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Minneapolis General Hospital and Glen Lake Sanatorium

December 1958

REPORT ON

MINNEAPOLIS GENERAL HOSPITAL

AND GLEN LAKE SANATORIUM

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REPORT ON MINNEAPOLIS GENERAL HOSPITAL AND GLEN LAKE SANATORIUM

By the

Health, Hospitals and Welfare Committee

Citizens League of Minneapolis and Hennepin County

Report No. 95

Approved by

Board of Directors

December 3, 1958

C O N T E N T S

REPORT ON MINNEAPOLIS GENERAL HOSPITAL AND GLEN LAKE SANATORIUM

MAJOR RECOMMENDATIONS

1. For the foreseeable future the community must retain General Hospital as an institution providing out-patient and acute hospital care for the indigent and emergency and contagious care for all.

2. The community should therefore face the fact that it must provide adequate financing for the hospital.

3. We believe that the following steps should be taken without delay:

a. The County Welfare Board should make every effort to institute mandatory referral of county welfare patients to General Hospital to the practical limit of the hospital's capacity.

b. The Glen Lake Sanatorium Commission should take whatever steps are necessary to remodel the main building and cottages so the sanatorium can provide in-patient care for acutely-ill non-tuberculosis patients.

c. As soon as Glen Lake is ready to receive them, and to the limit of its capacity, county welfare patients should also be referred to Glen Lake.

These three steps can be taken without legislative action.

4. We believe that the 1959 Legislature should enact legislation to transfer General Hospital to the County Government and place it with Glen Lake Sanatorium under a single independent governing body and a single medical administration.

5. Following the enactment of such legislation, the County Welfare Board should require all county welfare patients to get their hospital care at General Hospital, University Hospitals or Glen Lake Sanatorium.

All the above presumes continuation of Glen Lake Sanatorium as a governmental institution. If a serious proposal is presented for operation and/or ownership of Glen Lake Sanatorium by a non-governmental group, we would propose to reexamine the recommendations relative to Glen Lake.

THE COMMITTEE

The following members of the Health, Hospitals and Welfare Committee were active in the study and deliberation on this report and approved the recommendations, except as noted below. Those whose names are asterisked were members of the sub-committee.

*Lauress V. Ackman
Committee Chairman
*James Stephan
Sub-committee Chairman
Merle V. Abbott
Rev. David E. Archie
*John Atwood
Frank Birch
Mrs. Frank Bishop
*Dr. A. Falk
Edith Foster
Mrs. J. H. Green
K. W. Halden
*Dr. Cyrus O. Hansen
*Arthur Hartwell
*Gene Hickey
Carolyn Joyce
*Russell K. Lewis
Dr. Shirley Miller
Mrs. Donald Peddie
*Mrs. Herbert F. R. Plass
Millicent Purdy
*Honore Rouse
Mrs. Clinton A. Schroeder
*Gertrude Tennant
Dr. Walter W. Walker
*Mrs. Walter W. Walker
*Miss Mary A. Walsh

Mrs. Walker and Dr. Hansen dissented from the committee's conclusion that mandatory referral of county welfare patients to General Hospital and Glen Lake should be instituted, on the grounds that it would interfere with the patient-physician relationship.

I

BACKGROUND AND OBJECTIVES OF CURRENT STUDY

Since its inception in 1952 one of the main concerns of the Health, Hospitals and Welfare Committee of the League has been the effective functioning of Minneapolis General Hospital. In fact, the committee's first project was a general review of the hospital's functioning, with particular emphasis on the physical plant and alleged fire hazards.

In recent years, the hospital's major problem has centered around the obtaining of sufficient money to operate effectively as a first rate service and teaching institution. Official and community discussion of this problem has ranged from consideration of ways of increasing fees charged private patients to suggestions for abolishing the hospital entirely and caring for the present patient load at voluntary institutions. Much of this concern has been directed toward finding a fuller use of the hospital since there has been a general feeling that the money problem is caused by the fact that the hospital is being used below capacity. The discussion thus has indicated a need for examining the entire theory upon which the hospital has been functioning, and all possible suggestions for placing it upon a sound basis.

This discussion has been carried on in official City bodies, such as the City Council and the Board of Public Welfare; in the Hennepin County legislative delegation, among voluntary hospital groups, in the Hennepin County Medical Society, in the press, and among numerous civic groups.

Sometimes the discussion has been broadened to include Glen Lake Sanatorium, for the sanatorium while not in the same financial situation as General has had an increasing problem of vacant beds. The hearings on the sanatorium's 1959 budget again brought out official and community concern with the sanatorium's future.

In view of these problems, the Health, Hospitals and Welfare Committee decided it was well worth its time and effort to take a close look at General Hospital and Glen Lake Sanatorium and their roles in the community, and to see what changes, if a any, the Citizens League feels should be made in their roles and operation for the long-run good of the community.

Our objective has been to determine the best provision of hospital services to the indigent and the tuberculous within the financial resources available, the most efficient use of hospital facilities, and a just distribution of the public costs.

Recognizing that changes, if indicated, would be likely to require legislative action, we have aimed to come to conclusions and recommendations before the 1959 Legislature gets under way.

II

COMMITTEE PROCEDURE

A sub-committee was appointed to conduct the hospital study. It developed an outline of major questions to be answered and, because the problem is essentially a community-wide one, had in mind conducting a number of interviews of knowledgeable persons representing significant groups in the community which have a special concern with the hospital. It was decided to invite representatives of these groups to meet with the committee and discuss the questions raised. This was done, and in a series of meetings the committee heard representatives of the General Hospital medical administrative staff, the hospital superintendent, the executive secretary of the Minneapolis Board of Public Welfare, the acting executive secretary of the Ramsey County Welfare Board, the acting dean (now dean) of the University Medical School, a number of members of the Hennepin County Medical Society, a representative group of voluntary hospital administrators and the executive secretary of the United Hospital Fund.

The committee also requested the president of the Central Labor Union to send a CLU representative to discuss labor's view on General Hospital with the committee, but although he twice agreed to come personally, he was unable to appear either time.

With regard to Glen Lake Sanatorium, the committee had available the 1956 study of the sanatorium by the League's County Government Operations Committee and the 1956 study by the special committee of the Community Welfare Council. A member of the latter group played an active part in the present study.

Concurrently, with its own committee people and staff, the sub-committee gathered fiscal and other pertinent data from the institutions and other sources.

III

THE PROBLEM OF GENERAL HOSPITAL

General Hospital's major problem in recent years probably may be summed up in one word - money.

Table 1 in the appendix summarizes the financial history since 1948. The table does not, however, reveal the stresses and strains that underlie the hospital's fiscal position. It shows that revenue and balances exceed expenditures and that the hospital ends each year in the black. Not shown are the fact that in order to achieve this balance certain employee groups have had to go without salary increases granted other City employees, that from time to time the hospital has had to cut back on necessary equipment purchases, and that certain service expansions felt necessary by the medical and administrative staff have had to be postponed or else undertaken at a reduced level.

The financial problem arises from several causes:

(1) Increased costs of goods and services, resulting from a rising price index and liberalized compensation, fringe benefits and working conditions for employees.

(2) Reliance on property tax revenues which do not keep up with these increased costs because of (a) a relatively fixed millage limitation (1), (b) a tax base increasing at a relatively slower rate than the price index.

The restrictive effect of the hospital's millage limit has been moderated in recent years by transfers of substantial sums from other funds under the Board of Public Welfare, namely, the Welfare and Poor Relief funds. However, these funds are also under property tax millage limitations and, if transfers are continued, eventually will run out of margin to aid the Hospital Fund. In fact, this is what has happened in 1958 when the recession put an unforeseen demand upon the Poor Relief Fund, with the result that the Hospital Fund will net about $110,000 less in transfers from the Welfare and Relief funds than was anticipated in 1957.

To place the hospital's financial condition in its proper perspective, a number of observations are necessary.

First, the annual agonizing that the hospital goes through before its budget is finally adopted certainly is more indicative of the headaches in financing experienced by the hospital authorities than the balanced figures finally adopted in the budget and generally reflected in our Table 1. For the practice of the Board of Public Welfare, which makes the final budget determination of the hospital along with the budgets of the Relief Division, Workhouse, and the Health Division, has been to require the individual departments to submit their original budgets mainly on the basis of revenues allotted to them. This means that the hospital can anticipate for sure only the returns from the Hospital Fund property tax levy and miscellaneous revenues, chiefly fees from paying patients. A glance at Table 1 and the transfers in from other Welfare funds will indicate how much the hospital relies on money from the other Welfare Board funds to meet its needs.

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(1) The hospital's authorized property tax of 5.0 mills (adjusted for homestead exemption), in effect since 1945, was increased to 5.5 mills (adjusted) by the 1957 Legislature.

Because the hospital has had to go through the yearly process of anticipating with certainty only revenue from its own resources, and then has had to depend on the Welfare Board to allot what it could from the other Welfare Board funds, the hospital's fiscal uncertainty has been greater than the final results of the budgetary process indicate.

Last year the City Council took a step toward easing this condition by asking the Welfare Board to consolidate its funds to be used for giving salary increases to the employees of its four divisions, so that there would not be inequities among employees of these divisions. If the Welfare Board would consolidate the funds under its jurisdiction and end the fiction of appearing to finance each function out of the fund specifically allotted to it, the hospital's annual uncertainty would be somewhat further relieved.

A second point about the hospital's financial situtions is that in many respects it is not a unique one in the City government. Other Welfare Board agencies face money problems repeatedly. As already noted, this year the Relief Division has had to receive help from other City funds. Also, other City departments likewise are constantly facing financial problems. Thus agencies under the City Council's Current Expense Fund have for a number of years now had to tighten their belts and in some cases restrict services.

In some respects, however, the Hospital's financial problems are unique. In the first place, the provision of emergency hospital care and acute hospital and out-patient care for the indigent and medically indigent can not be reduced with as little immediate detriment to the community as, for example, a stretch-out in garbage collection schedules or the use of fewer policemen for directing traffic. The hospital is obligated to meet these hospital needs just as the Relief Division is obligated to provide relief to the eligible needy.

In the second place, it is more difficult for the hospital than other municipal activities to reduce its expenses to meet reduced demand for its services. The hospital's five services, (medicine, surgery, psychiatry and neurology, obstetrics and gynecology, and pediatrics) are fairly independent of one another and a drop in the work load of one can not result in a proportionate decline in staff, or transfer of such staff to another service or shutting down of a ward.

It should also be pointed out that the hospital is now operating with minimum staffing in many departments. Many experts would like to see certain functions increased or strengthened and in addition some services added. Actually, the hospital has been limited by finances and has had to adjust its services to the money available.

IV

THE PROBLEM OF GLEN LAKE SANATORIUM

The major problem of Glen Lake Sanatorium is the decline in patient load, due to the recent great strides in arresting tuberculoses through new drugs and surgical techniques. The patient load declined from 539 in 1952 to 323 in 1957. On a rated capacity of 550 beds, this is a drop in occupancy rate from 98% to 59%.

The result has been an increase in the cost per patient day from $13.56 in 1952, to $25.89 in 1957. Disregarding for the moment the question of whether this steep rise in unit cost might be slowed down by administrative measures, it is clear that the maintenance of a large unused capacity will inevitable continue to rise with

further decline in the incidence of tuberculosis and improvements in case finding and treatment. It is also clear that there is an economic waste in leaving beds stand empty while the demand for beds for non-tuberculosis illnesses is great and increasing.

V

POSSIBLE METHODS OF DEALING WITH GENERAL HOSPITAL PROBLEM BY CONTINUING THE HOSPITAL AS A CITY INSTITUTION OR ABANDONING IT

1. Increased efficiency and economy.

The City Council and Welfare Board early this year employed a management consultant firm at a cost of $12,000 to survey the hospital's management practices for the purpose of suggesting the best way of effecting economies. This is commendable, and in time should result in reduced costs. However, we do not feel that it is likely to yield the magnitude of savings needed to obviate other measures to improve the hospital's financing.

2. The adjustment of salary levels of certain personnel to bring them in line with salaries paid comparable positions in private industry and voluntary hospitals.

For some time a recurrent criticism of General Hospital has been that it pays certain employee groups more than similar employees receive in other hospitals. Nurses are the group usually singled out, and they defend their pay differential on the grounds of the more difficult working conditions in General Hospital.

With the recent money shortage at the hospital, however, the Board of Public Welfare has not been able to grant cost of living increases regularly to its employees. As a consequence, the employees such as nurses who formerly had higher salaries than their counterparts outside, receive salaries equal to or lower than the latter's. The hospital superintendent says this has been reflected in the loss of some employees to other hospitals, mainly nurses and anaesthesiologists.

Other employees, such as building custodians, have had a salary experience similar to nurses and some other technicians -- higher salaries than outside but the differential disappearing because of no increases in recent years.

The salaries of these employees are related to salaries paid to other City employees. This becomes, therefore, a problem of City salary levels as a whole compared with outside salaries as a whole, and is a general problem for the City's governing bodies, particularly the City Council, to deal with. We believe that General Hospital salaries should be equal to but not more than or less than those paid in other hospitals.

3. Abolition of Board of Public Welfare with welfare functions being placed directly under the City Council and appointment of a hospital advisory commission.

Much of the strain of the hospital's financial pinch has developed around the discrepancy between salaries paid employees of the Welfare Board and salaries paid employees of other City agencies. In a previous report of this committee concerned with the Charter provisions relating to the health and welfare functions (June 1957) the situation was summarized as follows:

"1. The Welfare Board has responsibility to keep its employees' salaries at a comparable level with salaries paid other City employees, but (a) it lacks the fiscal authority to raise the additional money and (b) the nature of its operation makes it difficult to reduce manpower in order to spread what is available among fewer employees.

"2. The City Council has limited legal responsibility to help provide funds for the Welfare Board and it has fulfilled this responsibility and even more, as evidenced by its transfer of money from other funds.

"3. No one agency of the City Government has authority and responsibility for equitable treatment of employees in salary matters in the several separate agencies. The Board of Estimate and Taxation has authority to set maximum tax levies, but it has no power to direct equitable salary treatment among the various agencies.

"The result is that employees performing similar duties in the same governmental jurisdiction are receiving unequal pay, with inevitable feelings of injustice, unfair competition among agencies for people to fill vacant positions, and deterioration of morale."

The committee recommended that the best solution to this situation would be to abolish the Board of Public Welfare as a supervisory and administrative body, and place the four divisions directly under the City Council. On the assumption that Charter revision might provide for setting up a chief executive in the City government, the committee also recommended that for administrative purposes the four welfare divisions be placed under the chief executive. If a chief executive were not set up, the committee still recommended abolishing the Welfare Board and placing the administrative divisions, including the hospital, in the same organizational framework with the City Council agencies.

"While under this alternative the Welfare Board as presently constituted would disappear and division heads would be appointed by and directly responsible to the chief executive, the value of an interested group of citizens for advising on health and welfare functions and for interpreting the divisions' work to the community should be retained by setting up an advisory health and welfare commission, or separate health and welfare commissions."

We still believe that if a serious charter revision effort is undertaken that the aforementioned changes in the health and welfare organization should be part of the revision, so long, of course, as these functions are still being exercised by the City government.

4. Reduction of certain services now provided by the hospital yet not essential to the operation of a general hospital.

It seems that this is not a feasible alternative. In fact, the tendency is in the other direction for general hospitals serving as teaching institutions. This is because well-rounded teaching programs require a full complement of the services to be provided by the hospital.

In recent years, for example, General Hospital's psychiatric service has been expanded in response to the demand for such service as an integral part of the teaching program, as well as the fact that in the long run it will be of real service to the community, as a preventive as well as a restorative function. Also, this year efforts to establish a research laboratory finally culminated in success, due to the raising of voluntary contributions. The driving force motivating the group of doctors who pushed this accomplishment was the belief that adequate research facilities are necessary to a total service and teaching program.

It is sometimes suggested that the hospital could reduce costs by giving up its program of teaching doctors and nurses. In 1956, however, the chief of medical services estimated that the services of visiting staff and internes and residents at the hospital were worth over $1,000,000 and were costing the City only about $190,000. A similar favorable balance exists for the City in regard to nurses' training. In addition, of course, there are the intangible benefits to the community of the highest type of patient care, and ready access to the source of supply of skilled doctors and nurses for the entire community.

It appears, therefore, that if General Hospital is to continue in its present role as a tax-supported hospital with a related teaching function, there is little prospect that it can reduce any of its services. In fact, as medical science progresses, the hospital will be compelled to increase services.

5. Permit visiting staff to bring private patients to the hospital and permit non-staff physicians to refer their patients to the hospital for the specialized treatment available there.

Doctors on the staff at the University Hospitals are permitted to have their own patients for treatment at the hospital. As private pay patients they provide another source of income for the hospital.

It has been suggested that the visiting staff at General Hospital have a similar privilege to treat their patients at the General. This does not seem feasible because these physicians also have staff appointments at voluntary hospitals where they currently take their pay patients. Diverting some of these patients to General would create competition for the voluntary hospitals. In addition, physical facilities for private patients (such as private rooms) are not now available and to provide them would require considerable capital expense.

6. Possibility of abandoning General Hospital and sending present indigent emergency and contagious patients now treated there to voluntary hospitals.

One of the possible solutions proposed for General Hospital's building problem back in 1952 during the Citizens League's first study was the gradual abandonment of the hospital and assumption of responsibility for its services by voluntary hospitals. Because the idea was advanced by leading figures in the hospital and medical fields at that time, the League took pains to determine how feasible and serious it was. Our conclusion was that the answer was uncertain because of the number of important questions that were left unanswered.

Over five years have passed since that time and there has been a number of significant developments in the voluntary hospital field, most important of which is the United Hospital Fund drive. The committee therefore decided it was important again to review the relationship of General Hospital's role to the voluntary hospitals, and particularly to see whether this provided a better adjustment for the hospital's recurring fiscal problem as well as perhaps a sounder long run role in the community. Deliberate efforts were therefore made to get the views of members of the medical society, voluntary hospital administrators, the United Hospital Fund and the University Medical School.

We may summarize the advantages, disadvantages and problems of abandonment of General Hospital as follows:

Advantages

a. To the extent that the University Medical School could work out the arrangements, it would permit all the voluntary hospitals to improve their interne teaching programs, with consequent improvement in the general tone of services in these hospitals. We were impressed that none of the groups consulted contradicted the view that a teaching institution is able to provide better hospital service than a non-teaching institution. It seems desirable that paying patients as well as public and emergency patients have the benefit of such improved service.

b. Along with improved interneship programs would come other improvements in the voluntary hospital services, such as genuine out-patient and emergency care facilities. These also are essential to teaching institutions and redound to the benefit of all patients cared for at such institutions.

c. It would remove the still-remaining stigma of patients' going to an "indigent" hospital.

Disadvantages

a. Loss to the community of one central teaching hospital for indigent patients. The free services donated by the medical profession to one central hospital have permitted the establishment of excellent patient care, teaching and research programs.

b. Loss to the community of one central emergency and accident service. The volume of this service has been sufficiently large to support a highly-trained and most efficient staff. Were this work divided among several hospitals it is doubtful if as good a service would result.

c. The attraction to the community of young physicians by the excellent training program at the General would suffer as it is doubtful if all of the voluntary hospitals could develop sufficiently good programs to attract the same quality of internes and residents.

d. The very existence of a governmental hospital financed from public funds acts as a limiting factor on finances and cost of patient care. Were all care to be given in voluntary hospitals the community would have no direct control of costs of this care.

Problems

Statement of the disadvantages indicates some of the problems which would be involved in abandoning General Hospital. Three may be singled out:

a. The working out of adequate arrangements between the University Medical School and the voluntary hospitals for teaching appointments and the other conditions necessary to maintain adequate scholastic standards at the voluntary hospitals.

b. Adequate provision for people now employed by the General Hospital. This includes protection of pension rights, salaries, etc.

c. Working out of satisfactory arrangements for continuing in the voluntary hospitals the nursing training now carried on in General Hospital.

In our opinion, the disadvantages and problems connected with abandoning General Hospital at this time outweigh the advantages, and we therefore believe that the hospital should continue as a governmental institution.

When the time comes, however, for decision on major replacement of physical structures of the hospital, this fundamental problem should be carefully reviewed by responsible community leaders. It must be considered and decided and the decision carried through essentially by the same group who have planned and sparked the United Hospital Fund, plus local government officials and the leaders of the University Hospitals, which also have a stake in the future of General Hospital.

We suggest that the Citizens League assume responsibility for seeing that these community leaders are brought together at the proper time, to make this decision.

7. Increasing patient income by increasing the number of County Welfare cases at the hospital.

A good deal of interest has been shown in recent years in increasing the number of County Welfare old age assistance (OAA), aid to dependent children (ADC), aid to the disabled (AD) and aid to the blind (AB) patients going to the hospital as a way of boosting the hospital's revenue. This is based upon the belief that the hospital has a large number of empty beds which create fixed costs that must be paid regardless of whether the beds are occupied and that the income from having the additional patients would more than offset the additional operating costs of providing for their care. County Welfare costs are shared among the County, State and Federal government.

The hospital's rated capacity at the present time is substantially less than it was at the time of our original hospital study in 1953, as indicated by the following figures:

GENERAL HOSPITAL

Normal bed capacity

Service	1952(1)	1958(2)
Medicine	245	141
Surgery	106	117
Psychiatry & neurology	42	79
Obstetrics & Gynecology	125	40
Pediatrics	111	57
TOTAL	629	434

(1) called normal capacity by Superintendent Holmquist
(a) called current bed complement by Superintendent Smith.

The reduction of 195 beds normally available is due to expansion of the social service department into one of the stations, loss of space due to remodeling and other physical improvements at the hospital, and the removal of beds from many

stations on the grounds that they were placed there in the first place more as an emergency measure than with any intent of representing the desirable normal bed capacity.

Since 1952 the average daily census at the hospital has varied between 341 (in 1952) and 295 (in 1954). For the first six months of 1958 it was 333. On a 434 capacity, a 333 census represents an occupancy ratio of 77%. Since a desirable occupancy ratio is considered to be 80% - 90%, a 77% ratio can not be regarded as an indication of gross under-use.

Still, it does leave room for expansion, and warrants close examination of the suggestion that County Welfare patients should be sent to the hospital in greater numbers. To do this, it is necessary to go into some detail as to the county welfare program and its relationship to General Hospital.

Relationship of County Welfare program to General Hospital.

Under the township system of relief prevailing in Hennepin County, cities, villages and townships are responsible for poor relief. The City of Minneapolis maintains General Hospital as part of its relief responsibility. The County government, on the other hand, is responsible for the federal assistance programs (OAA, ADC, AD, AB), which are financed jointly by the County, State and Federal governments. These welfare functions are administered under much more detailed regulation by the State Government than are the direct relief programs.

Until the late 1940's, County assistance recipients needing medical care had free choice of physician and hospital. At that time the State Welfare Department issued a regulation that hospital care must be obtained at a "public facility" whenever available. Because Federal regulations would not permit payment of the Federal share of County grants for persons in public facilities, this meant in effect that county welfare recipients should go to locally-supported institutions, such as General Hospital, and thus become solely a charge on the local community instead of receiving some funds from the State and Federal government. Presumably this State regulation was promulgated as a result of legislative criticism of the mounting State cost of medical care under the county welfare program, and was an effort to push this cost on to the local communities which had their own hospitals. This meant mainly Minneapolis and Ramsey County.

In an effort to comply with the new State regulation regarding public facilities, the Hennepin County Welfare Board in 1950 worked out a procedure whereby before physicians could refer county aid recipients to voluntary hospitals, they had first to check to see whether a bed were available at General Hospital. This was tried for about three months, and ran into many administrative difficulties. There were administrative complications of clearing with the hospital or the Welfare Board 24 hours a day, seven days a weeks. Another problem arose from the stigma which the hospital still had from the depression days as a hospital for relief cases. With this feeling carrying over, many county aid recipients, who had been accustomed to going to voluntary hospitals, balked at being forced to go to General Hospital. Public officials sometimes came to their support in their refusal to go to General, and in addition there was some difficulty in getting full cooperation from all physicians, since the physician had to surrender his case to the General staff when his patient went there.

After about three months, County Welfare Officials sought to confer with the physicians and General Hospital officials on improving the procedure. However, at about the same time, City officials decided they did not wish to continue to finance County cases, so they directed that City payments for County Assiatance hospital

care at General be terminated. The County Welfare Board was left no choice but to send all its assistance patients to voluntary hospitals.

Late in 1950 the Federal law was amended to permit county aid recipients to go to public facilities, and they were then received at General as patients paid for out of County welfare funds. This situation continues till today. However, it is probable that the break occurring in 1950 when the City refused to accept County welfare patients as "free" patients had some effect in reducing the number of patients who subsequently came to General Hospital, since such patients, once having established a relationship with a voluntary Hospital through their physician, probably were reluctant to go back to General Hospital, which deservedly or otherwise still had some of the stigma developed during the depression days, and since going to General would mean severing their direct hospital connection with their physician.

Today State Welfare Department regulations still require county welfare patients to go to public facilities for hospital care, if the facilities are available, and feasible. County welfare workers maintain that they urge their public assistance recipients to use General Hospital whenever possible, but in 1957 the hospital had an average county welfare census of 59 out of the total 198 in all hospitals and there was still unused capacity at General.

Why doesn't the County Welfare Department send more patients to General? Why doesn't it, in fact, follow Ramsey County's example and send all its patients to General, as Ramsey sends them to Ancker?

Ancker Hospital in Ramsey County.

Ancker Hospital in Ramsey County is frequently cited in discussion about General Hospital. The essential difference between Hennepin County welfare patients and General Hospital, on the one hand, and Ramsey County welfare patients and Ancker Hospital on the other, is that Ancker has always had ample capacity to receive all county patients in Ramsey County whereas General Hospital has not been able to receive all Hennepin County's county patients. Ancker has a bed capacity of 840 beds, including TB beds. In October 1957, the hospital had an average patient census of 78 TB patients and 481 of all other patients, including OAA and ADC patients.

In General Hospital on the other hand, as we have seen, there are 434 beds, and 333 are used, including 59 county welfare patients out of a total of 198 at all hospitals.

Thus, for county welfare patients to be directed to General Hospital requires that some procedure be set up for discriminating between county welfare patients, since General can only handle a certain portion of the total. This necessarily involves difficulties which Ramsey and Ancker do not have to face.

It has been suggested that it would be possible to avoid this problem of discriminating between welfare patients who go to General and those who go to voluntary hospitals by pooling the combined vacant capacity of General and Glen Lake Sanatorium to handle these patients. Consideration of this proposal involves more analysis of the Glen Lake problem and the alternatives suggested for its solution, and will therefore be discussed in that section of this report.

"Free choice", and the voluntary hospitals.

Mandatory referral of all county welfare cases to General Hospital and Glen Lake Sanatorium, or to one or the other, runs into two problems. The first is the so-called "free choice" of hospital and thus physician. The second is the effect on the patient loads and thus the income of the voluntary hospitals.

With regard to the first problem, it is clear from the recital of the history of policy of hospital care on county welfare cases in the foregoing pages that "free choice" is really not a right of the patient at all in the event adequate public facilities are available and feasible to which they can be referred. On the practical side, we hear conflicting statements by members of the medical profession as to the significance in numbers of their welfare patients and as to the frustrations and red tape involved in taking care of welfare patients they send to voluntary hospitals.

With regard to the effects of diverting the present county welfare patient load in voluntary hospitals to public hospitals, last year the average county welfare patient census in voluntary hospitals was 139, out of a total average census of about 2,500, or about six per cent. If General Hospital took 20 to 40 more of these patients it would not make much of a dent on any one of the voluntary hospitals, and according to the General Hospital superintendent, would ease the hospital's financial situation considerably.

We believe that the County Welfare Board should immediately reestablish the practice of 1950 of requiring physicians to clear with General Hospital as to availability of beds there before sending them to other hospitals. While there are procedural difficulties to be worked out, we believe the administrative and medical personnel involved are imaginative and determined enough to develop a workable program. General Hospital's financial situation should be enough incentive for a maximum effort in this direction.

We believe that in recent years the hospital's reputation as a place to receive care has been substantially enhanced and this reputation has become sufficiently well-known so that much of the negative attitude toward the hospital has been overcome.

On the other hand, the hospital should strive to make its services more attractive and convenient for the County patients. One suggestion we have heard from a competent source is that the hospital provide visiting physicians service for county welfare patients. It already has such service for relief patients, but not for county welfare patients. As a result, when county welfare patients released from the hospital become ill at home they must go into the hospital again in order to receive a General Hospital physician's attention. Rather than bother to do that, they are inclined to call a private physician and thereafter become his patient and are generally sent to a voluntary hospital instead of General if they again need hospital care.

Adequate financing is vital

General Hospital, as any key City service, deserves financial support adequate to avoid occurrence of financial emergencies every year. We believe that adoption of the suggestions outlined above would provide an easier financial and administrative atmosphere within which the hospital could continue to operate as a city institution. However, if after making an effort to put into effect the suggestions on finding economies, straightening out wage problems and instituting mandatory referral, the hospital is still in financial straits, we believe every effort should be made to find addition-

al resources for it. The hospital is a vital community asset and the community should face the fact that it needs adequate financing if it is to make its maximum contribution.

VI

POSSIBLE METHODS OF DEALING WITH THE GLEN LAKE SANATORIUM PROBLEM

These include the use of vacant beds for non-tuberculosis care under County operation, or under non-governmental operation.

1. Use of vacant beds for non-tuberculosis care under County operation.

There appear to be two general types of non-tuberculosis care which could be given in the vacant beds at Glen Lake: (a) Nursing home care and (b) general hospital care for acute and convalescent illness.

(a) Nursing home care.

A principal recommendation of the Community Welfare Council in 1957 was that vacant beds be made available at Glen Lake for nursing home care for patients able to pay in whole or in part as well as for the medically indigent. This was based on the shortage of nursing home facilities in the county and the ready adaptability of the facilities at Glen Lake for such care.

While the Legislature was asked at the 1957 session to permit use of the sanatorium for nursing home facilities, this type of use was specifically excluded.

(b) General acute and convalescent care.

The Community Welfare Council also recommended that the Sanatorium Commission seek legislation which would permit greatest possible utilization of those facilities not required for tuberculous patients. Presumably this would include use for acute and convalescent care, although the CWC felt that under existing conditions the only need for general hospital facilities at the sanatorium would be for the care of some of the patients already housed there for nursing care. One of the major conditions was continuation of the policy of hospitalizing in voluntary hospitals the county welfare patients requiring acute care.

The 1957 law on Glen Lake permitted use of beds for convalescent and acute care, but to date no such cases have received care at Glen Lake.

We believe that a sound policy for Glen Lake would be to institute mandatory referral to the sanatorium of county welfare cases needing acute and convalescent hospital care. Such a policy could be with or without provision for alternative referral also to General Hospital, although we believe it should be accompanied by such possible referral to General.

With this would be the operation of an emergency service for all people, indigent and non-indigent.

The advantages of this arrangement would be:

(1) Use of a sizable part of the unused bed and staff capacity at the hospital for a purpose for which the capacity is already suitable or may be made so without much apparent difficulty.

(2) The relief which the use of this capacity will provide for the bed shortage in voluntary hospitals.

(3) The establishment of an emergency service in an area of the county which is already well-settled and gives promise of great population expansion in the future.

(4) The administrative advantage of government's discharging its responsibility for the hospital care of the indigent in government-controlled institutions.

The disadvantages of this arrangement would be:

(1) The immediate impact on the finances of the voluntary hospitals, from loss of an average patient load of about 140. However, the distribution of these patients among the voluntary hospitals is such that this change's effect on any one hospital would be considerably minimized.

The type of staff control over patients would determine whether the physician-patient relationship of county welfare patients would be disturbed. If the sanatorium became a closed teaching facility similar to General Hospital the existing physician-patient relationship would be severed, since patients on entering the hospital would come under control of the teaching staff and internes and residents. On the other hand, if the existing permanent staff in the sanatorium functioned alongside private doctors who had staff privileges similar to their privileges at voluntary hospitals, the present physician-patient relationship of county welfare patients would be continued.

In either case, however, we believe the overall advantages of this system of using the vacant beds at Glen Lake Sanatorium would outweigh the disadvantages.

2. Use of vacant beds for non-tuberculosis care under non-governmental operation.

There has recently been a suggestion that faster action would be forthcoming in getting use out of the vacant beds at Glen Lake if the Institution were leased or sold to a non-governmental group for operation. Not having been able to get the details of any concrete proposal of this kind, we are not in a position of comment on it as an alternative to suggestions already made. Should such a proposal be made, however, we would plan to compare it with the other alternatives.

VII

PLACING GENERAL HOSPITAL UNDER THE COUNTY WITH GLEN LAKE SANATORIUM

It is sometimes suggested that the best solution of the General Hospital problem would be to transfer the hospital to the County. Some groups apparently advocate this move in the belief that, compared with the City government the County government is less restricted by property tax limitations and has a more liberal attitude toward public expenditures.

In considering this alternative, therefore, we think it is worthwhile to repeat the objective which we believe should be the primary concern in considering the General Hospital problem: to determine the best provision of hospital services to the indigent and the tuberculous within the financial resources available, the most effecient use of hospital facilities, and a just distribution of the public costs. We do

not believe that the relatively greater availability of funds should be a factor in considering transfer of the hospital to the County, since we feel that whichever government is responsible for the hospital, the community should finance it adequately and the hospital should be operated with all possible economy and efficiency.

Under what conditions, if any, would it be desirable to transfer General Hospital to the County government? Before considering the possible conditions, it is important to have a clear picture of the way hospital care for the indigent and medically indigent is currently handled throughout the County, since transfer of the hospital would doubtless have an effect on this system and the way it is financed.

Present pattern of hospital care for Hennepin County indigent.

University Hospitals is maintained by the State primarily as a teaching institution but secondarily to provide care for any indigent resident of Minnesota who needs it. Admission upon recommendation of the patient's physician, is granted when the case is of teaching interest and when a county commissioner certifies as to the person's need, financially and medically. Indications are that few cases are turned away because they lack teaching interest. In Hennepin County, County Commissioners require a doctor's certificate as evidence of medical need.

The "public pay" cost of University Hospital patients is shared fifty-fifty between the State and the county of residence.

Hennepin County townships and municipalities outside of Minneapolis have no public hospitals of their own to which to send their indigent. In rare cases, to our knowledge, do they send them to voluntary hospitals, for which the governmental unit must stand the bill. The usual procedure is to send the indigent to the County Commissioners office where, after presentation of doctor's certification and a checking of financial resources, they are certified to University Hospitals. Thus, the county as a whole pays for one-half of their bill. Of this, of course, the City taxpayers pay a share proportionate to the City's share of the County's taxable valuation, or about 70% currently.

Minneapolis residents also use the University Hospitals under this procedure. Some of these are cases that require treatment which is available at University but not at General. Deep therapy is an example. The bulk, however, appear to be persons who could be cared for at General but do not go there because (1) they do not qualify under General's financial eligibility standard but do qualify under an apparently more liberal County Board standard, or (2) they have a personal preference for University and find their preference honored by a County Commissioner.

To the extent that persons presumably eligible for General Hospital care go to University Hospitals, the City is of course shifting part of their hospital expense to non-Minneapolis taxpayers in the County. This could possibly be a reason for the County Board's liberal certification policy, since four-fifths of the commissioners are from Minneapolis.

A League analysis of Hennepin County indigent patients (other than county welfare) admitted to University Hospitals through the County Commissioners office in 1952-53 showed the following:

Place of settlement	1952	1953
Minneapolis	637	747
Suburban and rural Hennepin	596	727
Total	1233	1474

Projecting this percentage distribution to 1957 expenditures and taxes indicates the following distribution of benefits received and payments made for hospital care at General and University hospitals for indigent patients (other than county welfare) from Hennepin County.

ESTIMATED DISTRIBUTION OF HOSPITAL BENEFITS AND EXPENSES BETWEEN MINNEAPOLIS AND REST OF HENNEPIN COUNTY, FOR HOSPITAL CARE OF HENNEPIN COUNTY INDIGENT GIVEN AT UNIVERSITY AND GENERAL HOSPITAL

(excluding county welfare cases)

1957 (000 omitted)

Dollar benefits received(1)

	Minneapolis residents	Suburban residents	Total
At General Hospital	$ 3,177	$	$ 3,177
At University Hospitals	390	374	764
Total	$ 3,567	$ 374	$ 3,941
%	90.5	9.5	100.0

Paid for

	by Minneapolis	by Suburban Hennepin	by State	Total
At General	$ 3,177	$ -	$ -	$ 3,177
At University	$ 267	$ 115	$ 382	$ 764
Total	$ 3,444	$ 115	$ 382	$ 3,941
%	87.4	2.9	9.7	100.0

(1) These are the tax dollar costs of benefits received, since they do not represent for example, the full dollar value of services provided by internes, residents and teaching staff.

It is obvious from these figures that, because of the use of University Hospitals for hospital care for the indigent and medically indigent of suburban and rural Hennepin, the taxpayers of that area are paying much less in local (county) taxes than the benefits they receive.

Parenthetically it is interesting that the figures indicate that, contrary to common belief, Minneapolis taxpayers are also paying less in local (city and county) taxes than the benefits they receive, also because of the use of University Hospitals.

Conditions of change to a county hospital.

The present distribution of benefits and payments points up the importance of the type of conditions under which Minneapolis General Hospital might be transferred to the County. Any substantial shift of fiscal burden to any one the three taxing areas involved (Minneapolis, rural and suburban Hennepin County, and the State) would need to be avoided, unless at the same time an inequity were corrected or an offsetting public good obtained.

The following questions indicate the range of variables in changing General Hospital to a county institution:

(a) Would the County manage the hospital as a self-supporting institution with patient costs being fully charged to the patient or back to governmental units responsible for his indigency or medical indigency costs,or would the costs of public-pay patients be covered by a county wide tax?

(b) Would township and municipal relief responsibility continue or would relief responsibility also be transferred to the County?

(c) Would the County Board continue sending about as many patients from the County, including Minneapolis, to University Hospitals, or would it thenceforth insist that all who can receive care at General be sent there?

(d) Would the County Welfare Board try directing more OAA and ADC patients to General, or would it continue the present policy?

(e) What would be the relationship to Glen Lake Sanatorium? Would the General Hospital come under the same governing body, management and financial support as Glen Lake, and would services be correlated with one another, or would both continue separately as at present?

In choosing among the various alternatives suggested by these questions, the most important single factor is which pattern will produce the best hospital care for Hennepin County residents. While the question of township vs. County relief would not affect the direct provision of hospital care, it does have a marked effect on a uniform treatment of the Hennepin County residents who are eligible for hospital care.

Problems of General Hospital and poor relief system should be separated.

In much of the discussion about transferring General Hospital to the County, there is an underlying assumption that the transfer would need to be accompanied by a switch from the present township relief system to the county relief system in Hennepin County.

It is true that Minneapolis relief recipients needing hospital care must get it at General Hospital if it is available there, and that proposal for the conversion to the county relief system usually include transfer of the hospital as part of the package. However, we see nothing legally or practically which would necessitate a switch to the county relief system if the hospital were transferred to the County. The two are quite separable problems.

As to the advisability of requiring the conversion to the county relief system if the hospital were to be transferred, we take a negative view. This is because of the serious differences of opinion which exist in Hennepin County over the county relief system. The hospital's future need not become involved in this controversy, and we believe that it should not.

Proposal for transfer of General Hospital.

Assuming continuation of the township system of relief, we believe the most satisfactory situation for shifting General Hospital to the County would be to place it with Glen Lake Sanatorium under a single governing body and a single medical administration, continue to require Minneapolis relief patients to receive their care at General with the cost of their care being charged back to the City, and require all county welfare patients to receive their care at the two institutions and University Hospitals.

(a) Administration of General Hospital and Glen Lake Sanatorium by a single governing body and a single medical administration.

There seem to be some obvious administrative advantages in having the two public hospitals under the same governing body and administration, so as to have consolidated purchasing and stores, personnel administration and the establishment of uniform standards for the care of indigent patients. If the University Medical School were to work out a teaching program at Glen Lake similar to that at General, the Joint administration of the two institutions would make teaching coordination much simpler. Finally mandatory referral of county welfare patients to General Hospitals, involving the use of a limited number of beds, would be more easily handled under this arrangement because of the closer ties to Glen Lake.

We suggest that the hospital plant be transferred without charge to the County government.

(b) Continuation of policy of requiring Minneapolis indigents to get their care at General Hospital with cost being charged back to Minneapolis.

This recommendation follows from the fact that the township system of relief will be continued, since under that system the responsibility for medical and hospital care continues with the township or municipality of settlement. It would seem reasonable, however, that the charge for Minneapolis poor relief patients should be adjusted for the cost of plant depreciation, in recognition of the City's investment in the plant. Other patients (county welfare and private pay patients) should be charged the full per diem cost, including plant depreciation. The difference between patient charges should be made up by a county-wide tax.

(c) Mandatory referral of all county welfare patients to Minneapolis General, Glen Lake Sanatorium and University Hospitals.

As indicate previously, we believe that the immediate solution for fuller usage of General Hospital is mandatory referral of county welfare patients to the Hospital and that as soon as Glen Lake is able to take them, such patients should also be referred there. Under a unified governing body and medical administration the problems of coordinating services between the two institutions would be simplified. Certainly the difference in location and the differences in specialized services of the two institutions would provide advantages in patients going to one institution rather than the other, but this would be worked out better under a single coordinated administration than under independent institutions.

The county would continue to send about the same number of indigent patients to University Hospitals as now are sent there. This follows again from the conclusion to keep the relief system as it is. Sending patients -- from Minneapolis as well as from rural and suburban Hennepin -- to University hospitals is necessary because of some of the specialized services available there. Also it enables the County to take advantage of the State sharing in hospital costs. From the University Hospitals standpoint, these cases are essential for instructional purposes at the Medical School.

VIII

GENERAL CONCLUSIONS AND RECOMMENDATIONS

. General Hospital, like any organization, should constantly examine and re-examine its organization, policies and administration for the purpose of getting the most for its money. The Board of Public Welfare should be commended for having contracted for the recent management study, and should follow through to see that the greatest benefit is derived from the study and its recommendations.

. It is important that the hospital be able to pay its employees salaries and wages comparable to the community patterns, and the same as similar employees in other agencies of the City government. This has been difficult because of the separation of the hospital and other health and welfare functions from the City Council. The Council traditionally has taken the lead in salary matters as it has had greater financial resources than the Welfare Board to provide salary adjustments. If the hospital is to continue under the City government, we believe that this salary and financing problem will be remediable only if the hospital is made part of an integrated administration with other agencies directly under the City Council. We concur with the recommendation of the League's Forms and Structure Committee that this should be done by abolishing the Board of Public Welfare and, if necessary, setting up an advisory Health and Welfare Board or boards.

. If General Hospital is to continue as a teaching institution providing general acute and emergency care, we do not believe that it is feasible to reduce its services. In fact, the tendency seems to be more in the other direction.

. It does not seem feasible to expand the patient load at General by permitting the visiting staff to bring private patients there.

. While there are advantages as well as disadvantages to the suggestion that General Hospital be abandoned and the services be provided by voluntary hospitals, we definitely feel that the disadvantages are weightier at this time.

. Contrary to general opinion, there is no right, legal or otherwise, to free choice of hospital by county welfare patients. Under State regulation such patients must be referred to public institutions when the institutions are available and feasible. The feasibility of referral to General Hospital has been questioned because the hospital does not have enough beds to accommodate all the county welfare patients needing hospital care, and the practice of sending only a part of these patients to the hospital would require differentiation among patients.

We are confident that this problem of differentiating can be worked out with adequate attention and serious effort on the part of hospital and welfare officials, and therefore recommend that mandatory referral of County welfare patients to General Hospital be instituted immediately.

We believe the foregoing recommendations would ease the financial and administrative problems of General Hospital. Should additional financing be necessary, we believe the City or County as the case may be should make every effort to find it. The provision of hospital care for indigent and emergency cases is vital to the community. The hospital must have adequate finances to assure continued provision of this care.

. We believe that Glen Lake Sanatorium can be effectively used by providing acute and convalescent hospital care for county welfare patients. These patients should be referred mandatorily to the sanatorium, with or without arrangements for such referral to General Hospital also.

We believe the foregoing recommendations would go a long way toward resolving the basic current problems of General Hospital and Glen Lake.

. Consistent with these recommendations, but as a further step toward a sounder future role for Glen Lake and General Hospital, we believe that the two institutions should be under a single governing body and a single medical administration. This would have administrative advantages, for handling personnel, equipment and supplies at the two institutions and for expeditions arrangements for mandatory referral of all county welfare patients to the two institutions. Should the Sanatorium be tied in with the University Hospitals, for teaching purposes, the consolidation would also be in the interest of better overall coordination of the patient care of the two institutions.

. We believe that transfer of General Hospital to the County should not be tied in with conversion to county responsibility for poor relief administration. Each township and municipality should continue to provide for its own poor, but the City of Minneapolis should be required to continue sending its poor relief cases to General Hospital, unless care can be better provided at Glen Lake or University. The County should charge the cost of Minneapolis relief cases at General Hospital back to the City of Minneapolis.

. We suggest that the hospital properties be transferred to the County at no charge to the County government. However, the charge for patients of Minneapolis residence should be adjusted for the cost of plant depreciation, in recognition of the City's investment in plant. Other patients (county welfare, and private pay emergency and contagious patients, for example) should be charged full per diem cost including plant depreciation. The difference between patient charges and patient costs should be made up by a county wide tax.

Table I

MINNEAPOLIS GENERAL HOSPITAL

Resources and Expenditures

1948 - 1958

(000 omitted)

Resources	1948	1949	1950	1951	1952	1953
Opening balance	$ 25	$ 70	$. 4	$ 2	$ 158	$ 225
Tax Receipts:						
Real and Personal Property	1,507	1,629	1,681	1,735	1,809	1,913
Bank excise, grain	20	17	19	21	28	20
In-patient fees, Miscellaneous	308	416	380	608	910	984
Transfers in:						
From Public Welfare	394	322	522	465		
From Public Relief	365	350	116	46	383	506
From Current Expenses			36	96		
From other		7	55			
TOTAL RESOURCES	$2,619	$2,810	$2,814	$2,973	$3,288	$3,648
Disbursements:						
Personal services	$1,933	$2,171	$2,047	$2,226	$2,403	$2,583
Other operating expend.	615	634	600	569	650	794
Reserve for lands & bldgs						
Building repairs			106			
Transfers out:						
To Perm. Impvt. Fund			59	20	10	20
To Public Welfare						
TOTAL DISBURSEMENTS	$2,549	$2,805	$2,812	$2,815	$3,063	$3,397
Taxable Valuation (000)	$269,786	$292,686	$300,272	$307,918	$326,572	$338,549
Tax rate (mills)	5.635	5.62	5.62	5.635	5.615	5.615
Consumer's price index (1947-1949=100.0)	103.2	102.2	103.2	110.8	114.9	115.6

Minneapolis General Hospital - Resources and Expenditures - page two

Resources	1954	1955	1956	1957	Est. 1958
Opening balance	251	201	234	98	226
Tax receipts					
Real and Personal Property	$1,912	$1,972	$2,037	$2,093	$2,309
Bank excise, grain	22	33	14	19	17
In patients fees, miscellaneous	857	849	900	1,082	1,000
Transfers in:					
From Public Welfare	506	434	518	714	522
From Public Relief				350	121
From Current Expense	69=	134			
From other		182			
TOTAL RESOURCES	$3,617	$3,805	$3,703	$4,356	$4,195
Disbursements:					
Personal services	2,643	2,757	2,776	2,924	2,870
Other operating expend.	751	799	829	991	941
Reserve for lands & bldgs				214	207
Transfers out:					
To Perm Impvt Fund	20	16			
To Public Welfare					
TOTAL DISBURSEMENTS	$3,414	$3,572	$3,605	$4,129	$4,018
Taxable valuation (000)	$340,991	351,174	$360,389	$375,625	$382,371
Tax rate (mills)	5.615	5.625	5.61	5.60	6.10
Consumer's price index (1947-1949=100.0)	117.3	117.5	117.7	121.6	