

PUBLIC HOSPITAL SYSTEMS IN NEW YORK AND PARIS

Edited by

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PLANNING FOR THE HOSPITALS OF ASSISTANCE PUBLIQUE IN PARIS

Dominique Jolly and Victor G. Rodwin

Planning for the fifty public hospitals of AP has evolved from a process of projecting bed requirements by medical discipline and individual facility to a process concerned with reorganizing the entire configuration of hospital services and adopting strategic responses to a changing environment. This chapter analyzes the nature of this transformation. It begins with an overview of the rationale for planning at AP, the organization of the Planning Division, its general methods, and the challenges it must overcome. Then, it distinguishes three phases in the evolution of AP's planning: 1) reconstruction and modernization; 2) reorganization; and 3) the formation of strategic options. And it describes each phase with respect to its economic context and to the goals and methods of planners.

AP'S PLANNING DIVISION

Any large organization—public or private—whatever its activities, must be capable of questioning itself, periodically redefining its objectives and *modus vivendi*, and seeking improvements to assure its future. AP has not escaped this general principle. Given the number and importance of its facilities and skilled personnel, the high costs of its services, and the five- to ten-year time lag between a decision to build a hospital and its actual operation, AP has a special responsibility to be economical in the use of its resources. To do this requires careful programming of new investments,

coordination of its multiple activities, and a search for systemwide complementarity so as to avoid duplication of services. The Planning Division plays a crucial role in this process, for it must anticipate and analyze priority needs and propose ways of achieving them.

Established in 1976—twelve years after the first AP master plan—AP's Planning Division is responsible for the elaboration of the general plan for all fifty hospitals as well as for each individual hospital's specific plan. It is divided into six units. The largest one—the planning unit—is charged with elaborating the general and specific plans. It relies on support from the other five units: 1) the research unit, which produces studies on specific medical disciplines and compares the relative efficiency of AP's six hundred hospital services; 2) the hospital organization unit, which assists various facilities with planning renovations and new buildings; 3) the epidemiological unit, which tracks the morbidity of AP's patients based on hospital discharge data; 4) the evaluation unit, which is responsible for assessing the quality of care in selected hospital service units; and 5) the evaluation of technological innovation unit, known as the CEDIT (see chapter 10), which is responsible for technology assessment.

Since 1976, the Planning Division's staff has grown from ten to seventy. It now attempts to fulfill four functions:

1. to integrate its planning in the national context established by the Hospital Law of 31 December 1970, which regulates all hospital construction and capital expenditures;
2. to assist the director general in making investments as a function of therapeutic efficacy and economic rationality and to clarify and measure the operating expenditures generated by capital investments (this second objective appears particularly important in an economic context, where all increases in hospital expenditures must be justified before regulatory authorities);
3. to allow AP to assure coherence between its different hospitals within the context of periodic concern about increasing the role of decentralized management;
4. to propose to the director general choices and priorities among all of AP's medical activities.

To fulfill these functions, the Planning Division has focused on two kinds of planning: general and sectoral. General planning aims to define needs and to devise a plan for AP over the medium term, which can subsequently be updated in the course of implementation in response to changing health care needs and medical technologies. Sectoral planning is, itself, divided into two components: vertical planning by institution and horizontal (systemwide) planning by medical discipline or category of capital expenditure or population at risk.

Both vertical and horizontal planning aim to assess health care needs on the basis of service utilization by medical discipline. This involves a description of the existing situation within given medical disciplines, evaluation of ongoing activities, epidemiological studies, and profiles of hospital users. It also involves studies of the factors affecting the evolution of health services (epidemiological and demographic considerations, on the demand side; and an inventory of existing infrastructure, on the supply side). In addition, it involves specifying objectives and strategies for the medium term and proposing pragmatic programs and their geographic distribution.

Such planning requires not merely a rough estimate of health care needs but also the needs of medical care personnel and support staff. It must proceed with great humility because many diagnostic and therapeutic procedures will, no doubt, be obsolete by the time new plans are implemented. One response to our limited predictive capabilities is to focus on improving knowledge about the changing social context and the factors most likely to influence it. But even when this work is completed with all possible rigor, changes in the political and economic environment may alter the best predictions.

Given these difficulties of planning, it is prudent to admit our limited understanding of the future and to think through alternative scenarios to specific problems. It is also important to recognize that planning for AP is handicapped by the absence of a planning process for the entire Paris region. Not least is the problem of implementation; for the medium term is often at odds with the annual budgetary process. It would be helpful to reform decision-making processes so that multiyear contracts could be established between AP and the government to authorize an agreed-upon timetable of priority investments.

The above concerns are largely technical. But the experience of planning for AP hospitals suggests that choices in health planning, however well supported by technical justifications, are only one component of a broader reflection about the health care system and society at large. As the planning process for AP has evolved since the 1960s, it has been affected most notably by its changing economic context, which has, in turn, influenced the goals and methods of the planners.

PLANNING AS RECONSTRUCTION AND MODERNIZATION

For almost two decades following World War II, nothing was done about rebuilding and modernizing public hospitals in France. Paris was no exception.

In 1946, a National Planning Commission was established as part of a broad set of measures to strengthen the role of the state in the control and direction of economic development. The First Plan focused almost entirely on reconstruction of major industry. The Second Plan (1954-1957) began to assess needs for construction of new hospitals and modernization of old ones. It was not until the Third and Fourth Plans that there developed a serious concern for hospital infrastructure. Needless to say, this attention coincided with a period of economic growth.

The First AP Master Plan

In 1963, the health division of AP's central administration produced the first general plan for AP. The plan covered a period of twelve years (1964-1975) and was elaborated by the director general's medical advisor.¹

Since AP had not built a single new hospital since 1935, there was a general consensus that the quantitative level of hospital beds was inadequate. Moreover, since AP's hospital infrastructure dated from the seventeenth and eighteenth centuries and had rarely been restored, much of it was dilapidated. Also, AP planners believed that there was a poor geographic distribution of hospitals. They were concentrated mostly in the south of Paris around the Latin

Quarter and in the north around the major railway stations. In the west, however, hospitals were lacking and in the east their numbers appeared inadequate.

Demographic studies indicated a stagnation in the growth of Paris' central-city population and a significant increase of the population projected in two departments of the first ring around Paris—Seine and Seine-et-Oise—for 1975. There appeared to be hospital-bed deficits in the suburbs of Paris as early as 1962 and this situation was projected to deteriorate in 1975. The First Plan, therefore, had a precise objective: to construct new hospitals given the current and future population needs and the exigencies of the hospital reform of 1958; and to restore a number of other hospitals.

More specifically, between 1964 and 1975, the plan called for the construction of four new university hospital centers in the first ring of Paris and eleven more hospitals in the second ring of Paris. The university hospitals included two large ones of over thirteen hundred beds, one in Creteil, the other in Aubervilliers; and two hospitals of six hundred beds each in the north and south—Bichat and Bicêtre. The eleven hospitals in the first and second rings around Paris called for roughly five hundred beds each.

Over the twelve-year period beginning in 1963, the plan called for a systemwide increase in short-term acute bed capacity from twenty thousand to thirty thousand. In addition, it called for the renovation of an additional five thousand beds. The plan also called for greater specialization of hospitals and already emphasized the importance of technical diagnostic and therapeutic ancillary services, which came to be called the "technical plateau" of the hospital.

To what extent was this ambitious plan implemented during the period 1964–1975? Of the four university hospitals planned, three would be finally built during the second master plan (Bichat, Bicêtre, and Henri Mondor in Creteil).² In addition, a number of new buildings were added to existing hospitals. As for the eleven hospitals planned for the periphery of Paris, only seven were finally built.³ They were located in the suburbs, where the population was growing and where the need was greatest.

With regard to the renovation of dilapidated communal wards, known as the "humanization of hospitals," which was to be achieved by the progressive elimination of these wards and their conversion to private rooms with one, two, and four beds, the plan was rela-

tively successful. Nevertheless, as of 1973, 40 percent of AP beds (15,865) were still in large communal wards. It was not until the completion of the following plan (1976–1986) that Parisians saw the complete elimination of these wards.

The Second AP Master Plan

Twelve years after the first AP master plan, two new trends surfaced that forced reexamination of some of the plan's initial assumptions. First, the demographic growth of the Paris region decreased due to the decline in the birth rate. Second, there was a secular decline in average hospital lengths of stay and a growth in day-hospital procedures and in outpatient consultations.

The second master plan covered a ten-year period (1976–1986) and focused on hospital modernization.⁴ It succeeded in fulfilling four principal goals: 1) "humanization" of outdated Paris hospitals by converting large communal wards into private rooms; 2) construction of long-term care facilities (fourteen hundred beds within the central districts of Paris); 3) reduction of three thousand acute beds to compensate for decreases in lengths of stay and the growth of outpatient services and day hospitalizations in medical service units; and 4) investment in new, state-of-the-art medical equipment, including the development and reorganization of ancillary services.

This new plan stressed the fact that AP's hospital equipment was insufficient and outdated and that the second phase of AP's modernization should emphasize equipment expenditures, not hospital beds. The need to offer state-of-the-art medical technologies within budget limits led to the creation of a technology assessment unit—the CEDIT (see chapter 10). Between 1976 and 1984, AP acquired new scanners, magnetic resonance imaging (MRI) capability, and equipment for nuclear medicine and radiotherapy. Also, medical and surgical units continued to grow more specialized, as evidenced by the growth of specialized intensive care units for medicine, surgery, infants, and other functions.

PLANNING AS REORGANIZATION

The economic context for the third master plan was altogether different from that of the first and second. Hospitals throughout France understood that their budgets were now under careful scrutiny and that growth depended on achieving efficiency gains. The AP system faced a special challenge since the census of 1982 indicated that the population of Paris and the first ring, from which AP hospitals received 71 percent of all admissions, was decreasing in size. Moreover, patient demands had evolved. There was a new tendency on the part of patients to want to avoid inpatient hospital stays. This was reinforced by the growth of physicians in private practice who tended to delay hospitalization whenever possible. As a consequence, the length of hospital stays at AP were decreasing by 2.5 per cent a year.

It was in such a context that the second master plan was revised, in 1983–1984, and a decision made to proceed with a third five-year master plan for 1985–1989.⁵ One of the foremost goals of the third plan was to achieve a consensus among the major forces at AP and outside about the nature of AP's major problems, new policies and ways to implement them. This tall order required new approaches to planning: more consultation and participation within the AP system, quantifiable investment objectives, and mechanisms for monitoring plan implementation. All major activities at AP were subject to searching reflection about their existing and future orientation.

The new plan was a response to the imposition of prospectively set global budgets and a hiring freeze on all nonmedical hospital personnel. It was based on an understanding achieved between the Central Office and representatives of AP physicians to transcend individual hospital goals and to think rather in terms of AP as a system that could be strengthened, as a whole, through reorganization. The idea behind this approach was to justify a major capital expenditure program as a strategy for reducing the rate of increase of operating costs from 10 percent a year (1978–1982) to 2.5 percent during the period of the plan.

To do this, the plan proposed a three-pronged strategy. First, it sought to contain costs by closing seven dilapidated hospitals (a capacity reduction of two thousand beds), eliminating an additional

five hundred beds in existing service units, and opening long-term care facilities on most of the sites vacated by the seven closed hospitals. Second, it sought to redeploy most of the affected personnel—over three thousand workers—in two new hospitals (six hundred beds each), in new sectors short of staff, and into training programs for ancillary staff required for the operation of new medical equipment.⁶ Third, it sought to upgrade existing facilities by improving hospital information systems, human resources management and more generally the coordination of inpatient and outpatient services.

The third master plan's strategy was presented in the form of eight action plans, each of which included a projected budget. The most important action plan—in terms of both "shock value" and budget—aimed to adapt AP's existing structures to the evolution of health care needs. This somewhat vague goal, which implies a need for reorganization, refers to five restructuring operations and a range of other hospital-specific projects. All of these projects were designed to reduce acute beds by roughly two thousand over the five-year period, to increase day-hospital procedures and outpatient consultations, and to consolidate ancillary services and expensive new medical technologies. A number of specific cases serve as examples of the kinds of reorganization involved.

For instance, an acute hospital for infectious diseases that was in a dilapidated state, Claude Bernard, was closed and some of its service units were transferred to the Bichat hospital. The projected investment for transferring the service units to Bichat was 80 million francs whereas the renovation of Claude Bernard would have cost 137 million. The expected savings in operating costs from this "restructuring" scheme has been estimated at 56 million francs a year. Also, it is expected that 450 jobs will be redeployed and 320 beds opened in the old Claude Bernard hospital for the frail elderly.

Another example of restructuring involved the construction of a new six-hundred-bed hospital in the fifteenth arrondissement of Paris to compensate for the closing of three old and dilapidated AP hospitals—Boucicaut, Vaugirard and Laënnec. The operating expenditures of the new hospital were estimated at 700 million francs—assuming a redeployment of four hundred staff from the other three hospitals. Since this restructuring has resulted in a decrease of three hundred beds, it is expected to produce an annual

savings of 67 million francs compared to the costs of operating the three older hospitals. In place of the older hospitals there will be a center for long-term care for the elderly.

Yet another example of restructuring involved finally constructing the new pediatric hospital—Robert Debré—which was originally proposed in the second master plan of 1976. This hospital has now replaced two old dilapidated pediatric hospitals: Bretonneau and Hérold. The principal activities of these hospitals have been transferred to the new one while achieving a reduction of eighty-four pediatric beds and adding a new sixty-bed maternity ward. Meanwhile, Bretonneau and Hérold are scheduled for conversion into a 240-bed long-term care facility.

Beyond adapting existing structures, the third master plan called for seven other action plans, which sought to

1. maintain a high level of technology and clinical research;
2. develop and extend a dynamic personnel policy;
3. improve hospital hygiene and renovate buildings;
4. improve patient relations and rapid referrals;
5. develop long-term care for the elderly;
6. accelerate computerization of hospital information; and
7. adapt functional and industrial services to the plan's objectives.

Items 1 and 2 require further comment because they represent significant change in comparison to previous policies.

The problem of maintaining a high level of technology and clinical research (item 1) was addressed by reinforcing ancillary services and acquiring new medical technologies. Concurrently, the technology assessment unit, CEDIT (see chapter 10), was strengthened and new initiatives were launched to evaluate the quality of hospital services. For example, local committees for medical care assessment were established in all hospitals. The problem of developing and extending a dynamic personnel policy (item 2) was addressed by introducing three measures: more continuing education, improved working conditions, and increased employee benefits.

Implementation

Since the third master plan, a committee charged with monitoring the plan's implementation was established. The balance sheet presented to the board of directors of AP in 1989 was largely favorable since the level of investment was actually higher than that originally projected (slightly over 1 billion francs a year) and most of the restructuring projects are completed or in the process of completion.

The new Robert Debré pediatric hospital was completed and opened its doors to patients in May of 1988. The two dilapidated hospitals that it replaced no longer provide acute care services and will soon be remodeled to serve the frail elderly. All the organizational and architectural studies for the new hospital in the fifteenth arrondissement have been completed and construction was scheduled to begin in 1990. Also, the Vaugirard hospital has closed and Boucicaut and Laënnec will no longer provide acute care as soon as the new hospital in the fifteenth arrondissement opens. And Claude Bernard hospital has closed and some of its activities have been transferred to Bichat.

Finally, more personnel redeployments than originally planned have been accomplished (fifty-one hundred instead of three thousand), sixteen hundred acute care beds were closed over the course of three years, and a number of other smaller projects were completed. Tarnier hospital has been converted to a day hospital, a cardiology center was shifted from Emile Roux to Henri Mondor, and certain service units were shifted from Fernand Widal hospital to Saint-Louis. What is more, the major capital expenditure projects were completed. This whole string of accomplishments would appear to suggest that the third master plan was an unqualified success. But there were certain failures as well.

The most important failure was in the area of long-term care. Only half as many beds were opened as projected. This is a severe handicap given the aging population of the Paris region. In addition the operating costs of medical service units have continued to increase beyond all projections, particularly in the areas of chemotherapy, immunotherapy, transplantations (e.g., the costs of cyclosporine-type treatments), and AIDS.

PLANNING AS THE FORMATION OF STRATEGIC OPTIONS

During the course of the 1985–1989 plan, a number of policy changes occurred that altered AP's environment. While AP and other public hospitals in France were feeling the effects of prospectively set budgets, private hospitals, paid on a per-diem basis, were authorized to merge and to acquire certain expensive new medical technologies. A number of mergers were successfully concluded and many private hospitals acquired such medical equipment as kidney dialysis machines, radiotherapy equipment, digitalized angiography units, lithotriptors, and MRI units. In light of the emerging health care market anticipated with European integration in 1992, a number of banks and other financial groups seriously considered investing in the health care sector.

By 1986, Central Office managers at AP quite suddenly realized that the private sector in the Paris region represented a potential source of competition with the public sector. In response to this threat, AP's Planning Division embarked on an altogether new exercise—a collaborative reflection on long-range strategic choices for AP. Three scenarios were developed, all of which assumed a "high tech" hospital in the twenty-first century (see chapter 13). Following this exploration of alternative futures, the Planning Division conducted surveys and interviews to identify the perceived strengths and weaknesses of the AP system. Finally, the Planning Division formed a vast number of working groups to analyze the collected information and to participate in proposing strategic options for the period 1990–1995.

The purpose of the reflection on long-run strategic choices for AP was to produce some small shock waves among physicians and head nurses and to sensitize them to the new competitive environment in which they worked and to some possible responses and their effects; hence the scenarios. The Planning Division sent a copy of the book published on the basis of this exercise to fourteen thousand AP staff.⁷ Meanwhile, it forged ahead on the survey and interviews to identify the strengths and weaknesses of AP and to clarify the opportunities and threats from all potential competitors.

All of this work was done on the basis of one fundamental assumption: that AP could do more and perform better. This

assumption summarizes the seven priority issues that lay the basis for preparing the fourth master plan:

1. the importance of increasing patient satisfaction;
2. the development of a personnel policy that creates a sense of belonging to a dynamic public enterprise;
3. the improvement of communication within the AP system;a
4. the improvement of the management information system based on medical and administrative data;
5. the encouragement of medical progress by relying on referral centers and clinical research;
6. the adaptation of AP's structures to the evolution of health care needs and medical activities;
7. the achievement of productivity gains for the AP system.

The Application of a New Approach to Planning

These priority issues and the new approach to planning has encouraged thinking about AP not just with respect to individual facilities or service units or medical disciplines but rather in terms of complementary activities both within and outside of AP. Thus, AP's centers of excellence have received more attention and its other activities have been assessed in relation to the outside competition and to other complementary service units within AP. Presumably, such an approach should enable AP managers and clinicians to situate themselves with respect to their competition, to define strategic options (e.g., growth, restructuring, or maintenance) for specific activities, and, perhaps most important, to motivate AP's staff and develop a new systemwide synergy.

The result of the surveys and interviews revealed a number of well-acknowledged AP strengths: its large size, its powerful centralized administration, its full-time physician staff and university professors, its high-tech hospitals, medical research, and its notoriety as evidenced by its significant role as a regional, national, and even international referral center for tertiary medical care. In addition, the survey and interviews revealed a respect for the good quality of AP's nursing staff and for the socioeconomic mix of its patients.

As for AP's weaknesses, there was widespread consensus that there are not enough nurses, that the hotel component of health care is inadequate when compared to the private sector, and that the civil service status of most personnel provides neither enough opportunities for professional mobility nor for the use of "sticks and carrots" in human resources management. In addition, there was consensus about the bureaucratic organizational style of AP management—the complicated procedures and long time that it takes to get anything done, the excessive power of the Central Office and of the Ministry of Health, the limits on expensive medical technologies, and the weaknesses of AP's management information system and level of computerization.

On the basis of these surveys and interviews, the Planning Division initiated some analysis and reflection at two levels of AP to devise some strategic responses. At the central level, twenty-eight working groups were formed to consider systemwide management issues such as personnel policy, investment planning, and contracting out for a range of services such as catering and laundry. These groups also considered special issues that cut across traditional medical disciplines, for example, AIDS, cancer, day surgery, molecular biology, long-term care for the elderly, and transplantation.⁸ And thirty working groups of physicians were formed to reflect on the future of their specialties.

At the local level, the Planning Division organized one-day seminars in strategic planning in each of the fifty-one hospitals. These so-called strategic forums brought together the local managers and the medical staff along with representatives of nursing and major functional departments within the hospital. The first exercise undertaken in the course of these forums was to define each hospital's "medical strategy." Portfolios of medical activities were analyzed in terms of their "life-cycle," i.e., whether they were new and promising enterprises such as MRI or whether they were mature or even declining activities such as surgery for kidney stones.

The following exercise involved breaking down the hospital's medical activities into strategic units. For example, instead of analyzing orthopedics, traumatology, hand surgery, and arthroplasty as separate activities, they were examined as a set of complementary activities. Likewise, oncology, cardiology, and other substantive areas were discussed in relation to the hospital's medical profile. On

the basis of these kinds of analysis, and keeping in mind the Planning Division's studies of scenarios, of private-sector competition, and of strengths and weaknesses, each hospital participated in the formation of its own strategic plan.

By March of 1989, fifty hospital-specific strategic plans were received by AP's Planning Division. The next step was a form of internal bargaining at the central level and the formulation of a kind of systemwide industrial policy or general strategic plan for all of AP.⁹ Like all previous plans, this six-year plan for the period 1990-1995 will require the backing of the Consultative Medical Committee, the Joint Employer-Trade Union Committee, and, of course, AP's board of directors as well as the Ministries of Health and Finance. But in contrast to previous plans, the fourth master plan projects a midplan reappraisal after three years.

The Content of the Fourth Master Plan

The fourth master plan suggests that the number of acute beds remain stable at roughly eighteen thousand due to the increased case load of AIDS patients. It also suggests that the aggregate number of long-term care beds remain stable, but it calls for an increase in their number in the central city of Paris to compensate for their reduction in the second ring around Paris. For the first time, the fourth plan includes an important qualitative geriatric component that calls for two or three experiments that would significantly improve the quality of life for the elderly in AP hospitals.

In the area of AP's industrial services, the plan calls for major restructuring and selective investments in food services, laundry, and the central pharmacy to achieve productivity gains. Over the course of six years, the plan aims to redeploy six thousand personnel, of whom over one-half are expected to come from the industrial and administrative sectors. Beyond the reorganization of these essential services, the plan gives much attention to the organization of medical activities.

For example, with regard to capital expenditures on medical equipment it calls for the replacement of all "worn-out" equipment and the upgrading of laboratories and acquisition of new equipment in the domain of molecular biology, virology, and immunology.

Likewise, the plan calls for the reorganization of medical specialties, particularly cardiology. Presently, there are eighteen service units specialized in cardiology and six for cardiovascular surgery. The plan proposes to create seven fully equipped centers for both medical and surgical aspects of cardiovascular care. These units will operate twenty-four hours a day and serve as the principal referral centers for all of AP. Meanwhile, eleven medical cardiology units will continue to function, but with lower levels of equipment.

Although during the third master plan levels of investment were far larger than that called for in the plan, the fourth plan proposes to increase investments even further to 12 billion francs over the six-year period—6.6 billion for major construction and renovation, 4.4 billion for medical equipment, and 1 billion for computers and management information systems. More specifically, the plan calls for major action programs for AIDS, cardiology, molecular biology, and long-term care for the elderly. Not least, it calls for a policy of greater decentralization, improved human resources management, and active communication of the ideas in the plan. After all, since roughly five thousand people participated in the planning process, it seems reasonable to inform the other seventy-three thousand people whose cooperation is essential to its implementation.

CONCLUDING OBSERVATIONS

In the course of its evolution, the time horizon for AP's plans has become shorter. Also, the sense of AP, as a system, has become stronger when thinking about investment planning. Paradoxically, as AP's corporate identity has become stronger, the Central Office has encouraged greater decentralization and autonomy for facilities with the intent of improving day-to-day management.

As AP's planning has evolved from reconstruction and modernization to reorganization and, most recently, to the formation of strategic options, there has been greater participation in the planning process. This has resulted in making the Planning Division and, more generally, the Central Office more accountable to all those who have participated. Thus, the Planning Division has monitored more carefully the implementation of the plan and intervened more aggressively within the Central Office when other

divisions take measures that violate the plan. Nevertheless, the plan is still very much vulnerable to changes in the economic context and to policy shifts at the level of central government.

NOTES

1. Dr. Pierre Charbonneau served as the director's medical adviser during this period and later served as director of health at the central ministry. He has written about these experiences in his book *Combat pour la santé: Une politique vécue* (Paris: Ed. Médicales et Universitaires, 1976).
2. Bichat's new 940-bed hospital, Bicêtre's new eight-hundred-bed hospital and the new Saint-Louis eight-hundred-bed hospital were not completed until 1980. The planned hospital at Aubervilliers, however, was never built.
3. These hospitals included five acute care facilities—Ambroise Paré (680 beds), Henri Mondor (1,290 beds), Louis Mourier (540 beds), Antoine Béchère (480 beds), and Jean Verdier (400 beds)—and three long-term care facilities: Joffre Dupuytrin (1,050 beds); Charles Richet (800 beds); et René Muret (815 beds).
4. It was during this period that the new Bichat, Bicêtre, and Saint-Louis hospitals were completed.
5. *Plan Directeur Général (1985–1989)* (Paris: Assistance Publique, 1985).
6. The new hospitals are known as *L'Hôpital du 15^{ème} Arrondissement* and *Robert Debré*.
7. D. Jolly, ed., *L'Hôpital au XXI^{ème} Siècle* (Paris: Economica, 1988).
8. Other examples include sexually transmitted diseases, oncology, molecular biology, drug abuse, day care, and MRI services.
9. "L'Assistance Publique veut mener une politique 'industrielle'" *Le Monde*, 29–30 May 1988.