THE COSTS OF HOSPITALIZATION

FOR INDIGENTS IN HAWAII

by

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SUMMARY

The costs of hospitalization for indigents in Hawaii are intimately related to hospital costs in general. Both nationally and locally, hospital costs have been rising significantly in recent years. According to the consumer price index, hospital costs have risen faster than that of any other type of medical service. In turn, the rise in costs of medical services has outstripped the increase in costs of any other type of personal expenditure.

The practice of medicine is not amenable to mass-production methods; advances in medical science and technology have increased rather than reduced hospitalization costs to the patient. With the advent of further advances in medicine, it is likely that hospital costs will rise even higher.

There is a significant disparity in hospital charges in metropolitan Honolulu as opposed to Rural Oahu and the neighboring counties. Some explanations offered for this disparity are: (1) hospitals in Honolulu provide a greater variety of ancillary services; (2) hospitals in Honolulu do not receive county subsidies as county hospitals do on the neighboring islands; and (3) most of the graduate physician and nurses' training programs are conducted at Honolulu hospitals.

Under the present arrangement, the government has little control over costs incurred directly at the hospitals. However, it may be possible for the hospitals to effectuate efficiencies and economies in some of their operations which would in turn benefit everyone, including indigents. The government can do little but to maintain controls over the program to prevent abuses.

Comparisons and analyses of cost data indicate that there are no flagrant abuses within the program. At least in Honolulu, adequate safeguards are taken to keep them at a minimum. However, there are some indications that, in Honolulu, treatment of indigents by interns may result in more diagnostic tests and consequently, a higher average cost per patient for ancillary services when compared with private paying patients. Since charges for ancillary services usually are higher than the actual expenditures incurred to provide these services, it may be possible to arrange for special rates for indigent patients in order to effect some savings.

There are many gaps in the coverage of this study, especially in the neighboring counties. A more intensive and comprehensive review of the whole program may reveal specific areas of possible savings and changes. On the other hand, no matter what changes are made in the program, providing free hospitalization to indigents will continue to be expensive.

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SENATE RESOLUTION NO. 142

WHEREAS, the ever increasing costs of medical care and hospitalization for the aged and indigent has been of great concern to the territory and the counties in the administration of the medical care program; and

WHEREAS, the concern over increasing costs has led to the move for the conversion of Maluhia Hospital into a City and County General Hospital; and

WHEREAS, it appears that the rising costs are due to the lack of controls of the charges made by the hospitals for the care and treatment of these patients and the services rendered; and

WHEREAS, the Senate Ways and Means Committee of the Thirtieth Legislature believes that a careful, definitive study should be made of this practice, in the light of the increasing costs of this program upon the finances of the Territory; now therefore,

BE IT RESOLVED by the Senate of the Thirtieth Legislature of the Territory of Hawaii that the Legislative Reference Bureau of the Territory be, and it is respectfully requested to study the practice of private hospitals in the rendering of medical care and in the costs therefor charged to the counties for the care and treatment of indigent and medically indigent patients.

DATED: May 1, 1959
HONOLULU, HAWAII

I. THE PROBLEM AND SCOPE OF STUDY

The rising costs of medical care, especially of hospitalization, constitute a problem which is common throughout the whole of the United States, and Hawaii is no exception. This rise in costs is of concern to the general public, the medical profession and the hospitals but is of special interest to the state government in regard to the costs of the indigent[1] hospital care program. The Legislature of the State of Hawaii has expressed this concern by directing the Legislative Reference Bureau to study "the practice of private hospitals in the rendering of medical care and in the costs therefor charged to the counties for the care and treatment of indigent and medically indigent patients."[2]

The problem of medical care for indigents, of which hospital care is a part, is a complex one and there have been several local studies conducted on this subject matter.[3] However, none of these deal extensively with hospitalization costs. This study is limited to costs of hospital services rendered by private hospitals to indigents which are paid for by the counties to the hospitals from state and federal matching funds.

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[1]Unless enclosed by quotation marks to denote the particular category, indigent includes both "indigent" and "medically indigent." When used with quotations, "indigent" refers to persons who are on the welfare rolls of the State Department of Social Services. A person who is "medically indigent" has enough resources to care for his basic needs of food, clothing and shelter but cannot pay for his own medical bills without affecting his ability to provide for these basic needs.

[2]Senate Resolution 142, 30th Territorial Legislature, Regular Session of 195[illegible].

[3]See Chamber of Commerce of Honolulu, Subcommittee on Public Medical Care of the Public Health Committee, Public Medical Care in Hawaii (Honolulu, 1947) for the last comprehensive cost study of the program. For the administrative aspect of the problem, see Jess H. Walters, The Administration of Indigent Medical Care in Hawaii (University of Hawaii: Legislative Reference Bureau, Report No. 2, 1959).

The costs of the hospital care program for indigents are intimately related to the costs of hospitalization in general. The question of cost control appears to be the area in which the legislature is most interested. Thus, this study will attempt to review the problem of rising hospitalization costs in general and in Hawaii; compare and analyze the costs of hospitalization of indigents; describe the services rendered to indigents as compared to non-indigent patients; explore some of the reasons for existing conditions; and survey the control system presently in force.

II. THE RISING COSTS OF MEDICAL AND HOSPITAL CARE

In 1958, the American people spent approximately $16.5 billion for private medical care, 11 per cent more than they did the year before. This sum comprised approximately six per cent of the public's total outlay for all of its personal needs; over the last ten-year period, this percentage had varied between four and five per cent. In terms of dollars spent, the public's total medical care expenses have nearly doubled during this same decade and, in the last five years alone, there has been a 40 per cent increase.[4]

According to the consumer price index, the rate in the rise of medical costs was greater--44 per cent--from the base period of 1947-49 to 1958 than the increase in any other kind of personal expense. Even since 1953, the cost of medical care rose 15 per cent and this rate of increase still ranked first over all other personal expense items (see Table 1).[5]

Of the total of $16.5 billion expended by the American public in 1958 for medical care, $4.5 billion were for hospitalization. This represented an increase of two per cent over 1957; 32 per cent over 1953; and more than 50 per cent over 1949. The distinct rise in private expenditures for hospital care over the past decade can be attributed to many factors, among which the most obvious are the rising standard of living; the greater demand and utilization of hospital care which are in part attributable to prepaid health insurance; changes in the character of hospital care itself--more concentrated care given to patients and the use of new and expensive drugs; and the great advances made in the fields of medi-

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[4]Health Insurance Institute, Health Insurance Data 1959 (New York, 1959), pp. 7, 44.

[5]Ibid., p. 48.

Table 1.

CONSUMER PRICE INDEX IN THE UNITED STATES, 1935-1958

(1947-49 = 100)

Year	All Items	Medical Care	Food	Apparel	Housing	Trans-portation	Personal Care	Reading and Recreation	Other Goods and Services
1935	58.7	71.4	49.7	50.6	--	69.6	--	--	--
1936	59.3	71.6	50.1	51.0	--	70.2	--	--	--
1937	61.4	72.3	52.1	53.7	--	71.3	--	--	--
1938	60.3	72.5	48.4	53.4	--	71.9	--	--	--
1939	59.4	72.6	47.1	52.5	--	70.2	--	--	--
1940	59.9	72.7	47.8	53.2	--	69.8	--	--	--
1941	62.9	73.1	52.2	55.6	--	72.2	--	--	--
1942	69.7	75.1	61.3	64.9	--	78.5	--	--	--
1943	74.0	78.7	68.3	67.8	--	78.2	--	--	--
1944	75.2	81.2	67.4	72.6	--	78.2	--	--	--
1945	76.9	83.1	68.9	76.3	--	78.1	--	--	--
1946	83.4	87.7	79.0	83.7	--	82.1	--	--	--
1947	95.5	94.9	95.9	97.1	95.0	90.6	97.6	95.5	96.1
1948	102.8	100.9	104.1	103.5	101.7	100.9	101.3	100.4	100.5
1949	101.8	104.1	100.0	99.4	103.3	108.5	101.1	104.1	103.4
1950	102.8	106.0	101.2	98.1	106.1	111.3	101.1	103.4	105.2
1951	111.0	111.1	112.6	106.9	112.4	118.4	110.5	106.5	109.7
1952	113.5	117.2	114.6	105.8	114.6	126.2	111.7	107.0	115.4
1953	114.4	121.3	112.8	104.8	117.7	129.7	112.8	108.0	118.2
1954	114.8	125.2	112.6	104.3	119.1	128.0	113.4	107.0	120.1
1955	114.5	128.0	110.9	103.7	120.0	126.4	115.3	106.6	120.2
1956	116.2	132.6	111.7	105.5	121.7	128.7	120.0	108.1	122.0
1957	120.2	138.0	115.4	106.9	125.6	136.0	124.4	112.2	125.5
1958	123.5	144.4	120.3	107.0	127.7	140.5	128.6	116.7	127.2

Source: United States Department of Labor, Bureau of Labor Statistics, as published in Health Insurance Institute, Source Book of Health Insurance Data (New York, 1959), p. 46.

cine and medical technology. It is significant that hospital room rates in 1958 comprised 27 per cent of total medical outlay and from a base period of 1947-48, showed the greatest percentage of increase among all medical care costs--98 per cent (see Table 2). Also in 1958, the average cost per patient day--total expenditures divided by the total number of patient days--amounted to $28.17, double the per patient day cost of ten years ago (see Table 3). According to the United States Department of Health, Education and Welfare, the average patient remained in the hospital for 8.6 days in the year July 1957 to June 1958.[6]

The statistics presented above point out that throughout the whole of the United States, the costs of medical care in general and of hospital care in particular have increased significantly during the past decade and even more sharply during the last several years. Although comparable statistics for Hawaii are not available, there is every reason to believe that Hawaii is not an exception to the the national trend, especially in Honolulu. This opinion is based on the report of one of the largest hospitals in Honolulu that its average per patient day costs were $33.17 and $36.40 for the fiscal years 1958 and 1959,[7] respectively, and there is no particular reason to believe that there are great differences in the per patient day costs between this hospital and the other hospitals in Honolulu. In view of the national trend, it is not surprising that hospitalization costs in Honolulu have increased sharply.

The costs of hospitalization in Rural Oahu and the neighbor islands are considerably lower than in the city of Honolulu. However, as indicated by the hospitalization cost data for the indigent medical care program provided by the State

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[6] Ibid., pp. 7, 47-50, 52.

[7] Queen's Hospital, Annual Report 1959 (Honolulu, 1959).

Table 2.

CONSUMER PRICE INDICES FOR MEDICAL CARE ITEMS
IN THE UNITED STATES, 1935-1958

(1947-49 = 100)

Year	All Medical Care Items	Hospital Room Rates	General Practitioners' Fees	Surgeons' Fees	Dentists' Fees	Optometric Examination and Eyeglasses	Prescriptions and Drugs
1935	71.4	47.1	73.9	73.8	68.2	80.5	83.0
1936	71.6	47.5	74.2	74.1	68.3	80.7	82.8
1937	72.3	48.8	74.6	74.3	69.9	81.2	83.3
1938	72.5	49.9	74.6	74.6	70.0	81.3	83.8
1939	72.6	50.1	74.6	74.8	70.1	81.9	83.5
1940	72.7	50.4	74.7	74.0	70.1	82.6	83.2
1941	73.1	51.4	74.9	74.7	70.3	82.8	83.9
1942	75.1	55.4	76.6	76.8	72.1	83.9	85.8
1943	78.7	59.8	81.3	81.3	75.4	87.5	86.4
1944	81.2	62.5	84.8	84.5	79.6	89.6	87.2
1945	83.1	64.4	86.8	86.9	83.0	90.8	87.9
1946	87.7	73.3	91.1	90.9	87.9	92.5	89.5
1947	94.9	87.4	96.9	96.2	95.2	96.2	96.1
1948	100.9	102.1	100.6	101.0	100.3	100.2	101.2
1949	104.1	110.4	102.5	102.9	104.4	103.5	102.7
1950	106.0	114.6	104.0	104.5	106.9	104.5	103.9
1951	111.1	126.9	108.0	107.3	110.9	109.2	106.9
1952	117.2	139.5	113.0	111.5	113.3	110.5	107.9
1953	121.3	148.2	116.1	113.9	117.0	109.4	108.9
1954	125.2	156.8	119.9	115.2	120.9	108.0	110.1
1955	128.0	164.4	124.3	116.4	122.0	109.5	111.2
1956	132.6	173.3	128.4	118.2	124.4	111.2	113.7
1957	138.0	187.3	134.5	120.9	127.4	115.5	116.7
1958	144.4	198.0	139.3	122.7	131.4	116.7	120.7

Source: United States Department of Labor, Bureau of Labor Statistics, as published in Health Insurance Institute, Source Book of Health Insurance Data (New York, 1959), p. 50.

Table 3.

AVERAGE COST PER PATIENT DAY
IN NONFEDERAL SHORT-TERM
GENERAL AND SPECIAL HOSPITALS*
IN THE UNITED STATES,
1946-1958

Year	Average Cost Per Patient Day
1946	$ 9.39
1947	11.09
1948	13.09
1949	14.33
1950	15.62
1951	16.77
1952	18.35
1953	19.95
1954	21.76
1955	23.12
1956	24.15
1957	26.02
1958	28.17

Source: American Hospital Association as published by Health Insurance Institute, Source Book of Health Insurance Data (New York, 1959), p. 52.

* Excludes psychiatric and tuberculosis hospitals.

Health Department, the costs in these areas have also been rising steadily in the past several years.[8] The rising costs are also reflected in the fact that no less than 14 small hospitals situated outside of Honolulu have closed down primarily because of operating losses since 1948.

Thus, in Hawaii, the costs of medical care and especially of hospital care have been rising sharply during the past decade or so. However, it is significant that this trend is nation-wide and by no means confined to Hawaii. Continuing new discoveries in medicine and changes in the character of medical treatment will probably push prices even higher. It appears that there is no prospect for any change in the trend of rising medical and hospital costs in the foreseeable future.

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[8]Territory of Hawaii, Department of Health, Annual Report, Statistical Supplements, 1953-1958, various pages.

III. THE COST OF HOSPITALIZATION IN HAWAII

The total costs of the hospital care program for indigents are determined by two component factors: (1) the rates charged by the hospitals for various services rendered; and (2) hospital usage by indigent patients, such as the number of patients; kinds and frequency of medical and hospital services provided; the length of stay in the hospitals, etc. Hospital rates are determined by such factors as the number and types of hospitals in the community; the size of the hospital and its bed occupancy rate; the quantity and quality of services provided; the internship, residency and nurses' training conducted; and generally, the efficiency of hospital operations. In order to place the costs for the hospital care program in their proper perspective, it is necessary to first look at hospital rates and costs in Hawaii in general.

The last comprehensive survey of hospital costs in Hawaii was conducted by the Hospital Costs Committee of the Chamber of Commerce of Honolulu in 1949. This study disclosed that as early as 1949, rising costs were a major financial problem both for the institutions and the communities they serve. Hospital care is extremely important to community health; yet, now as then, it threatens to become a luxury priced beyond the budget of many average income families.[9]

In Hawaii, as elsewhere, revolutionary changes in the science and practice of medicine have enlarged both the scope and function of hospitals. Likewise, greater public acceptance and recognition of their role in promoting the health and welfare of the citizenry have resulted in enlargement of facilities and increased usage. The development of new diagnostic and treatment procedures has not

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[9]Hospital Costs Study Committee, Chamber of Commerce of Honolulu, Hospital Costs in Hawaii (Honolulu, 1949), p. 7.

only lengthened the life span but has caused a marked reduction in the average length of stay by patients in hospitals.[10] However, the very advances which have made these changes possible have created, unfortunately, serious financial burdens for these institutions and their patients. Unlike most industries, advances in medicine and medical technology have not decreased hospital expenditures but have increased the costs to patients. This is due in part to the personal nature and complexity of such services which necessitate special skills and training.[11] In other words, hospital services cannot be provided on a mass production basis. Thus, past experience shows that medical and hospital costs are more likely to go up with new discoveries. Probably, part of these rising costs can be offset by efficiencies and economies in hospital operations but this offsetting influence is likely to be only negligible.

Since the end of World War II, most of the smaller plantation and proprietory hospitals throughout the state have closed down or have consolidated operations because of operating losses and drastic population decreases in the areas they had served. Thus, the number of general hospitals in the state has dropped from 39 in 1949 to 25 today, as classified and reported by the Division of Hospital Facilities of the State Department of Health. This development was not totally unexpected, as the aforementioned survey of 1949 classified 17 hospitals as having capacities too small for types of services rendered or for economical operations, and made a strong case for consolidation of operations, especially in the rural districts.[12] What effects this rather wide-spread abandonment of "neighborhood"

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[10]Various data report that average length of stay has shortened from 13 days in 1920, 9.3 days in 1930, and 8.3 days in 1940 to about 6.0 days in 1958.

[11]Hospital Costs Study Committee, op. cit.

[12]Ibid., p. 34.

hospitals had on the rates charged by the remaining institutions which took over their services are not known, but it is probable that some economies have resulted. On the other hand, whether or not present medical and hospital services are adequate in the communities formerly served by the discontinued institutions can only be determined by a detailed survey which is beyond the scope of this study.

In metropolitan Honolulu, there have been no private general hospitals going out of business during the same period. Quite to the contrary, a major facility, the Kaiser Foundation Hospital, has been added recently. This is due, in part, to the tremendous population growth of Honolulu. As a result, there are now four general hospitals of considerable size and two others with more specialized operations in this city.[13]

Probably the most striking characteristic of hospital costs in Hawaii is the big disparity in the rates charged by hospitals situated in Honolulu and hospitals located in Rural Oahu and the neighboring islands. The difference in costs is substantial when expressed in the form of costs per patient day. For instance, for the period January - June, 1958, it is estimated that it cost the state an average of $31.49 per patient day to care for an indigent patient in Honolulu while the comparable average cost elsewhere was $17.25, a difference of $14.24.[14] There are reasons why this situation exists and some of them will be outlined in the following paragraphs.

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[13]The former are Queen's, St. Francis and Kuakini in addition to Kaiser and the latter are Kapiolani Maternity and Kauikeolani Children's Hospitals.

[14]Calculated from data compiled by the Hospital and Medical Care Division, State Department of Health.

A significant factor which explains part of the difference in hospital costs between Honolulu and the other areas is that of "ownership." Many of the hospitals outside of Honolulu are owned either by plantations or operated by the county governments concerned.[15] In both types, the subsidies given to the hospitals by the plantations and the counties are not charged to the patients and this makes their rates that much lower. It has not been possible to determine the exact amounts of subsidy provided to these hospitals. On the other hand, hospitals in Honolulu are operated by private non-profit organizations and there is a heavier reliance on patient payments to cover operating expenditures.

Another factor which probably affects hospital costs in Honolulu is the presence of competition among the six privately-owned hospitals in the city. Normally, in most businesses which operate for profit, a certain amount of competition is healthy since it has the effect of lowering prices. However, in the case of hospitals, which are non-profit organizations and already have high operating costs, competition generally results in lower bed occupancy rates for all of the competing institutions. In general, fewer patients result in higher rates charged to patients unless substantial non-operating income--donations, endowments, government subsidies, etc.--accrue to the hospital. Otherwise, the hospital is faced with financial insolvency. For instance, both Kapiolani Maternity and Children's Hospitals must compete with the obstetrics and pediatrics sections, respectively, of all the other general hospitals which in turn compete with each other. As a consequence, the bed occupany rates of all of these hospitals are lower than would be the case if there were fewer hospitals offering these services. This results in higher costs

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[15] Plantation hospitals are Kahuku and Ewa Hospitals in Rural Oahu. County operated hospitals are Hilo Memorial, Honokaa, Kohala and Kona on Hawaii; Central Maui Memorial, Kula General and Hana Hospitals on Maui; and Kauai Veterans' Memorial Hospital on Kauai.

to the patients who must shoulder rates which represent in part the administrative, maintenance and other overhead costs of all of these institutions instead of the expenses of a single or lesser number of higher occupancy hospitals. However, if the demand for all of the institutions keeps them at high bed occupancy rates, the patient should not be burdened with rates which are as high as in the former case. On the other hand, the availability of hospitals provide many intangible values which cannot be measured strictly in terms of dollars and cents or hospital rates. These are geographical proximity, especially in emergencies; convenience to patient and family; and even the preferences and state of mind of the patient which may affect his recovery.

Hospitals in Honolulu generally are larger than those situated elsewhere in Hawaii. According to the 1949 survey, hospitals with larger operations tend to incur higher operating costs and higher costs per patient day. On the whole, the larger Honolulu hospitals also provide more ancillary services such as X-ray facilities, more extensive laboratories, physical rehabilitation centers, specialized surgery and treatment facilities, etc.[16] This sheds further light on the reasons for higher costs in Honolulu. It is only natural that both patients and doctors would prefer to use the more modern hospitals with the latest facilities. However, these patients must pay the higher prices of the additional services provided. Thus, it appears that the patient is caught between the desire to receive the best treatment to effectuate the quickest and best cure and the higher rates that many of these same treatments entail.

Another reason for the higher hospital rates in Honolulu is that the larger hospitals in Honolulu also operate most of the various medical training programs in the state. However, these training programs--intern, resident physician and

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[16] Ibid., p. 32.

graduate nurses--are vital and indispensable parts of the total medical profession in Hawaii and must be carried out if the people of the state are to continue to enjoy the high quality of medical and hospital care presently available to them. These programs benefit everyone and, hence, are necessary to the general public health and welfare of all the residents of the state. Other state governments have recognized the importance of medical training in this respect and have seen fit to establish nursing and medical schools and affiliated hospitals, thereby subsidizing all or part of the medical training programs operating within their boundaries. In Hawaii, the only facility supported largely by taxes, among the training programs enumerated above, is the College of Nursing at the University of Hawaii. Two other graduate nurses' schools and the internship and resident physician training programs are almost completely financed by the private hospitals where they are in operation. Thus, the patients who enter these hospitals are paying a large share if not most of the costs of these programs which benefit not only themselves but the state as a whole.

The costs of personal services are also important to any hospital cost study since payment of wages and salaries generally constitute most of the total hospital operating expenditures. This is due primarily to the necessity of maintaining three shifts of personnel on a 24-hour-a-day basis. The 1949 study called for a review of personnel utilization by all of the hospitals with a view toward efficiency.[17] The utilization of personnel and the costs of personal services is especially significant to hospital costs in Honolulu. This is because the private hospitals in Honolulu pay their staff personnel, excluding physicians, much lower salaries than the civil service wages paid at Maluhia Hospital. For instance, as

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[17]Committee on Hospital Costs, op. cit., pp. 20-21, 27-29.

of October 15, 1959, the starting salary for a graduate nurse at Maluhia Hospital was $384.00 per month while in comparison the average starting salary for the private hospitals was about $292.00 per month, a difference of $92.00. Generally, although the contrasts in salaries for positions other than graduate nurses were not as great, significant differences existed for all positions (see Table 4). It can readily be seen that if salaries paid by the private hospitals approach those paid by Maluhia Hospital, the costs of hospital care in Honolulu are likely to be boosted even higher. It was believed that it is only a matter of time before the private hospitals must begin to pay comparable salaries.[18]

In summary, it can be said that there are many factors which affect hospital operating expenditures. These expenditures, in turn, will largely determine the rates charged by the hospitals. The preceding paragraphs have tried to identify some of the complex factors connected with hospitals costs and rates. Value judgments about hospital costs are extremely difficult to make because of these factors and many other intangibles which enter into the problem.

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[18]Personal interview with Mr. Kent W. Longnecker, Acting Administrator, Maluhia Hospital and Administrator, Leahi Hospital. Mr. Longnecker presently holds these dual positions.

Table 4.

AVERAGE MONTHLY SALARIES PAID BY PRIVATE HOSPITALS IN HONOLULU BY MINIMUM AND MAXIMUM RANGES IN COMPARISON TO MALUHIA HOSPITAL, AS OF OCTOBER 15, 1959

Positions	Maluhia Hospital	Average for Private Hospitals
Graduate Nurse	$384-513	$292-335
Supervising Graduate Nurse	444-594	381-445
Practical Nurse I	273-366	218-241
Practical Nurse II	287-384	---
Supervising Practical Nurse	287-384	---
Dietitian	384-513	334-391
Supervising Dietitian	444-594	423-496
Cook I	287-384	238-268
Cook II	316-423	261-299
Supervising Cook	349-466	292-334
Assistant Cook	248-332	258-298
Kitchen Helper	236-316	195-231
Supervising Kitchen Helper	260-349	221-251
Medical Laboratory Technician	444-594	325-379
Telephone Operator	287-384	225-266
Medical Social Worker	423-566	358-429
Senior Occupational Therapist	403-539	368-426
Occupational Therapist	---	333-383

Source: Office of Hospital Administrator, Maluhia Hospital, mimeographed table.

IV. HOSPITAL CARE FOR INDIGENTS IN HAWAII

So far, it has been indicated that, nation-wide, hospital costs and charges have gone up at a steeper rate than any other form of personal expenditure item when measured by the consumer price index, and that Hawaii is no exception to this trend. It has also been determined that, in Hawaii, hospital costs are significantly higher in Honolulu than in Rural Oahu and the neighboring islands. Some of the reasons behind these situations have been explored. All of these factors, in turn, directly affect the hospital care program for indigents. This section of the report is devoted to a discussion on some of the basic objectives of the program; a brief description of how the program presently operates; an attempt to determine the services provided to indigent patients as compared to non-indigents; and comparisons and analysis of cost and other data.

Assumptions and Objectives of the Program

Medical and hospital care for indigents is only a part of the totality of public welfare and public health programs in the state. However, it is a highly important part. A previous report makes the point that illness and impairments are principal causal factors producing dependency on public aid. Therefore, it seems that the public interest in providing for the health care of the needy extends beyond humanitarianism to the consideration of keeping at a minimum the cost of dependency in terms of both human resources and tax funds needed to maintain dependent persons.[19] Thus, it appears that one of the objectives of the hospital

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[19] Jess H. Walters, op. cit., pp. 6-7. Mr. Walters' study is a comprehensive and excellent study of the problem of indigent medical care and its administration in Hawaii. It is recommended reading since many of the problems discussed therein are pertinent to the present study.

care program for indigents is to help them return to their jobs and become self-supporting.

Another apparent area of concern is that of need for assistance and how it is affected by standards of eligibility. The "indigent" who is on the Department of Social Services' public assistance rolls qualifies automatically for free medical and hospital care. On the other hand, the "medically indigent" is determined by and according to eligibility standards set by each county jurisdiction. Since under the present system "indigents" are given preference over the "medically indigent," the latter are provided with medical and hospital care from "residual" funds. It is difficult to determine whether eligibility standards are set by the counties according to the appropriations available or whether the standards are set to provide adequately for the actual need and then appropriations calculated to meet the need. At any rate, if standards are defined so that the eligible population is large, the total cost of the program will be that much higher; and the converse would also be true. For any jurisdiction, the determination of whether or not the eligibility standards are adequate to meet the actual and total needs for medical and hospitalization assistance is almost an impossible task because of so many unknown variables. Again, this in itself is a major research project which is beyond the scope of this study. However, there is research presently being conducted for the State Health Department on another aspect of eligibility standards. The Health Department project is designed to define eligibility standards uniformly throughout the state.[20]

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[20]Personal interview with Professor Harold Jambor, School of Social Work, University of Hawaii, who is doing the study for the State Health Department.

Probably one of the few areas of agreement existing between the medical profession, public health and public welfare personnel and the people of the state in general is on the basic tenet that necessary medical and hospital care should be provided equally without regard to a patient's ability to purchase it and without regard to the racial, social or financial status of the patient. Given these fundamental assumptions, it becomes important to determine whether or not medical and hospital services are being provided on an equal basis to both indigent and non-indigent patients. This problem will be further discussed later in this report.

In summary, it should be noted that program objectives must be clearly defined if the hospital care program for indigents is to be directed toward the attainment of desirable goals and if achievements within the program are to be measured properly. There are some indications that program goals are hazy. Among these, probably the most noticeable is the lack of uniformity on standards of eligibility among the counties. At any rate, the clarification of the program goals is one of the first steps which must be taken if the program is to function properly.

Description of the Program[21]

It would be helpful to describe briefly the present operations of the hospital program for indigents. The program is a complex one. It is federal- state- and county-financed, state- and county-administered, and county-executed, with all three levels of government entering into the audit procedure. The complex

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[21] Most of the information contained in this section of the report was obtained through interviews conducted with the following persons: Mr. Lee Wheeler, Acting Director, Hospitals and Medical Care Division, State Department of Health; Dr. Raymond Hiroshige, Assistant City and County Physician, Maluhia Hospital; Mr. Jack Wakayama and Mr. Francis Ishida, State Department of Social Services; and Mr. Edward M. Yoshimura, Supervising Medical Social Worker, City and County Health Department, Maluhia Hospital.

administrative problems arising out of this system are described in a previous study.[22]

The medical care program for indigents, of which the hospital care program is a part, has just been transferred from the State Health Department to the Department of Social Services under the present reorganization of the Hawaii State Government. The latter department plans to make some changes but is presently undecided on the exact alterations, pending further study of the program. In the meantime, the program is being administered without change.

Part of the program funds are provided by the federal government on a matching basis. The federal matching funds can be used only to provide care for "indigents." The medical and hospital care of "indigents" is part of the categorical assistance program for which federal funds are made available.[23] The state matches the federal funds as its share of costs for providing care to "indigents" and also appropriates additional state funds to provide similar care to "medical indigents" for which federal funds are unavailable. The counties participate directly in this financing procedure only to the extent that they must make up the difference if federal and state funds are insufficient to cover the total costs of the program. However, the counties actually bear most of the costs of administering the program and further operate hospitals which provide free care to some indigents. For instance, Maluhia Hospital houses indigents with chronic illnesses without cost to the program. Other county hospitals are paid for care rendered to indigents but their rates are lower than would be the case if they were private institutions without county subsidies. Subsidization of county hospitals benefit all

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[22]See Jess H. Walters, op. cit.

[23]These categories are Old Age Assistance, Aid To The Blind, Aid To Dependent Children and Aid To The Totally and Permanently Disabled.

patients, indigents and non-indigents alike. However, to the extent that the costs to the state for care of indigents at county hospitals are less because of this subsidization, the counties are making "hidden" contributions to the program.

The federal matching and state funds appropriated to the programs are allotted quarterly to the counties on the basis of a "recipient loan formula." The counties then have the responsibility of providing or acquiring medical and hospital care for "indigent" and "medically indigent" persons. In the case of the latter, the qualification for free care is determined by county medical social workers, subject to review by the Department of Social Services.

At this stage, it is necessary to describe the system of government physicians which exists in Rural Oahu and the neighboring counties. At present, there are 40 government physicians in the state. They are appointed by the State Health Department and receive a salary for providing medical services without charge to indigents in their districts, including surgical and all other services at hospitals. However, they get additional payments of one dollar per outpatient visit and a drug allotment.

In Rural Oahu, government physicians are also hired by the City and County of Honolulu as county medical officers for their respective areas. In this capacity, they are required to give physical examinations to City and County police officers, firemen and civil service applicants in the rural areas, and to provide emergency and other medical services.

In Honolulu, there are no government physicians. Both inpatient and outpatient care are provided by private hospitals and their staff physicians, residents and interns, the latter under supervision. A staff physician is in complete charge of a case and makes the final medical decisions. Residents and interns are paid by the hospital. They and the staff physician, who donates his services, get no fees from the government.

In Honolulu, referrals to the county for free hospitalization often come from the hospital where a patient goes for treatment, especially when the patient requires quick hospitalization. The county medical officer on duty reaches a tentative agreement with a hospital staff physician on the need and the length of hospitalization, based on the diagnosis provided by the staff physician. This information is then forwarded to the medical social worker who makes a financial investigation of ability to pay. If the patient is found to be an "indigent" on the public welfare rolls, he automatically is provided with free hospitalization. If the applicant is determined to be "medically indigent," the medical social worker decides whether the county will pay all or part of the hospitalization costs, depending on the patient's financial resources. This information is then forwarded to the Assistant City and County Physician, who makes the final medical determination on the need for hospitalization and the reasonableness of the duration of hospitalization. Any extension in the duration of hospitalization must get the personal and prior approval of the Assistant City and County Physician. Most of the cases are processed according to the above procedures.

In the case of an emergency, the hospital can admit the patient first and then refer the case to the county within 72 hours. In the case of elective hospitalization--when the treatment of some condition requires hospitalization, as in the case of a tonsillectomy, but there is no urgency--both the determination of eligibility and the approval for hospitalization is completed prior to hospitalization. Elective hospitalization takes place within two or three weeks after the approval procedure has been completed and there usually is a backlog of about six cases. Such a delay often takes place because of over-encumbrance of funds as reflected by the number of indigent patients hospitalized at any given time. It is understandable that the Assistant City and County Physician would be reluctant to admit an elective hospitalization case when over-encumbrance is indicated. As

patients are discharged and the hospital rolls of indigents approach a more normal level, the elective hospitalization cases are admitted.

The exact procedures for the neighboring counties have not been verified but it is believed that they generally follow the same pattern. An exception is that the approval for hospitalization is made by the government physician who also makes hospital visits and discharges the patient when further hospitalization becomes unnecessary. It will be recalled that these counties also have their own medical social workers who determined eligibility for free care under the program.

The foregoing discussion explains how the hospital care program for indigents operates at present. The scope of this study does not permit a determination of the uniformity or the adequacy of the procedures utilized in each county. However, it appears that the system, taken as a whole, is a workable one.

Hospital Costs and Usage

Just as the most striking characteristic of hospital costs in general was found to be the great difference in rates charged by hospitals in the city of Honolulu and by hospitals elsewhere, the most significant factor of hospital costs of the program for indigents is that this disparity is carried over into program costs. This is understandable and to be expected since indigents occupy the same hospitals as non-indigent patients in general throughout the state. Thus, many of the cost comparisons and the analysis of data deal with this aspect--Honolulu versus the "rural" areas. There also is greater emphasis placed on costs for metropolitan Honolulu. Honolulu figures largely in Oahu's share of the program money which amounts to about 70 per cent of the total costs of the program for the whole state.

Total Program Costs -- The total costs to the state of the hospitalization program have been rising at an average rate of about $35,000 a year since 1956, following a significant dip after a high of 1953. Total costs, as reported by the

State Health Department, were as follows:

YEAR	COST (Thousands of Dollars)	CHANGE BETWEEN YEARS (Thousands of Dollars)
1953	982.3	----
1954	NA*	NA
1955	833.2	-149.1**
1956	737.2	- 96.0
1957	766.2	+ 29.0
1958	806.4	+ 40.0

* Not available.
** Difference between 1953 and 1955.

By contrast, the number of indigent patients admitted to hospitals has been steadily decreasing; in 1958, this number was almost 4,500 persons, approximately 1,000 patients less than in 1953 (see Table 5). Thus, the total costs have been going up despite a decrease in patients. Part of the increase in total program expenditures can be attributed directly to rising hospital costs and rates in general. However, this study will try to analyze other factors which may be contributing to increasing program costs.

Rate of Hospital Admissions -- In 1958, the national rate for hospital admissions was 125 persons per 1,000 population.[24] Comparable statistics for Hawaii and for the program could not be obtained. However, a rough estimation[25] for "indigent" patients--those on the public welfare rolls as opposed to the "medically indigent"--indicates that, in 1958, the admission rate for this group was approximately 165 admissions per 1,000 "indigents." This indicates that "indigents" in Hawaii had a higher admission rate than the national average by approxi-

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[24]Health Insurance Institute, op. cit., p. 55.

[25]This estimation is indeed a rough one. It was calculated on the basis of a monthly average load of 16,752 "indigents" during 1958 as reported by the State Department of Social Services and an estimated 2,784 "indigents" who were hospitalized in 1958.

Table 5.

COST OF HOSPITALIZATION OF INDIGENTS
BY COUNTIES: STATE OF HAWAII
1953-1958 (1954 unavailable)

Cost Categories by Counties	1953	1955	1956	1957	1958
Total Number of Admissions:					
Honolulu	4,078	3,609	3,511	3,305	3,273
Hawaii	1,080	867	707	618	582
Maui	408	453	599	499	463
Kauai	243	264	199	180	172
STATE	5,809	5,193	5,016	4,602	4,490
Cost by Category of Patient: (thousands of dollars)					
a. Indigent:					
Honolulu	362.6	360.5	296.1	311.0	319.9
Hawaii	87.8	74.1	83.7	82.0	96.7
Maui	47.8	43.3	56.8	40.0	45.8
Kauai	48.3	47.9	32.1	43.0	44.8
STATE	546.5	525.8	468.7	476.0	507.2
b. Medically Indigent:					
Honolulu	363.4	280.0	284.9	293.6	271.5
Hawaii	89.8	47.3	6.4	5.5	7.7
Maui	14.6	17.5	7.4	25.9	25.9
Kauai	11.2	4.9	4.2	0.5	8.1
STATE	479.0	349.7	302.9	304.7	313.2
Total Cost to State Government: (thousands of dollars)					
Honolulu	690.8	605.9	553.2	576.7	579.6
Hawaii	171.3	116.3	88.7	85.5	103.4
Maui	61.1	58.3	59.3	60.6	70.5
Kauai	59.1	52.7	35.9	43.4	52.9
STATE	982.3	833.2	737.1	766.2	806.4

Source: Annual Reports 1953, 1955-1958, State Health Department, Statistical Supplements.

mately 40 patients per 1,000 population. This comparison admittedly is not the best possible because of the lack of precise data. However, if it is assumed that the hospital admission rate in Hawaii is not too different from the national rate and that the admission rate for the "indigents" is also indicative of the admission rate for the total program, the rather substantial disparity reflect in the above comparison still indicates that the admission rate for the program is probably higher than for the general non-indigent population in Hawaii. However, the exact margin by which the admission rate for indigents is higher is unverifiable.

Why would the hospital admission rate be higher for indigents as compared to non-indigents? A logical explanation is that indigents generally possess poorer health than non-indigents. A previous study makes the point that there is a close relationship between illness and poverty as revealed by a national survey.[26] Other studies tend to substantiate the fact that persons on welfare or on the verge of indigency are the most susceptible to disease and illness.[27]

The hospital admission rate for each of the counties generally parallels its population ratio. There are some slight variations but these are insignificant and can probably be explained by the differences existing between the counties of such factors as the age of population; divorce rates; illegitimate birth rates; and other factors which contribute to indigency. Here again, there are no startling "irregularities" in the pattern of admission rates in the counties which call for further investigation of this aspect of the problem.

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[26]Jess H. Walters, op. cit., pp. 3-4.

[27]For instance, see Margaret Greenfield, Medical Care for Welfare Recipients --Basic Problems (Berkeley, California: Bureau of Public Administration, 1957), pp. 7-17.

Average Cost Per Patient Day -- The average cost per patient day is determined by dividing the total cost of hospitalization by the total number of days spent in the hospital by indigents. The average cost per patient day to the hospitalization program should not be confused with the average cost per patient day to the hospital. The latter is derived by dividing the total operating expenditures of the hospital by the total number of days spent by patients in the hospital. To the hospital, the average cost per patient day of the program is the average income per patient day received from the government for the care it provides to indigents (see Table 6).

As noted previously, the average cost per patient day at hospitals in metropolitan Honolulu is considerably higher than at hospitals in Rural Oahu and the neighboring counties. For a six-month period--January to June, 1958--the average cost per patient day was calculated from State Health Department data to be as follows:

County	Average Cost Per Patient Day	
Honolulu	$30.40	
City		$31.49
Rural Oahu		21.26
Hawaii	13.64	
Maui	16.28	
Kauai	17.82	
AVERAGE FOR STATE	$23.51	

Thus, to treat one indigent patient for a day at a Honolulu hospital costs the state about one-third more than in Rural Oahu; almost twice as much as in Maui and Kauai Counties; and more than two-and-one-half times as in Hawaii County.

The average cost per patient day can be segregated into the average costs for room and board and for pharmaceutical and other medical and ancillary services. This breakdown, for the same period, was estimated from a quick analysis of bills from each of the hospitals participating in the program:

Table 6.

DURATION AND AVERAGE
COST OF HOSPITALIZATION OF INDIGENTS
BY COUNTIES: STATE OF HAWAII
1953-1958 (1954 unavailable)

Cost Categories by Counties	1953	1955	1956	1957	1958
Total Number of Admissions:					
Honolulu	4,078	3,609	3,511	3,305	3,273
Hawaii	1,080	867	707	618	582
Maui	408	453	599	499	463
Kauai	243	264	199	180	172
STATE	5,809	5,193	5,016	4,602	4,490
Total Number of Patient Days (by hundreds):					
Honolulu	459.3	318.2	262.6	248.6	203.9
Hawaii	191.3	95.1	71.0	70.8	75.9
Maui	72.3	49.0	46.2	43.4	42.6
Kauai	54.9	37.7	25.1	29.7	31.7
STATE	777.8	500.0	404.9	392.5	354.1
Average Length of Stay In Days:					
Honolulu	10.1	8.8	6.2	7.1	6.2
Hawaii	15.7	11.0	10.1	11.2	13.0
Maui	15.0	10.8	9.9	8.3	9.2
Kauai	21.6	14.3	10.2	16.4	18.5
STATE	12.0	9.6	8.3	8.4	7.9
Average Cost Per Patient Day:					
Honolulu	$16.69	$19.04	$21.07	$23.18	$28.42
Hawaii	10.12	12.22	12.49	12.07	13.61
Maui	9.97	11.92	12.84	14.45	16.57
Kauai	11.28	13.98	14.31	14.64	16.66
STATE	14.10	16.67	18.21	16.96	22.77
Average Cost Per Admission:					
Honolulu	$169.40	$167.88	$157.56	$174.39	$177.08
Hawaii	158.65	134.09	125.57	138.31	177.64
Maui	149.87	128.70	99.08	125.76	152.32
Kauai	243.01	199.07	180.28	241.25	307.49
STATE	169.11	160.44	146.96	144.68	179.60

Source: Annual Reports 1953, 1955-1958, State Health Department, Statistical Supplements.

County	Estimated Cost Per Patient Day, Room and Board		Estimated Cost Per Patient Day for All Other Services	
Honolulu	$13.65		$16.75	
City		$13.76		$17.73
Rural Oahu		12.55		8.71
Hawaii	9.99		3.65	
Maui	11.14		5.14	
Kauai	13.71		4.12	
AVERAGE FOR STATE	$12.48		$11.03	

As it can readily be seen, the room and board rates are higher in Honolulu but only by a relatively moderate margin. The big difference in Honolulu rates is reflected in the estimated cost for other than room and board services. These are, among others, X-ray, laboratory tests, medication and drugs, surgery, etc. The costs for other than room and board per patient day in Honolulu are about twice as much as in Rural Oahu and about three times higher than in the neighboring islands. Some of the reasons for the higher hospital rates in Honolulu have already been discussed. These are: the intern and other graduate medical training programs being conducted at Honolulu hospitals; the fact that counties and plantations subsidize their hospitals; and that Honolulu hospitals provide more ancillary services than elsewhere. The last point is obvious from the data just presented above. However, there are other reasons why ancillary rates are higher in Honolulu than in other areas. The following paragraphs will try to present some of the additional reasons why this is so.

First of all, it is a generally known fact within the medical and hospital circles that charges for room and board are inadequate to cover the actual expenditures incurred for providing these services. For instance, hospitals in the Detroit, Michigan area have agreed to "freeze" ancillary rates and raise the room and board charges, as needed, until they realistically reflect actual expenditures.

It has been almost ten years since this agreement was put into force but the room and board rates have not yet caught up with expenditures.[28] Thus, in most hospitals, it appears that ancillary services are the "money-making" side of hospital operations which "subsidize" the room and board expenses.[29] At the city hospitals, actual room and board expenditures are higher than at hospitals situated outside of the city, primarily because more services are provided by the metropolitan institutions. However, the rates charged for ward services are only slightly higher in Honolulu than elsewhere, indicating that there may be greater reliance on income from ancillary services to make up room and board expenses by hospitals in Honolulu than in others.

Ancillary services at Honolulu hospitals are not only greater in variety but are more accessible to the physician and his patient. In addition, whenever appropriate, the indigent patient locally is provided with more consultative services by specialists, if only because these specialists are available and donate their services. These consultations almost invariably are followed by additional tests and treatments at the recommendation of the consulting specialist.

One of the reasons for the higher charges for ancillary services in Honolulu reportedly is due, in part, to the treatment of indigents by interns. It was strongly stressed, however, that this is not necessarily a bad thing, nor does it mean that indigent patients are getting inferior treatment. Doctors with private patients are reluctant to let interns treat their patients. Generally, a private doctor with a paying patient will determine the patient's symptoms, make a diagnosis, verify his diagnosis and administer the treatment. An intern, however, may

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[28]Personal interview with Mr. Lee Wheeler, Acting Director, Hospitals Division, State Department of Health.

[29]Almost all of the persons contacted agreed with this contention.

run additional tests to confirm his diagnosis and also determine that nothing else is wrong with the patient. Thus, the extra tests will usually result in a higher cost to the government in the form of charges for ancillary services simply because the government pays for the treatment of indigents by interns. On the other hand, it is difficult to state flatly that this practice constitutes "over-treatment" because these extra tests are useful from the medical point of view. Furthermore, it is generally true that an indigent is physically more "run-down" than a non-indigent. Thus, it can be argued that it is a medical necessity to make more diagnostic tests to determine his physical condition.

The following indicates the differences in the average cost per patient day to a private paying patient at a leading hospital in Honolulu in 1958 as compared to treatment of an indigent patient at Honolulu hospitals during the first half of 1958:

Patient	Average Cost Per Patient Day	Estimated Cost for Room and Board	Estimated Cost for Other Services
Indigent*	$31.49	$13.76	$17.73
Non-Indigent**	$33.46	$16.90	$16.56

* From State Department of Health. Data for period January-June, 1958. The average cost per patient day for the whole of 1958 was $28.43 for the whole island of Oahu.

** Calculated from data reported by the City and County Health Department and the annual report of a leading hospital in Honolulu for the year July 1957 to June 1958.

From the above data, it appears that indigents are receiving slightly more ancillary treatment than non-indigents. Whether this is a situation where indigents need these extra services because of their generally poorer physical condition or because interns tend to engage in "over-diagnosis" is a difficult question which probably cannot be answered.

A last factor which accounts further for the higher costs of hospital treatment for indigents in Honolulu is the fact that the occurrence of pregnancy cases is much higher in Honolulu in proportion to the other counties. Pregnancy is singled out because it has the highest average cost per patient day--$37.29--of all of the different types of cases analyzed and also have the highest ancillary charges. This is because pregnancy cases are charged a flat rate for delivery and have a relatively short patient stay of about three days.

It will be recalled that the average cost per patient day for other than room and board in Honolulu was $17.73 which is more than four times higher than the composite average for the neighboring counties of $4.30. The preceding discussion has tried to explain why ancillary costs are high in Honolulu. At first glance, however, since the charges in the other counties are so low in comparison, it raises a question of whether the ancillary services provided in the neighboring islands are adequate. On the other hand, it may be that the county subsidies of their hospitals are covering most of the expenses of the ancillary services which are not included in the charges by these county hospitals.

Average Lenth of Patient Stay -- A factor which affects profoundly the total cost of the program and also the number of patients who can be treated is the length of stay that indigent patients remain in the hospital. In 1958, the average lengths of patient stay in hospitals, by counties, were as follows:

County	Average Length of Stay in Days
Honolulu	6.2
City	5.9 (estimated)
Rural Oahu	6.6 (estimated)
Hawaii	13.0
Maui	9.2
Kauai	18.5
AVERAGE FOR STATE	7.9

This data reveals that patients in the Counties of Hawaii, Maui and Kauai remained in the hospital for respective average lengths of time which were one and one-half, two, and three times longer than in Honolulu. Thus, there is hardly any semblance of uniformity throughout the state in this regard.

A further analysis of data reveals that average patient stays went down significantly in all jurisdictions from 1953 to 1956. In 1957, however, only the average for Maui County went down; the averages for Honolulu and Hawaii counties went up about a day; and the average for Kauai County jumped by more than six days. In 1958, Honolulu was the only jurisdiction to lower the average stay to the same level as 1956 while the average lengths of hospitalization rose by about two days in the remaining counties. Thus, generally speaking, Honolulu has been the only jurisdiction in which the average length of patient stay has gone down consistently while in the neighboring counties, the most recent trend is upward after a decline from 1953 to 1956. Program-wise, the lower patient stays in Honolulu have been able to counteract the rising trend in the other jurisdictions and it may be said that, with the exception of 1957, the average length of stay has been going steadily down.

In 1958, the average days per patient stay for the program, in comparison to other averages, were as follows:

Hospital Population	Average Days Per Patient Stay
Indigent Program	7.9
Honolulu City	6.1 (estimated)
Others	12.0 (estimated)
National Average*	8.6
Honolulu Average**	5.7 (estimated)

* At short-term hospitals only.
** As reported by two leading hospitals in Honolulu. This includes indigents treated at these hospitals.

The above data reveals that for the program as a whole, indigents in Hawaii are discharged from hospitals sooner than the average patient nation-wide. However,

when the average for the program is broken down into the averages for Honolulu and elsewhere, the average for the latter exceeds the national average.

A trend in medical treatment has been more concentrated care and shorter patient stays. It seems that Honolulu is the only local jurisdiction which is following this pattern in its program for indigents. On the other hand, there is a reason why patient stays in Honolulu, as recorded for the program, are shorter. In Honolulu, indigent patients with long-stay chronic illnesses are hospitalized at Maluhia Hospital. Additionally, even non-chronic patients in a convalescent stage are transferred to Maluhia to keep costs down. These costs are not included in program cost data. In other words, Honolulu has indigents who accumulate long patient stays but because Maluhia Hospital is financed by the county, this is not reflected in program costs.

In Honolulu itself, it appears that the indigent patient remains in the hospital slightly longer than the non-indigent. Here again, as elsewhere, the indigent may be beset with special problems which require his longer hospitalization. For instance, a large number of bachelor indigent patients cannot be released from the hospitals until nearly full recovery because there would not be anyone to care for them. Generally, the home environment of indigent patients is less conducive to home convalescence.[30] Furthermore, there is a larger proportion of aged who are generally less responsive to treatment among indigents. These and other factors tend to result in longer patient stays among indigents.

Abuses in the length of patient stays in the hospitalization program for indigents, if any, are probably negligible. There has been no evidence uncovered to believe that such abuses exist. Each jurisdiction probably has its own reasons

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[30]Personal interview with Mr. Edward M. Yoshimura, Supervising Medical Social Worker, City and County of Honolulu, Maluhia Hospital.

and circumstances which have resulted in the varying average lengths of hospitalization. For the program as a whole, it may be said that length of stays are relatively short when compared to other states. For instance, a New Jersey commission called for an intensive study of length of hospital stay by indigents in that state because it was found that 43 per cent of total indigent patients were being hospitalized for 15 days or longer.[31] Thus, it appears that the Hawaii program, in respect to length of stay in hospitals, generally compares favorably to other jurisdictions and to hospitalization policies for non-indigents.

Average Cost Per Patient Stay -- The average cost per patient stay or the cost per admission is probably the most significant measurement of hospitalization costs. It ties together the average cost per patient day and the average length per patient stay.

In 1958, the average costs per admission for the hospital care program for indigents, by counties, were as follows:

County	Average Cost Per Admission	
Honolulu	$177.08	
City		$182.61 (estimated)
Rural Oahu		129.00 (estimated)
Hawaii	177.64	
Maui	152.32	
Kauai	307.49	
AVERAGE FOR STATE	$179.60	

Only a little over $30 separate the averages for metropolitan Honolulu and the County of Hawaii on one hand and the average for the County of Maui on the other --their composite average is estimated at about $178.00. However, when the averages for the County of Kauai and Rural Oahu, respectively at the top and bottom

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[31]The New Jersey Commission to Study the Administration of Public Medical Care, Report and Recommendations (Trenton, 1959), p. 43.

of the range are included, the margin of difference jumps to $178.50. This situation raises two basic questions.

The first concerns the average costs for Honolulu, Hawaii and Maui. These jurisdictions have similar costs. Whether this is just a coincidence or whether there is a manipulation of length of patient stays, based on the estimated number of patients and the appropriations available, is probably a moot question. Nevertheless, the point to be made is that the costs in these jurisdictions should not be taken for granted. Secondly, if the costs in Honolulu, Hawaii and Maui are reasonable, then the average costs for Kauai and Rural Oahu are suspect as being too high and too low, respectively. The answer to these questions can only be provided by an intensive survey of costs at hospitals within each jurisdiction. Because the situation is different in each area, conclusions on the reasonableness of costs can only be drawn after such a survey is conducted.

A leading hospital in Honolulu reports that its average income per admission (average cost to the patient) was $210.96 for the year ending June 30, 1959. When indigents treated at this hospital are extracted, this average rises to approximately $213.25. During 1958, as calculated from data reported by the City and County Health Department, the comparable cost per indigent to the state at the same hospital was $191.75. The difference of $21.50 can be accounted for by the lower ward rates paid by the state for indigents and the higher semi-private and private room rates paid by many private paying patients. Thus, in Honolulu, it is probably correct to assume that the average cost per admission for indigents is fairly reasonable in comparison to the average for non-indigents.

Because the data on hospital costs are rather sketchy, especially for hospitals in the neighboring counties, it has not been possible to present many facts which are pertinent to this study. Detailed comparisons and analysis of costs,

however, can be valid only if due consideration is given to differences existing in each jurisdiction. There may be good reasons, for instance, why the average cost per admission is relatively high in Kauai County. Aside from these particulars, however, is the more general question of whether or not any abuses exist within the program. Here again, only a detailed study can provide answers to this question.

V. COST CONTROL

Cost control is an area of concern to the legislature. Attempts were made throughout the study to determine whether costs for the hospital care of indigents are rising because of the lack of controls of the charges made by hospitals and the services rendered. This chapter will be devoted to a discussion of this particular problem.

The evaluation of costs must always be made in relation to what is received in return for the money expended. Thus, the question should be, are costs reasonable for the quantity and quality of services provided? So far, it appears that indigents are being provided with medical services which are substantially comparable to those received by private paying ward patients. There are no separate facilities set aside exclusively for occupany by indigents. Thus, both indigents and private paying patients may occupy beds side by side in the wards.

The government has several possible ways to run the hospital care program for indigents. They are: (1) to continue the present system under which patients in Honolulu are treated at private hospitals and patients elsewhere at either private or county hospitals but all the hospitals are reimbursed by the state or county at going rates; (2) to negotiate a flat per diem rate which would be binding on all hospitals; (3) to enter into a contract with a hospital submitting the lowest bid on an annual basis; and (4) in Honolulu, to establish a county general hospital where all indigents would go for treatment.

A basic philosophy under which the hospital care program for indigents has always been administered is that the state pays the "going rates" to the hospitals. Consideration has been given to the possible negotiation of a reimbursable cost formula by which the government pays a flat per diem rate to the hospitals but, so far, it is believed that this would result in a higher cost to the state than

presently being incurred.[32] This is true because indigents occupy wards at the lowest rates, whereas private patients occupy semi-private and private rooms as well. A flat average per diem rate would most likely be closer to the rate being charged for a semi-private room.

To award the program to a single hospital on the basis of a bid or to treat all indigents at a single county hospital would, at the minimum, raise some serious problems for the intern training programs at the private hospitals and may even result in their discontinuance in some of the hospitals. This may be adversely affect the accreditation of these institutions and may not be in the best interests of the medical profession and the general health and welfare of the people of the state. In considering the possibility of operating a county general hospital in Honolulu to treat indigents, it must be noted that many of the problems being encountered by the private hospitals would still have to be faced by a government hospital. It does not necessarily follow that hospital care for indigents can be provided more cheaply at a government institution. Furthermore, whether the government can provide the same quantity and quality of services and facilities at less cost can only be determined by a detailed study. Similarly, whether the cost of initiating and operating a county general hospital only for the purpose of controlling hospital costs for indigents would be justifiable is debatable.

Thus, it appears that the only practicable recourse available to the government is to continue the program under the present system. Under this system, the government relinquishes much of its power to control specific costs for the program which are incurred at the hospitals. However, hospitals can take action to

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[32]Personal interview with Mr. Lee Wheeler.

effectuate efficiencies and economies in their operations, although there are some costs over which even the hospitals have little or no control.

For instance, it is interesting to note that a survey committee of hospital costs in 1949 suggested that savings and better equity in the sharing of costs would be derived by consolidating all "graduate" nurses' training at the University of Hawaii.[33] Similarly, a medical advisory committee raised the question of a single affiliate intern training program in Honolulu, and even discussed the possible consolidation of several hospitals under a single board of trustees to eliminate duplication of services.[34] Other areas cited as possibly being amenable to savings were centralized purchasing and other housekeeping services such as laundry.[35] Thus, others have recognized that there are certain aspects of hospital operations which can be subjected to economies and efficiencies. However, the government does not possess any effective sanctions to enjoin the hospitals to make any changes; it is entirely up to the private institutions to act voluntarily.

On the other hand, the possible "over diagnosis" of indigents by interns has been touched upon earlier in this report. The question of whether or not this is the case probably cannot be resolved one way or the other. However, available cost data indicate that charges for ancillary services are higher for indigents than for

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[33]Chamber of Commerce of Honolulu, op. cit., pp. 35-36.

[34]Kent W. Longnecker, Chairman, The Medical Advisory Committee to the Mayor and the Board of Supervisors, a Report Dated March 4, 1959, 5 pp.

[35]Chamber of Commerce of Honolulu, op. cit., p. 37; personal interview with Mr. Kent W. Longnecker. The 1949 survey cited the example of Cleveland, Ohio, where centralized purchasing is practiced. The Cleveland experiment reportedly produced savings averaging 12 to 14 per cent a year. The survey, however, also observed that the local situation was not ripe for the initiation of centralized purchasing in 1949, but suggested an attempt at some future date.

private paying patients. As a specific example, it was pointed out that the City and County pays $10 for a cardiography which is estimated to cost the hospital approximately $5. The Medical Advisory Committee recommended that special consideration be given to City and County patients by the hospitals where charges for ancillary services are concerned. The committee, after acknowledging that the private hospitals need the indigent program [for intern training], charged the hospitals with the responsibility to control the amount of usage of these services. The best way to accomplish this, it was suggested, is to pay only the costs of supplies or drugs used. Under the present practice, each hospital can administer any of these ancillary services to the limit and charge the county at the going rate paid by private patients, who may or may not avail themselves of such services.[36] Since the hospitals benefit from the fact that indigents are allowed to be treated by them, it does not appear unreasonable to suggest that such an arrangement be made. Short of either reducing services or providing care to fewer patients, special rates for ancillary services appear to be the only direct way that the government can effectuate savings or reduce costs.

Any savings or reduction in costs that can be derived in the program will result in a reduced unit cost per patient. This is extremely important since a reduced unit cost makes possible an increase in the number of persons who can be treated or in the services provided, or in both without an increase in total costs. Also, if the demand for services remains the same, the reduced unit cost will result in lesser total program costs. However, no matter what action is taken, providing free hospital care to indigents will still be expensive.

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[36]Kent W. Longnecker, Chairman, op. cit.

In the City and County of Honolulu, the controls against abuses are reported to be adequate. There are several points at which a check is made to prevent any flagrant abuse. These are:

1. A preliminary check by a county medical officer on the need for hospitalization and the length of stay, based on a medical diagnosis.

2. A determination of eligibility for free medical care by a county medical social worker.

3. A final medical determination by the Assistant City and County Physician on need and length of hospitalization.

4. A daily review of a list of patients by the Assistant City and County Physician so that over-encumbrance of appropriations can be kept to a minimum.

5. Personal and prior approval of the Assistant City and County Physician required for any extension in duration of hospitalization.

6. Bills checked by the City and County Health Department for accuracy and reasonableness.

7. Bills rechecked at state level.

Thus, it can be seen that many checks are made to prevent abuses. In addition, as mentioned earlier, the City and County transfers patients in the convalescent stage to Maluhia Hospital to keep costs down.

The control systems in force in the other counties have not been looked into. These counties, however, send all bills to the state agency where a review is made of each bill submitted. It may be profitable to investigate further the controls in effect, especially in Kauai where the average length of admission is the longest and the average cost per admission is the highest among all the counties. In fact, because there are gaps in this study, especially in areas pertaining to the neighboring counties, it may be advisable to conduct a comprehensive and intensive review of the total program.