POPULAR GOVERNMENT

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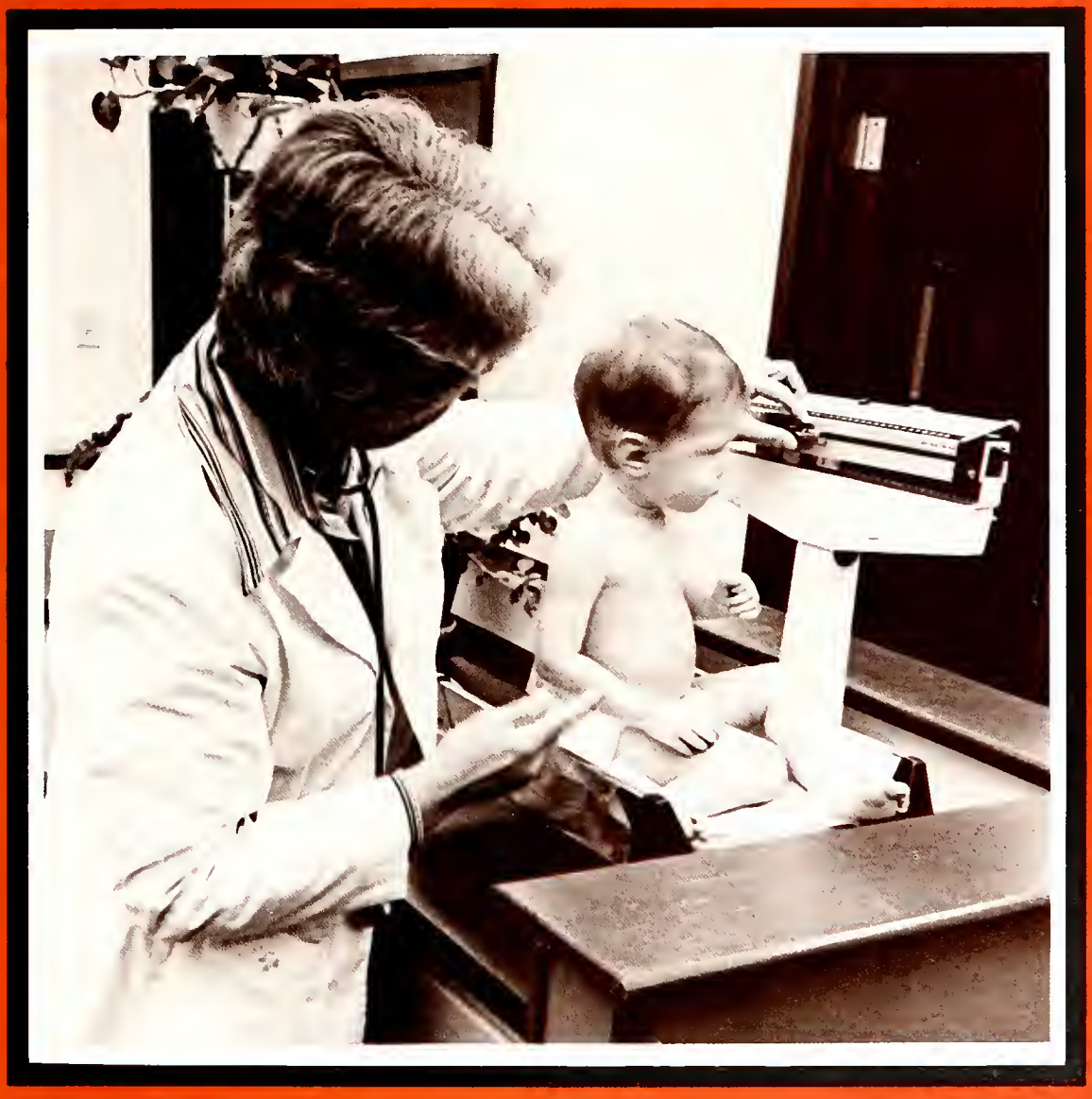

Rural Health Care / Malpractice / Causes of Prison Deaths /
Hospital Rate Regulation / Black City Manager Looks at His Job /
Public Retirement Systems / Coates Center / Plea Bargaining

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Photographs: Cover photo of a family nurse practitioner at the Snow Camp Community Health Center is from Health Services Research Center, The University of North Carolina at Chapel Hill. Other photos are from the Area Health Education Centers Program, School of Medicine, UNC-CH; Office of Rural Health Services, Raleigh; North Carolina Hospital Association; Health Services Research Center; and North Carolina League of Municipalities.

CONTENTS

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Rural Health Care: North Carolina's Challenges and Accomplishments

Edward F. Brooks

TO MANY NORTH CAROLINIANS, one of the state's most prized characteristics is its rurality. The beauty of its mountains, sandhills, and beaches; the bounty of its forests and farmlands; and even the mysteriousness of its swamps all contribute to a cherished environment and way of life. Yet this same rurality has created a severe dilemma in health care because it is so difficult to make medical services readily available to rural persons. The problem is significant and nationwide, and has been for decades; it is a complex problem with no simple or universally effective solutions. But North Carolina is solving it with perhaps greater success than any other state.

While the state's achievements are remarkable, they are by no means complete. Despite major investments that were made to increase the availability of medical services, thousands of North Carolinians still remain geographically isolated from sources of primary care.[1] Nevertheless, a centralized physician-recruitment program, a new approach in helping rural communities develop health centers, large-scale efforts to educate primary care professionals, and a recent decision to increase the ability of some local health departments to offer primary care services all have had a significant impact on the accessibility of medical care throughout most of the state. These accomplishments are all the more considerable given the extent of the problem in North Carolina.

The challenge

Rural persons are doubly handicapped when it comes to access to medical services. First, the large majority of physicians prefer to locate in the relatively affluent urban and suburban areas that have greater resources in terms of hospitals and medical personnel and equipment. Rare is the doctor who chooses a rural practice. Second, fresh air and sunshine notwithstanding, living in rural areas can be hazardous to many people's health. These two unhappy facts combine to create a situation in which rural people, who have a relatively greater need for medical services than nonrural people, often cannot meet that need because those services are not readily available.

The national and state tendency for physicians to locate in the large population centers is not a recent one. In fact, over fifty years ago a major report concluded that there were hundreds of rural areas in the United States (including several in North Carolina) where medical care was "most inadequate or absolutely lacking."[2] The growing number of reasons why most doctors practice in or near large communities includes, among others:

—Physicians' need for ready access to clinical support facilities, equipment, and personnel. This need in-

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1. The *Report of the Governor's Primary Care Task Force,* submitted to Governor Hunt in March 1979, defines "primary care" as follows:

> Primary care is continuous ambulatory health care to which the individual and/or family has direct access. It is coordinated with and provides an entry to all sectors of the health services system. This includes prevention and detection of illness, care of common illness, management of long-term health needs and referrals to and from secondary and tertiary services. Primary health care services may be directed toward the total population or a selected segment thereof.

2. From a report issued by the Conference of State and Provincial Health Authorities of North America in 1923, summarized in William A. Pusey, "Medical Education in Medical Services: 1. The Situation," *Journal of the American Medical Association* 84 (January 1925), 281-85.

corporates the enormous growth of medical technology and physicians' increased dependence on that technology.

—The preference of many doctors to practice among their professional peers.

—The tendency for physicians to locate in communities similar to those in which they and their spouses were raised (usually in a city or a suburban area).

—The tendency for doctors to locate near where they went to medical school or took their internship or residency.

—The availability of continuing education in an urban community.

—The 24-hour-a-day, seven-days-a-week burden of small-town solo or partnership practice.

Even the grossest indicators reflect the shortage of medical services in this country's rural areas that results from such factors. There are, for example, 141 counties in the United States (two of them in North Carolina) with no primary care physicians. Over half a million people live in these counties.[3] In 1975 nearly nine out of every ten nonfederal physicians were located in the nation's 300 major metropolitan counties.[4] Perhaps the most striking statistic is the ratio of physicians to population. In 1976 there was one active, nonfederal physician for every 392 people living in the core counties of the nation's Standard Metropolitan Statistical Areas (SMSAs)—the nation's most densely populated counties. In contrast, there was only one doctor for approximately every 2,500 people in the most sparsely populated counties outside the SMSAs.[5] While there are problems with using counties as units of analysis and with a gross statistic like the physician/population ratio, the conclusion is nevertheless clear: Doctors generally do not locate in the nation's rural areas. Moreover, until recently the problem was considerably more severe in North Carolina than elsewhere in the United States.

Rural persons suffer "from a wide range of illnesses and conditions which [urban persons] suffer to a lesser degree."[6] People who live in rural areas have a 30 to 40 per cent higher death and disability rate from accidents than those in urban areas, and farming ranks among the most dangerous occupations. The death rate from automobile accidents is also two-thirds higher in rural areas than in urban areas. Chronic illnesses affect one in six rural residents, compared with one in ten urban dwellers, and they contribute significantly to more restricted-activity days, bed-disability days, and work-loss days for those who live outside SMSAs. Infant and maternal mortality rates probably present the most striking indication of the "increased risk" associated with rural living. Rural women constitute only 20 per cent of all American women of childbearing years, but they account for 50 per cent of all maternal deaths. The infant mortality rate in non-SMSAs is almost 25 per 1,000 live births; in SMSAs the figure is 22 per 1,000 live births.

The picture these statistics present is somewhat lopsided. There are, of course, health hazards to living in crowded, often polluted cities. Still, the idea that rural living is healthy living needs to be revised if one is to appreciate fully the severity of the health care delivery problem in the rural areas of North Carolina and elsewhere.

Because North Carolina is predominantly rural, the challenge of making health care available is particularly great. Except for Pennsylvania, no state has more people living in rural areas (that is, places with fewer than 2,500 people). In 1970, 55 per cent or 2,800,000 of the state's citizens lived in rural areas. Recent population studies estimate that North Carolina's population has grown to 5,525,000 since 1970.[7] While most of this growth has been in the more densely populated Piedmont counties, the number of rural people in the state is approaching 3,000,000. Making primary health care services accessible to that many geographically dispersed people is an enormous task.

North Carolina's relative poverty compounds this challenge. The press recently reported that for the second straight year, per capita income in North Carolina has dropped in relation to per capita income in the rest of the country.[8] The state's average income per person rose from $5,916 in 1977 to $6,607 in 1978, but its ranking fell from thirty-seventh in 1976, to fortieth in 1977, to forty-first in 1978. Despite Medicare and Medicaid, the financial barriers to medical care are rising because of sharply increasing costs. These barriers are especially hard to overcome in rural North Carolina—where many people have per capita incomes far below the state average, where the need for medical services is particularly acute, and where until recently those services were few and far between.

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3. Extracted from *Health Manpower Shortage Area Data Base* (Division of Computer Research and Technology, National Institutes of Health, September 19, 1978).

4. *Supply and Distribution of Physicians and Physician Extenders* [staff paper prepared for the Graduate Medical Education National Advisory Committee, DHEW Publication No. (HRA) 78-11], p. 37.

5. Adapted from *Health–United States, 1978* [DHEW Publication No. (PHS) 78-1232], Table 127, p. 342.

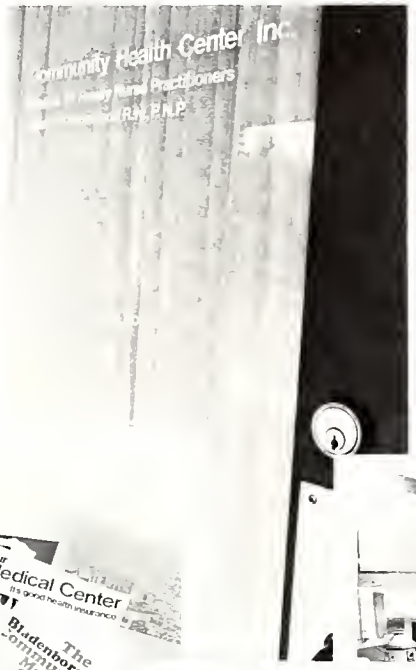
6. Stephen G. Sherman, "Primary Care in Rural North Carolina: A Policy Analysis of/for State Involvement," Spring 1979 (unpublished paper in the Health Services Research Center Library at The University of North Carolina at Chapel Hill). The discussion of the relative health of rural and urban persons paraphrases much of Mr. Sherman's treatment of the subject.

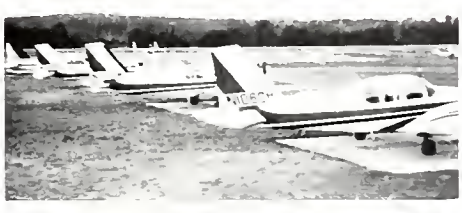
7. From an article by Bill Noblitt that appeared in the *Chapel Hill Newspaper* for March 25, 1979. It quoted U.S. Census Bureau and North Carolina Department of Administration figures.

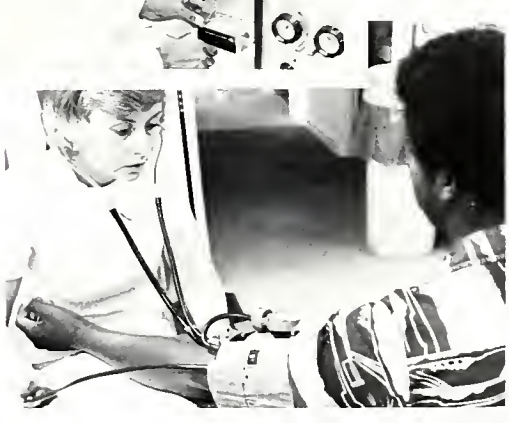
8. From an article in the *Chapel Hill Newspaper,* May 20, 1979. Figures cited are also from this article.

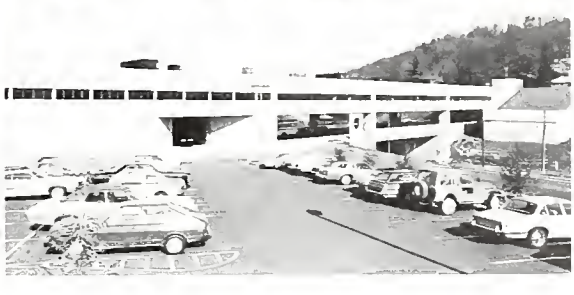
Rural Health Services

Photos show necessary aspects of delivering health services to rural areas: community support, teaching, clinical and other technical facilities, available air transportation, and modern buildings.









Another dimension of the problem is that for much of this century, the trend in medical education was to produce increasingly specialized physicians. Proportionately fewer doctors entered primary care practices while ever more doctors pursued specialized careers that required basing their practices near the largest, most complex hospitals. The result was that the most seriously ill patients were likely to receive excellent specialized care in hospitals, but more and more people with "everyday" illnesses like the flu or an earache had considerable difficulty in finding primary care. Consequently, improved access to care has required that the pool of family and other primary care physicians be enlarged.

NORTH CAROLINA HAS ADDRESSED the problem of access to health care head on. Among its efforts are three programs that stand out for their pervasiveness, their innovation, and—at least for one program—the controversy surrounding it.

1. Education of health care professionals, especially primary care physicians and such "new health practitioners" (hereafter NHPs) as physician's assistants and nurse practitioners. The North Carolina Area Health Education Centers program (AHEC) and the new medical school at East Carolina University represent the state's largest recent investments to affect the supply and distribution of medical and other health care personnel.

2. Establishment of the Office of Rural Health Services in the Department of Human Resources. This office has a physician-recruitment program, and it has established rural health centers that are staffed mainly by NHPs who are supervised clinically by physicians located in other communities.

3. Funding of primary care services in selected county health departments throughout the state.

Leaders of these efforts avoid claiming that they alone are directly responsible for the improvements of the last decade in health status resources for North Carolinians. An Area Health Education Center director, for example, would not claim that the physician/population ratio in a group of counties has improved because of AHEC's work. Other factors that contribute to the improvement might be the Office of Rural Health Services' recruitment program, the fact that some physicians would have moved to those counties anyhow, or the influence of the federal government's National Health Service Corps health manpower placement program. Still, while the activities of any one effort may not account for specific improvements, North Carolina's progress in the last ten years would not have occurred without the extensive training, recruitment, and health center development activities that have gone on in the state.

New sources of care

During the 1960s and early 1970s there was concern in this country that there were too few doctors—especially primary care physicians like family practitioners, internists, pediatricians, and obstetrician-gynecologists. With the development of new medical schools, expansion of old ones, and shifting of resources to educate more primary care specialists, the physician-shortage worries abated. In fact, some students of health services say that we now have an oversupply of doctors. But there is no agreement on what the "right" number of physicians is. Moreover, the right number of doctors and medical resources in one community may be inappropriate in another.

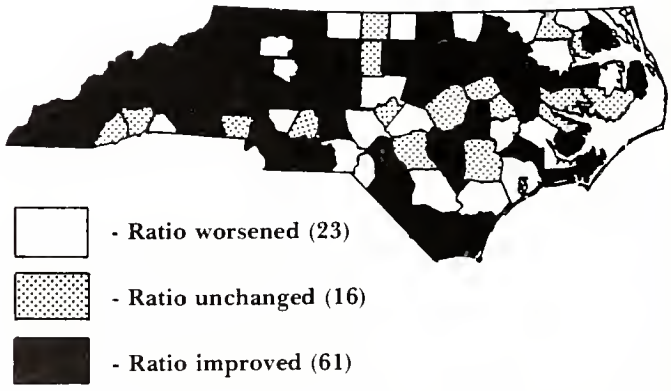
Even if experts cannot agree on the right number of physicians, in regard to North Carolina most of them do agree that there were far too few primary care physicians at the beginning of the decade and that their distribution left much to be desired. Between 1964 and 1970, the ratio of physicians to population declined in 51 counties—most of them rural. The ratio improved in only 22 counties. In 1969 the state averaged one doctor for every 2,150 people living in rural areas. The national average was one for every 1,800 persons.[9]

North Carolina's situation in terms of the supply and distribution of primary care physicians was especially bleak. The ratio of its population to primary care doctors was greater than 4,000 to one in 25 counties and between 2,500 and 4,000 to one in another 36 counties. Such ratios are too high—people who live in areas with population/physician ratios this high generally have

9. From an article quoting Eugene S. Mayer that appeared in the Raleigh *News and Observer* for May 23, 1979. Dr. Mayer is director of the North Carolina Area Health Education Center Program.

Figure 1

Change in Population/Physician Ratio Per County Active Nonfederal Primary Care Physicians, 1972-78.



Patient Care Provided by the Office of Rural Health Services.

difficulty obtaining primary health care services. This was particularly true at the beginning of the 1970s, when physicians were virtually the sole source of primary care in North Carolina.

In contrast with the grim situation of ten years ago, by 1976 North Carolina had equaled the national average of one physician for every 1,650 people in rural areas. In general, the state's supply of physicians has grown by 18 per cent since 1964, while the nation's supply has increased by 12 per cent. The primary care physician/population ratio improved in 61 counties between 1972 and 1978. Significantly, most of these counties are among the state's most rural—that is, least densely populated. Distribution of primary care doctors within North Carolina, therefore, has improved greatly. In comparing nonmetropolitan counties between 1971 and 1976, North Carolina's total physician/population ratio improved by about 38 per cent over the national ratio. (See Figure 1.)

These statistics indicate a considerable improvement over the past few years in the state's supply and distribution of doctors. It is no longer adequate, however, to assess primary health care resources solely on the basis of the number, type, and location of physicians. For example, while the primary care physician/population ratio improved in over three-fifths of the state's counties, it grew worse in nearly another fourth (23) of the counties between 1972 and 1978. But for most of these counties, appearances deceive. Health centers established with Office of Rural Health Services assistance are located in seven of these 23 counties. Other clinics, which are staffed partly by NHPs, have been (or are being) developed in another six counties. Finally, three more counties are served by the primary care units newly established in their local health departments. This means that 16 of the 23 counties where the ratio of primary care doctors to population has declined have new, nontraditional sources of basic medical care. While physician/population ratios remain an important indicator of the extent of medical resources, they no longer summarize the full situation in North Carolina because more is being done than simply increasing the supply and distribution of physicians. Training physicians and NHPs, developing clinics staffed by NHPs, and making primary care available in health departments all contribute to the dramatic improvement in the availability of health care in rural North Carolina.

Educating health personnel

In its effort to improve the availability of primary health care North Carolina has spent the most money on educating physicians and other health personnel. It is too soon to tell precisely what impact these expenditures will have. For example, one of the state's two largest investments in health education is the new four-year medical school at East Carolina University. Several years remain before the school's first graduates will enter practice. Its proponents expect that many of its graduates will locate in the eastern part of the state, the region in which—despite the recent improvements—relatively few primary doctors practice compared with the Piedmont and mountain areas.

The other investment is in the North Carolina Area Health Education Centers program (AHEC). The primary objective of the AHEC program is "to use the educational network to upgrade the expertise, increase the numbers, and improve the geographic and specialty distribution of health manpower of all types within the predominantly rural 100 counties of the state by *decentralizing* medical, dental, pharmaceutical, and public health education and by regionalizing nursing and allied health education, primary care residency training, and continuing education."[10]

The AHEC program assumes that adequate distribution of doctors in North Carolina depends on thorough distribution (and high quality) of all other health personnel. Four secondary goals support this primary objective:

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10. Eugene S. Mayer, Glenn Wilson, and C. Thomas Nuzum, "The University of North Carolina Experience," in Alvin R. Tarlov, et al., eds., *University/Regional Partnerships for Medical Education and Health Care: An Internal Medicine Perspective* (Fulton, Missouri: The Ovid Bell Press, 1979).

1. To expose university health science students and primary care residents to opportunities for community practice.
2. To encourage more health science students to choose primary care practice by broadening their clinical experience.
3. To develop regionalized university/community networks which can rationalize health manpower education and training activities throughout the state in order to minimize duplicative programs and interinstitutional conflicts.
4. To perform these goals in a manner which enriches the quality of health manpower education and training programs without compromising the service responsibilities of community hospitals, service agencies, and community practitioners.[11]

The AHEC program's decentralized organizational structure contributes greatly to its success in promoting more widespread distribution of primary care in the state. This decentralized structure is a concomitant of the fact that the program is not authorized to educate health care personnel but rather coordinates the educational activities of others.

North Carolina is divided into nine Area Health Education Center regions (see Figure 2), each of which contains an AHEC. An AHEC is "a health care delivery institution with the capacity to conduct clinical training . . . which agrees to undertake undergraduate, graduate, and continuing and inservice education for all health personnel" in the region.[12] Each AHEC has links with other hospitals, doctors' offices, pharmacies, public health departments, and other health care organizations and also with educational institutions in its region. These links serve to spread the training of health services personnel throughout each region and help assure that the education of health personnel reflects local needs.

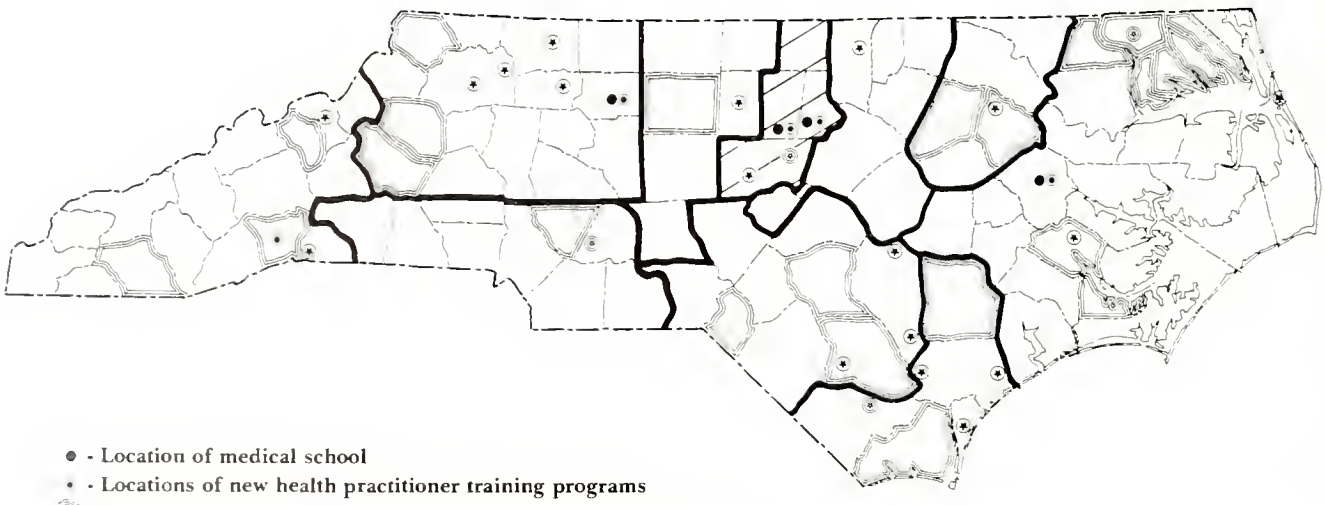
The nine AHECs are linked directly to a university health sciences center—six to the University of North Carolina at Chapel Hill and one each to the Bowman Gray School of Medicine, the Duke University Medical Center, and the School of Medicine at East Carolina University. The program is centered in a small staff that is directed by an associate dean of the UNC-CH medical school. The other three medical schools carry their responsibilities under contract with UNC-CH.

11. *Ibid.*

12. *Ibid.*

Figure 2

Locations of Selected Primary Care Training and Delivery Programs in North Carolina: Summer 1979



The University of North Carolina at Chapel Hill was one of ten universities in the United States to receive a federal contract to develop an AHEC program in 1972. Within two years the General Assembly, realizing the importance of the program, appropriated $28.5 million—mainly in capital funds—to expand AHECs throughout the state. Over the next three years the state invested another $20 million in the AHEC program and now provides about 70 per cent of its funding.

This large investment is paying off in North Carolina's increased medical manpower. The AHEC program is now establishing 300 new primary care residencies for physicians who are completing their training. When all of these positions are developed in 1980, there will be 668 primary care residencies in the state. About 210 of these will be in family practice—up from only 30 in academic year 1973-74.

It is too early to say precisely how many of these residents will stay in North Carolina and how many of those who stay will locate in the state's medically underserved areas. The first group of 38 totally AHEC-trained family practice residents enter practice this year. The early indications are that 25 of them will remain in North Carolina and that 15 of these will practice in communities of less than 10,000 people.

The Area Health Education Centers program also supports the training of a new kind of health care personnel—physician's assistants and nurse practitioners.[13] These medical personnel are trained to diagnose and treat many illnesses that traditionally have been dealt with by physicians. With the approval of the State Board of Medical Examiners and (for nurse practitioners) the State Board of Nursing, they practice under the clinical supervision of doctors, often in different (though close by) communities from their supervisors.

The physician's assistant programs at Duke (started in 1965 as the first in the nation) and at Bowman Gray predate AHEC. These programs function independently of AHEC, though both receive financial assistance from it to help support the community-based training of their students. The AHEC program has played a larger role in developing and financing the training programs for family nurse practitioners at the School of Nursing at East Carolina University and at the Mountain AHEC in Asheville (in association with Western Carolina University).

These new health practitioner training programs, with many other factors, have promoted the activities of the state's Office of Rural Health Services (ORHS).

Satellite Medical Center

Whitakers Medical Center. Whitakers, an eastern North Carolina town with a population of approximately 1,000, has a health center that is a satellite of the Tarboro-Edgecombe Health Services System. The photographs to the right show the existing building that was remodeled for this purpose. In many small communities new construction is also used for local health (medical) centers.

13. The Area Health Education Centers program is deeply involved in training dentists, nurses, pharmacists, and other health personnel throughout the state. But because this paper focuses on the availability of primary medical care in North Carolina, this discussion of AHEC has concentrated on physicians and NHPs.

This agency was established in 1973 expressly to improve access to primary care services in rural areas of the state. One of ORHS's chief functions is to help rural communities establish health centers, staffed usually by family nurse practitioners and physician's assistants. Its services are essentially technical assistance and are based on a premise described by its director:[14]

> You cannot merely give a community group funds and manpower and expect a quality and stable program to appear. Where preparation has been inadequate, results are predictable. People will be unprepared for the task: goals will be unclear, roles and responsibilities will be ill-defined, and skills will remain undeveloped. The program will undoubtedly suffer from poor utilization, wasted resources, and disillusioned participants who often become bitter about the experience.
>
> It is the purpose of technical assistance to provide the environment of support where a new [community] organization can grow and develop the confidence and skills to run a medical program. A group must be given time and support.

With ORHS support, selected communities have developed primary care centers designed to avoid long-term dependence on state or federal funding. Most of the existing eighteen centers and the four clinics that are now being developed were initiated by local communities, not by ORHS.

Developing a center seems to be a simple and straightforward process, but actually it is complex. ORHS must give technical assistance in such diverse areas as planning and managing not-for-profit organizations, facility design and construction, legal matters, medical records, working relationships between NHPs and supervising physicians, public relations, fundraising, and other fields.[15] ORHS representatives determine whether there is likely to be enough demand in a community to support a health center. If so, the state provides $5 (up to $95,000) for every $1 raised by the community to help start a clinic. Thereafter, the state continues to help fund operational costs until the health center becomes self-sufficient. Even after this objective has been reached, the ORHS continues to provide some technical assistance.

Approximately 75,000 rural North Carolinians who formerly had little access to primary care are now served by health centers set up with ORHS assistance and funds. The program's considerable success has attracted worldwide attention. Planners from Alabama, Colorado, Georgia, Oregon, South Carolina, Tennessee, and Virginia and from Ghana, the Ivory Coast, Portugal, and Tunisia have come to Raleigh to study ORHS, and an ORHS staff member has visited Tunisia to provide help in improving that country's delivery of primary care services.

ORHS's other major activity—recruiting primary care physicians—has also attracted considerable attention. ORHS has played a significant role in bringing 134 doctors to smaller North Carolina communities in the past few years, but it functions mainly in a behind-the-scenes manner by letting community leaders do most of the talking with prospective physicians. ORHS identifies good prospects, brings these doctors together with community leaders in the communities, and advises the local people on the best ways to deal with the physicians during their meetings. Again, the process seems more simple than it is. It is, in fact, an arduous task based on a thorough knowledge of the dozens of factors affecting physicians' (and their spouses') decisions to locate in given communities. The objective is not merely to "place" a doctor in a town, but to have him or her stay there for more than just a couple of years. Early indications are that for many communities this objective will be reached.

Local health departments

Realizing the seriousness of the medical care availability problem in this state, the General Assembly—at Governor Hunt's request—appropriated $2.75 million for two years beginning July 1, 1978. This money—which was in addition to the funding for the AHEC program, the ORHS activities, and other training efforts—is to provide for "primary care services through local health departments in those areas where citizens of the State are . . . unable to obtain these services . . . ."[16] Though a few health departments had provided some primary care services for the past several years, the legislation was greeted with dismay in some quarters. Many physicians (represented mainly by the North Carolina Medical Society), criticized the program because, they said, it failed "to provide 24-hour-a-day, seven-day-a-week access to clinic staff," its costs were too high, and "nurse prac-

14. ORHS has been directed since it began by James Bernstein, who, while he was with the Health Services Research Center at UNC-CH, helped to establish one of North Carolina's first clinics (in Walstonburg, Greene County) to be staffed by nurse practitioners and physician's assistants. The quote comes from his testimony in hearings before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, on H.R. 10553, a bill to amend the Public Health Service Act and other laws in regard to financial assistance for health services delivery, February 1978.

15. Using the North Carolina experience and by assessing the many other rural community efforts to establish health centers throughout the United States, the UNC-CH Health Services Research Center and the Office of Rural Health Services have prepared a set of six practical books to help communities establish primary care centers: *The Rural Health Center Development Series* (Cambridge, Mass.: Ballinger Publishing Co., May 1979).

16. N.C. Sess. Laws 1977, Ch. 302.

titioners were to provide services under supervision of individuals who were not in a position to provide adequate overseeing and to assume full responsibility."[17] These physicians and some others questioned whether this expenditure was a wise approach to making primary care services available to the residents of the 22 mostly rural counties in the program. (See Figure 2.)

In partial response to this criticism, Governor Hunt appointed a task force, which included members of the North Carolina Medical Society and the Old North State Medical Society, to study the program. The task force concluded in its report of March 1979 that:

1. There is a need for publicly funded primary care among certain segments of the population;
2. Planning to meet the needs for primary care can best be accomplished through local collaboration efforts; and
3. There is a need for coordinated planning in North Carolina that will encompass all publicly funded primary care program development.[18]

The report also made several recommendations designed both to help insure that the program is aimed at each locality's needs and to promote cooperation between physicians and public health officials. If the task force's recommendations are followed, North Carolina is likely to fund primary care services in the jurisdictions of selected local health departments for the foreseeable future.

The future

The AHEC and the ORHS programs, the new medical school at East Carolina University, and the local health department primary care program are diversified efforts that invest a large amount of state tax funds in making "everyday" medical services more available to North Carolinians. These efforts have had significant success, and the state's achievements have brought considerable attention and praise to North Carolina.

Despite this success and the fact that AHEC and ORHS cooperate closely, however, the Governor's Primary Care Task Force expressed concern "that failure to consolidate planning for publicly funded primary care programs could jeopardize [their] success and credibility."[19] The key word here is *planning*. The task force did not suggest centralized control of the several state-supported programs that affect primary care. Perhaps its members recognized the quality of each program's leadership and the soundness of the several distinct approaches to the problem of delivering primary care. The challenge, then, is to improve the impact of all the programs without hindering the capacity of any one program.

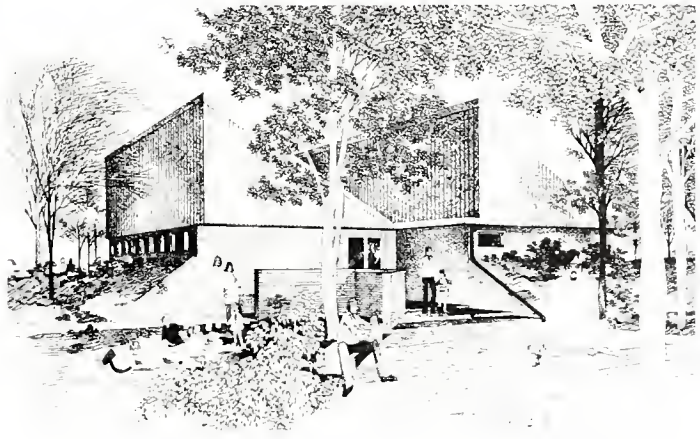
It is quite likely that, given its record in developing programs to meet the primary care needs of many of its citizens, North Carolina may also assume leadership in efforts to reduce the need for care through preventive health services. As medical care costs rise nationally and as the marginal benefits of additional investments in diagnosis and treatment become smaller, the desirability of maintaining and promoting health and preventing disease becomes ever clearer.

The challenge to improve the health of this state's citizens can be addressed two ways: by making the best possible medical care services readily available to everyone and by preventing the need for those services. North Carolina has made great progress with the former approach. Its future success, however, will be measured by how well it succeeds in implementing effective health promotion and disease prevention strategies. □

17. E. Harvey Estes, Jr., "Message of the President to the House Delegates," *North Carolina Medical Journal* 39, no. 5 (May 1978).

18. James E. Davis, et al., "Report of the Governor's Primary Care Task Force," submitted to the Governor, March 1979.

19. *Ibid.*



Architect's rendering of the new Bladenboro Community Health Center.

A Malpractice Crisis for North Carolina?

Patrice Solberg

ON APRIL 5, 1979, the Wake Medical Center agreed to pay $1.15 million to settle a malpractice case out of court. This settlement is by far the largest settlement or award of record in North Carolina. The case concerned a patient who was left blind and bedridden after being improperly anesthetized for plastic surgery.[1] At about the same time that this case was settled, a malpractice suit was filed against the Wake County Health Department alleging negligence in the insertion of an intrauterine device, failure to provide adequate follow-up care, and failure to obtain informed consent before the device was inserted. This case marks perhaps the first malpractice action brought against a North Carolina health department.

Both of these suits give cause to reevaluate the actions taken by the 1976 General Assembly to ward off a perceived, impending malpractice crisis. What precipitated the 1976 legislation? What actions did the legislature take? How effective were those measures? What actions remain open for legislative consideration?

History of the 1976 crisis

It is important to realize that the malpractice crisis was not brought about by an increase in the number or size of judgments rendered against North Carolina health care professionals. In fact, as of 1974, providers in this state were subject to fewer suits and smaller judgments than those in almost any other state.[2] The crisis centered on a dispute between the State Insurance Commissioner and the St. Paul's Fire and Marine Insurance Company, which insured 75 hospitals and about 90 per cent of the state's physicians and surgeons. In 1974 St. Paul's demanded an 82 per cent rate hike. After many negotiations, the Commissioner granted the increase until June 1975, with the hope that the General Assembly would have acted by that time to make malpractice insurance available at reasonable rates.

The General Assembly responded in 1975 by creating the Health Care Reinsurance Exchange to insure high-risk areas of practice, such as anesthesiology, and spread losses among member companies in proportion to their share of the total liability market. All general liability insurance companies were required to join the Exchange and offer malpractice policies. The 1975 legislature also created the Legislative Study Commission for Malpractice Insurance to investigate the insurance problem and to propose legislation to insure the availability of malpractice coverage.[3]

The Exchange was almost immediately challenged in court. In 1976 the State Supreme Court would strike down the Exchange on the grounds that requiring companies who have never before written malpractice policies and who are not trained to do so was unreasonable and a violation of the due process clause of the State Constitution.[4]

Meanwhile, St. Paul's applied for an additional rate hike and for permission to change the form of its policies from "occurrence" to "claims made." An "occurrence" policy insures a provider for any malpractice that occurs during the time the policy is in effect. Because claims are often filed several years after the alleged malpractice, it is difficult to project the amount of reserves that must be set aside to defend and pay judgments under "occurrence" policies. The "claims made" policy insures a provider for claims actually filed during the time the policy is in effect, which reduces the difficulty of determining necessary reserves.

When the Commissioner and St. Paul's could not agree on the rate hike and the policy form, St. Paul's announced in September 1975 that it would no longer offer malpractice coverage in North Carolina. To insure physicians and surgeons left in the lurch, the state Medical Society created the Medical Liability Mutual Insurance Company, and the North Carolina Hospital Association created a self-insurance trust to insure the hospitals. Later that year, the Commissioner and St. Paul's finally compromised and St. Paul's resumed writing coverage, but

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1. News and Observer (Raleigh), April 6, 1979.

2. Department of Health, Education, and Welfare, Report of the Secretary's Commission on Medical Malpractice (1973).

3. N.C. GEN. STAT. Ch. 58, Art. 18C; 1975 N.C. SESS. LAWS Chs. 623, 861.

4. Hartford Accident and Indemnity Co. v. Ingram, 290 N.C. 457, 226 S.E.2d 498 (1976).

on a "claims made" basis. In this atmosphere, the Study Commission prepared its report to the legislature.

Study Commission recommendations

In its report to the General Assembly in 1976, the Study Commission concluded that two problems faced the state in the area of malpractice insurance: (1) companies may again withdraw from the insurance market, thus forcing health care providers to stop providing services; and (2) the soaring cost of insurance could force physicians in certain areas to curtail their practice. To address these two problems, the Commission made the following recommendations:

Statute of limitations. The statute of limitations sets the amount of time that a plaintiff has to file a lawsuit. Pre-1976 law permitted plaintiffs to sue as late as ten years after the action that gave rise to the malpractice claim. The statute did not apply to minors until they reached the age of majority (18 years of age). Thus a minor could bring suit for an injury inflicted at birth until he reached the age of 28. This "long tail" of claims makes it difficult for an insurance company to predict the number of claims that it must defend and the costs of the claims. Also, it is difficult to defend cases when memories have faded and witnesses have left the state. To reduce these problems, the Commission recommended that the statute of limitations be lowered to four years. For minors seven years or older, the statute should be the same as for an adult.

Consent to treatment. The law requires health care providers to obtain voluntary, informed consent to treatment. In order to give a legally binding consent, the patient must have been told the risks, benefits, alternatives to, and nature of the procedure he is about to undergo. Yet the law is not clear how many risks must be described. If there is a 1 in 3,000,000 chance of death, must this be disclosed? What about the patient who becomes unduly frightened when he learns of the risks and refuses medical care that is necessary to save his life? Treating a patient without informed consent is classified by some courts as a type of medical malpractice and by others as a battery. Battery is defined as an unlawful touching of another person when that touching would be offensive to a person of reasonable sensibilities. Some have argued that the constitutionally guaranteed right to privacy requires providers to obtain informed consent. To clarify the obligation to obtain informed consent, the Commission recommended a statute to provide that so long as providers tell the patient the risks commonly disclosed, there could be no liability. In determining whether the patient understood the risks disclosed, the test should be whether a reasonable person would have understood the risks from the information provided, not whether the patient actually understood the risks. This part of the recommendation would relieve the provider of trying to peer into his patient's mind to determine whether he actually understood the information conveyed.

Good Samaritan. The purpose of a Good Samaritan law is to encourage laymen and health care providers to render care in emergencies by giving them limited immunity from suits for malpractice. Pre-1976 law granted this protection only when care was rendered to victims of motor vehicle accidents on the public highways. The Commission recommended extending it to cover all emergencies that do not occur in the normal course of business of the person rendering care.

Malpractice standard of care. In the early days of malpractice litigation, courts decided that because communications were poor, it would not be fair to judge "small town" doctors according to what a "big city" doctor would do. This "locality rule" provided that doctors should be judged according to what their colleagues in the same community would do in a similar situation. Two factors caused courts to relax this rule. First, it was very difficult for the plaintiff to persuade a physician from the defendant's community to testify against his colleague. This may have caused meritorious claims to fail. Second, communications had improved significantly and the reason for the rule no longer existed. Courts began applying a nationwide or regional standard of care, increasing the chances of a successful suit. The Commission recommended limiting liability to cases in which the defendant's care did not measure up to standards in his or a similar community.

Ad damnum clause. The ad damnum clause in the plaintiff's complaint states the amount of damages to which the plaintiff feels he is entitled. When a suit that asks for an astronomical amount of money is filed, the accompanying publicity could ruin the career of providers named as defendants even if the claim is frivolous. Also, the Commission felt that the publicity only fueled the malpractice crisis by encouraging similar suits. It therefore recommended that plaintiffs not be allowed to state in their complaints the requested amount of damages.

Collateral sources. In some states any award to a plaintiff is reduced by whatever compensation he receives from other sources unless he has paid premiums for that compensation. Referred to as a collateral source rule, this principle reduces the defendant's financial burden and keeps the plaintiff from collecting windfall profits. For example, a jury award would be reduced by moneys received pursuant to Workmen's Compensation or Medicare but not by the amount paid pursuant to a private health insurance policy. The Commission recommended adopting this type of collateral source rule.

Periodic payments. To ease the payoff burden on defendants and to protect plaintiffs from unwisely spending money awarded pursuant to a large judgment, the Commission recommended that when the damages exceed $100,000, the trial judge should have the power to order periodic payments instead of lump-sum awards.

Patient's Compensation Fund. To insure that malpractice coverage is always available at a reasonable rate for claims in excess of $100,000 and to provide a fund to pay injured patients, the Commission recommended establishing a Patient's Compensation Fund. Participating health care providers would have to provide or obtain the first $100,000 coverage and would pay premiums to finance the fund.

Arbitration. To reduce the high costs of litigation, the Commission recommended that health care providers and the public be made aware of a state law recognizing the legality of agreements that permit an arbitrator chosen by the

parties to settle differences rather than go to court. Although some states have enacted laws requiring patients to arbitrate their claims, the Commission felt that such a law might be ruled an unconstitutional interference with a citizen's right of access to the courts.

Self-insurance. Representatives from North Carolina Memorial Hospital and the University of North Carolina School of Medicine asked the Commission to support legislation authorizing them to self-insure. They produced statistics showing that in five years the NCMH-UNC Medical Center had paid over $690,000 in premiums for malpractice coverage, while only $13,000 had been paid in claims. To bring about a cost savings, the NCMH representatives requested and the Commission endorsed a self-insurance program.

Response of the 1976 General Assembly

The Study Commission's recommendations were presented to the 1976 short session of the General Assembly. A short session differs from a regular session in that only certain matters can come before it. In the 1976 session the resolution authorizing the consideration of malpractice legislation was limited to those bills resulting from the Commission's recommendations and introduced by the chairman of the House or Senate Insurance Committee. Once this resolution—viewed as a gag attempt by some—was passed, most of the Commission recommendations sailed through the legislature in one form or another.

Statute of limitations. The General Assembly agreed to shorten the statute of limitations, but not as short as the Commission had requested. Under the 1976 law, the plaintiff now has up to four years to discover an injury and file a claim. If a nontherapeutic foreign object is left in the body the plaintiff has up to ten years to bring suit.[5] The statute for minors is the same as for adults, except that if the period expires before the child reaches 18, he has one extra year to file suit. This decision reflects an attempt to protect defendants from unreasonably late suits and to give patients a reasonable amount of time to discover an injury and file suit.

Consent to treatment. The legislature enacted a consent to treatment statute patterned after the Commission recommendations. It provides, however, that if a reasonable person would have consented to treatment, no recovery can be had against a provider who renders treatment.[6]

Good Samaritan, standard of care, and self-insurance. The Good Samaritan law was broadened pursuant to the Commission's request. Commission recommendations concerning the standard of care[7] and self-insurance for the UNC School of Medicine and Memorial Hospital were also followed.[8]

Ad damnum. The legislature declined to prohibit plaintiffs from stating their damages, but it provided that when the plaintiff claims more than $10,000 in damages, the complaint may not specify the amount but may state only that the damages exceed $10,000.[9]

Collateral sources and periodic payments. The legislature declined to adopt the Commission recommendations concerning collateral sources. It apparently felt that plaintiffs were entitled to dual reimbursement in these cases and that the amount of money involved was not excessive. The legislature also declined to give judges the authority to award periodic payments, perhaps because it disagreed with the Commission's conclusion that patients would squander their awards.

Patient's Compensation Fund. The legislature created a Health Care Excess Liability Fund patterned after the Commission's recommendations. The Fund provides up to $2 million coverage per occurrence and an annual aggregate of $2 million in coverage. It is administered by a board of governors chosen from the Medical Society, the Hospital Association, the State Nurses' Association, the Dental Society, and another health care profession. The Fund will make a payment only when the plaintiff, the defendant, or the defendant's insurer gives reasonable advance notice of the controversy.[10]

Insurance reports. The General Assembly added a bill to the Commission package. It had become disgruntled with its inability to determine whether requested insurance rate increases were justified, whether there was a malpractice crisis, and the extent of the malpractice problem. It therefore required insurance companies to file reports of their activities with the State Insurance Commissioner.[11]

Loopholes in the 1976 legislation

In a review of the 1976 malpractice package, flaws in the legislative package become painfully apparent. By identifying these problem areas, steps can be taken to rectify the problems they pose.

Statute of limitations. The new statute of limitations provides that if a nontherapeutic foreign object is left in his body, a plaintiff has up to ten years to discover the harm and to file a malpractice suit. This exemption was intended to cover cases in which sponges, needles, and other surgical instruments are left in a patient's body. Because the damage in these cases may not become apparent for several years, the legislature felt it unfair to preclude these lawsuits by enacting a short statute of limitations. Courts in other states, however, have interpreted the term "nontherapeutic foreign object" broadly. One ruled that a drug could be a nontherapeutic foreign object.[12] Another court ruled that an improperly severed Fallopian tube was a nontherapeutic foreign object.[13] That case concerned a patient who sued a physician for malpractice in performing a sterilization operation that was not successful.

Consent to treatment. The present consent to treatment statute provides that health care providers have obtained a valid consent when they give patients information similar to that given by other providers in similar

5. N.C. Gen. Stat. § 1-15 (Supp. 1977).

6. N.C. Gen. Stat. § 90-21.13 (Supp. 1977).

7. N.C. Gen Stat. § 90-21.14 (Supp. 1977).

8. N.C. Gen Stat. Ch. 116, Art. 26 (1978).

9. N.C. Gen Stat. Rule 1A-8(a) (2) (Supp. 1977).

10. N.C. Gen Stat. Ch. 58, Art. 26B (Supp. 1977).

11. N.C. Gen Stat. § 58-21.1 (Supp. 1977).

12. Raymond v. Eli Lilly and Co., 412 F. Supp. 1392 (D.C.N.H. 1976).

13. Paul v. New York, 389 N.Y.S.2d 277 (N.Y. Ct. Cl. 1976).

communities. If all the providers in the community decided not to give any information to patients, then they would all be immune from suit and patients could be subject to treatments they knew nothing about. The statute could even be read to allow providers to experiment on patients without the patients' knowledge. If the right to know the risks of proposed treatments is protected by the federal or state constitution and this statute offers a way for providers to infringe upon that right, the statute may be unconstitutional and invalid.

The consent to treatment statute also provides that when a reasonable person would have consented to treatment, no recovery can be had against a provider who renders treatment. If it is true that the right to consent to treatment rises to the level of the constitutionally protected right to privacy, this provision might be unconstitutional because it could be used to force treatment on one who earnestly but unreasonably refuses treatment. For example, some Jehovah's Witnesses earnestly believe that accepting a blood transfusion is prohibited by Biblical teachings. Though most people would agree that it is unreasonable to refuse a blood transfusion when necessary to save life, the courts have held that a Jehovah's Witness has a right to refuse treatment in these circumstances.[14] If the consent to treatment statute were applied, this patient could be forced to receive treatment against his will. This would violate his right of privacy and his right to religious freedom. It is unlikely that any justification for these violations would be accepted by the courts.

Good Samaritan. As enacted, the Good Samaritan law does not apply to one who renders services in the "normal and ordinary course of [his] business or profession." If a volunteer rescue squad worker injures a patient, is he covered by the Good Samaritan law? He certainly is not rendering services "in the normal and ordinary course" of his profession because he may ordinarily be employed as a farmer or cab driver. Also, his conduct is the type of conduct that the Good Samaritan law was drafted to encourage. Yet the Attorney General has ruled that because the patient expects the same standard of care from members of a volunteer squad as from paid rescue workers, volunteers are not protected under this law.[15] The resulting confusion has caused some of these volunteers to consider not providing services.

Standard of care. The General Assembly has decided that health care providers should be held to the standards of others in their "same or similar" community. Still, it is not clear how large a community might be. It could be a city, a county, a state, or a region. In fact, the State Supreme Court has indicated that the size of the community might, in some cases, be the entire country. The case before the Court concerned a person who was improperly treated for a gunshot wound in the lower leg. Because treatment for this type of injury is "essentially the same throughout the United States," the Court found that for the purposes of this case, the locality was the entire United States.[16]

Ad damnum clause. Although the General Assembly made it clear that it opposed making public a plaintiff's request for more than $10,000 in malpractice damages, it provided no penalty for violating this statute's provisions. Thus the statute is often ignored.

Insurance reports. The statute requiring insurance companies to file reports with the Insurance Commissioner can yield only an indication of the status of malpractice litigation in this state. Hospital self-insurance trusts set up by the state Hospital Association in 1975 are not required to file these reports. The statute also does not cover any company, such as the American Nurses' Association (ANA), that sells policies to North Carolina residents but does not have an office within the state's geographical boundaries. Also, the data required to be filed do not give a complete picture of the extent of malpractice-related claims in the state. Because there is no duty to report the number of claims filed in a given year, it is not possible to determine whether the number of claims has risen. Also, because there is no requirement for reporting the amounts awarded or agreed upon as a settlement, it is not possible to determine whether the awards are greater than in previous years. The only indication of whether awards are greater is the report of the amount of awards or settlements that have actually been paid.

While these reports are less than complete, the data drawn from them for 1978 give some idea of the extent of the malpractice litigation in North Carolina. The relevant facts from those reports are summarized in Table 1.

Alternatives not considered by the General Assembly

HEW recommendations. In 1973 the Department of Health, Education, and Welfare published a report on medical malpractice.[17] The recommendations of this report were not aimed solely at making it more difficult for patients to win malpractice suits. The HEW report considered ways to minimize the likelihood that suit would be brought in the first place by suggesting ways to improve the quality of patient care. Those recommendations included the following:

(1) There should be a risk-management program in all health care facilities to determine the causes of patient injuries and to take steps to eliminate those hazards. Under a risk-management program, practitioners report problems in patient care to the risk manager, who investigates the report to determine how to avoid recurrences of the problem. North Carolina Memorial Hospital, in Chapel Hill, has a risk-management program that has already been responsible for identifying and discarding defective equipment that could have caused injuries. Another benefit of the program is that investigations of potential malpractice claims are carried out soon after the event has occurred, when memories are fresh and witnesses are available. One problem with risk management is that it is not clear whether the reports of incidents can be subpoenaed by a plaintiff's attorney for use in court. If they can be, providers will be reluctant to file reports, fearing that the docu-

14. *See* Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).

15. Opinion of the Attorney General to Mr. I. O. Wilkerson, 46 N.C.A.G. 42 (1976).

16. Ricker v. High Point Memorial Hospital, 285 N.C. 519, 206 S.E.2d 196 (1974).

17. HEW Report of the Secretary's Commission, *supra* note 2.

Table 1

Professional Liability Insurance 1978
(North Carolina)

	Physicians and Surgeons	Other Health Care Providers	Hospitals	Other Health Care Facilities	Policies[1] Effective Before 1/1/76
No. Claims Pending at Beginning of Year	170	17	36	6	400
No. Claims Pending at End of Year	549	33	67	7	332
No. Claims Settled and Paid by Agreement of Parties or by Court Judgment	30	22	4	4	12
Highest Award	$60,000	$5,000	$14,000	$1,000	$80,000
Lowest Award	$ 14	$ 7	$ 1,500	$ 250	$ 500
No. Claims Closed without Payment	69	14	27	3	88
No. Claims in which Court Award Paid	3	0[2]	0	0	2
No. Court Claims Settled Out of Court with Award Paid	27	3[2]	4	4	10

1. These policies were written on the "occurrence" basis, not the "claims made" basis and are therefore reported separately.
2. Data from one company not available.

ments will later be viewed as a confession of negligence. Clarifying legislation could resolve this problem.

(2) Licensing boards should have several disciplinary options available, including requiring remedial training for negligent practitioners. Now, the only option a board may have is to revoke the license of an errant licensee. Understandably, boards are reluctant to deprive such a person of his sole means of support. It has been alleged that this reluctance deters boards from taking action against negligent practitioners.

(3) Legislation should be passed that describes the circumstances in which hospitals can revoke a practitioner's privilege to practice in the facility. Many hospitals fear to take action against senile or incompetent staff because of the threat of slander or libel suits. Legislation should set forth procedures to be used and give qualified immunity from suit.

(4) Continuing education for all licensed health care providers should be required to keep practitioners informed about technological and scientific advances.

(5) Specialty boards that certify a provider as an expert in a particular aspect of practice, such as obstetrics, should periodically re-evaluate the providers they certify.

The federal crisis and response. Between 1968 and 1971 the number of medical malpractice claims against federal health care providers grew by 255 per cent, even though the number of inpatient admissions declined and no increase occurred in the number of outpatient visits.[18] These statistics were not the only indication of a malpractice crisis. Until 1974 most courts had ruled that United States government physicians were exempt from personal liability for malpractice because they were public officials performing "discretionary" duties. Injured plaintiffs could only sue the government for damages. But in 1974, a federal court rejected the proposition that rendering medical care was "discretionary" and held that government physicians could be held personally liable for malpractice.[19] Congress responded by enacting legislation providing that, as of October 8, 1976, those injured by federal health care providers practicing within the scope of their duties when the injury occurred may not sue the provider but may only sue the federal government under the Federal Tort Claims Act.[20] These health care providers need no longer fear malpractice liability nor purchase insurance.

The federal response for North Carolina. State and local governments in North Carolina should investigate the federal program to determine whether similar protection could be extended to their health care providers. If the case recently filed against the Wake County health department is a sign of things to come, this protection will be needed. As health departments render more types of health care, they may find themselves more subject to suit. The local health departments alone employ over 1,000 public health nurses, many of whom are not covered by any insurance whatsoever. Before adopting a program similar to the federal government's, however, several legal questions must be resolved. Although this article cannot deal with all of these problems in detail, a few of them are described below.

If the program were designed for state employees, the plaintiff's recourse would be to sue the state under the State Tort Claims Act. Unlike the federal act, however, the state act places a $30,000 limit on the amount of damages that the state will pay for each incident.[21] That is, the maximum compensation for injuries caused by state-employed health care providers would be $30,000. Other states have enacted legislation that limits the amount of damages available to injured patients, and in some of these states, the courts have held these limits to be unconstitutional on the grounds that they deny patients their right to be fully compensated for loss as guaranteed by the due

18. *Id.* app. at 29.

19. Henderson v. Bluemink, 511 F.2d 399 (D.C. Cir. 1974).
20. 10 U.S.C.A. 1089 (1976).
21. N.C. GEN. STAT. § 143-291 (1978).

process clause of the federal or state constitution.

If the provider is employed by the county, the limit of the award under current law would be the amount for which the county is insured.[22] If a county elected not to purchase insurance, the plaintiff would be denied any recovery. This result would doubtless also run into trouble with the courts.

If these and other problems are met, the federal response could be adapted by state and local governments to provide protection for their health care providers.

Other suggestions

No-code orders. A "no-code" order is an order given by a physician that no cardiopulmonary resuscitation (CPR) will be performed on a patient who has suffered either heart or breathing failure. The result of not giving CPR is usually death. The orders are typically given with regard to patients who have little time left to live and are in pain. Although North Carolina has enacted a "brain death" statute authorizing discontinuance of artificial means of life support when a committee of physicians makes certain findings, there is no legislative guidance about the legality of the "no-code" order. At present health care providers face the possibility of criminal and civil charges when they issue and carry out these orders. Legislation should be written to clarify the matter.

Birth control. The 1977 legislature provided that physicians could give minors birth control devices without first consulting their parents, but it is not clear whether nurse practitioners and physician's assistants may also provide these services to minors. These health care providers are authorized to render the services to adults, and many do prescribe birth control devices for minors in health departments. The 1977 law should be clarified to make it clear whether these professionals are practicing within the law.

Abortion. The state abortion law provides that abortions after the first 20 weeks of pregnancy are illegal unless necessary to save the life or health of the mother. The U.S. Supreme Court has made it clear that keying the legality of abortions to a certain time in the pregnancy is unconstitutional. The legislature may prohibit abortions only after a physician determines that the fetus is viable. Because our law is unconstitutional, it cannot be used to prosecute a physician who performs late abortions. If it is to be constitutional, it must be amended in accordance with guidelines from the Supreme Court.

Medical records. There is no clear law that defines the amount of information that a health care provider may or must disclose concerning a patient. If a public official, such as the Governor, is in the hospital emergency room, may the hospital report his condition to the press? May it call his wife to inform her of his condition? Again, legislation could respond to these questions.

Conclusion

The legislature can resolve these and other issues by clarifying the obligations that health care providers owe to their patients. Although the malpractice crisis in this state is not anywhere near the level reported in other states, current events show that this situation might not long continue. Thus a reexamination of malpractice laws and other statutes governing health care providers seems appropriate. Clearly, much could be done to protect health care providers from unwarranted suits and to protect the public from unprofessional professionals. □

22. N.C. Gen. Stat. § 153A-435 (1978).

Book Review

Land Use in a Nutshell. By Robert R. Wright and Susan Webber. (St. Paul, Minn.: West Publishing Co., 1978.) Pp. xxxv, 316. Paperback, $5.95.

Planners and attorneys who want a quick, easily readable introduction to the field of land-use planning and regulation will find this compact and inexpensive volume just what they desire. As with all short surveys of complicated fields of law, the book is flawed by the shallowness of its coverage. (Those wishing more detail should consider Donald C. Hagman's *Urban Planning and Land Development Law,* issued by the same publisher, which is the "standard" hornbook in the field.) But aside from the annoyance of minor factual misstatements or inaccurate analyses, *Land Use in a Nutshell* can be read and reread with profit, by both newcomers to the field and those who have been around long enough for their legal knowledge to have rusted.—*PPG*

Many deaths in custody could be avoided by greater awareness of the prisoner's physical condition when he is jailed.

Causes of Deaths in North Carolina Jails and Prisons 1972-76

Page Hudson and John Butts

THE CHIEF MEDICAL EXAMINER'S OFFICE is responsible for investigating all deaths in North Carolina that occur under certain exceptional circumstances. By statute[1] and by custom, medical examiners investigate all deaths that occur in police custody, and they perform an autopsy in each case. Since one goal of the State Medical Examiner System is to reduce homicides, suicides, accidental deaths, and preventable natural deaths, the Chief Examiner's Office conducted a study of deaths that occurred in North Carolina jails and prisons between 1972 and 1976. We believed that we would not only uncover specific problems but also identify characteristics that would be useful in averting future prison deaths. This article is a short report of that study. Our data came from medical examiner, autopsy, and toxicology reports plus information from jail and prison authorities whom we interviewed.

During the five-year (1972-76) study period, 223 people died in North Carolina jails and prisons. Of the total, 144 deaths occurred in local jails and 79 took place in the state prison system. The jails—approximately 110—are primarily county and municipal facilities; they house new arrestees, prisoners awaiting trial, and misdemeanants who are serving sentences of usually less than six months. In the 1972-76 period, the jails had about 200,000 admissions per year and an average daily population of about 28,000. Although there were an approximately equal number of whites and nonwhites in the average daily population, the admission rate was about 3:2, white to nonwhite.[2] The State Department of Correction operates over 80 prison units—including Central Prison, which has a hospital that provides medical and surgical care for the entire prison system and the local jails. State prison inmates are convicted persons who are serving sentences for felonies and more serious misdemeanors. They number about 13,500, including 1,300 at Central Prison.[3]

NATURAL CAUSES AND SUICIDES were the chief causes of deaths during this period. So-called natural disease accounted for nearly half (102) of the 223 deaths. Suicides (70) constituted one-third of the total, and accidents and homicides each accounted for a tenth. It must be noted, however, that nearly half of the homicides resulted from a single act of arson. In

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1. N.C. Gen. Stat. §§ 130-192 through -202.

2. Census data, Department of Human Resources, Jails and Detention Branch.

3. Census data furnished by the Department of Correction.

four instances the manner of death remained obscure, although the causes were evident.

Natural deaths. Of the 102 prisoners who died "natural deaths," 30 were middle-aged alcoholics whose deaths were attributed to the alcohol withdrawal (delerium tremens) syndrome—often known as "fatty liver" or the "DTs." Most of these deaths occurred within the first three days of incarceration. It was clear from our review that several known alcoholics were jailed on public drunk charges—whereas their problem was alcohol withdrawal, not intoxication. Various manifestations of coronary heart disease accounted for another 35 of the 102 natural deaths. The period of incarceration in these cases varied from hours to many years. Miscellaneous diseases accounted for death in the remaining third of the natural deaths.

Suicide. Seventy prisoners took their own lives, a grimly impressive third of all deaths in custody. A disproportionate 54 of the 70 suicide victims were white males, mostly under age 40. Not only were the suicides concentrated in the first day, but close to half (34) of all suicides occurred in the first 12 hours of incarceration. Twenty-one per cent took place in the first three hours! Of the prisoners who took their own lives in the first twelve hours, 85 per cent were intoxicated at the time of death, and the majority of the suicide victims had been booked on alcohol charges such as "public drunk" and "DUI." (It is estimated that over half of all jail confinements in North Carolina involve intoxicated persons.)[4]

Sixty-five of the 70 suicide victims hanged themselves; 27 of these 65 used a belt. It is still not standard procedure to deprive even the intoxicated jailee of his belt in many of our facilities. One jail had five hangings in four years—four of which involved belts. In the two years since the jail changed its policy and routinely removed belts, there have been no suicides despite at least five efforts, four of which were hanging attempts. During these unsuccessful attempts the prisoner consumed sufficient time and created enough commotion with nonbelt material that the efforts were discovered and thwarted. Not one of those would-be suicides has subsequently taken his or her life.

Accidents. Three types of accidents accounted for 18 of the 25 fatal accidents. Five were acute drug-abuse deaths that involved pentazocine (Talwin) in Central Prison, barbiturates in a prison camp, Freon (antiperspirant) and tetrachlorethane (Nu-Type) in prison youth centers, and heroin in a county jail. Five deaths resulted from falls, which were related to alcohol and/or a seizure disorder and closely followed admission to county jails. Acute alcohol poisoning killed eight. All eight of these victims had been incarcerated a few hours before death on public drunk charges, and they continued to absorb recently ingested alcohol from their stomachs that reached fatal alcohol concentrations while their jailers and fellow prisoners assumed that they were "sleeping it off." Seven had recently ingested at least a fifth of whiskey; the eighth had been drinking methanol. All but one were white, and their average age was 60 years (two were 73). The remaining seven accidents were each of an individual nature.

Homicide. We found in our study of homicides that most involved the killing of one prisoner by another prisoner; one or two prisoners received a fatal injury from "friends" just before arrest; one was shot in an escape attempt; and another was shot by a deputy during booking. One death is still under investigation—the arresting officer may have inflicted the fatal beating. And nine deaths were caused by an arson event in a prison camp.

Four deaths were classified as "undetermined" in the study. Only four of the 223 prisoners who died were female.

NINETY-SEVEN OF THE 223 fatalities occurred within the first 24 hours of custody. Most of these prisoners were arrested on charges directly related to alcohol; but regardless of the charge, at least 51 of the 97 were intoxicated when they died. Among those who died after more than one but less than 30 days in custody, there was a striking positive correlation between alcohol-related arrest and fatty change in the liver—a good indication of alcohol abuse that is detectable at autopsy.

We strongly believe that the toll of avoidable and untimely deaths in North Carolina jails and prisons can be reduced significantly. Changes can be made that would be both humanitarian and cost effective. We have identified four problems that not only represent the highest risk to prisoners but also may be the easiest to remedy. These are:

(1) Acute alcohol withdrawal syndrome ("DTs");
(2) Failure to distinguish symptoms of alcohol withdrawal from intoxication;
(3) Fatal alcohol overdose; and
(4) Suicide in an obviously high-risk group: relatively young, typically white, intoxicated males who have just been jailed.

Our impression is that the community—the citizenry—is concerned about investigation of deaths in custody only when the deaths result from so-called police brutality. This is ironic since nearly all prison deaths occur in other ways, and in fairness the fault should be laid upon the community, the citizens, county officials, and the medical profession rather than on custodial officials. It is these groups who provide the handicaps, the guidelines, and the constraints with which those who have custody of prisoners must work. □

The squeeze is on in terms of hospital costs. If hospital revenues are cut, either the services must be reduced or the hospital must close.

Hospital Rate Regulation and the Quality of Patient Care

Kaye Lasater and Stephen C. Morrisette

THE ADVOCATES of hospital rate regulation as a means of containing hospital costs suggest that the government knows more about operating a hospital than people who are specially trained in this field. They also imply that hospitals are not committed to cost effective operation or to reducing the inflation rate of health care costs. These theories are mistaken.

On the contrary, the increase in health care costs has come in good part from government regulation and policy. Hospitals deal constantly with hundreds of government agencies that enforce literally thousands of regulations affecting hospitals. The cost of complying with these regulations is staggering. A study of New York hospitals, which operate under state-mandated rate controls, reported that in 1977 the annual cost to New York hospitals for complying with government regulations was approximately 115 million man-hours.[1] This is the equivalent of more than 56,000 hospital employees spending full time on regulation matters—enough employees to staff 70 hospitals with 250 beds each.

The experience of other states that have instituted state-mandated hospital rate regulation makes it clear that this regulation is far from satisfactory. For example, in Massachusetts, a state with a long history of rate-setting, nearly 60 per cent of the hospitals incurred deficits from operations in each of the past two years.[2] In New York, also a rate-setting state, four out of five hospitals incurred deficits in 1977.[3]

Colorado, after experimenting for two years with a hospital rate-setting commission, abolished the commission in early 1979. While the abolition issue was before the Colorado legislature, the prime sponsor of the original legislation to create the commission stated, "I had high hopes for what would be accomplished, but it became just another layer of bureaucracy . . . There has to be a better way to control costs."[4] The *Denver Post,* a strong supporter of establishing the commission in 1977, urged the legislature to drop the commission: "Abolishing the Colorado Hospital Commission is the best step the 1979 Legislature can take to insure quality health care at reasonable cost in Colorado."[5]

One small hospital of 50 beds in Colorado had to spend more than $30,000 just to get its budget approved by the commission. Yet it sought only a 6.6 per cent increase—far under the limit of 9.5 per cent imposed by the commission.[6] Another small hospital was forced to spend more than 1,000 hours of administrative time in preparing forms required by the commission.[7]

In 1977, impressed by the argument that a state commission might forestall federal control, many Colorado citizens believed that state hospital regulation would be better than further federal intervention. However, it became obvious that the fear of federal intervention stampeded Colorado into authorizing a layer of bureaucracy that would ultimately cost its taxpayers dearly.

ALTHOUGH PROPONENTS of hospital rate-setting legislation point to a reduced increase in hospital costs

Kaye Lasater is public relations director for the North Carolina Hospital Association and Steve Morrisette is director of government relations.

1. New York State Hospital Association.
2. Editorial, *Review* magazine, December 1978.
3. New York State Hospital Association, *Seventh Annual Fiscal Pressures Survey,* 1977.
4. Sen. Fred E. Anderson, member of the Colorado legislature.
5. Editorial, *Denver Post,* January 29, 1979.
6. *Ibid.*
7. *Ibid.*

for some states that have implemented rate-setting mechanisms, it is obvious that the financial difficulties of hospitals in many of those states jeopardize the quality of health care.

An examination of a hospital's cost and expense structure provides insight into problems caused by decreased revenue that has been mandated by government regulation. The hospital in Figure 1 has struck a balance between four elements of revenue and four of expense. This hospital, being well run, tips slightly toward the gain side—revenues are greater than expenses. Most nonprofit hospitals have small net gains (around 2 per cent of gross revenues.)

Suppose the decision is made to reduce the high cost of hospitalization. The proposals to reduce cost are that (1) multiphasic blood examinations on routine admissions will no longer be paid for by insurance, which means that this examination ordinarily will not be made; and (2) the hospital will be permitted to charge no more for drugs than the average charge for the same medication in area retail pharmacies. These steps are considered helpful in curbing the cost of hospital care. But what are the effects on the hospital? Eliminating the lab's multiphasic blood exam on every admission means a sizable loss of hospital revenue. However, hospital *costs* are unaffected. Figure 2 shows the imbalance between costs and revenues that is created by reducing the lab-pharmacy revenues. The diagram shows that none of the elements of hospital expense—personnel, equipment, overhead, and supplies (except for autoanalyzer chemicals)—are materially affected by eliminating these revenues. No technicians are laid off; the lab still is open around the clock; no equipment has been sold; and heating, cooling, and lighting the lab cost as much as before the loss of revenue. The same number of pharmacists work the same hours each day dispensing the same drugs, and the heating, cooling, and lighting expenses remain.

The net effect of these two ideas is to trip the hospital into a sizable deficit position. What must be done to restore the balance? Two things are possible: (1) raise charges on remaining services offered to offset the loss of lab and pharmacy revenue, and (2) cut costs.

The four components that constitute cost in this illustration are difficult to alter. However, it is only on the cost side of the balance that any lasting effect on hospital expenses (and therefore charges) can be made. Eliminating sources of revenue does not necessarily affect the expense of running a hospital. Reducing cost frequently results in reduced services. If a hospital is efficiently managed in all aspects of cost, reducing services may be the only way to cut expenses significantly. And any legislative proposal, such as a rate-setting commission, that tries to reduce costs by holding down revenues in an efficient hospital will result in one of two situations: Either the number and the quality of services offered by the hospital will be reduced or the hospital will close its doors.

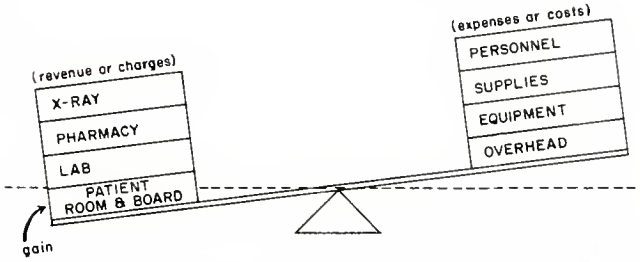
HOSPITAL COSTS are affected by inflation and by a change in the commodity that is being purchased. A brief look at some services offered by hospitals will show that inflation in hospital charges per service has been roughly equal to that of the general economy.

Why, then, have overall hospital charges been increasing at a higher rate than inflation? Because hospitals are providing more and better services. Between 1971 and 1976 the number of services provided per admission changed in the following ways:

—Diagnostic X-rays per admission increased by 26 per cent,
—Lab tests per admission increased by 60 per cent,
—Physical therapy treatments increased by 50 per cent,
—Registered-nurse man-hours increased by 23 per cent,
—Hospitals equipped to provide EKG increased by 13 per cent,
—Hospitals equipped to provide respiratory therapy increased by 19 per cent,

Figure 1

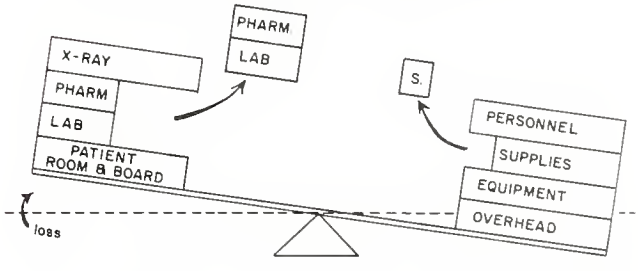
Balance of Hospital Costs and Expenses in a Well-Run Hospital



Source: From Wyatt E. Roye, "Careful With That Scalpel in Cutting Hospital Costs," unpublished paper, 1979. Mr. Roye is coordinator of the North Carolina Voluntary Effort.

Figure 2

Balance of Hospital Costs and Expenses after a Revenue Reduction



Source: From Wyatt E. Roye, "Careful With That Scalpel in Cutting Hospital Costs," unpublished paper, 1979. Mr. Roye is coordinator of the North Carolina Voluntary Effort.

—Hospitals equipped to provide physical therapy increased by 12 per cent.

One major cost for any hospital is labor. Generally, salaries and wages constitute 60 to 65 per cent of all hospital costs. Thus any increase in the minimum wage has a drastic effect on hospital costs. Whenever the minimum wage is increased, the effect ripples throughout the salary scale because the wage differential among the categories of employees is usually maintained. Congress has mandated that during January 1978 through January 1981 the minimum wage will increase by 39 per cent. But no increase in productivity is guaranteed with this increase in labor costs.

Increased use of facilities also brings increased costs. A larger and older population increases the demand on hospital services. Persons 65 and older represent 11 per cent of the total population, yet they constitute 38 per cent of total hospital inpatient days. Elderly persons have a higher incidence of chronic conditions that require longer and more frequent hospital stays. In 1979 the over-65 age group will increase by a half-million people—the fastest-growing segment of our population.

Hospitals face cost increases because of technical improvements in the services they provide. These advances are the products of the continuing national investment in biomedical science and technology. Most of us who have visited a hospital recently can agree that the technology available in hospitals today is much greater than even a few years ago.

As mentioned earlier, government regulations and policy have had major roles in the increase of health care cost. Specific examples are the Medicare and Medicaid programs. The hospital is reimbursed for Medicare and Medicaid patients on the basis of "allowable costs." The reimbursement by government is always less than the actual cost of delivering care to these patients, thus creating a loss that must be added to the hospital's rate structure. That means that Blue Cross and private insurance policyholders as well as patients who pay their own bills subsidize every Medicare and Medicaid patient.

Aside from the obvious expense of creating a government rate-setting mechanism, health care professionals fear that the quality of health care will be jeopardized by such a program. Although health care professionals are seeking to reduce the rate of inflation, they are also dedicated to maintaining high-quality care.

THE NORTH CAROLINA HOSPITAL ASSOCIATION believes that the best approach to containing hospital costs is through the Voluntary Effort. The Voluntary Effort (VE) plan was developed by the North Carolina Hospital Association, the North Carolina Medical Society, Blue Cross and Blue Shield

C. J. Harris Community Hospital, Sylva.

of North Carolina, private insurance carriers, and private business and civic leaders in an effort to reduce significantly the rate of increase in hospital costs. The VE plan involves all segments of the health care industry. To attack problem areas, VE takes into consideration the cost-containment history of the individual hospital in calculating its Voluntary Effort goal. The program is showing significant success in North Carolina, and the Voluntary Effort plan has been commended by the American Hospital Association and others who have reviewed it. The goal of the Voluntary Effort is to reduce hospital costs by 2 per cent a year for two consecutive years. It is predicted that North Carolina hospitals will exceed the goal.

The rate of increase in hospital costs since January 1979 has remained well below the increase in the Consumer Price Index. This is contrary to a prediction made by the Fiscal Research Division of the North Carolina General Assembly last December, when a spokesman for the Division stated that if hospital costs continued to increase at the rate of the preceding six months, an annual rate of inflation of 19.75 per cent from April 1, 1978, through March 31, 1979, would result. If this prediction were accurate, the success of the Voluntary Effort would be even more impressive, since the actual increase in health care costs is projected to be well below 12 per cent in North Carolina for the year April 1, 1978-March 31, 1979.

North Carolina's hospitals compare very favorably with hospitals across the country in almost every category of comparison. North Carolina hospitals rank forty-seventh in the average costs of a semiprivate room, forty-fourth in expenses per inpatient day, and ninth in occupancy rate. These statistics clearly demonstrate that North Carolina's hospitals have been active in cost containment even though they serve the needs of a very large number of patients each year.

We believe that the Voluntary Effort is the most effective plan of controlling the increase in hospital costs in North Carolina while maintaining quality patient care. □

The Future of Hospital Rate Regulation in North Carolina

Ted Kaplan and James D. Johnson

MUCH OF THE CURRENT national debate on medical cost containment has centered on ways to restrain rising hospital rates. Because of rising costs of providing Medicaid to the poor and the rising cost of medical care to the general public, in 1977 the General Assembly created the Legislative Commission on Medical Cost Containment. During the 1979 session the Commission introduced legislation (Senate Bill 678) calling for mandatory review and approval by a special commission of all hospital rate increases in North Carolina. While the bill did not pass, it generated considerable debate and is still eligible for consideration when the legislature convenes in June 1980.

Why have hospitals been singled out from the remainder of the medical care industry for so much attention by the state and federal governments? The answer lies in the high inflation rate in the hospital industry over the past ten years.

Hospital costs are now the largest component of health expenditures in the United States. In 1977, 40 per cent of the total health care dollars in the United States, or between $63-65 billion, went to hospitals.[1] Currently, no one can say with certainty how much Americans are spending on hospital care, but nationally Blue Cross, the American Hospital Association, and the federal government seem to agree on this range.

The tables on the next page are helpful in examining the growth of expenses and in comparing hospital expenses with other items—medical and nonmedical. Table 1 gives the growth in expenses for all hospitals in the United States over the past 17 years, including federal and state hospitals. A better measure of expenditures in local hospitals can be found by looking at total expenses for community hospitals in the United States and the breakdown in that table of costs per day per patient (Table 2). Another measure of the growth in hospital costs is the Consumer Price Index. Table 3 summarizes the trends in this area for 1960-76.

Since 1974 the State Department of Administration has prepared a survey called "North Carolina Cost-of-Living Indicators." Table 4 shows trends in selected items in this index. Over this 3½-year period medical care costs increased by 57.4 per cent, exceeded only by fuel and utilities, which increased by 69 per cent. At the same time the hospital portion of the medical care index cost-of-living indicators for North Carolina increased by over 68.5 per cent.

Why are hospital costs rising?

Harvard economist Martin Feldstein has argued that rising hospital costs have been produced by governmental and private health insurance coverage and rising incomes.[2] Widespread health insurance coverage reduces an individual's out-of-pocket costs for hospital care, and the patient then feels free to demand higher-quality care, new facilities, and more medical personnel. Health insurance coverage also allows a hospital to charge higher prices without a corresponding reduction in demand; the additional revenue can be used to purchase new equipment and buildings and to enlarge the staff.

Other economists have emphasized the impact of labor costs on hospital inflation. Since a large portion of a hospital's expenditures is for labor, these economists see unionization and higher salaries for skilled medical personnel as contributors to inflation.

Representative Kaplan is a member of the North Carolina General Assembly from Forsyth County and is co-chairman of the Legislative Commission on Medical Cost Containment. James D. Johnson is a member of the North Carolina General Assembly's Fiscal Research Division.

Gayle Fletcher and Debora Bridgers helped in preparing earlier drafts of the article.

1. "Health Care Spending Balloons," *Perspective: The Blue Cross and Blue Shield Plans Magazine* (Winter 1978).

2. Martin Feldstein, "The High Cost of Hospitals—And What To Do About It," *Public Interest,* 1977; Karen Davis, "Rising Hospital Costs: Possible Causes and Cures," Health Conference of the New York Academy of Medicine, 1972.

Medical Care Cost Comparisons

Table 1

Expenditures for All Hospitals in the United States

Year	Expenditures (Millions)	%Increase
1960	$ 8,421	—
1965	12,948	—
1966	14,198	9.3%
1967	16,395	15.6
1968	19,061	16.5
1969	22,103	16.2
1970	25,556	15.3
1971	28,817	12.9
1972	32,667	13.1
1973	36,290	11.0
1974	41,406	13.5
1975	48,706	17.6
1976	56,005	14.9
1977	63,630	13.5

Source: American Hospital Association, *Hospital Statistics*, 1977.

Table 2

Expenditures for All Community Hospitals in the United States

Year	Expenditures (Millions)	%Increase	Adjusted Per Patient-Day Expenditures	%Increase
1972	$25,462	—	$ 94.87	—
1973	28,372	11.4%	102.44	7.9%
1974	32,617	15.1	113.55	10.8
1975	38,962	19.3	133.81	17.8
1976	45,240	16.1	152.76	14.1
1977	51,647	14.2	173.98	13.9

Source: American Hospital Association, *Hospital Statistics*, 1977.

Table 3

Annual Rates of Increase in the Consumer Price Index (CPI) and Selected Medical Care Components— Selected Periods 1960-76

Category	Fiscal 1960-66	Fiscal 1966-71	Economic Stabilization Program 8/71 - 4/74	Post-Control Period 4/74 - 12/76
CPI, All Items	1.4	4.5	6.4	7.5
CPI, All Services	2.2	6.0	5.1	8.9
Medical Care, Total	2.6	6.5	4.3	11.0
Medical Care Services	3.2	7.7	4.9	11.6
Hospital Service Chg.	N/A	N/A	4.6	13.4
Semiprivate Rm. Chg.	6.0	14.6	5.7	15.4

Source: Subcommittee on Health, Committee on Ways and Means and Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, *Hospital Cost Containment* 95th Congress, 1st Session (Washington, D.C.: May 1977).

Table 4

Price Indexes Seasonally Unadjusted for Selected Cost-of-Living Indicators for North Carolina (Base: April 1974 = 100.0)

Category	1974		1975		1976		1977		1978[1]
	April	October	April	October	April	October	April	October	October
Food	100.0	105.5	107.7	113.5	112.0	113.0	119.0	120.7	132.9
Restaurant Meals	100.0	106.1	111.4	115.9	119.7	123.6	132.1	137.0	151.0
Home Ownership	100.0	109.9	108.7	111.7	112.8	116.8	117.9	121.5	134.4
Fuel and Utilities	100.0	109.9	119.8	128.9	130.5	135.2	151.0	158.6	169.0
Public Transportation	100.0	104.9	116.1	116.1	123.5	128.1	130.2	135.7	139.0
Motels and Hotels	100.0	102.0	103.2	103.4	108.6	109.5	113.0	117.2	131.4
Medical Care	100.0	109.6	112.4	118.9	122.2	128.6	134.7	143.8	157.4

1. In 1978 cost-of-living indicators were released only in October.

Source: North Carolina Department of Administration, *North Carolina Cost-of-Living Indicators*, 1974-78.

Others have argued that unnecessary capital expenditures and new medical technology have contributed to hospital inflation. Advocates of this theory point to unoccupied hospital beds and demands by *all* hospitals within a given area to acquire extremely sophisticated equipment (like CAT scanners) as examples of capital costs that help to generate hospital inflation.

Finally, some analysts have emphasized the role of the present reimbursement systems used by governments and private insurance companies as contributors to rising costs. Many current reimbursement systems pay hospitals on the basis of costs; thus the incentives for administrators and physicians to eliminate unnecessary spending is reduced.

Most economists agree that health insurance, government programs, and current medical practices have restructured the health care market in such a way that the pressures of competition and supply and demand do not function in their traditional manner. The health care market is now so structured that consumers, providers, and third-party payors (insurance companies and government) are insulated from the economic consequences (i.e. costs) of their decisions.

The consumer of medical services pays only a small part of any bill as an out-of-pocket expense. Most of the cost of health care in this country is paid through insurance or government expenditures. What the consumer sees is the marginal increase in the cost of health care as reflected in his insurance premiums. Very often even premium increases are not an out-of-pocket expenditure but are paid by the employer. Therefore, consumers have very few incentives to seek economically efficient providers of medical care.

Health care providers assume little risk because there are consumers who can and will demand virtually unlimited amounts of service, and insurance mechanisms that will pay for most of the cost of these services. The insurance programs, both private and governmental, also have few ways of discriminating between efficient and inefficient providers. Under our present system a hospital may charge considerably more for a given procedure than the one directly across the street and continue to attract customers and receive reimbursement from government and private insurance companies.

Insurance companies that pay for health care are in the business of spreading risks, not taking them. If the cost of health care for a given group of consumers rises above actuarial estimates, these costs will surely show up as an increase in insurance premiums very soon. The costs of increases in government health care programs, such as Medicaid and Medicare, are paid out of increased appropriations by Congress and state legislatures.

National and state efforts to control hospital inflation

Federal proposals and legislation. During recent sessions Congress has considered a number of proposals aimed directly or indirectly at holding hospital costs down. In 1974 it enacted Public Law 93-641, the National Health Planning and Resources Development Act. This complex legislation can be divided into two parts: health planning and determination of need. P.L. 93-641 establishes local health system agencies (HSA); in North Carolina there are six HSAs whose responsibilities include planning for the health needs of a given geographical region and determining that region's need for new facilities and services (Western North Carolina—I, Piedmont—II, Southern Piedmont—III, Capital—IV, Cardinal Health Agency—V, and Eastern Carolina—VI). The most critical feature of P.L. 93-641 is the linkage of health planning to determination of need through federal requirements for state certificate-of-need laws. P.L. 93-641 requires each state to enact certificate-of-need laws in order to receive certain federal health funds. It attempts to contain rising hospital costs by requiring approval of new institutional health services and capital expenditures for buildings and equipment that cost over $150,000. Congress apparently was convinced that there is a relationship between hospital inflation and excessive capital construction and purchases of new equipment.

After almost a year of study, the Legislative Commission on Medical Cost Containment introduced a certificate-of-need bill that met the requirements of P.L. 93-641 during the 1977 session of the General Assembly. The bill passed with a few amendments and became law on January 1, 1979.[3]

More recently Congress has turned its attention to proposals for direct means of curtailing rising hospital costs, as opposed to the more indirect methods like certificates of need. Some of these plans, such as those proposed by Sen. Herman Talmadge of Georgia, are aimed only at slowing hospital inflation within the Medicare and Medicaid programs and involve modification of the current practice of reimbursing hospitals on the basis of costs.

In 1977 the Carter Administration introduced a far-reaching hospital cost-containment plan. The Administration's proposal would have placed a mandatory 9 per cent growth ceiling on all hospital revenues and a permanent nationwide limit on capital expenditures for hospital buildings and equipment. The Administration's plan drew immediate opposition from the American Hospital Association and the American Medical Association; both argued that it would lead to a decline in quality of hospital care in the United States. In the months that followed, the Administration's proposal was hotly debated in both the Senate and the House of Representatives. Finally in 1978, during the waning days of the 95th Congress, a watered-down version of the President's bill passed the Senate but died in the House of Representatives.

In early March 1979 President Carter sent a new hospital cost-containment bill to Capitol Hill and called it "[o]ne of the clearest tests of Congress' seriousness in dealing with the problem of inflation." The new Carter proposal is a substantial modification of the 1977 plan and corrects many deficiencies of the original bill.

Instead of mandatory controls with an inflexible expenditures ceiling on all hospitals, the new proposal recognizes the voluntary efforts of the American Hospital Association and sets as a nationwide goal a 9.7 per cent increase rate for hospital expenses in 1979. This goal will be difficult to reach since the nationwide rate of increase in hospital expenditures has never been below 10 per cent in recent years. The President's plan allows the 9.7 per cent goal

3. N.C. Sess. Laws 1977, Ch. 1182 (second sess. 1978).

to be revised upward if the inflation rate exceeds the Administration's original estimates. If the 9.7 per cent goal is not achieved by voluntary means, then a mandatory rate-control program will go into effect on January 1, 1980. The bill exempts hospitals that fall into the following categories from mandatory controls:

1. Hospitals that receive more than 75 per cent of their revenues from approved health maintenance organizations;
2. Rural hospitals with fewer than 4,000 inpatient admissions per year;
3. Hospitals less than three years old;
4. All federal hospitals.

North Carolina Blue Cross-Blue Shield and the North Carolina Hospital Association estimate that as many as 93 out of 163 hospitals in this state would be automatically exempt from the mandatory controls. Most North Carolina hospitals would receive the automatic exemption because they have less than 4,000 inpatient admissions per year.

Three other provisions of the President's bill might also lead to exemption from mandatory controls for many hospitals. If the voluntary goal was not met nationally and the mandatory controls went into effect, all hospitals in a given state would be exempt if the state's aggregate rate of increase in hospital costs met the voluntary goal. To insure some equity among the states, a voluntary goal would be set for each state on the basis of its population and wage characteristics. But if a state's hospitals as a group did not meet the voluntary goal, an individual hospital could be exempt if it met the target. Finally, hospitals in states that operate their own mandatory cost-containment programs would be exempt from any national program. The Department of Health, Education, and Welfare (HEW) has indicated that nine states—New York, New Jersey, Massachusetts, Maryland, Connecticut, Rhode Island, Colorado, Washington, and Wisconsin—would qualify under this exemption at this time. States that established new mandatory programs for controlling hospital costs after the national program began could be exempt if they met certain federal standards. HEW has estimated that under the various exemption procedures more than half of the nation's hospitals would be exempt from the mandatory program if it went into effect.

The fate of the Carter cost-containment legislation is cloudy at present because of congressional preoccupation with energy problems and inflation. Also linked to hospital cost containment is the question of national health insurance; many believe that the congressional mood is such that no national health insurance legislation will pass without some provision for hospital cost containment.

While opposing the Administration's mandatory program for cost containment the American Hospital Association and its state affiliates announced the creation of a voluntary program in November 1977. The voluntary effort was developed in response to Dan Rostenkowski's (D-Ill.) challenge to the hospital industry to control its own cost. The goal of the national Voluntary Effort is to reduce the rate of increase in hospital expenditures by two percentage points each year during 1978 and 1979—from 15.6 per cent to 11.6 per cent per year over the biennium. The North Carolina Hospital Association quickly endorsed this national voluntary effort, but details of its plan were not released until July 1979.

State programs for cost containment. By 1978 fifteen states had enacted some type of legislation that requires the disclosure, review, or regulation of hospital rates or budgets. Eight of these state programs are operated by independent commissions or boards with membership drawn from both provider and consumer groups. The remaining seven programs are operated directly by the state agencies.

The success of these state cost-containment efforts is much in dispute. HEW and the commercial insurance companies, represented by the Health Insurance Association of America, have generally supported state regulatory efforts. Although the American Hospital Association has endorsed state regulatory efforts as superior to any national regulatory plan operated by the federal government, the North Carolina Hospital Association strongly opposed Senate Bill 678, which was introduced this year and provided for mandatory rate review. Nationwide, local hospital associations have generally opposed state regulation of hospital rates. The principal argument against state rate review is that the review will simply create another layer of bureaucracy and produce more unnecessary governmental regulation without accomplishing what could be achieved more easily by voluntary hospital action.

Some assessment of the impact of state regulatory programs can be made by comparing states with rate review and mandatory compliance with those with rate review and only voluntary compliance and then comparing both groups with those states with no rate review. (See Table 5.)

For this two-year period those states with mandatory rate review and mandatory compliance did better than those states with rate review only. The

Medical Park Hospital, Winston-Salem.

Table 5

Percentage of Change in Costs of Hospital Services 1976-77

Average Increase	Percentage of Change in Total Expenses		Percentage of Change in Expenses Per Admission	
	1977	1976	1977	1976
United States	14.2%	16.1%	12.4%	14.1%
North Carolina	15.5	15.8	14.3	11.8
Nine States[1] with Mandatory Rate Review and Mandatory Compliance	12.1	15.6	11.1	14.8
Five States[2] with Mandatory Rate Review and Voluntary Compliance	16.6	17.4	15.0	14.9
36 states and District of Columbia (including N.C.)	19.3	18.3	14.8	15.5

1. Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, Wisconsin.
2. Arizona, Maine, Minnesota, Oregon, Virginia.

Source: Department of Health, Education, and Welfare, "Effectiveness of State Hospital Cost Containment Programs—Information Memorandum" (Washington, D.C.: 1979).

five states with rate review and voluntary compliance generally fared better than those states with no state rate review. North Carolina's rates of increase for the same period were lower than those states that had rate review and voluntary compliance but not as low as the rates of those states with totally mandated programs. North Carolina was also above the national average in expenses for both years. It should also be noted that several states that have no state rate review had rates of increase well below the national average.

While the impact of hospital rate regulation is still under study, there is some indication that regulation does reduce hospital expenses.

The proposal for North Carolina

Following the 1978 session of the General Assembly, the Legislative Commission on Medical Cost Containment began an extensive study of programs for state hospital rate review. This process involved not only reviewing legislation from other states but also hearing testimony from the directors of the Maryland and New York rate-review agencies. From this research, the Commission decided to introduce a hospital rate-review bill modeled after the Maryland legislation.

S.B. 678, which may be reconsidered in the 1980 session would create a five-member North Carolina Health Services Cost Review Commission. The members would be appointed by the Governor and confirmed by the General Assembly. The appointment process is modeled after that currently used for the State Utilities Commission. No more than two Commission members could be affiliated with or employed by a hospital, health product manufacturer, or insurer that provides coverage for hospital care. Service as a hospital trustee, director, or employee of a hospital is considered affiliation or employment for the purpose of the bill. Unlike Utilities Commission members, members of the Health Services Cost Review Commission would not spend full time at their assignment.

After July 1, 1980, the Commission would have the power to (1) assure all purchasers of hospital services that total costs of these facilities are reasonably related to the total services offered by the facility; (2) determine that hospital revenues, as expressed by rates, are related to actual costs; (3) insure that rates are set equitably among all purchasers or classes of purchasers of services; (4) insure that a hospital's growth in total revenues is reasonably related to the inflation in costs of goods and services; (5) establish a growth ceiling for a hospital's aggregate revenues; and (6) project annual hospital revenues and approve the reasonableness of the rates projected to generate the revenues.

For nonprofit and governmental institutions, the Commission would establish rates that would permit the hospital to render "an adequate level of effective and efficient health services in the public interest and which shall fully account for, and adequately protect from inefficiency and waste, all taxpayer investment and public monies used . . . in establishing the institutions."

Proprietary or profit-making hospitals would be allowed sufficient rates to permit them to render effective and efficient health services in the public interest and provide the owners with the opportunity to earn, through efficient and sound management, a fair profit on their investment.

After July 1, 1980, a hospital could not change its rates without the Commission's approval. If the Commission did not make a decision within 120 days from the effective date of the new rate, the rate would go into effect.

The bill also provides that the Attorney General may participate in Commission proceedings when he deems his participation to be in the public interest. The action of the Attorney General before the Commission would be similar to that which now occurs before the Public Utilities Commission.

All administrative rules of the Commission and any hearings that might arise in the course of its rate reviews would fall under the Administrative Procedures Act.

The bill provides that the certificate-of-need authority now under the Secretary of the Department of Human Resources shall be transferred to the new Commission on July 1, 1981.

Because of the similarities between S.B. 678 and the provisions for the Maryland Hospital Rate Review Commission, the Maryland program was used as a starting point for estimating personnel needs for a rate-review commission in North Carolina. Maryland, however, has less than 50 hospitals, while North Carolina has 160 that would be covered under S.B. 678. The current staffing pattern of the North Carolina Public Utilities Commission was also used to estimate personnel

needs. The cost estimates are based on one conception of what staff needs might be for a rate-review commission in North Carolina. Others might well choose a different staffing pattern. Since the staff would be phased in over the first year of the Commission's operation, the estimates of cost for the first year would be approximately $370,000; in the second year, with the Commission fully operational, the cost would be approximately $600,000. In addition, the transfer of the certificate-of-need function to the Commission would bring on board staff and other costs for which state and federal funds appropriations of $346,000 are already budgeted. With strong presidential and congressional interest in state review programs, it is likely that some Commission's expense would be offset by federal grants.

S.B. 678 also requires that the Commission, in establishing accounting and reporting systems, consider systems already used by the hospitals in order to prevent duplication and unnecessary costs to the public in implementing rate review in North Carolina.

This state's hospital expenditures are more than $1.2 billion per year. Thus for every 1 per cent the Commission could reduce expenditures, $12 million would be saved in North Carolina.

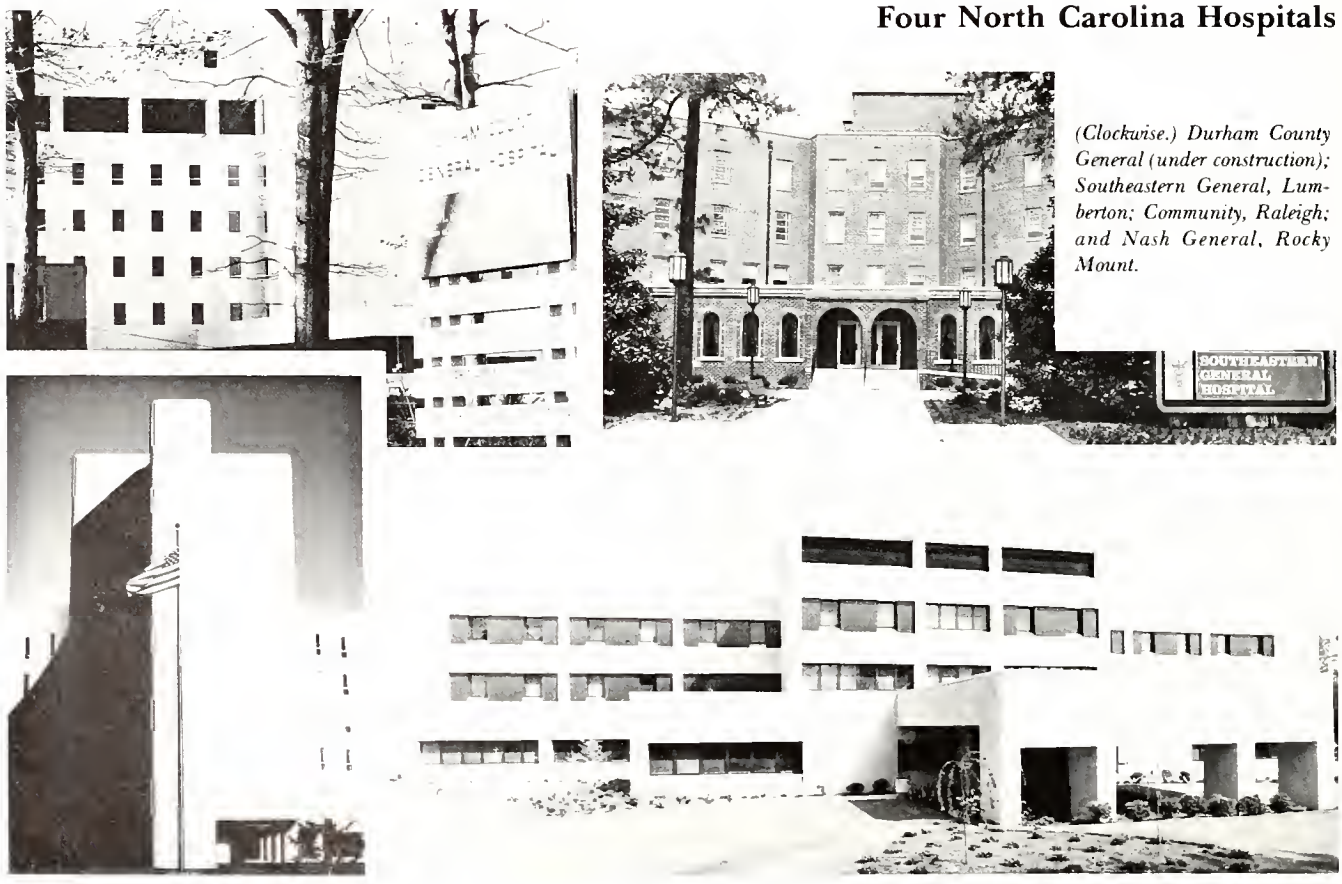
Conclusion

The future of any cost-containment legislation in North Carolina rests on three issues: the effects of the North Carolina Hospital Association's voluntary effort, the fate of proposed legislation before Congress, and the cost of state-supported medical programs—especially Medicaid. These issues, separately or jointly, could compel the General Assembly to pass some form of hospital cost-containment legislation or to reduce services or eligibles in the Medicaid program—as in 1977.

The North Carolina Hospital Association's alternative to the proposed legislation is the Voluntary Effort, a form of self-policing. The success of this program depends on the cooperative efforts of all the hospitals in the state. While there are benefits from this collective action to hospitals as a group (avoiding government rate regulation being the largest), at the level of the individual hospital powerful incentives still exist to increase expenditures. For example, if a hospital's administrator and board of trustees are under strong pressure from the medical staff to add a new service by purchasing a new and expensive piece of equipment, the expenditure probably will be made even if it means exceeding the hospital's voluntary goal. Without a stronger series of incentives for hospitals to meet their voluntary goal and penalties of some sort of those who do not achieve it, the future of the Voluntary Effort is in doubt.

The move to enact hospital cost-containment legislation in North Carolina is a cautious one, but current trends in the cost of health care are forcing the need for action. S.B. 678 offers one alternative to our current rising hospital costs if the Voluntary Effort fails. □

Four North Carolina Hospitals



(Clockwise.) Durham County General (under construction); Southeastern General, Lumberton; Community, Raleigh; and Nash General, Rocky Mount.

Perspectives of a Black City Manager

Richard Knight, Jr.

IN JUNE 1976 Mark Keane, executive director of the International City Management Association, wrote an article that appeared in *Public Management,* the Association's magazine. In that article Keane revealed a dream that he had about the International City Management Association Conference for 1986. He would, he said, "attend meetings with the National Black Caucus of Managers, the National Caucus of Women Managers, and the Democratic Managers' Caucus." In the article he also predicted that future trends and projections for the municipal management profession would yield many more black, female, and Hispanic Americans as managers of cities, counties, and councils of government. He speculated that at least 10 per cent of the ICMA-recognized municipalities would have a minority or female manager by 1986.

As I read Keane's article I hardly suspected that one month later, in July 1976, I would be appointed by the Town of Carrboro as the first black manager of a predominantly white municipality in North Carolina.

Before becoming Carrboro's manager, I was employed by the City of Durham. I had begun my employment as an administrative assistant in Durham's budget and management division, and I also served as the city's investment officer. I then became an administrative assistant to the assistant city manager for community development. My final position was as administrative assistant in the city manager's office. Each Durham position had a twofold effect on my career plans. Working in these various positions gave me the practical experience I needed for my present position, and it also fostered my ambition to become a city or town manager—an ambition (which I realized sooner than I had expected) that I was encouraged to fulfill by Harding Hughes, who was Durham's city manager while I was there.

I find it hard to describe and assess my management experiences in a predominantly white municipality because I have no basis for comparison in managing a predominantly black municipality. Still, I would like to share some of my candid views and experiences since I became Carrboro's manager.

IN MANY WAYS, my management experiences have not varied greatly from those of my white colleagues. We all have mayors and city councils who make policy; we all have staffs of various sizes and complexities to supervise; and we all have citizens who expect the manager to make certain that services are delivered. Moreover, we have the same day-to-day complaints about potholes, waterline leaks, drainage, sanitation pickup, etc. Managers share concern over the same types of issues—federal intervention into local affairs, the lack of revenues to meet citizen needs and demands, competitive wages for employees, etc. And like other workers, managers have family responsibilities to maintain. Balancing family responsibilities with job-related pressures is a delicate task that is compounded by the sizable demands on a manager's time after normal work hours. Managers also have committee and professional meetings, workshops, and seminars to attend or conduct. And then there are always special situations that require the manager's attention—fires, drainage problems, snowstorms, power shortages. Time on the job after work hours is time away from the family.

ISSUES THAT ARE common to the profession have neither escaped me because I am black nor been intensified because of my race. Although management issues may be clear and objective, the potential for discrimination exists because some people make race a primary factor in their everyday interactions. When it is apparent that an employee or citizen is having difficulty separating personal prejudices from the issues at hand, I have found it advantageous to disregard racial slurs or innuendoes.

An example of how personal feelings about race can cloud an issue occurred when I recommended and the town board adopted a bi-weekly payroll system for town employees. One disgruntled employee could not accept the fact that a bi-weekly payroll is more cost-effective than a weekly payroll. To him, the important fact was that the change was made by a black man who had mishandled his authority and thereby verified the employee's stereotyped concept of what a black person is not.

One simply has to let such reactions slide off if one is to do the job well. I try to remember who and what I am, that I have a mission, that I feel good about myself,

The author is the town manager in Carrboro, North Carolina.

and that I can get the job done. I totally discount what I hear about black males feeling insecure in decision-making roles in predominantly white organizations. I can discount it because I have accepted the premise that all men are created equal, and that—once a problem has been defined—the next step is to find the best solution to it. I also realize that it is essential to retain a professional attitude toward the job, to be fair, and to be honest.

By not reacting, or overreacting, to situations that have racial overtones, I have been able to establish good working relationships with the Carrboro town council and with the town staff. Together we have taken some worthwhile steps. We have developed the town's first land-use and public facilities plans and acquired several major federal grants. We have also established performance standards for each department, upgraded salaries and employee benefits, developed a personnel policy, organized a citizen information hotline, begun a housing assistance plan, developed a long-range investment portfolio, lowered the town's fire insurance rating, and accomplished many other things that we are all proud of.

CHANGE OF ANY KIND usually involves a period of adjustment for those who are affected by that change. The Carrboro town staff probably experienced two kinds of reactions when I became manager. First, they felt the natural stress and anxiety that comes with any new command. Second, some employees probably feared that my values and experiences as a black might clash with the values and experiences of the white majority.

The people of Carrboro had some mixed expectations about my arrival as manager. I remember the irate black gentleman who announced to a water department teller that the new manager, who was a black man, would straighten the town out and would see to it that all of the employees in that department were fired.

To dispel any misconceptions or uneasiness that may have existed among town workers, my first official act on my first work day as manager was to call a staff meeting of all department heads. That meeting had two purposes. First, it gave me the opportunity to introduce myself and to meet the various department heads. Second, I announced my professional objectives, the most immediate being to help the department heads carry out their responsibilities. I also emphasized that our roles were mutually supportive and that without cooperation we could not function as a team. Contrary to the irate customer's claim, I said that there would be no immediate changes in current positions.

It is only fair to say that I also needed a period of adjustment in my new position. I too had to adapt to new and more challenging responsibilities as well as to new personalities. As part of my orientation, I toured the town to meet all of the employees in the field, and I visited with the department heads and employees at town hall. These visits gave me the opportunity to observe working conditions, equipment, and styles of field operations and to gain a perspective that was useful later when I began recommending new town procedures and equipment.

RECENTLY I ATTENDED a meeting that discussed "Lack of Role Models for Black and Women Managers in the Public Sector." The implication of that topic and the discussion that followed was that blacks and women must be role models for other blacks and women. Contrary to popular belief and the concern that current black aspirants to careers in public management have about role models, I do not feel that role models must be of either the same race or the same professional field.

In my own personal life I was not exposed to a black city manager to pattern myself after—there were none within my experience—yet I was able to achieve my personal goal of becoming a manager. My role models crossed ethnic and professional lines. I observed the best characteristics of many people—black, white, Indian, doctors, lawyers, teachers, etc. Modeling is not limited to a single profession or person. A good model is a composite of the characteristics of many professions and individuals, and one can certainly identify with that model and emulate standards of excellence regardless of skin pigmentation or profession.

HERE IN CARRBORO, right next door to the University of North Carolina at Chapel Hill, I am often asked by public administration majors and other students about management as a career. These are my views about what faces a person, whether black or white, who is considering a management career.

First, one must be willing to work beyond the eight-hour office day—to sacrifice personal time. Sacrifice and hard work are common to many other professions, but I feel that they are especially intensified for a public official who attends to the needs of taxpayers—many of whom know little about the operations of local government.

Communication skills are essential for a management career. These include the ability to state issues clearly and objectively, to educate citizens about government operation in order to close the gap between realistic and unrealistic demands for services, to compromise when extreme measures are under consideration, to listen, and to synthesize views.

Belief in oneself and one's capabilities is also crucial. As Rudyard Kipling said, "If you think you can, you

will. If you think you can't, you won't. The race is not to the swift or the strong, but to the man who thinks he can."

A manager needs budgeting and personnel experience. A sound budget is crucial to the effective operation of a municipality. Personnel experience is needed not only to motivate the work force but also to empathize with employee needs, demands, and working conditions.

He also needs to be a leader. Leadership ability is crucial to the effective operation of any organization because the leader's style permeates the organization and is often reflected in how other members of the organization carry out their tasks.

Managers should be sensitive to the needs of their community, and black managers should have a special awareness for the particular needs of the community's black citizens. Black people have traditionally viewed city halls as large imposing structures that represent the "system." A black manager should therefore try to include those who have felt left out. But he must also have the courage to say "no" to some of the demands or requests from individuals or interest groups who expect special treatment simply because the manager belongs to their racial group.

As a manager, I have had to recognize that my mandate is not to change things overnight or to right all the wrongs of the past. My mandate is to serve all the people as fairly and objectively as possible. This recognition helps me maintain my own mental and physical stability, and it helps me keep a clear perspective on the total picture—that is, the needs of the whole community. Maintaining this posture has not been easy; tough decisions are never easy. Still, while government cannot *be* all things to all people, government can *listen* to all people.

Needless to say, the final prerequisite for a manager is training in the theoretical aspects of public administration. The best training is that which permits a venture into the theoretical on the basis of a sound practical background.

FOR A BLACK, one fringe benefit of managing a predominantly white municipality is increased visibility. As a result of my new visibility, I find myself serving on a number of boards and committees. This exposure has not only fostered my personal growth but also helped the cause of affirmative action.

For those in need of a role model, I hope that my increased exposure will serve to inspire more blacks to pursue the management profession. For those who find it difficult to judge a person on his worth, I hope my tenure and accomplishments in Carrboro will demonstrate to potential employers that blacks can handle the challenge.

Whatever success I enjoy as a manager, it is important to note that managing a municipality requires the dedicated work of many professionals and paraprofessionals. The staff of Carrboro is to be commended for its efforts in helping to meet the town's objectives.

For the racially aware, let me close with the thought that being black has endowed me with neither any special ability to make decisions for other blacks nor any special ability to make decisions for whites. I am a city manager who happens to be black. I am a representative of Keane's dream and of the gradual realization of the Declaration of Independence—a realization that has been "too fast for some, too slow for others." □

Book Review

GUIDE TO NORTH CAROLINA HISTORICAL HIGHWAY MARKERS (Raleigh: Division of Archives and History, Department of Cultural Resources, 1979. Pp. x, 262). Available from Division of Archives and History, Raleigh, for $2.50 plus $.50 handling and mailing charge. Illustrated with maps and photographs; indexed.

The new edition of the *Guide* (the first in 15 years) sets out the texts of over 1,200 regular and special highway historical markers placed throughout the state as a part of a program begun in 1936 by the agency now known as the Division of Archives and History. The volume is conveniently indexed by subject and also by county.—*JLS*

The Soundness of Public Retirement Systems

How Does North Carolina Compare?

W. Michael Smith

CONCERN OVER STATE and local government employee pension plans—by public managers and employees, elected officials, private-sector financial institutions, and the taxpaying public—has increased significantly over the past ten years. (Senator Thomas Eagleton once described the public pension system in the United States as a "financial time bomb.")[1] The tremendous growth of state and local government employment during the prosperous sixties and early seventies and the economic difficulties of the mid- and late seventies have intensified interest in the pension situation.

In a document issued in March 1978 and authorized by the Employee Retirement Income Security Act of 1974 (ERISA), the Subcommittee on Labor Standards of the House Committee on Education and Labor reported that insufficient statutory and regulatory controls exist for public pension systems and concluded that most of the state and local government pension systems that were studied fail to protect the government and the interests of participants and beneficiaries adequately.[2]

This article will briefly discuss the problems disclosed by the congressional report, describe the benefits and financing of the major retirement systems administered by the State of North Carolina, and compare these North Carolina systems with state and local systems elsewhere.

The author is Director of Administration for the City of Asheville, North Carolina.

1. William N. Thompson, "Public Pension Plans: The Need for Scrutiny and Control," *Public Personnel Management* (July-August, 1977), 204.

2. House of Representatives, Committee on Education and Labor, *Pension Task Force Report on Public Employee Retirement Systems* (Washington, D.C.: U.S. Government Printing Office, March 15, 1978).

Congressional findings

The Labor Standards Subcommittee's Pension Task Force Report studied 6,630 state and local government pension systems that were in operation in 1975, and it covered 12.7 million active and retired employees. The report made the following general conclusions:

1. These pension systems have a substantial impact on the social, economic, and political fabric of the United States. At the same time, so little of the nature and scope of their operations is known or understood by plan members, government officials, and taxpayers that there is not uniform or adequate regulation and control of these systems. Generally, then, the inherent vital public interests are not protected.

2. Because of serious deficiencies in the disclosure of pension system operating information and the lack of uniform external auditing standards, the potential for abuse is great.

3. The level and provisions of benefits in state and local government pension systems compare very favorably with those of private-sector pension systems. But other plan provisions—such as vesting (the participant's right to employee and employer contributions), payment of low interest rates on returned employee contributions, protection against forfeiture of the employer-financed portion of vested benefits, and restrictive "break-in-service" rules—fail to meet minimum ERISA standards established for private-sector pension systems.

4. Funding provisions in pension plans operated by state and local governments are generally inadequate. While substantial reserves have been accumulated in the system as a whole, 17 per cent of the plans still are funded on a pay-as-you-go basis. Pay-as-you-go funding, simply defined, involves paying pension benefits to present retirees out of current operating revenues. In other words, reserves are not set aside during an employee's working years to pay his pension benefits after he retires. Moreover, many systems that are funded with reserves set aside ahead of time to make future benefit payments are operated with unrealistic actuarial assumptions and standards.

Another funding problem that exists in state and local government systems is employers' use of revenues that lack stability and predictability to pay benefits—such as allocations from state insurance premium taxes, federal revenue-sharing funds, and other limited special tax levies. Good actuarial practice dictates a rational relationship between the sources and level of revenues and the funding needs of the plan.

5. Administration and fiduciary responsibility in state and local government pension systems are frequently inadequate. Administration of such plans was found to be without proper statutory guidance and without clear-cut allocation of fiduciary responsibil-

ity. This situation has resulted in favoritism and abuse in determining benefits, in failure to disclose vital information to plan participants and the public, in Internal Revenue Code violations, and in plan insolvencies. In addition, the Report found widespread inappropriate investment practices that ranged from investment of nontaxable pension funds in low-yielding, nontaxable state and local government securities to overly restrictive plan provisions that limited investment yield.

The problems and overviews of state and local government pension systems have been echoed in earlier public and private studies of public employee retirement systems. The problems persist—and apparently grow worse—emphasizing the need for an increased understanding of the retirement systems by plan participants, public officials, and taxpayers.

North Carolina's systems

In North Carolina most state and local government employees are members of one of the seven retirement systems operated by the state. State employees and employees of the public education system are members of the Teachers' and State Employees' Retirement System (the State System). The state administers three retirement systems for employees of the towns, cities, counties, and other local jurisdictions in North Carolina: the Local Governmental Employees' Retirement System (Local System), the Law Enforcement Officers' Benefit and Retirement Fund (LEO), and the Firemen's Pension Fund (Firemen's Fund). The Department of State Treasurer operates three smaller retirement systems for judges, district attorneys, and clerks of court. Table 1 shows the membership and financial assets of these systems.

Of the state-operated pension systems for local government employees, the Local System is the most significant and encompassing. On December 31, 1978, 199 cities and towns, 90 counties, and 243 local public health and social service agencies, ABC Boards, library systems, and other miscellaneous local governmental jurisdictions were participating units. The only major units of local government that did not participate fully were Asheville and Wilmington, both of which plan greater or full participation in the future.

The oldest state-sponsored system is LEO, which began operations in 1940. The State System came next in 1941, followed by the Local System in 1945. The court employees' retirement plans were established in 1974 and 1975.

All but two of these retirement systems are governed by the same board of trustees, consisting of the State Treasurer (chairman), the Superintendent of Public Instruction, one state representative appointed by the Speaker of the House of Representatives, one state senator appointed by the President of the Senate, and ten members appointed by the Governor. (For the Local System, two local government representatives appointed by the Governor are added to the Board alongside the regular fourteen members.) LEO is governed by a ten-member board of commissioners. The Firemen's Fund is governed by a board of trustees composed of the State Auditor, the Insurance Commissioner, and three other members appointed by the Governor.

All state-operated pension systems except the Firemen's Fund are administered by the State Treasurer's Office. The Firemen's Fund is administered by the State Auditor.

A comparison

Pension systems are often thought of in terms of the benefits they provide and how they are financed. This article will discuss and compare these two aspects of North Carolina's public employee pension systems with the findings of the 1978 congressional study and earlier studies of state and local government retirement systems.

Benefits. All of the North Carolina systems are *defined-benefit* plans. That is, the retirement benefit is established in advance by a formula, and the employer's contributions are treated as the variable when costs are determined. In a typical defined-benefit plan, the employee's length of service, his annual salary, and a set percentage factor are used in a predetermined formula to compute his annual retirement benefit. He is promised this annual benefit after retirement regardless of the amount of his contributions or his employer's contributions or the investment earnings on these contributions. In contrast, in a *defined-contribution* plan, his retirement benefit would be determined by the amount of contributions made by him and his employer and the interest earned by investing these contributions.

Table 1

Membership and Financial Assets of the State and Local Employees' Retirement Systems

System	Number of Participants[1] Active	Retired	Total	Total Assets[2] (Millions)
Teachers' and State Employees' System	224,004	32,173	256,177	$2,622.8
Local Government Employees' System	56,193	5,696	61,889	395.1
Law Enforcement Officers' System	8,151	805	8,956	142.3
Judges' and Court Administrators' System	197	75	272	5.9
District Attorneys' System	37	4	41	.9
Superior Court Clerks' System	101	9	110	1.7
Firemen's Pension Fund	7,909	1,768	9,677	13.4
Totals	296,592	40,530	337,122	$3,182.1

1. Participant figures for all systems except the Firemen's Pension Fund are as of December 31, 1978. Participant figures for the Firemen's Pension Fund are for June 30, 1978.

2. Total assets are as of December 31, 1977, for all systems but the Firemen's Pension Fund, which are for June 30, 1978.

Source: "The Administrator's Report on the Public Employees Retirement System of North Carolina," North Carolina Department of State Treasurer, January 1, 1979.

In a defined-benefit plan, the benefit amount may be expressed as a fixed dollar amount (as in the Firemen's Fund) or as a function of wages (total or average), years of service, and a fixed multiplier. The six plans administered by the Treasurer's Department use this latter type of benefit formula.

In their 1976 study of state and local government pension systems, Greenough and King reported that 90 per cent of the plans studied used the defined-benefit approach. They found that the typical formula used (as the six major North Carolina systems do) three basic elements: a percentage factor, a salary factor, and a service factor.[3]

The typical plan in the Greenough and King study used a single percentage factor, most frequently 1.5 per cent, for computing normal or service-related retirement benefits.[4] Robert Tilove found in another 1976 study of state and local pension systems that the median percentage factor used in determining benefits of public employees was between 1.6 and 2.0 per cent for plans not integrated with Social Security and 1.25 per cent for integrated plans.[5] (Integration with Social Security means that the total amount of pension benefits is a combination of benefits from Social Security and from the employee's pension system, the system's payments equaling the difference between the amount from Social Security and the total benefit.) In contrast, a Bankers' Trust Company survey in 1970 found the average benefit accrual rate to be 1.25 per cent for nonintegrated private-sector plans.[6]

The North Carolina pension systems are not integrated with Social Security and use the percentage factors shown in Table 2.

The North Carolina pension systems, again excepting the Firemen's Fund flat-rate formula, use two salary factors. The three small retirement plans covering court system employees base the salary factor on the final compensation; that is, the annual equivalent of the rate of pay the employee received just before retirement. It is interesting to note that North Carolina judges retire on August 1 rather than July 1, so that pay increases granted at the beginning of the state's new fiscal year are reflected in their retirement benefits. The salary factor in the three largest systems' (the State System, the Local System, and LEO) benefit formula is the average compensation in the four consecutive years of service in the system that produce the highest average.

Table 2

Percentage Factors in the North Carolina Pension Systems

System	Percentage Factor[1]
Teachers and State Employees	1.55%
Local Governmental Employees	1.55
Law Enforcement Officers	1.55
Judges	
District court judges	3.00
Superior court judges and administrative officers of the courts	3.50
Appellate judges	4.00
District Attorneys	3.00
Clerks of Superior Court	3.00

1. Percentages as of December 31, 1978. The Firemen's Fund uses a flat-rate formula and not a percentage factor for calculating retirement benefits.

Greenough and King found that the salary factor most frequently used in state and local government retirement plans is the final-average type. Typical formulas used the highest three to five or final three to five years to compute the average. Tilove reported that 75 per cent of the systems he studied used a final-average salary factor of five years or less. The shorter the period used to compute the salary factor, the greater the opportunity for abuse. For instance, an employee may be granted a much larger than normal salary increase in his final year or two so that his retirement benefit is increased, or he may be given large amounts of overtime that will greatly increase his final salary when compared with his actual normal rate of pay, thereby increasing his retirement benefit. Both the Bankers' Trust Study and a 1969 U.S. Department of Labor report on private-sector pension plans found that private plans are much less likely to use a final average salary factor than public plans. Private plans usually use a *career* average, which produces a benefit level that is 30 per cent or more lower than a final-average salary factor.[7]

The service factor in the basic benefit formula used by the larger state systems is the total years of creditable service, which corresponds to the findings on typical plans in both the Greenough and King and the Tilove studies as well as in the congressional Pension Task Force Report. The only exceptions noted in these studies were a small number of plans that place a maximum on the years of service that would be credited for normal or service-related retirement.

Several other factors relating to the benefit provisions of the three major state retirement systems may also be compared with typical provisions in other state and local government pension systems.

Retirement age. The State System and the Local System provide for a normal retirement age of 65. LEO allows normal retirement with full benefits at age 55 without any minimum service requirement. However, retirement with unreduced benefits is also permitted in all three systems at any age after 30 years of service. Because of this provision, many employees retire from these systems much earlier than age 65, thereby lowering the average retirement age. This is also happening in other state and local government retirement systems. Tilove found that 70 per cent of the plans he studied had an effective normal retirement age under 65. The Pension Task Force Report observed that many large state and municipal retirement systems for general employees have virtually the same provisions as the North Carolina systems for full benefits at any age after 30 years of active service and that pension systems operated for police and fire employees often have more liberal provisions, such as full benefits at any age after 20 to 25 years of service.

3. William C. Greenough and Francis P. King, *Pension Plans and Public Policy* (New York City: Columbia University Press, 1976), p. 6.

4. *Ibid.*

5. Robert Tilove, *Public Employee Pension Funds* (New York City: Columbia University Press, 1976), pp. 11-12.

6. Bankers' Trust Company, *Bankers' Trust 1970 Survey of Employee Savings and Thrift Plans* (New York: 1972).

7. Harry E. Davis and Arnold Strasser, "Private Pension Plans, 1960-69—An Overview," *Monthly Labor Review* (July, 1970), 50.

Early retirement benefits. The movement to allow public employees to take reduced benefits before the date that they would be eligible for normal full retirement benefits has been identified in a number of recent studies. Tilove found that 80 per cent of the plans he studied in 1972 had early-retirement provisions, compared with 40 per cent in an earlier study.[8] The 1970 study found that early-retirement provisions were more prevalent in private-sector plans—87 per cent of the industrial plans included in this survey had early-retirement provisions.

The earliest age at which employees in the North Carolina State System and the Local System can retire with reduced benefits is 50 after 20 years of creditable service. Participants in LEO may retire with reduced benefits at age 50 with 15 years of service.

Disability retirement benefits. The State System and the Local System provide benefits to members with five or more years of service who are found to be totally disabled. The benefit is calculated the same as for a normal retirement, using the average compensation before the disability and the number of years of service the disabled employee would have had if he/she had worked until age 65. No distinction is made between service- and nonservice-connected disabilities, and no reduction is made in the benefit for disability benefits received from other sources, such as Workmen's Compensation or Social Security.

LEO does distinguish between duty- and nonduty-related disability in establishing minimum service requirements in regard to eligibility for benefits. The requirements are one year of creditable service for disability that results from line-of-duty service and ten years for disability that occurs off the job.

The Pension Task Force Study found that typical plans for large state and municipal retirement systems for general employees had provisions for both service- and nonservice-connected total disability. Nearly all public plans had provisions for service-connected total disability. This study reported that half of all large state and municipal general employee plans reduce disability benefits by at least a portion of Social Security or Workmen's Compensation benefits.

Tilove found that eligibility for disability pension was generally set forth in terms of minimum service requirements: most frequent requirement, ten years; next, five years. He also reported that disability benefit formulas are related to the normal retirement benefit formula in 80 per cent of the state and local plans he surveyed. About one-third of the plans in his report had specific provisions for service-connected disabilities, and most of them made offsets for Workmen's Compensation or Social Security benefits.

The disability provisions of the North Carolina systems are, on the average, more generous than those of other state and local government and private-sector plans. Eligibility standards for qualifying for disability benefits are also less strict in the North Carolina pension systems than in most other states' public systems.

Postretirement benefit adjustment. Because of rapidly rising prices in recent years, provisions for adjusting retirees' benefits have been made in many state and local government pension systems. The Pension Task Force Study found that over 90 per cent of the employees covered by the surveyed plans had "cost-of-living" adjustment provisions. The adjustments may be unlimited, ad hoc (adjusted from time to time after special consideration by a retirement board, legislature, or other official body), or limited by a constant percentage or some function of the actual cost of living as reflected in the U.S. Department of Labor's monthly Consumer Price Index (CPI). Tilove found in his study that about half the employees of state and local plans are covered by automatic postretirement adjustment benefits.

Beginning in 1970, the three major state systems began annual increases in the retirement allowances of retired members whenever the CPI exceeds the previous year's by more than 1 per cent. The adjustments are statutorily limited to 4 per cent, but the General Assembly has made an additional ad hoc permanent adjustment of up to a total of 8 per cent in recent years.

Financing and fiscal soundness. On the other side of the retirement-plan coin from benefits is the cost of providing the benefits—or in pension jargon, funding the plan liabilities. The liabilities that must be covered are retirement benefits that are currently being paid, benefits promised to active employees, and benefits that will be promised to workers not yet employed. Funding for these liabilities is becoming a major concern for state and local governments, and it is claiming a greater share of these governments' financial resources. The 1978 Pension Task Force Report found that in 1975 the total annual benefit payments made by the 6,630 state and local government pension systems totaled nearly $7.3 billion. In the same year, the North Carolina systems disbursed over $85 million in retirement benefits.

To pay for these liabilities, pension plans engage in a variety of financing tactics. The most direct approach is for the employer to meet the obligations with current operating revenue—the "pay-as-you-go" method. Pay-as-you-go funding is held in wide disrepute among pension-plan experts, although a surprising number of public plans—including all federal plans—still use it wholly or partially. As previously cited, the Pension Task Force Report found that 17 per cent of state and local government plans still operate on a pay-as-you-go basis. The primary drawback in this type of pension financing is the tendency of growing benefits payments to absorb ever-increasing amounts of operating revenues as the plan and its participants mature. For example, in two unfunded pension systems operated for policemen and firemen by the City of Asheville, the annual outlay for pensions grew from $32,000 in 1950 to $250,000 in 1974 and was projected to increase to $2.1 million per year before stabilizing.[9] These plans ceased operation on a pay-as-you-go basis in 1977.

Another disadvantage to pay-as-you-go funding is that it provides little or no assurance that future benefits obligations will be met. The future obligations are created as employees work today, but since reserves are not set aside to match the obligations, payment depends on the availability of operating revenue when the obligations come due

8. Tilove, *Public Pension Funds*, pp. 32-36.

9. H. Gray Hutchison and Associates, "Actuarial Study, Analysis and Recommendations: Retirement and Group Insurance Benefits, City of Asheville" (Raleigh, N.C.: January 14, 1975).

and benefits must be paid. The availability of future funding for pay-as-you-go plans will depend in part on the willingness of citizens to tax themselves to pay the benefits.

A third disadvantage of pay-as-you-go plans is that present employees' contributions to the retirement system are used not to finance their future retirement benefits but to pay pension benefits for current retirees.[10]

The other broad system for funding pension plans is the "advance" or "reserve" method. Any funding scheme in which the contribution level is above the current requirement for benefit disbursement constitutes advance or reserve funding.[11] This approach sets out to avoid the problems inherent in pay-as-you-go funding by accumulating and investing the excess contributions and earning interest on them.

The most popular and by far the most widely used type of advance funding is "actuarial" funding. The Pension Task Force Report found that about two-thirds of all state (including North Carolina's) and half of all local retirement systems use actuarial funding methods.

Actuarial funding is based on the use of statistical calculations and assumptions about the future to compare the assets on hand plus contributions to be made in the future with anticipated benefit payments in order to determine whether the advance funding scheme is adequate. A large part of actuarial funding concerns determining the extent to which past service costs have been reduced by amortization. Past service costs are defined as contributions to a pension system that are required because of retroactive increases in benefits that are due to present employees for past years of work. A fully funded plan is one in which all past service costs have been paid for and only normal costs are met currently, so that each active employee's pension is paid for by the time he retires.[12] Normal costs are the annual contributions to a pension system for benefits that accrue to active employees for their service or work that year. A pension plan that has a ratio of present assets to anticipated benefit payments equal to 1.0 (or 100 per cent) is said to be "fully funded."

The 1978 Pension Task Force Survey found that the mean and median ratio of assets to anticipated benefit payments or accrued liabilities in the state and local plans was 51 per cent. For the largest 25 state and local systems surveyed, the mean and median ratios were both 58 per cent. As of December 31, 1977, this ratio for the North Carolina Teachers' and State Employees' Retirement System was 72 per cent; the Local Governmental Employees' Retirement System, 84 per cent; and the Local Enforcement Officers' Benefit and Retirement Fund, 90 per cent.[13]

The Task Force deemed assets-to-accrued-liability ratios of 40 to 50 per cent or more to be adequate and ratios of 70 per cent or more "above average." However, when comparing the assets-to-accrued-liability ratios of different retirement systems, one must be aware that this measure can vary greatly from system to system because the systems' actuarial assumptions and funding methods differ. In other words, a high ratio does not always indicate above-average or even adequate funding. The North Carolina systems use conservative actuarial assumptions and acceptable funding methods, so that the ratios shown above are reliable indicators of the funding condition of our retirement systems. Furthermore, these ratios have been improving. In the State System the assets-to-accrued-liability ratio rose from 69 per cent in 1975 to 72 per cent in 1977, and in the Local System it went from 81 per cent in 1975 to 84 per cent in 1977.[14]

Another frequently used measure of funding adequacy is the ratio of current plan assets—assets already on hand—to the total current annual benefit payments. If a plan's assets-to-benefit-payment ratio (ABPR) is at least 15 to 1, the plan is generally thought to have adequate funding. The Pension Task Force reported that a third of all state and local pension systems fail to meet this test.

In 1977 North Carolina's State System had an ABPR of 23:1, the Local System, 35:1, and LEO, 47:1. Comparisons made from the Task Force Report indicate that nearly half the plans surveyed had ABPRs of less than 20:1, and two-thirds had ABPRs of less than 35:1. A 1976 report by John Nuveen and Company found that the average ABPR was 18:1 for state plans and 12:1 for major city plans. Nuveen concluded that an ABPR of less than 18 may indicate "an unrealistic rate of funding."

In an actuarially funded plan, all employer and employee contributions that are made to pay for the employee's retirement benefits will be completed during his active work career. Since no disbursements from these contributions will be made until the employee retires, these funds are not needed right away and may be invested. Investment earnings are very important in making adequate pension benefits available at moderately low contribution rates. If no interest earnings are realized in an actuarially funded pension plan, the ratio of contributions to anticipated benefits must be 1:1. However, assuming an average investment yield of only 3.5 per cent, the contributions will double in value over a twenty-year period.[15] In a fully funded plan, a difference in one percentage point in investment yield may reduce the amount of contribution that an employer must make each year by 15 to 20 per cent.[16]

Managers of public pension funds have traditionally purchased the most conservative and secure fixed-interest obligations of private corporations and governmental agencies and then held them in the fund's portfolio to maturity. This practice has held down investment yields in the state and local government retirement systems. Today many such systems are becoming interested in maximizing investment income in the face of inflation and greatly increased demands for employer contributions to pension funds.

A benchmark that compares the investment performance of pension plans is the extent to which investment

10. Tilove, *Public Pension Funds,* pp. 135-36.

11. Hamilton and Bronson, *Pensions,* p. 105.

12. Thomas P. Bleakney, *Retirement Systems for Public Employees* (Homewood, Illinois: Richard P. Irwin, Inc., 1972), p. 120.

13. North Carolina Department of State Treasurer, *The Administrator's Report on the Public Retirement Systems of North Carolina* (Raleigh, N.C.: January 1, 1979), pp. 12-13.

14. *Ibid.*

15. Bleakney, *Retirement Systems,* pp. 132-33.

16. Tilove, *Public Pension Funds,* p. 203.

earnings cover annual benefit payments. The Nuveen report found that the average percentage of benefit payments covered by investments was 90 per cent for state plans and 59 per cent for major city plans. In 1977, comparable percentages for the three major North Carolina retirement systems were 141 per cent for the State System, 202 per cent for the Local System, and 383 per cent for LEO.

Finally, the financial condition of a retirement system, and ultimately the security of the participants, rests on the employer's ability and willingness to pay. This is especially true of public plans. In view of recent taxpayers revolts, less than adequately funded state and local retirement systems raise the specter of unmet obligations. Therefore a test often used to measure the extent of state and local government outlays for pension systems is the ratio of retirement contributions to expenditures for salaries. Since salaries are a significant expense for all such employers, they represent an excellent basis for comparing costs among retirement systems.

The 1976 Nuveen study found that the national average employer contribution for state plans was 12 per cent of salaries. For major city plans, the rate was 17 per cent. The Pension Task Force reported the national average employer contribution for large state and local government plans was 16 per cent of payroll. This contrasted with an average private-sector employer contribution of 6 per cent of salaries reported in 1975 by the U.S. Chamber of Commerce.[17]

In North Carolina the employer contribution rate in 1978 for the State System was 9.12 per cent and typically 7 per cent for the Local System. The employer contribution rate for the Law Enforcement Officer's Benefit and Retirement Fund is fixed at 4.84 per cent of payroll.

Conclusions

The provision of a retirement plan for employees and their survivors by a public employer is an extension of the employment relationship. This relationship can last a long time. Some workers will be employed at age 20 and may receive retirement benefits until they reach 80 or more. The costs of establishing and operating a retirement plan are growing, and the operation of public pension systems in other states is emerging as a potential financial disaster for their members, for sponsoring jurisdictions, and for the taxpaying public.

When viewed in the aggregate, state and local government pension systems provide greater benefits than most private pension plans. The use of benefit formulas based on final salary, effective retirement ages that are lower than 65, automatic adjustments in postretirement benefits, and liberal disability provisions all mark state and local pension systems as very generous. This generosity also stems from the fact that few plans have their benefit structures integrated with Social Security benefits. Paying retirement system benefits without regard to benefits from Social Security often produces disposable retirement income greater than disposable income earned just before retirement. The possible future impact of such liberal benefits on taxpayers is made more precarious by pay-as-you-go funding and serious underfunding practices. One chief obstacle to any reform is the unknown or undisclosed extent of the financial burden already promised to future retirees of state and local governments.

Formulation of state and local government pension policy is often marked by unsystematic and uninformed actions. Perhaps the most disturbing aspect of this process is the disproportionate influence that state and local government employees have had on the laws that affect their own retirement systems. Another problem is the divided responsibility and authority between state and local governments, which can result in the legislation of pension system benefits by one level of government and payment of costs by another level.

Fortunately the development and operation of the retirement system for state and local government employees in North Carolina has been marked historically by legislative and administrative responsibility and sound financial management. However, some recent developments give cause for concern. Among these are:

1. The 1979 General Assembly accepted a recommendation by the Teachers' and State Employees' Retirement System's board of trustees to award 5 per cent postretirement adjustment to retired members. However, the General Assembly funded only 4 per cent of this increase (by actuarial gains), but provided no General Fund appropriation to cover the additional 1 per cent, thereby increasing the present value of accrued liabilities by $13 million.

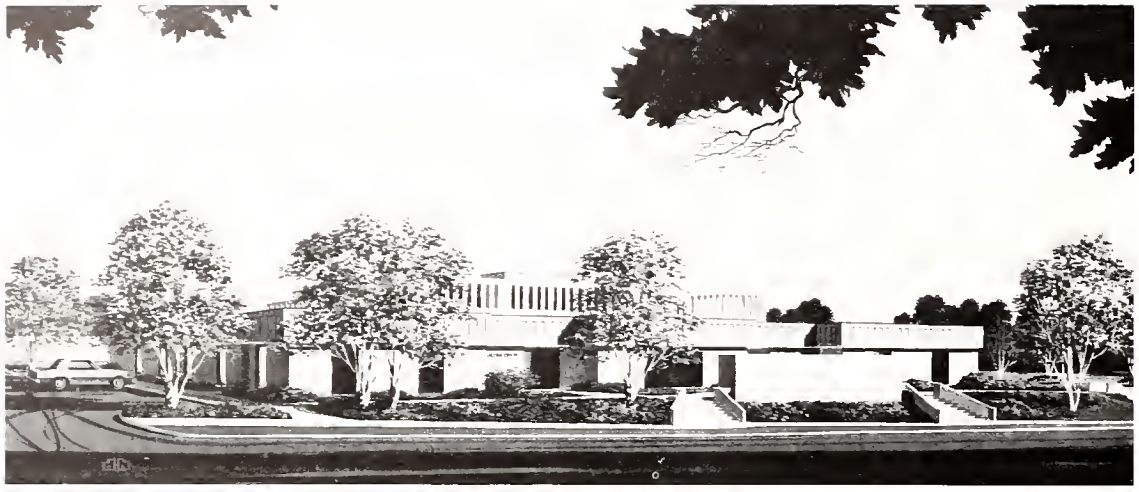
2. A strong effort was made in the 1979 General Assembly to adopt an increase in pension benefits in the State System via the "rule of 85" (allowing retirement at any age so long as age and years of service totaled 85) with no increase in employer contributions. If adopted, this action would have increased the present value of the system's accrued liabilities by $45 million.

3. Over 80 other bills were introduced in the 1979 General Assembly that would have affected the North Carolina pension systems. Many of these bills were introduced to benefit a single or small group of participants; had they been adopted, considerable cost increases would have resulted. A number of these bills have been carried over to the 1980 short session.

4. Although for the first time all bills dealing with the North Carolina systems in the General Assembly were accompanied by an actuarial note divulging the cost of the proposed action, the General Assembly seemed to pursue the legislation without realistic regard for the cost contained in the notes.

These remarks are not meant to criticize proposed change in the North Carolina pension systems; rather, they are intended to encourage retirement system members, public officials, and taxpayers to insist that the same sound principles of administrative and financial management and benefits development that have brought the North Carolina pension systems to their present position of strength be maintained and continued. Only in this way can North Carolina avoid the ills besetting other state and local government pension systems across the country and still maintain that delicate balance between a fair, competitive system of benefits and an acceptable, reasonable cost to the taxpayer. □

17. Chamber of Commerce of the United States of America, *Employee Benefits. 1975* (Washington, D.C.: U.S. Chamber of Commerce, 1976).



The Albert Coates Local Government Center

IN LATE SEPTEMBER the League of Municipalities and the Association of County Commissioners dedicated their new office building in Raleigh—the Albert Coates Local Government Center.

Governor James B. Hunt, Jr., speaking at the dedication, summarized the occasion: the realization of a plan by the League of Municipalities and the Association of County Commissioners to acquire an office building that would permit them to serve the people of North Carolina more efficiently. The Governor also said that it was an opportunity for these organizations to express appreciation to Albert Coates, the founder of the Institute of Government at Chapel Hill.

The groundwork for the Coates Local Government Center, at the corner of Lane and Dawson Streets, was begun in 1972 when the League and the Association agreed jointly to acquire a Raleigh site. In 1975 the two groups found a suitable location and held a groundbreaking ceremony in 1978.

The $1.9 million center, which is free of debt, includes meeting and conference rooms and a multipurpose auditorium with adjoining catering facilities, visitor lounges with conference and telephone facilities, and 90 off-street parking spaces. The building contains 25,000 square feet and was financed by voluntary contributions from the state's 100 counties and 432 municipalities.

League President Jim Melvin, Mayor of Greensboro, and County Association President, Albert McMillan, Scotland County Commissioner, received ceremonial keys to the center shortly before Governor Hunt and Professor Coates cut the ribbon on dedication day, September 22.

Albert Coates paid particular tribute to his wife at the dedication and to the other men and women who worked with him from the early beginnings through the growth of the Institute.

At the League and Association dinner the night before, Professor Coates said, in part:

> What the Joseph Palmer Knapp Building has meant to the working staff of the Institute of Government of the University of North Carolina at Chapel Hill, and what the Legislative Building in Raleigh has meant to the working Representatives of the people of North Carolina in the General Assembly—
>
> This is what this Local Government Center you will dedicate tomorrow morning will mean to the working staffs of the North Carolina Association of County Commissioners, and the North Carolina League of Municipalities: in the increased effectiveness of their work with local, state, and federal officials in general, and with the General Assembly of North Carolina in particular.

—PMD

Plea Bargaining in the Open: The Supreme Court Sets the Limits

L. Poindexter Watts

PLEAS OF GUILTY account for an estimated 90 per cent of all criminal convictions secured in this country.[1] Undoubtedly many of the defendants enter their pleas because they are guilty and do not wish to prolong the criminal process,[2] but many other defendants or their attorneys negotiate to secure concessions as to the charge[3] or the sentence[4] in return for entering their guilty pleas.[5] While a few of those who engage in these negotiations dislike the term,[6] the process is commonly known as "plea bargaining."[7]

Although some form of plea bargaining has certainly been used in handling criminal cases ever since a public prosecutor became primarily responsible for trying criminal cases,[8] the traditional view has been that the discretionary "administrative" handling of cases by officials was an abuse and that the ideal method was an open, judicious procedure.[9] In the 1960s, however, a number of commentators began to challenge this traditional view and to accept administrative disposition as an inevitable part of any criminal justice system designed to cope with large numbers of cases.[10] The emphasis of reform was to

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1. D. NEWMAN, CONVICTION: THE DETERMINATION OF GUILT OR INNOCENCE WITHOUT TRIAL 3 (1966) [hereafter cited as NEWMAN].

2. *Cf.* T. REIK, COMPULSION TO CONFESS: ON THE PSYCHOANALYSIS OF CRIME AND PUNISHMENT (1959).

3. The prosecutor has almost complete discretion to dismiss or reduce charges; even in jurisdiction where the judge has a formal check on this power, it is likely to become a formality except in unusual cases. R. MOLEY, POLITICS AND CRIMINAL PROSECUTION 154 (1929) [hereafter cited as MOLEY]. In recognition of this fact, North Carolina's revised criminal procedure, which took effect in 1975, placed the dismissal power solely in the prosecutor. N.C. GEN. STAT. § 15A-931.

4. Sentence bargaining may or may not involve the judge. The three possibilities are: (1) some degree of active participation by the judge in negotiating the plea; (2) tentative ratification by the judge of a sentence bargain struck by the prosecution and the defense, before the plea is entered, subject to the judge's power to change his mind if he discovers additional facts that warrant imposition of a different sentence; and (3) total refusal by the judge to commit himself. Even in the third instance, however, many judges will give substantial weight to a sentence recommendation that a prosecutor is willing to make in open court, and bargaining for a *recommendation* as to sentence does occur. See Bond, *Plea Bargaining in North Carolina*, 54 N.C. L. REV. 823, 824-30 (1976) [hereafter cited as Bond]. *See also* Alschuler, *The Trial Judge's Role in Plea Bargaining*, Part 1, 76 COLUM. L. REV. 1059 (1976) [hereafter cited as *Judge's Role*].

5. Major incentives for the prosecutor or judge to enter into plea bargaining are the desire to expedite cases and to achieve certainty of result. This article will treat pleas of no contest or nolo contendere (see N.C. GEN. STAT. § 15A-1011) as if they were guilty pleas. For purposes of criminal punishment they are in fact the same, and the only differences arise as to collateral civil consequences.

6. AMERICAN BAR ASSOCIATION PROJECT ON STANDARDS FOR CRIMINAL JUSTICE, STANDARDS RELATING TO PLEAS OF GUILTY, Commentary to § 3.1, at 61 (Approved Draft 1968) [hereafter cited as ABA STANDARDS, PLEAS OF GUILTY (1968)]. The current American Bar Association Standards as to pleas of guilty were adopted February 12, 1979; at publication time the latest text available, which has been adopted without change, was in AMERICAN BAR ASSOCIATION STANDARDS RELATING TO THE ADMINISTRATION OF CRIMINAL JUSTICE, CHAPTER 14, PLEAS OF GUILTY (2d ed. tentative draft 1978) [hereafter cited as ABA CRIMINAL JUSTICE STANDARDS, CHAPTER 14; references to section numbers in Chapter 14 will utilize "14" plus a hyphen before the section number].

7. Formal references almost always use some other terminology. *See* ABA CRIMINAL JUSTICE STANDARDS, *supra* note 6, Standard 14-3.1 ("plea discussions and plea agreements"); N.C. GEN. STAT. § 15A-1021 ("plea conference"; "plea arrangement").

8. *See* NATIONAL COMMISSION ON LAW OBSERVANCE AND ENFORCEMENT, REPORT ON PROSECUTION 5-6 (1931) [hereafter cited as REPORT ON PROSECUTION].

9. Alschuler, *The Prosecutor's Role in Plea Bargaining*, 36 U. CHI. L. REV. 50 (1968) [hereafter cited as *The Prosecutor's Role*]: "During most of the history of the common law, pleas of guilty were actively discouraged by English and American courts. For centuries, litigation was thought 'the safest test of justice.' " *But see*, C. SILBERMAN, CRIMINAL VIOLENCE, CRIMINAL JUSTICE 279 (1978): "If plea bargaining is a fall from grace, the fall occurred over a century ago."

10. *E.g.*, NEWMAN, *supra* note 1; Packer, *Two Models of the Criminal Process*, 113 U. PA. L. REV. 1 (1964). Compare Note, *Plea Bargaining and the Transformation of the Criminal Process*, 90 HARV. L. REV. 564 (1977). But for a statement that administrative handling of routine cases has long been a practical reality, see REPORT ON PROSECUTION, *supra* note 8, at 4. *See also* MOLEY, *supra* note 3, at 149-92.

take discretionary decisions out of the back room, to make them legitimate, and to provide honest and rational guidelines for exercising the discretion.[11] A companion goal was to make plea bargaining equally available to similarly situated defendants.[12]

From the welter of reform proposals in the 1960s and early 1970s dealing with criminal justice, almost all specifically addressed the matter of plea bargaining.[13] Despite some dissenting voices,[14] the momentum was clearly with those who would bring plea bargaining into the open. In 1973 North Carolina's Criminal Code Commission recommended a statutory recognition of plea bargaining, and its proposal, with some modification, was enacted as part of the code of pretrial criminal procedure that took effect September 1, 1975.[15]

During this period of ferment, a number of cases involving the validity of guilty pleas or plea bargains reached the United States Supreme Court, and the Court played its part in legitimating open plea bargaining.[16] A 1978 case, *Bordenkircher v. Hayes*,[17] gave prosecutors great leeway in striking plea bargains, and left few doubts as to the legality of the practice. Nor is there much doubt that the safeguards[18] placed around new-style plea bargaining make it a much more rational and desirable process than it was.

The emphasis of reform was to take discretionary decisions out of the back room, to make them legitimate, and to provide honest and rational guidelines for exercising the discretion. A companion goal was to make plea bargaining equally available to similarly situated defendants.

Paradoxically, as plea bargaining has gained legal respectability, it has come under increasingly sharp public attack. Although one can marshal a number of solid reasons for opposing the practice, and one professor has made his reputation by a series of thoughtful articles critical of plea bargaining,[19] my overall impression is that the get-tough-with-crime mood of the public is primarily responsible for the increased hostility. This mood translates into what I see as two distinguishable patterns: (1) a general attack on plea bargaining now because it has become highly visible, without a full understanding of the improvements made over the old system in which plea bargaining could result in unmerited leniency; and (2) an assault on plea bargaining as part of an overall attack on the exercise of discretion in processing criminal cases.[20] The drive to restrict discretion has taken several forms—including the push for speedy-trial legislation, strict or presumptive sentencing, and abolition of parole discretion.

Those who would reduce discretion have diverse motives. Some are in the "get-tough" camp simply by instinct; others talk about enhancing the deterrent effect of the criminal law by imposing sure, swift, but short sentences. Still others find the disparity of treatment of persons in similar situations to be highly unjust, and hope that a more structured system that permits less discretion will reduce these differentials.

With this general background, we can turn to a series of cases from the United States Supreme Court during the last ten years dealing with guilty pleas and plea bargaining.

Issues in Supreme Court guilty-plea cases: 1969-78

Although the United States Supreme Court had touched on the guilty plea in earlier cases like *Moore v. Illinois*[21] and *United States v. Jackson*,[22] the first relatively recent case in which the guilty plea was the pivotal issue dates from

11. *See* President's Commission on Law Enforcement and Administration of Justice, The Challenge of Crime in a Free Society 134-36 (1968).

12. ABA Criminal Justice Standards, *supra* note 6, Standard 14-3.1(c).

13. *See* ABA Standards, Pleas of Guilty (1968), *supra* note 6; President's Commission on Law Enforcement and Administration of Justice, Task Force Report: The Courts 108 (1967); National Advisory Commission on Criminal Justice Standards and Goals, Report on Courts 42-65 (1973) [hereafter cited as NAC Report on Courts]; National Conference of Commissioners on Uniform State Laws, Uniform Rules of Criminal Procedure, Rules 441-44 (1974); American Law Institute, A Model Code of Pre-Arraignment Procedure, Article 350 (1975) [hereafter cited as ALI Code].

14. *E.g.*, NAC Report on Courts, *supra* note 13, Standard 3; *The Prosecutor's Role*, *supra* note 9.

15. N.C. Sess. Laws 1973, Ch. 1286, as amended by N.C. Sess. Laws 1975, Ch. 166.

16. *See, e.g.*, Santobello v. New York, 404 U.S. 257 (1971).

17. 434 U.S. 357 (1978).

18. Under the cases discussed below the judge must ask the defendant personally about the circumstances surrounding the plea and not accept it unless it is properly made. With an open plea bargaining, the judge should receive truthful answers and realistically protect defendants from improper pressure. In addition, the 1968 ABA Standards (and North Carolina statutes based on them) give other specific protections. For example, the defendant is allowed to withdraw his plea if the bargain falls through [ABA Standards, Pleas of Guilty (1968), *supra* note 6, § 2.1(a); N.C. Gen. Stat. § 15A-1024], and the fact that plea discussions occurred cannot be admitted into evidence [ABA Standards, Pleas of Guilty (1968), *supra* note 6, § 3.4; N.C. Gen. Stat. §15A-1025]. The 1979 ABA Standards give even greater protection to defendants in the above areas. ABA Criminal Justice Standards, *supra* note 6, Standards 14-2.1 and 14-3.4.

19. *The Prosecutor's Role*, *supra* note 9; Alschuler, *The Defense Attorney's Role in Plea Bargaining*, 84 Yale L.J. 1179 (1975); Alschuler, *The Supreme Court, the Defense Attorney, and the Guilty Plea*, U. Colo. L. Rev. 1 (1975) [hereafter cited as *Supreme Court and Guilty Plea*]; *Judge's Role*, *supra* note 4.

20. *See, e.g.*, N. Morris, The Future of Imprisonment 50-57 (1974). Discretion in criminal sentences is a special target. *See, e.g.*, Twentieth Century Fund Task Force on Criminal Sentencing, Report: Fair and Certain Punishment (1976); M. Frankel, Criminal Sentences: Law Without Order (1973).

21. 355 U.S. 155 (1957).

22. 390 U.S. 570 (1968).

1969: *Boykin v. Alabama.*[23] Boykin had pleaded guilty in the Alabama state court to common-law robbery and was sentenced to death. The Supreme Court avoided the issue of whether the death penalty for common-law robbery was constitutional and disposed of the case by holding that the guilty plea was invalid because the record did not affirmatively show that it had been knowingly and voluntarily made. This requirement was then in Rule 11 of the *Federal Rules of Criminal Procedure,*[24] but *Boykin* broke new ground in imposing a substantial part of that rule on the states under the due process clause of the Constitution. The result of *Boykin* is that each trial judge who accepts a guilty plea, at least in felonies, must hold a question-and-answer session with the defendant to determine for the record that he understands the nature of the charge and the consequences of the plea, that there is a factual basis for the plea, and that the plea is made "voluntarily." The emphasis on voluntariness sets the stage for later cases testing the limits of this concept when the defendant reluctantly accepts a plea bargain through fear of worse consequences if he goes to trial and is then found guilty.

The Court held that the prosecution as a matter of due process of law was bound by its bargain.

The next year, 1970, the Supreme Court handed down three cases in which challenged guilty pleas were held valid. The timing of these three decisions may have been calculated to discourage overly broad interpretations of *Boykin*—to keep a probable majority of prisoners in the United States from going to court to challenge their guilty pleas. These three cases, often called the guilty-plea "trilogy," covered two types of challenges to pleas.

Two of them, *McMann v. Richardson*[25] and *Parker v. North Carolina,*[26] involved guilty pleas entered by defendants who had given confessions to the police that they later repudiated as having been coerced. When the guilty pleas were entered, the defendants believed that those confessions would be heard by their trial juries, and this belief played a part in their choosing to plead guilty. In *McMann v. Richardson,* developments after the trial made it clear that a jury could not pass upon whether a confession was voluntary, and a jury would not be permitted to learn of any confession if the trial judge ruled it to be coerced;[27] in *Parker* admissibility of the confession at trial would have turned on a complex of facts and there was room for uncertainty, but the trend of later cases made it likely that the confession could not have been used.[28] Parker and the defendants in *McMann* therefore later attacked their guilty pleas as having been triggered by unconstitutional confessions. This raised the issue whether each waiver of the right to jury trial, by entry of the guilty plea, was "voluntary"—the standard set in *Boykin.*

Under certain cases emphasizing that a waiver of constitutional rights must be "knowing and intelligent,"[29] Parker and the defendants in *McMann* seemed to have grounds to attack their guilty pleas and get new trials. The Court, however, used a different analysis. It stressed that the defendants were all represented by counsel and entered their pleas after consulting with their lawyers. The Court said that a decision to plead guilty is made for reasons of strategy based on assessment of the various factors in a case, and it concluded that a guilty plea entered after consultation with competent counsel should not be upset because of counsel's mere error of judgment as to strategy.

In the third case, *Brady v. United States,*[30] the defendant had entered a guilty plea in federal court to the charge of kidnapping after the judge refused to try the case without a jury. This was important because at the time the kidnapping statute allowed only a jury to impose the death penalty. After Brady entered his plea, the United States Supreme Court in another case ruled that the death-penalty part of the kidnapping statute was unconstitutional because it discouraged jury trials.[31] Brady then tried to challenge his guilty plea on the ground that it had been induced by fear of an unconstitutional death penalty. Again, the Court stressed that Brady had consulted with counsel who met minimum standards of competence[32] and that decisions of

23. 395 U.S. 238 (1969).

24. The pertinent part of Rule 11 then read: "The court may refuse to accept a plea of guilty, and shall not accept such plea or a plea of nolo contendere without first addressing the defendant personally and determining that the plea is made voluntarily with understanding of the nature of the charge and the consequences of the plea .... The court shall not enter a judgment upon a plea of guilty unless it is satisfied that there is a factual basis for the plea." Rule 11 has since been expanded, but the substance of these provisions remains unchanged.

25. 397 U.S. 759 (1970).

26. 397 U.S. 790 (1970).

27. In Jackson v. Denno, 378 U.S. 368 (1964), the Court struck down a New York procedure that let the jury decide whether a confession was voluntary; the Court required the judge to pass on this issue and to keep the jury from learning about the confession if he found it to be involuntary. The defendants in *McMann* were tried before *Jackson v. Denno* was decided, and they alleged that fear of jurors' learning of their confessions triggered the guilty pleas.

28. The trial occurred before the rules of Miranda v. Arizona, 384 U.S. 436 (1966), began to open up interrogation rooms by providing warnings of the right of the defendant to remain silent and have counsel present. The decision whether a confession was "voluntary" was the controlling issue and depended on the totality of circumstances; during the pre-*Miranda* period the Supreme Court heard more and more disputed stories about what occurred in secret interrogation rooms, and it began finding that an increasing number of confessions were not voluntary and thus should be excluded. In *Parker*, the defendant was 15 years old when questioned, and under the Court's increasingly liberal standards he had a plausible claim of psychological coercion.

29. The fountainhead case is Johnson v. Zerbst, 304 U.S. 458 (1938).

30. 397 U.S. 742 (1970).

31. United States v. Jackson, 390 U.S. 570 (1968).

32. *See* Tollett v. Henderson, 411 U.S. 258, 267 (1973), which interpreted the "tril-

strategy in entering guilty pleas could not be later upset simply because a mistaken view of the law by the lawyer formed part of the decision.

In *North Carolina v. Alford*[33] the issues were substantially the same—with one new twist. Alford had counsel and was willing to plead guilty to second-degree murder to avoid the risk of the death penalty. In doing so, however, he continued to maintain that he was innocent. After the North Carolina death-penalty statute in effect at the time of Alford's plea was ruled unconstitutional, he tried to nullify his guilty plea; he contended that his plea was induced by fear of the unconstitutional punishment and was thus involuntary. In refusing to upset the guilty plea, the Court stressed the strong evidence of Alford's guilt entered at the sentencing hearing, the competence of his counsel, and the rationality of Alford's choice when made. Because there was a "factual basis" for the plea, the Court held that it was voluntary even though the defendant was at the time protesting his innocence.

Although there were factors of doubtful legality in the "trilogy" cases and in *Alford* that pressured the defendants into surrendering their rights to trial by jury, those guilty pleas did not directly pose issues that turned on negotiations with the prosecutor. The next significant case did. In *Santobello v. New York*[34] a prosecutor allowed the defendant to enter a guilty plea to a lesser offense and also promised that he would make no recommendation as to sentence. With office turnover, however, another prosecutor was assigned to the sentencing hearing and, apparently not knowing of the agreement, recommended the maximum misdemeanor sentence to the judge. It was imposed. The United States Supreme Court specifically upheld the legality of plea bargaining as to both charge and sentence recommendations, saying that with proper safeguards the practice was desirable to expedite the handling of cases. The Court held that the prosecution as a matter of due process of law was bound by its bargain, although the judge might not be. The Court's remedy was to remand the case for either specific performance of the agreement (resentencing before a different judge without any prosecutor's recommendation) or letting the defendant withdraw his plea of guilty. Four of the seven Justices who agreed on this disposition indicated that the trial judge to whom the case was remanded should choose which remedy was appropriate; the other three would have allowed the defendant to make his choice.

In *Dukes v. Warden, Connecticut State Prison,*[35] the Court again refused to set aside the guilty plea of a defendant who had counsel. Dukes had been unhappy with the lawyer who was assigned to represent him but, being indigent, could not secure different counsel. He first resisted his lawyer's pressure to plead guilty, then tried suicide, and finally entered a guilty plea while represented by the partner of the lawyer who had been assigned to his case. Before the sentencing hearing, at which the lawyer Dukes disliked again represented him, Dukes unsuccessfully attempted to withdraw his guilty plea. From prison Dukes brought proceedings to invalidate his plea, alleging for the first time facts that constituted a serious conflict of interest on the part of the lawyer who had been assigned to his case and had pressured him to plead guilty. The Court rejected the argument because (a) Dukes knew of this alleged conflict when he pleaded guilty and did not complain of it, (b) nothing indicated that the conflict of interest caused him to get misleading advice or to be ineffectively represented, and (c) Dukes had expressed satisfaction with the attorney's partner, who actually represented him in the hearing when the guilty plea was entered.

. . . the Court in *Dukes* went far to make guilty pleas stick—at least when the defendant had counsel who met minimum qualifications as to competence.

It is obvious that the Court in *Dukes* went far to make guilty pleas stick—at least when the defendant had counsel who met minimum qualifications as to competence. In contrast, a defendant who had been allowed to waive counsel when he entered his plea of guilty was permitted in *Fontaine v. United States*[36] to have an evidentiary hearing to explore his several claims for attacking his guilty plea.

After another case that refused to set aside a guilty plea that stemmed from apparent lawyer error,[37] the Court in 1974 and 1975 allowed two petitioners to succeed in overturning their guilty pleas.[38] In *Blackledge v. Perry,*[39] a case from North Carolina like several others involving guilty pleas, the Court does not state whether the defendant had counsel at the time of the guilty plea. The defendant had appealed for a trial de novo before a jury in superior court after he was convicted of a misdemeanor in the lower nonjury court. The prosecutor decided to raise the stakes and indicted Perry for a felony that involved the same facts as the misdemeanor. Perry entered a plea of guilty to the felony but later attacked that plea in proceedings that reached the United States Supreme Court. The Court held that (1) it was a denial of due process to escalate the charge after the appeal unless it had been impossible for the State to proceed with the felony at the outset; and (2) the defendant could still attack the constitutionality of the felony charge even though he had pleaded guilty to it in superior court. In *Menna v. New York,*[40] the Court indicated that a counseled plea of guilty could be set aside if an asserted double-jeopardy

ogy" cases to turn on whether the advice was within the "range of competence demanded of attorneys in criminal cases."

33. 400 U.S. 25 (1970).

34. 404 U.S. 257 (1971).

35. 406 U.S. 250 (1972).

36. 411 U.S. 213 (1973).

37. Tollett v. Henderson, 411 U.S. 258 (1973). The case was remanded for a hearing as to the lawyer's competence, but the test was the minimum one stated in note 32 *supra*.

38. A third case in which the petitioner prevailed is Lefkowitz v. Newsome, 420 U.S. 283 (1975). It is not treated in the text because it turned in part upon an interpretation of state law.

39. 417 U.S. 21 (1974).

40. 423 U.S. 61 (1975).

claim was valid. Although it has been argued that the rule against double jeopardy can be waived just as any other right can be waived and that a guilty plea is a waiver of procedural rights,[41] the majority seemed to place this defense that would bar the very bringing of the charge itself in a different category.

A somewhat different due process case is *Henderson v. Morgan*.[42] It involved a plea of guilty to a lesser offense that required proof of a specific element of intent (intent to kill) not in the higher charge, and the case presented a fact situation in which it was ambiguous whether the defendant specifically did intend to kill. In attacking his plea, the defendant alleged that he had no intent to kill and was not advised that this was an element of the crime to which his plea was entered. Though the lawyer negotiating the plea was apparently competent, the Supreme Court overturned the plea because the record did not show that the defendant had been advised of this crucial element.[43] The ramifications of this case are not clear, and it may express a rule that will apply only in unusual factual situations. Nevertheless, its impact may be to expand the level of detail in the questions addressed personally to the defendant that must be spread on the record when a guilty plea is accepted.[44]

Of the cases decided in the last two years, the one with a guilty-plea issue most easily disposed of is *Weatherford v. Bursey*,[45] in which an undercover agent attended pretrial conferences with the defendant and, maintaining his cover as a friend, falsely promised not to testify against the defendant. The defendant therefore elected to go to trial rather than plead guilty, and the agent testified for the prosecution. One of the defendant's lines of attack concerned the lost opportunity to enter a plea bargain—a course he would have taken had he known that his companion was an undercover agent. The Court quickly dispatched this argument by holding that a defendant has no constitutional right to a plea bargain.

The Court held that the prosecutor was entitled to bargain hard in encouraging guilty pleas.

Hutto v. Ross[46] has an unusual set of facts. After negotiating a plea with the aid of counsel, the defendant was asked by the prosecutor to make a statement concerning the crime. It was made clear that this action was not a requirement of the bargain struck, and the defendant made an incriminating statement concerning his embezzlement. Later the defendant changed lawyers, withdrew the guilty plea, and went to trial. At the trial the incriminating statement was introduced into evidence. In later attacking the use of the statement, the defendant contended that the statement was an involuntary confession that should have been excluded because it would not have been made but for the inducement of the aborted plea-bargaining process. On these facts the Court drew a distinction between the confession here made to the prosecutor and two types of admissions that are normally excluded: (1) statements made during plea negotiations[47] and (2) the guilty plea itself.[48] Stressing that the defendant knew that he did not have to make the statement, the Court upheld the conviction.

Bordenkircher v. Hayes[49] is the decision that has recently excited the most comment. The defendant was prosecuted on a forgery charge involving $88.30, an offense punishable by imprisonment for from two to ten years. The prosecutor offered to recommend a sentence of five years if the defendant would "save the court the inconvenience and necessity of a trial" by pleading guilty. Because the defendant had committed other felonies, the prosecutor threatened to bring enhanced charges under the habitual-criminal act if the defendant did not plead guilty. The defendant would not negotiate, and the prosecutor brought the habitual-criminal charges. When convicted, the defendant received the mandatory sentence of life imprisonment. In a 5-4 decision, the Court upheld the sentence, even though the state where the case arose, Kentucky, had in the meantime made its habitual-criminal act less harsh. The Court refused to distinguish between an action by the prosecutor *adding* charges that were legitimately available

41. *See, e.g., Supreme Court and Guilty Plea, supra* note 19, at 14-15. Professor Alschuler also found *Blackledge v. Perry* to be hopelessly at odds with the trilogy cases and *Tollett v. Henderson*.

42. 426 U.S. 637 (1976).

43. That the defendant be informed of the nature of the charge has long been a requirement of due process of law; this was an unusual case in that intent to kill was not an element of the first-degree murder charge brought, because the state proceeded under the felony-murder theory, but it was an element of the lesser included offense of second-degree murder.

44. The 1979 revision of the ABA Standards requires far more in the judge's inquiry. Specifically, the judge now should make sure the defendant understands the nature and *elements* of the offense to which the plea is offered. ABA CRIMINAL JUSTICE STANDARDS, *supra* note 6, Standard 14-1.4(a)(i).

45. 429 U.S. 545 (1977).

46. 429 U.S. 28 (1976).

47. The purpose of the rule is clear; many defendants would be reluctant to enter into plea negotiations if admissions made during the discussions could later be used against them. North Carolina adopts the rule in N.C. GEN. STAT. § 15A-1025; the federal prohibition is in FED. RULES CRIM. PROCEDURE, Rule 11(e)(6). The 1979 revision of the ABA Standards added "statements made by the defendant in connection with and relevant to such plea discussions" as not admissible in evidence in the section prohibiting admissibility, either for or against the defendant, the *fact* that he entered into plea discussions. ABA CRIMINAL JUSTICE STANDARDS, *supra* note 6, Standard 14-3.4.

48. The Court cited Kercheval v. United States, 274 U.S. 220 (1927), as prohibiting use of a withdrawn guilty plea as evidence of guilt at a subsequent trial. The 1979 revision of the ABA Standards added "statements made by the defendant in connection with such plea of guilty or nolo contendere" as not admissible in evidence in the section prohibiting admissibility against the defendant of the fact of a tendered plea of guilty or nolo contendere either not accepted or withdrawn. ABA CRIMINAL JUSTICE STANDARDS, *supra* note 6, Standard 14-2.2.

49. 434 U.S. 357 (1978).

and an action *dropping* charges in the course of plea bargaining. The majority said that a clever prosecutor could defeat a rule against adding charges merely by always loading the defendant with the maximum number of charges. Distinguishing *Blackledge v. Perry* as a case involving prosecutorial vindictiveness,[50] the Court's majority analyzed the prosecutor's conduct to see whether it was "vindictive." Stressing that there was clear-cut evidence of the former felony convictions and that the statute was constitutional even though harsh, it found no "vindictiveness" in the prosecutor's conduct. The Court held that the prosecutor was entitled to bargain hard in encouraging guilty pleas in an effort to expedite the criminal process.

In still another case from North Carolina, *Blackledge v. Allison*,[51] the Supreme Court affirmed a ruling that Allison was entitled to an evidentiary hearing on his claim that his guilty plea had been unconstitutionally obtained. Allison alleged that his counsel told him when he entered the guilty plea in 1972 to lie and say that no promises had been made to him, although he maintained he had actually been promised a ten-year sentence for pleading guilty. (He received a sentence of 17 to 21 years.) The Court observed that the story was plausible: in 1972 the case in which open plea bargaining had been approved, *Santobello v. New York,* was very new. The Court further noted that it was once common practice for prosecutors and defense counsel to work out sentence bargains, with the tacit approval of the judge, and yet instruct the defendant to say when his guilty plea was publicly entered that no threats, promises, or inducements had been made[52] in order to support the required finding that the plea was "voluntary." The Court therefore refused to find an absolute waiver of the right to challenge the allegedly broken bargain because of the contradictory statement made when the plea was entered. It noted that a transcript of plea with direct, detailed questions and oral answers was not used; Allison simply filled out a written questionnaire—at least as far as the record in the case indicated.[53]

The net effect of these cases is to make plea bargaining legitimate . . . . Except in unusual cases, both parties must abide by the bargain struck if there is a factual basis for the plea.

The opinion in *Blackledge v. Allison* is particularly interesting in contrasting the former covert procedure in plea bargaining with the current practice. The Court praised North Carolina's new code of pretrial procedure, effective in 1975, which explicitly allows "plea arrangements."[54] Before a guilty plea can now be accepted in a North Carolina superior court,[55] the judge must inquire whether the parties engaged in plea discussions, whether a plea arrangement was reached, and whether the State exerted any "improper pressure"[56] to plead guilty. The statute's overall standard is that the plea must be the "product of informed choice."[57]

Conclusion

The net effect of these cases is to make plea bargaining legitimate as an integral part of the criminal justice process. Except in unusual cases, both parties must abide by the bargain struck if there is a factual basis for the plea. If the defendant is represented by a lawyer and knows the operative factors surrounding a bargain, he will generally not be allowed to back out later unless there is a basic jurisdictional defect in the proceedings or the prosecutorial pressure to plead was clearly improper. Although the cases still require that the plea be "voluntary" before it is accepted, the phrase "product of informed choice" adopted by North Carolina from the American Law Institute[58] clearly describes the constitutional standard for plea bargaining more accurately.

The Supreme Court still must define the limits, but *Bordenkircher v. Hayes* gives the prosecutor a free hand in charge bargaining if there is evidence to support a potential charge and no demonstrated "vindictiveness." It is less certain what limits may apply to sentence bargains, although there is reason to expect that the overall scheme recommended by the American Bar Association and the American Law Institute will generally fall within whatever limits are set.[59] The Supreme

50. *Cf.* Chaffin v. Stynchcombe, 412 U.S. 17 (1973) (no vindictiveness for sentencing jury on retrial to impose greater punishment, as second jury was ignorant of the first jury's sentence).

51. 431 U.S. 63 (1977).

52. *See* ABA Standards, Pleas of Guilty (1968), *supra* note 6, Commentary to § 3.1, at 61: "[T]he parties typically act as if no prior negotiations had occurred. Trial judges, although they are aware that negotiation for pleas is a common practice, routinely ask the defendant whether any promises have been made to him. Notwithstanding the fact that the plea has been the subject of negotiation, the defendant usually answers in the negative, and the prosecutor and defense counsel seldom indicate to the contrary."

53. North Carolina now requires the superior court judge who accepts a guilty plea to address the defendant personally, informing him of certain rights and making required determinations. N.C. Gen. Stat. § 15A-1022(a), (b).

54. N.C. Gen. Stat. §§15A-1021 to -1027.

55. The North Carolina statutes on guilty-plea procedure do not apply to the misdemeanor-level district court. The need for formal safeguards is less, because the defendant has an absolute right to appeal even from a guilty plea and receive a jury trial in superior court. Plea bargaining of course occurs in the district court, and the minimum constitutional standards clearly apply to the process, but appellate review of specific actions in district court is rare since appeal leads to a new trial rather than a hearing on errors of the lower court.

56. *See* N.C. Gen. Stat. § 1021, Official Commentary, for a definition of improper pressure.

57. N.C. Gen. Stat. § 15A-1022(b) states that the judge may not accept the plea unless it is the "product of informed choice."

58. ALI Code, *supra* note 13, § 350.4(a).

59. Many details of the model provisions of the American Bar Association and the American Law Institute have been discussed in the text and notes above. For specific reference, *see* ABA Standards, Pleas of Guilty (1968), *supra* note 6; ABA Criminal Justice Standards, *supra* note 6, Chapter 14; ALI Code, *supra* note 13, Article 350.

Court considered a case[60] in 1979 that might have shed important light. It turned on the participation of the judge in the plea bargain. The issue that caused the case to be accepted for review was:

> Whether a guilty plea is obtained in violation of due process of law when it is induced by a judge's threat that, should the defendant be convicted after trial, he will receive a sentence almost four times greater than one once seriously discussed, and more than twice as great as the one then held out as part of a plea offer.[61]

Unfortunately, after hearing oral arguments, the Court decided that on the record of the case the above issue was not presented with any degree of certainty. Therefore, it dismissed the writ of certiorari in the case as having been improvidently granted. In a similar North Carolina case, the trial judge said in open court that he would have to give the defendant an active sentence because he refused to plead guilty to a reduced charge (pursuant to a plea bargain offered by the prosecutor), even though the judge knew nothing of the defendant's character and record; the North Carolina Court of Appeals remanded the case for re-sentencing, holding that the defendant's right to trial had been violated.[62]

North Carolina departs from the older models in explicitly providing that the judge may participate in plea discussions,[63] but the statute sets no guidelines as to his role. It can be inferred that he is to be more than the mere "ratifier"[64] of the sentence agreement reached by the parties, as in the models envisaged by the American Law Institute and the original standards of the American Bar Association, but how active a participant he can be is not clear. These answers must await further court decisions, though it is noteworthy that one of the chief critics of plea bargaining takes the position that if a jurisdiction does permit the practice, it is better for the judge to be openly and actively involved.[65] The revised standards of the American Bar Association provide for participation of the judge in plea discussions;[66] that is, in fact, the major change made.

The primarily legal considerations discussed above may be undercut to some extent by current developments. The 1979 General Assembly adopted legislation, effective in the summer of 1980, imposing presumptive sentencing.[67] If a judge gives an active sentence in a felony he must set out in writing his reasons for giving either a higher or a lower sentence than the presumptive one carried in the statute for that crime. Some observers predict that this will cause judges to give the presumptive sentence in all but highly unusual cases and thus take away a defendant's incentive to engage in sentence bargaining. On the other hand, bargaining could revolve around identifying the appropriate "mitigating" factors that the judge could put in writing to justify a lower than normal sentence. The impact of presumptive sentencing on plea bargaining will certainly be carefully watched. The potential for devastating dislocations can be seen from a simple mathematical calculation. If guilty pleas were reduced from 90 per cent to 80 per cent of all cases, the number of trials would be doubled. These figures may not strictly apply in the *felony* cases affected by the presumptive-sentencing act, though, and an unpredictable factor is that the judge's discretion to place a defendant on probation[68] or special probation (split sentencing)[69] remains unfettered.

The revised standards of the American Bar Association provide for participation of the judge in plea discussions.

Among other developments are experiments in various jurisdictions outlawing or restricting charge bargaining, sentence bargaining, or both. The best-known example is the action taken in Alaska. The Attorney General of Alaska, who controls prosecutions in that state, ordered a virtual halt to all plea bargaining on August 15, 1975.[70]

A study of the results of Alaska's ban on plea bargaining indicated some surprisingly mixed results in felony cases.[71] (1) Dismissal continued to be the most common disposition, accounting for about 50 per cent of the felony

60. Ramsey v. New York, 59 L. Ed. 2d 440 (1979).

61. *Id.*

62. State v. Boone, 33 N.C. App. 378 (1977), *aff'd*, 293 N.C. 702 (1977).

63. The last sentence in N.C. Gen. Stat. § 15A-1021(a) originally read: "The trial judge may *not* participate in the discussions." (Emphasis added.) In 1975 the General Assembly deleted the "not." N.C. Sess. Laws 1975, Ch. 117.

64. *See* Bond, *supra* note 4, at 827-29, discussing the difference between the judge as "mediator" as opposed to "ratifier" of the bargain.

65. *Judge's Role, supra* note 4, at 1122-54. See also Note, *Restructuring the Plea Bargain*, 82 Yale L.J. 286 (1972) (favoring judicial participation).

66. ABA Criminal Justice Standards, *supra* note 6, Standard 14-3.3 treats the role of the judge. The most important changes are:

(1) Authorizing a procedure whereby parties who cannot agree in plea discussions to request a meeting with the judge. If he consents, he serves as moderator and may either indicate what charge or sentence concessions would be acceptable or ask for a pre-plea report before deciding. The parties are to decide whether to accept any recommendation of the judge outside his presence. [Standard 14-3.3(c).]

(2) Providing that a moderating judge may "require or allow any person, including the defendant, the alleged victim, and others, to appear or to testify" during the plea conference. [Standard 14-3.3(d).]

(3) Requiring that all discussions at which the judge is present to be recorded verbatim and preserved, though the judge may seal the transcript for good cause. Normally the plea discussions involving the judge should be in open court, but the judge for good cause may hold them in chambers. The judge should not communicate with the parties on the plea except in the formal manner outlined above. [Standard 14-3.3(f).]

67. N.C. Sess. Laws 1979, Ch. 760. It also substantially abolishes parole, and substitutes day-for-day "good time." In addition the system of "gain time," in which some prisoners who perform special tasks receive further credit against the sentence, is retained.

68. N.C. Gen. Stat. §§ 15A-1341 to -1347.

69. N.C. Gen. Stat. § 15A-1351(a).

70. Rubinstein & White, *Plea Bargaining: Can Alaska Live Without It?* 62 Judicature 267 (1979).

71. M. Rubinstein, J. White, & S. Clarke, The Effect of the Official Pro-

cases. (2) Defendants whose felony charges were not dismissed were most likely to plead guilty and did so in about 40 per cent of the felony cases, before as well as after plea bargaining was banned. (3) Although there was a small increase in the trial rate (from 7 to 10 per cent), all of the additional trials apparently resulted in conviction—which probably explains why defendants continued to plead guilty. (4) Court disposition time, which was decreasing before the ban, continued to decline. The Alaska study showed that bargaining in fact declined sharply, both as to charge and sentence, after the ban. Sentencing became more severe in general, but not in cases involving violent felonies—only in drug, fraud, burglary, and theft cases. Before Alaska banned plea bargaining, defendants charged with felonies involving violence, burglary, and theft had indeed tended to receive more lenient sentences if they pleaded guilty. This sentence differential persisted after plea bargaining was prohibited in violent felony cases; it disappeared in cases involving burglary, larceny, and receiving stolen property—probably because these defendants were no longer receiving a sentence concession from plea bargaining.

Given Alaska's relatively sparse population, the question arises whether the results in that state will transfer to more urban jurisdictions. A possible answer may come from a recent study in the District of Columbia in which similar types of felonies disposed of by trial and by plea bargain were compared.[72] It appears that plea bargaining slightly increases the *rate* of conviction and does not generally reduce the severity of the sentence imposed except in robbery cases. The Alaska and District of Columbia studies, while differing somewhat in their conclusions, agree that in violent crimes such as robbery a judge will give a longer sentence on average after hearing the full facts in a trial than after the briefer presentation in a guilty-plea hearing, but the plea-negotiation process itself has little impact here.

Other studies are being generated in North Carolina in connection with Career Criminal Units being funded under grant in three prosecutorial districts.[73] The focus is on professional criminals—repeat felony offenders—and their cases are expedited by careful, early preparation for trial. A standard feature is a restriction on plea bargaining: no sentence bargaining at all and no charge bargaining unless the defendant agrees to plead guilty to the most serious felony count.[74] As the results of these experiments[75] and others are assimilated, a better picture may emerge as to the validity of the general premise on which plea bargaining is usually justified—that it is essential in courts that process a high volume of cases to expedite cases and to keep the system from being swamped.

In the long run, because prosecutors are elected officials, the wishes of the public will prevail. If the public continues to be hostile to plea bargaining because it feels that some defendants receive unmerited leniency primarily on the basis of their lawyer's "clout" or how crowded the docket may be, the public will have to decide whether it wishes to pay enough in taxes to assure a larger number of jury trials. At present the dimensions of the added costs are in dispute, but we have already taken the path that will lead to answers. □

HIBITION OF PLEA BARGAINING ON THE DISPOSITION OF FELONY CASES IN THE ALASKA CRIMINAL COURTS (Alaska Judicial Council, Dec. 1978). The statistical analysis reflected in this report was primarily under the direction of Stevens H. Clarke of the Institute of Government faculty.

72. W. RHODES, PLEA BARGAINING: WHO GAINS? WHO LOSES? (Pub. No. 14, PROMIS Research Project, Washington, D.C., Institute for Law and Social Research, 1978).

73. The districts are the 10th (Wake County), 12th (Cumberland and Hoke counties), and the 26th (Mecklenburg County).

74. Information based on conversations with prosecutors in the three districts. Another restriction in at least one district is that there is no bargaining at all after arraignment.

75. Career Criminal Units are funded by grants from the Law Enforcement Assistance Administration of the United States Department of Justice, and formal results will be published later. Informal reports indicate that these units are experiencing a substantial increase in cases going to trial. Since these units select the crimes they handle—serious crimes by repeat offenders—it is not clear that the results from these units will directly apply to the general run of cases.

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