

DESIGNATED IN THE  
"FEDERAL REGISTER"  
SEPTEMBER 2, 1975



DEPARTMENT  
OF  
HEALTH

STATE OF NEW JERSEY

Approx. Scale 1 inch = 18 Miles  
0 5 10 15 20 Miles

beds in the state, and the majority of specialty services are located in Area II. Yet with all this sophistication and specialty, it still has high TB, VD, morbidity, and other rates. These rates and others are mentioned below to give the reader at least an overview of some comparative indicators.

Of prime consideration, however, is that even these broad indicators may be somewhat misleading. This is due to the maldistribution of services and facilities provided rather than the scope and capabilities of the services and facilities themselves. For instance, the number of physicians per 1,000 population is misleading, in that Essex County (excluding Newark) brings the Area II average up to a level that is far above the number of physicians per 1,000 population in Warren County and Sussex County.

The following indicators are listed to provide an overview of significant health characteristics in Area II: (Table 19)

#### Physician Availability

Another significant point that must be emphasized is the age of the practicing physicians in Area II. These data are not for the total number of physicians licensed to practice in the state but reflect data for currently practicing physicians.



TABLE 17  
OVERVIEW OF HEALTH CHARACTERISTICS

	Area II (1975)	New Jersey (1975)	United States (1974)
Births per 1,000	12.1	12.3	15.0
Deaths per 1,000	8.7	8.8	9.2
Mortality:			
Infants (per 1,000 Live Births)	16.5	15.7	16.5
Heart Diseases per 100,000	358.2	368.3	338.6
Cirrhosis per 100,000	16.0	16.6	15.0
Morbidity:			
Tuberculosis per 100,000	18.3	24.8	14.8
Venereal Diseases per 100,000	420.5	277.9	460.5
Serum Hepatitis per 100,000	17.9	16.6	4.7

Sources: New Jersey Public Health Statistics, 1975. Monthly Vital Statistics Report.

TABLE 18  
Total Practicing Physicians

Age	Area II	New Jersey (state wide)	% of New Jersey
25-29	78	226	34.5
30-34	404	1,221	33.1
35-39	482	1,541	31.3
40-44	406	1,448	28.0
45-49	405	1,366	30.3
50-54	443	1,253	35.4
55-59	290	871	33.3
60-64	251	817	34.4
65+	470	1,337	35.2
Totals	3,259	10,080	32.3

Based upon the figures shown thus far, it has become increasingly clear that maldistribution of physicians is a major problem for the city of Newark. While it is equally clear that according to the data presented, Essex county as a whole is not experiencing physician manpower shortage problems. With this discovery it is easy to expect that the local HSA would have physicians manpower listed as a top priority for the Newark area. We found it interesting that this was not evident in the HSA's priority chart by county.

Clearly, in the five counties we reviewed, the supply, distribution, and availability of physicians and other health manpower must be increased. In some counties, such as Essex, Union, and Morris counties the basic ratio of one physician per 1,800 population appears to have been reached. But in the city of Newark, New Jersey acute shortages exist. In fact, these areas have census tracts which have either already been classified as medically underserved or critical health manpower shortage area.

TABLE 19

## Health Priorities Ranking by County

Essex County:

- Mental Health
- Health Services for the Aged
- Coordinated Institutional Services
- Emergency Medical Services
- Supply of Physicians

Newark City:

- Housing/Environment
- Maternal, infant child Care
- Mental Health
- Hypertension
- Venereal Disease Control
- Supply of Physicians
- Health Services for the Aged
- Dental Health
- Emergency Medical Services
- Health Facilities Planning

Morris County:

- Mental Health
- Emergency Medical Services
- Access to Existing Health Services
- Preventive Medicine Services
- Supply of physicians

Sussex County:

- Supply of Physicians
- Coordinated Institutional Services
- Mental Health
- Health Services for the Aged
- Emergency Medical Services
- Preventive Medical Services

Union County:

- Mental Health
- Health Services for the Aged
- Maternal, Infant Care
- Health Care for the Working Poor
- Coordinated Institutional services
- Preventive Medicare Services
- Consumer Education
- Supply of Physicians

Warren County:

- Supply of Physicians
- Mental Health
- Maternal, Infant Care
- Health Services for the Aged
- Emergency Medical Services
- Dental Health
- Coordinated Institutional Services

C H A P T E R I X  
SUMMARY OF CITY-WIDE HMO

Major Innovations

In a nutshell, this project proposes to use Medicaid funds on a prepaid capitation basis to deliver a comprehensive set of health services to the medically needy in one city. To accomplish this in an orderly fashion involves a reorganization of the existing health system in Newark through the implementation of several innovations. The most significant innovations proposed for Newark's health system are outlined below:

1. Enrollees

Prior to the implementation of the project, Medicaid coverage in New Jersey extends only to those who are eligible for cash grants under categorical assistance programs. Through waivers of Medicaid regulations, the Comprehensive Health proposes to enroll several categories of people in addition to those present Medicaid recipients who choose the plan. One group to whom the plan will be offered includes all those residents of Newark whose income places them between the present AFDC ceiling and an income equal to 133-1/3 percent of that ceiling. The second group will include all other residents of the city with premium levels calculated on the basis of the enrollee's ability to pay. Persons with incomes above the maximum will be required to pay the full

premium in order to participate.

## 2. Providers Reimbursement--Capitation

The plan proposes to reimburse providers through the prepayment of a capitation, the amount of which varies with the age of the enrollee. Through the prepayment mechanism, the Compre Health will assure the delivery of cost-effective services focused on the maintenance of health rather than on the treatment of disease. Implicit in this type of an arrangement is an incentive to enroll only healthy clients in order to avoid the risk of expensive therapeutic services. To overcome this incentive, the plan proposes to pay a higher capitation for those enrollees whose risk of illness is higher. In other words, the amount paid for a young enrollee will be significantly smaller than the amount paid for an elderly enrollee whose need for expensive services is likely to be much higher.

## 3. Ambulatory Cost Centers

It is clear that the existing health system in Newark is not prepared to absorb a large increase in demand or to accept reimbursement on a prepaid capitation basis. The increase in demand can be controlled, to some extent, through the enrollment mechanism; the organization of providers who are able to accept prepayments for the delivery of comprehensive care is a much more difficult problem. A simple increase in capacity--the ability to meet demand--is not sufficient for the purposes of Compre Health.

To insure that any increase in capacity will be suitable, the plan imposes several stringent and innovative conditions upon prime contractors with the plan. First, any hospital outpatient department which wishes to participate in the plan must be organized as a separate cost center. In this way, the hospital will be able to accurately account for the costs of ambulatory care within the institution. On the other hand, separate cost centers provide the means for Compre Health to audit costs on a system-wide basis.

#### 4. Team Care

All providers, except the physicians Foundation will be required to provide "team" care to its enrollees. Team care is defined as those services which would be provided by a group practice combining the skills of an obstetrician/gynecologist, a pediatrician, an internist, and nursing and social service professionals with necessary radiological and laboratory back-up. This team represents the minimum set of skills which are necessary for point-of-entry diagnosis, disease management and health maintenance.

#### 5. Sub-Contracts for Services

The Compre Health imposes a requirement for written contracts insuring the provision of those services which a provider cannot delivery in-house. The hypothetical team described above would enter into contracts (receivable by Compre Health) for the provision of mental health, dental, home health and health education services among others. Only when the provider exhibits evidence of such sub-contracted services can he be considered by the

plan as a potential prime contractor.

#### 6. Peer Review

Each potential prime contractor must have a peer review mechanism in place in order to begin negotiations with Compre Health. The details of this mechanism become a part of the contract with the plan. With the implementation of the Professional Standards Review Organization in New Jersey, the Compre Health will determine whether provider peer review functions can be integrated into that system. While the quality of the care delivered under the plan will be evaluated at the end of the demonstration period, the peer review requirement will provide a significant on-going quality assurance program. In addition, there will be a periodic medical audit on a sampling basis by the Compre Health staff.

#### 7. Encounter Form

Each provider will be required to use a single encounter form in combination with a single coding format. Without this condition, it would be impossible to measure the quantity or quality of the services delivered by the various contractors. With the utilization of standard data collection instruments, the Compre Health will develop a comprehensive set of data through which a variety of health service delivery vehicles may be compared with each other.

#### 8. Performance Contracts

Since the central aim of the project is the development of a more efficient and effective health care delivery system, the contracts executed with



primary system providers will be performance oriented. The contracts will not specify the inputs to medical care but will focus on provider output. Each contract will specify a set of services which must be delivered to every enrollee.

#### 9. Minimum Benefits Package

To develop standard contracts with a variety of provider organizations, the plan focuses on a minimum benefits package. It should be emphasized that the package is a minimum set and involves an attempt to operationalize the definition of "comprehensive" services.

#### Discussion

The process of implementation of a city-wide health maintenance organization is a difficult undertaking aimed at solving a complex problem. In general, medically underserved areas are underserved for three reasons: First, they lack support services for the practitioner. Second, they generate greater work loads than one or two physicians can reasonably meet. An HMO in the area may have a favorable impact on these problems. It is far more difficult to be successful with the third problem. . . . that the area is simply not, in the physicians' view, a desirable place to spend his life and raise his family.

This problem gives impetus to the creation of an innovative idea that should be offered at this point. The promise of the HMO is its ability to merge the continuity of operation and transferability of personnel of the industrial world with the needs of the health care industry. In industry, a young manager can expect to serve in several branch offices before settling permanently in the location of his choice. It is clear that this is a sharp contrast to the young physician, who ordinarily makes a permanent commitment to his location. Using the resources of an HMO, it should be possible to establish branch operations in underserved areas in which a physician can expect to serve before advancing to greater income and prestige through full partnership in a relatively large organization. An approach of this sort is an ideal use of an industrial technique for the requirements of health care.

Apart from the theoretical aspect of this idea, if it were to be implemented it could possibly solve one of the major problems encountered by Compre Health. Briefly, the issues surrounding the problem stem from efforts to give Compre Health a fair market chance to survive as an HMO. With its mandate to provide services to the public assistance populations (Medicaid, Medicaid Waiver and Newark's Welfare clients) and the Medicare population, Compre Health would find great difficulty in surviving beyond the demonstration period as a viable HMO. Being aware of the essential need for an adequate financial base, two key components were designed as part of the program.

One component includes involvement of the "self pay" population groups which are identified as union membership groups, private entrepreneurs, employer groups and other persons willing to pay for their own health care. It is felt that this group is critical to the financial income aspect of the health plan.

The second component is the "exclusive territorial rights" given to Compre Health by the U.S. Department of Health, Education, and Welfare when they approved the finding for Compre Health. The meaning of "territorial right" is that Newark is set aside for the development and implementation of Compre Health. During the demonstration, no other HMO can develop in Newark nor can other HMO's on its border focus its marketing efforts on the Newark population.

These issues obviously cause other HMO's great concern and problems as well. The Compre Health management believes that part of the reason for the poor results of the physicians manpower survey was due to factors related to these issues. Direct relationships stem from the HMO, independent physicians association model currently under development by the local Essex County Medical Society. The competition between the two groups is obviously keen.

Digressing to the industrial model discussed earlier and assuming for a moment that it were a reality, this major problem discussed here would be greatly minimized.

Another part of this general discussion must encounter the notion of whether an approach of this magnitude--reorganization of a health care delivery system--is actually a workable idea. On one side of the issue, the new idea cannot work without the early support and involvement of a majority of the individual and institutional health care providers. Clearly, the traditional fears and concerns must be discussed, argued and resolved in a face-to-face, educational and trustworthy manner. Obviously, there must be compromise and debate, after which the city-wide delivery system can be implemented.

On the other side of the issue certain conflicting goals make it clear that the city-wide system is destined for failure. The reason is simple. Compre Health has a board of trustees that is dominated by providers. That is, it is controlled by representatives from the hospitals, neighborhood health centers, medical and dental societies and other persons sympathetic to their cause. The conflict then is obvious. If Compre Health is successful it will cause a drastic reduction of in-patient stays. Therefore, from this success it would be expected that at least one, maybe two hospitals, would no longer be needed in the city of Newark which means that they would most likely go out of business and close their doors. This would mean also that several of those persons on the Compre Health board of trustees would be unemployed or, at a minimum, would have to search for new employment.

Can anyone rationally believe that members of the Compre Health board will let this happen? The critical question then is should the board be changed?

And if so, who should resign from the board? Can the President of the College of Medicine and Dentistry be asked to leave or should the Mayor's representative be asked to leave?

Compre Health management must work almost daily with these board of trustee members whether they are on the board of trustees or not. Obviously, important compromises must be made, but the important issue is whether the city-wide plan survives after the compromise.

### Future Projections

What happens to the Compre Health at the end of this demonstration project? In essence, if it achieves its goals, the plan should be able to continue and expand, serving all the residents of Newark. These future developments are envisioned:

1. Compre Health will serve as a model for a state-wide program of medical indigency for adoption by the State Legislature. This action will insure future operation of the project on a permanent basis.
2. The New Jersey Medicaid Program will encourage participation of regular Newark Medicaid populations in the plan, thereby considerably enlarging the Compre Health membership and scope of operations.
3. Newark Department of Health and Welfare participation in the demonstration project increases assurance of a permanent city-wide HMO.

4. The Newark Project will contribute a major base of data experience as well as instruments and mechanisms for a national health insurance system.

## BIBLIOGRAPHY

## Bibliography

- Bauer, K. and Densen, P. "Some Issues in the Incentive Reimbursement Approach to Cost Containment: An Overview," Medical Care Review, 1974.
- Bennett, A. "Health Care System, "Canada's National Health Plan," originally cited in Wall Street Journal, 57:16 December 13, 1976. Then cited in Bureau of Public Health Economics, Medical Care Review, School of Public Health, The University of Michigan.
- Beverlee, M. A. Health Maintenance Organization Objectives and Issues. U. S. Department of Health, Education and Welfare, Health Services and Mental Health Administration, DHEW Publication No. 73-13002.
- Brody, J. E. "How Educated Patients Get Proper Health Care." The New York Times, Tuesday, January 27, 1976.
- \_\_\_\_\_. "Incompetent Surgery is Found not Isolated." The New York Times, Tuesday, January 27, 1976.
- \_\_\_\_\_. "Publicity has Become Strong Medicine for Public Health." The New York Times, Sunday, November 28, 1976.
- Bureau of Public Health Economics, School of Public Health. Medical Care Review, The University of Michigan, 1976.
- Chronicle of Higher Education, February 28, 1977, Vol. XIV, No. I.
- Distribution of Physicians. American Medical Association, 1973.
- Distribution of Physicians in the U. S. American Medical Association, Center for Health Services Research and Development, Chicago, Illinois, 1974.
- Easton, A. The Design of a Health Maintenance Organization: A handbook for practitioners. New York: Praeger Publishers, 1975.
- Ehrenreich, B. and Ehrenreich, J. The American Health Empire: Power, Profits, and Politics. New York: A Health Pac Book, Random House, 1970.



- Freese, A.S. Managing Your Doctor--How to Get the Best Possible Health Care. New York: Stein and Day, 1974.
- Health Planning Information Series: Trends Affecting U.S. Health Care System. U.S. Department of Health, Education, and Welfare, 1975.
- "Health Services" Congressional Record, 120:H3270, April 25, 1974, cited in Medical Care Review, 1974.
- HMO's. Toward A Fair Market Test. Washington, D.C.: National Academy of Services, 1974.
- Hospitals. Journal of the American Hospital Association, 1976.
- Klan, S. The Great American Medicine Show: The Unhealthy State of U.S. Medical Care and What Can be Done About It. New York: Viking Press, 1975.
- The Law and Health Personnel, Comprehensive Health Planning Program. Minnesota State Planning Agency, St. Paul, Minnesota, 1970.
- McKinley, J.B. Politics and Law in Health Care Policy. Millbank Fund, 1971.
- Medical Care Review. Bureau of Public Health Economics, School of Public Health, University of Michigan, 1974.
- Myers, B.A. Health Maintenance Organizations; Objectives and Issues. U.S. Department of Health, Education, and Welfare, Health Services and Mental Health Administration, DHEW Publication No. HSM 73-13002.
- Proceedings of a Conference. Health Maintenance Organization, Medical Group Management, 1972.
- Realigning the Health Care Delivery System. A report of the 1971 national forum on hospital and health affairs. Conducted by the graduate program in hospital administration of Duke University.
- Robertson, E. "Health and Medicine" Section One, The Sunday Star Ledger, February 27, 1977.
- Sigmond, R. M. Controlling Hospital use Through Medical Staff Utilization Committees. Proceedings of the Fifth Annual Symposium on Hospital Affairs. Chicago, Illinois; University of Chicago, 1962.

Somers, A. R. The Kaiser-Permanent Medical Care Program--A Symposium  
The Commonwealth Fund. New York, 1971.

State Laws Affecting the Establishment of Health Maintenance Organizations.  
Institute for Interdisciplinary Studies. American Rehabilitation  
Foundation, Minneapolis, Minnesota, 1971.

Strickland, S. U.S. Health Care--What's Wrong and What's Right. A Potomac  
Association book, 1972.

Trends Affecting the U.S. Health Care System. Cited by Cambridge Research  
Institute for U.S. Department of Health, Education, and Welfare under  
Contract No. 230-75-0072, October, 1975.

"Urban Health." The Journal of Health Care in the Cities, Atlanta, Georgia, 1974.

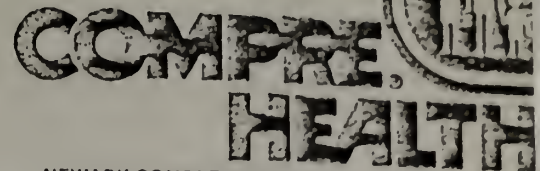
U. S. Department of Health, Education, and Welfare Press Release: March 9,  
1975. Cited in Medical Care Review, April, 1975.

U. S. News and World Report, Vol. LXXXII, No. 8, February 28, 1977.

Weatheville, R. L. and Nordley, J. M. A Census of HMO's (Including Further  
HMO Act Survey results and HMO enrollment estimates: Interstudy).  
Minneapolis, Minnesota.

## APPENDICES

APPENDIX A  
INITIAL LETTER TO PHYSICIANS



NEWARK COMPREHENSIVE HEALTH SERVICES PLAN  
24 COMMERCE STREET • SUITE 832 • NEWARK, NEW JERSEY 07102 • 201-642-1111

## TRUSTEES

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June 29, 1976

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\*Patricia Sheehan  
\*James Sheeran  
Edward Tabbanor, M.D.  
Manuel Vega  
kar Velez-Lopez  
John Waller, Dr. PH  
\*N.J. State  
Cabinet Members

We are very interested in acquainting you with the current plans and programming which have gone into the creation of the Newark Comprehensive Health Services Plan formerly known as the Medicaid Waiver Project. Under this newly revised program, we will be covering Medicaid and Medicare recipients, self-pay groups as well as the original Medicaid Waiver population. We will be offering these services under the mode of a Health Maintenance Organization.

Within the last month the State of New Jersey has appropriated to the project \$9,000,000 for Fiscal Year 1977 to be matched equally by the Federal government. As part of our operations, we are authorized to extend up to \$15,000 as a planning grant to help in the establishment of an Individual Physicians Association to serve the Newark population. This Physicians' Association is to be composed of physicians practicing in the Newark area and/or in areas contiguous to the City.

We are interested in meeting with the doctors of Essex County and will be contacting you in the near future.

Sincerely,

J. Pernell Parker  
Executive Director

Robert Sapin, M.D., Director  
Health Care Services

JPP/RS:mnw

APPENDIX B  
FOLLOW-UP LETTER TO PHYSICIANS



NEWARK COMPREHENSIVE HEALTH SERVICES PLAN  
24 COMMERCE STREET • SUITE 832 • NEWARK, NEW JERSEY 07102 • 201-642-1111

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Manuel Vega  
\*Mar Velez-Lopez  
John Waller, Dr. PH  
\*N.J. State  
Cabinet Members

### EXECUTIVE

### VICE PRESIDENT

J. Pernell Parker

August 2, 1976

*This is a follow up to our letter of June 29, 1976. Compre Health is now finalizing its contracts for the delivery of health services in Newark. We project October 1, 1976 as our first day of operations.*

*Already three neighborhood health centers and one hospital are prepared to participate as comprehensive ambulatory care centers. All hospitals in Newark are ready to serve as "back-up" facilities. We anticipate that the remaining Newark health facilities will become Compre Health providers within nine months of our start-up date.*

*The full participation of Newark physicians has been a major goal of Compre Health since the Plan's inception. We now need your professional cooperation to establish a "Physicians' Foundation" as an inherent component of our system.*

*Shortly, we will be organizing individual and group sessions to update you with the operational details of our Plan and to answer any questions you may have. We would be grateful if you would help us by answering this short questionnaire and returning it in the pre-addressed stamped envelope.*

*If you have any questions regarding the questionnaire, or the enclosed fact sheet, please feel free to phone the Division of Health Care Services at 642-1111.*

*Sincerely,*

Robert Sapin, M.D.  
Director  
Health Care Services

RS:mmw

APPENDIX C

PHYSICIAN OFFICE PRACTICE SURVEY



Physician Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician Specialty \_\_\_\_\_

Board Certified \_\_\_\_\_ Board Eligible \_\_\_\_\_ Other \_\_\_\_\_

Member of Physician Group Practice Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Group \_\_\_\_\_

Number of Physicians in the Group \_\_\_\_\_

Specialties Included in the Group (# by type) \_\_\_\_\_

\_\_\_\_\_

Hospital Affiliations and Staff Role \_\_\_\_\_

\_\_\_\_\_

1. Please indicate approximate size of current practice:

Number of Families (Estimate) \_\_\_\_\_ Number of Individuals (Estimate) \_\_\_\_\_

Please indicate capability to increase patient load in terms of number of patients: \_\_\_\_\_

2. Please indicate percentage of your office patients whose primary payment source is the following:

Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Private Pay \_\_\_\_\_

Blue Shield \_\_\_\_\_ Other Commercial \_\_\_\_\_

Other \_\_\_\_\_

3. Please indicate approximate number of patient referrals to other physicians made per month: \_\_\_\_\_

What are the specialty areas of these referrals?

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Proximity of referrals made:

Percentage within physician group practice \_\_\_\_\_

Percentage within Essex County \_\_\_\_\_

Percentage outside Essex County \_\_\_\_\_

4. Are you familiar with the HMO concept? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you acquainted with developing HMO programs in the Essex County Area?

Yes \_\_\_\_\_ No \_\_\_\_\_

Would you consider participating in an open-panel HMO program (an IPA) sponsored by the Essex County Medical Society

Yes \_\_\_\_\_ Would you like additional information \_\_\_\_\_ No \_\_\_\_\_

If yes, please sign the enclosed non-binding statement of interest and return in stamped envelope.

NON-BINDING STATEMENT OF INTEREST AND SUPPORT

As a physician, licensed to practice medicine and surgery in the State of New Jersey, I support and encourage the development of a health maintenance organization by the \_\_\_\_\_ in cooperation with the \_\_\_\_\_

. I am interested in providing medical and surgical services as a member of an Individual Practice Association sponsored by the \_\_\_\_\_ for the members of the health plan established by the Health Maintenance Organization (HMO). I am willing to discuss an agreement with the HMO including the following physician responsibilities:

1. To provide services to eligible HMO enrollees in accordance with their respective medical agreements.
2. To charge fees for such medical services on the basis of a fee schedule negotiated between the HMO and the Individual Practice Association.
3. To agree to a financial risk-sharing arrangement relating to physician compensation for medical services performed for HMO enrollees negotiated between the HMO and the Individual Practice Association.
4. To participate in and comply with the requirements of a peer review program established by agreement between the HMO and the Individual Practice Association, including quality assurance and utilization review procedures in such a program.
5. To refer HMO enrollees for hospital care to participating hospitals to the extent possible.

- 6. To refer HMO enrollees, when necessary, only to participating specialists, except for out-of-area emergencies and for services not available in the HMO service area.
- 7. To cooperate in the establishment and operation of a program to review and resolve complaints concerning physician services in a prompt and effective manner.
- 8. To cooperate in establishing and participate in a continuing medical education program for members of the Individual Practice Association.
- 9. To utilize a uniform unit record system for maintaining medical records for services to HMO enrollees, developed by the HMO.

It is my understanding that this indication of interest and support is subject to approval and acceptance of the organizational and financial plan finalized as a result of the planning and initial development phases of the HMO-IPA pursuant to the HMO Act of 1973 and grants thereunder to the

and the

I encourage and endorse the \_\_\_\_\_ and the \_\_\_\_\_ in their joint efforts to apply for an obtain a planning grant for the purpose of continued development of the HMO-IPA described above.

I understand this is not a binding agreement, but is intended to be a statement of my interest and support.

Dated this \_\_\_\_\_ of \_\_\_\_\_, 1976.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Address (Print)

APPENDIX D

PHYSICIAN FOUNDATION PARTICIPATION QUESTIONNAIRE

I. Are You Interested in Receiving Further Information By:

- A. Telephone call from Compre Health staff: \_\_\_\_\_
- B. Future mailings from the Plan: \_\_\_\_\_
- C. Individual meeting: \_\_\_\_\_
- D. Small group meeting: \_\_\_\_\_

II. Are You Ready and Willing to Become Involved:

- A. In the administration of the Physicians' Foundation: \_\_\_\_\_
- B. As a member of a working committee of the Foundation: \_\_\_\_\_
- C. To see patients and be reimbursed via the Foundation: \_\_\_\_\_

III. If You Are Neither Interested Nor Willing to Participate In The Foundation, Please Indicate Your Reasons:

- A. Desire to avoid government bureaucracy: \_\_\_\_\_
- B. Participation would require too much paper work: \_\_\_\_\_
- C. The Plan represents socialized medicine: \_\_\_\_\_
- D. Other: (Your comments will be appreciated): \_\_\_\_\_

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If you would like to receive the results of this questionnaire-survey, please fill in your name: \_\_\_\_\_

APPENDIX E  
GENERAL FACTS SHEET

WHAT IS IT? We are an organization built on the Health Maintenance model -- offering a series of improvements in the Newark health care provision system. The major elements are: pre-payment of fixed periodic premiums within a Citywide organization of practitioners. Compre Health is jointly funded by the State of New Jersey and the United States Federal government and administered by a private, autonomous non-profit corporation. Our Newark effort is unique in that an entire city's health delivery system will be coordinated in serving a broad-based enrolled population on a prepaid capitation basis.

WHY DO WE NEED IT?

1. The patient benefits in having predictable health care costs.
2. Costly hospital care is reduced through improved health education and preventive medicine for patients.
3. Providers are not confronted with billing and collection expenses for individuals.
4. Providers will be able to more effectively utilize and allocate scarce manpower resources through their involvement in a comprehensive Citywide network.
5. The project will serve as a working model to develop a cost-efficient delivery system and to upgrade the quality, continuity, availability and satisfaction of care by application of health maintenance principles.

HOW DOES IT WORK? All practicing physicians in the Newark area are eligible to participate in the Foundation. They utilize their own facilities and receive reimbursement for their services through the Foundation. Physicians will utilize Newark hospitals in which they now have staff privileges. Physicians would continue serving their non-Compre Health patients as well as members of Compre Health. Members using Compre Health would be able to choose a personal physician. Monthly payment will be made to the Foundation for all members selecting a physician in the Physicians' Foundation. Peer review of overall health care delivery will be effected by fellow physicians practicing in the Newark area.



