

Case 21

The Rochester Regional Hospital Council

The Commonwealth Fund, 1946

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Background. By 1942, after seventeen years of involvement in rural hospital-building, officers of the Commonwealth Fund had come to appreciate the vast gap in quality between urban and rural medical care. The rise of specialization in the practice of medicine had, by the early 1940s, yielded tremendous advances in medical technology. But the cost of treatment had also increased considerably. The escalating cost of medical care meant decreased access to it for much of the rural United States, where average incomes were significantly lower than in cities. In rural areas, access to medical care of high quality was such that “few communities [could] be self-sufficient and still maintain the average standard of living characteristic of industrial societies.”³¹²

Henry Southmayd, director of the Commonwealth Fund’s Rural Hospitals Program, discovered that rural hospitals linked to personnel at larger, more advanced urban hospitals tended to offer far better care than did standalone rural hospitals. The Fund, inspired by its experience in rural hospital-building, was, at the time, searching for a model by which access to hospitals could be expanded nationwide. The organization of hospital systems along regional lines had been tried before: in Great Britain in 1920 and in Maine in 1931. And, in other places around the country, limited attempts to create bonds among hospitals were already underway. All of this convinced the Commonwealth Fund to support a demonstration project to investigate the efficacy of a regional hospital network. It was hoped that a successful demonstration would show rural hospitals that regionalization could enhance their access to expert consultation services, clinical specialists, and other resources. In 1945, Rochester, NY, was chosen from among several options because it already had in place an active municipal hospital network (the Rochester Hospital Council, founded in 1939), an excellent school of medicine, and a “generally favorable level of economic and social development.”³¹³

Strategy. Representatives from the Commonwealth Fund held a series of conferences with health professionals in the region, and on February 18, 1946, the Regional Council of Rochester Hospitals was incorporated with a five-year grant from the Fund. Under the terms of that grant, \$75,000 per year was allocated to education and administrative support. \$200,000 per year was given for facility construction, and \$25,000 was budgeted for special projects. In 1951, the Fund approved three years of supplemental grants, diminishing annually. All told, the Commonwealth Fund invested \$1.51 million in the Rochester plan between 1946 and 1954.³¹⁴

Each hospital in the seven-county Rochester region was given an equal seat on the Council, which was empowered to coordinate the joint planning of new hospital construction and expansion, and the joint management of “certain institutional services.”³¹⁵ By “pooling clinical, administrative, and technical” capabilities, the Council’s members hoped to realize efficiency gains and, thereby, to expand access to high-quality hospital care. In addition, the Council (which, in 1951, combined with the Rochester Hospital Council to create the Rochester Regional Hospital Council) offered additional support to its members, such as consultation to help them pass inspections by the Joint Commission on Accreditation of Hospitals.

Outcomes. According to Dr. McGehee Harvey and Susan Abrams, of Johns Hopkins Medical School, “the region offered a kind of meeting ground for the medical school, the hospital planning group, and public health and medical care agencies.”³¹⁶ As hoped, the smaller, rural hospitals in the region benefited the most from the new network. Services like X-ray consultation and specialist care became available to a clientele that would not otherwise have had access to them, and, as early bureaucratic obstacles were overcome by increased personal interaction, the average quality of

medical care available throughout the region improved rapidly.³¹⁷

The experiment in regionalization attracted the attention and support of the Rochester-based Eastman-Kodak company. In particular, an Eastman-Kodak executive named Marion Folsom emerged as a driving force behind the Council. Folsom initiated in Rochester the practice of issuing “certificates of need” to facilitate hospital improvements and then lobbied to get that process instituted statewide by the New York Legislature. This Rochester innovation became the model for the federal Planning Act of 1966,³¹⁸ and is now standard practice in most of the states.

Near the end of Commonwealth’s initial five-year grant, the Council began supporting itself by assessing a per-bed fee from each of its member hospitals. As foundation support wound down, this fee increased steadily, reflecting the willingness of the hospitals to pay out of their own pockets to support the regional network, which by then had already become integral to the provision of care across the region.

Impact. In the creation of the Rochester Regional Hospital Council, the Commonwealth Fund stepped into a supporting role that other actors could not fill. As Harvey and Abrams noted, “[t]he Commonwealth Fund’s important contribution was its initiative in supporting the early phases of the Rochester Regional Health Plan, a function that government agencies and even other private foundations would have found difficult.”³¹⁹ Because the Fund took this initiative, this carefully developed and meticulously documented demonstration project laid the groundwork for what is now the norm in regional linkages connecting medical care providers by region.

Notes

312. Leonard S. Rosenfeld and Henry B. Makover, *The Rochester Regional Hospital Council* (Cambridge, Massachusetts: Harvard University Press, 1956).

313. Ibid.

314. A. McGehee Harvey and Susan L. Abrams, *For the Welfare of Mankind: The Commonwealth Fund and American Medicine* (Baltimore: Johns Hopkins University Press, 1986).

315. Ibid.

316. Ibid.

317. Ibid.

318. Ibid.

319. Ibid.