CITIZENS LEAGUE REPORT

HOSPITAL

CENTERS . . . AND A

HEALTH CARE

SYSTEM

Suggestions for the role of Hennepin County General Hospital and the new area-wide Comprehensive Health Planning Program

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Health Care
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MAJOR IDEAS . . . . . .

* For all the good intentions of everybody in it, the health care system is not delivering care that is sufficiently accessible and available to the people of the community. One of the basic problems is that it is oriented to treating people who are sick, rather than keeping people well.

* In large part this is because the arrangements that have grown up over the years for organizing and financing this huge service have been structured to encourage the use of relatively more expensive, in-hospital care, and to discourage relatively less expensive care--both in out-patient facilities short of hospitalization and in extended care facilities after hospitalization.

* The Twin Cities area, therefore, has become oversupplied with hospital beds . . . at its present 5 beds per 1,000 population. This imposes a serious cost on the community. There is a danger, too, that new beds built in the suburbs as the area grows will worsen the situation unless ways are found, at the same time, to consolidate facilities in the central cities.

* The arrangements for financing are especially critical: with the extension of medical and hospital insurance to almost everyone, costs incurred for personnel or equipment or buildings are "passed along" to everyone who pays insurance premiums. So far, no one has been in a position effectively to ask: "Are these expenditures really needed or not? Is this the most efficient way to distribute health resources?"

* It is time, now, locally to begin improving the management of the health care system toward the goal of improved utilization. A series of steps is required:

. . . . . IN OUR REPORT

* First, some agency needs to be made responsible for thinking about the system, and ways of improving utilization. This should be the new Metropolitan Health Board under the Metropolitan Council.

* Second, this agency needs to be given a combination of negative and positive tools. It needs the authority to regulate the expansion of beds. But mainly, it needs the ability to guide the development of the hospital system, and to encourage innovation in the delivery of care, by early involvement and constructive suggestions.

* Perhaps the key is to develop new incentives in the system that will reward hospitals and doctors providing care for keeping people well and for using resources more efficiently. The providers need to bear some of the financial risk from calling resources into use.

* There is a special opportunity for the public hospital to use its program and facilities to experiment with new ways of delivery, organizing, and financing care. Specifically, in the rebuilding of Hennepin County General Hospital the County Commissioners should:

  . Plan and develop the new core hospital facility jointly with the Swedish-St. Barnabas Hospital group across the street, with an eye toward maximum sharing of facilities and services.

  . Move ahead with its plans for a "vertically integrated" system of programs and facilities for its patient group. To be effective in setting new directions for the community, the hospital probably will have to be open to a representative, if limited, cross section of the population.

  The Metropolitan Health Board should encourage both efforts by Hennepin County.

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INTRODUCTION

In the course of our study we have come to understand that the problem respecting "Hennepin County General Hospital" is not what we had thought it to be . . . in 1963, when the hospital was transferred from city to county jurisdiction, or even in 1969 in the course of the referendum on its reconstruction.

We had generally thought -- and the public with us, we believe -- that it was primarily and perhaps essentially a problem of replacing an old and inadequate building.

We have come to understand, first of all, that "the General" is not only a hospital, but also a large doctors' office. And not a conventional doctors' office, either, but an integrated organization of physicians and other health specialists that does represent -- in relation to the pattern typical of most of the community -- a different way of (as we now say) "delivering" health care.

We have come to understand, too, that powerful trends -- particularly in the financing of health care -- are subtly but fundamentally altering the role of the public hospital by eliminating both the epidemic disease and the medical indigency -- individuals' lack of money with which to buy health care -- which originally brought the public charity hospital into being. These trends are raising major questions about the future of the institution which must be faced as the community moves to a decision on a rebuilding of its program and facilities.

We have learned, too, that we cannot resolve these questions about the public hospital's future without an understanding of the extraordinarily complex and difficult issues and problems that beset the entire health care system, for the public hospital is, in many ways, and especially in this community, central in it.

We now recognize more fully that the proposal being brought forward by the County is much larger, in its substance and in its implications, than the proposal for a new hospital for which $25 million was authorized in September 1969. It is, to a significant degree, a proposal for a new way of delivering health care . . . and a proposal which raises, we have come to understand, all of the most difficult and most sensitive issues involved in this fast-changing area.

We have, therefore, explored these issues about the organization and financing of hospital and medical care, and about the future of post-graduate medical education, broadly and carefully with individuals involved in -- and knowledgeable about -- the situation in this community, as well as with officials of Hennepin County.

In general . . . though much remains to be settled with respect to plans and to cost, and subject to the reservation expressed below . . . we are prepared to encourage the aggressive efforts being made by the County to set new directions for the health care system.

We do so partly because we sense, even among individuals and organizations in the private medical and hospital system most directly affected, an awareness of the profound troubles that do exist, and a recognition of the need for basic change. We sense a broad agreement, specifically, that the troubles in the health care system are not related, fundamentally, to a shortage of dollars . . . and that, additional dollars may, in fact -- as many believe they did, with the arrival of Medicare -- make the basic structural problems of the system even more acute.

The need is, rather for incentives, or pressures, that will work on providers to produce good health care at a lower, rather than at a higher price . . . and will, in fact, encourage the provision of good health, rather than treatment for illness.

Though many of the decisions about health care will remain matters of national policy, some things can be done, locally, about the organization of health services. In particular, the need now to rebuild the programs and facilities of the county public hospital affords such an opportunity . . . for a move away from the traditional pattern of development in small-to-medium, self-contained, independent hospitals, and away from the present emphasis on providing conventional hospital beds to which people can be admitted when they get sick. The well-meaning impulse to provide more hospitals and more dollars with which people can buy hospital care, we have learned . . . much as this may clash with the conventional wisdom . . . is not curing the problems of the health care system. It may, in fact, be compounding them.

We will spell out our arguments for this re-direction of policy -- and why it is incumbent upon Hennepin County to capitalize on the opportunity presented -- in the pages that follow. First, however . . . as essential background and because we believe the issues are so largely unknown to the community . . . we must explain the situation we found and the changes we see taking place, both in the community and in the public hospital specifically.

THE COMMUNITY PROBLEM: OF HEALTH CARE, ITS DELIVERY AND COST

1. *The dramatic changes -- occurring in the Twin Cities, as in other areas -- present both an opportunity and an increasingly urgent need for the conscious rebuilding of the health care delivery system.*

   a. Expectations are rising rapidly -- Traditionally, health care has been considered -- like education in the mid-19th century -- a private commodity . . . which individuals and individual families could purchase in such quantities as they might desire and as they could afford. Public programs, so far as they reached out to individuals and families, were essentially charity programs. Today, an adequate level of health care is increasingly being considered a right for each individual and family. Increasingly, too, public efforts are moving in the direction of giving individuals and families the economic resources with which they can buy health care as they choose.

   We have most recently become extremely conscious of the extent to which inadequate levels of health care remain in certain parts of the community and in certain groups in the population. Given the new expectations, this is no longer regarded as tolerable.

   Finally, the new interest is not simply in giving everyone an equal opportunity to get well after becoming sick . . . but rather in giving everyone an

equally good opportunity to enjoy good health without becoming ill. Powerful trends are, therefore, working to explore the possibilities of a shift from the treatment of acutely and chronically ill people to the maintenance of health and the prevention of illness.

b. Health care is increasingly a public concern -- The health care system continues very largely under private ownership and management. Yet it is coming more and more to be seen -- by the people in it as well as by the people outside it -- as having essentially the character of a public utility. Steady and rapid increases in cost are forcing the private institutions to turn increasingly to public financing -- sometimes to the governmental "public" through tax support and sometimes to the general community "public" through broad-based insurance arrangements. There is growing public concern, too, with the failure of the system to "close gaps" . . . with the mal-distribution of high-quality health resources around the state and around the urban area, and with the variations in the extent to which these resources are accessible and available to lower-income groups in the population. This concern with the health care system is reflected in many articles in general-circulation magazines, in television series, in studies by non-health-professional groups -- and by concern on the part of leaders of the health community themselves. There is every reason to believe the issues in the health care delivery system will continue to find their way increasingly, too, into the political discussions that are the principal forums for the making of public policy in the state and in the region.

c. Hennepin County feels a special responsibility for innovation -- This committee began with the charge from the General Hospital Referendum Committee last summer and from the Citizens League's Board of Directors to be particularly concerned with ways in which the rebuilding of the program and facilities of Hennepin County General Hospital might be used to contribute to strengthening of the health care system in the community as a whole. We have found that the leadership of Hennepin County -- as its strong financial support of the institution since 1963 suggests -- does feel a special responsibility . . . to develop new and different, and more effective, ways, both to prevent and to care for illness. We believe this must continue to be a primary focus for the public institutions, particularly if the bulk of the responsibility for the maintenance of health and treatment of illness is to reside with private individuals and private organizations.

2. *Major changes need to be made in the method of organizing and delivering health care if an assured level of quality is to be made available to all persons in the community, and if the emphasis is to be successfully shifted to prevention and health maintenance.*

We have explored with public health officials and with others in the Twin Cities area -- which we regard as a remarkably sophisticated health community -- the question of the health levels of the population in this area. We find remarkably little hard information available that would give us an accurate profile of the health of the people by disease entity, by location, by age, and by economic group. We have gotten some general indications here that this metropolitan community does not experience the same extremes of high and low quality that are found in many other parts of the country -- urban and rural. Nevertheless, as we have laid out before the experts visiting with us the "indictment" of the

health care system presented now in innumerable speeches and articles in both professional and general publications, we find little basic disagreement that, in general, what is described as characteristic of the system generally in this country is also characteristic of the health care delivery system in our community. Specifically, this suggests that:

a. Substandard health, and health care, exist in "pockets" of our population -- We are told there is here, as elsewhere, a high correlation between low income and poor health. We assume, therefore, that really intensive surveys of health levels would demonstrate unacceptably low levels -- as regards infant mortality, nutrition, mental health, dental problems, eye defects, prenatal care, and other problems normally regarded by the general population as undesirable and avoidable -- in those areas which we know do exist with very low incomes. These can be readily identified -- in the inner portions of the central cities and in a number of areas of older housing in the suburbs, as well. This correlation has been generally confirmed in areas like Minneapolis' Model Neighborhood, where resources have been available for fairly careful studies of health levels.

b. Health care is not uniformly available to all -- We have used "available" to refer to the physical (and time) proximity of health care services to people in the community. We have been presented preliminary findings of a study which shows a continuing movement of private physicians and other health professionals out of the inner cities — continuing a pattern that in the past has led to a virtual disappearance of private practitioners from Minneapolis' lower north side. We see much reason to believe that this is an inevitable response of the health care delivery system to the changes taking place in the distribution of population. We simply do not know at this point whether this is a trend that will slow itself, once a redistribution of health services has been reached . . . or whether it will continue until a really serious shortage of services and facilities is reached in the entire older inner portion of the city. We see some merit, too, in the argument that health facilities and services are not necessarily unavailable to residents of the inner city simply because they may no longer be physically located in these neighborhoods: It may be, in some cases, as short and a more convenient drive to a doctor located in the suburbs than it is to a doctor located downtown. Nevertheless, the availability of transportation is, also, unevenly distributed among groups in the population and among portions of the community -- particular with the elderly. And, because it is in the inner city neighborhoods where automobile ownership is lowest and where public transportation to suburban locations is least convenient, we feel some special concern about the possibility that the number of physicians and other health professionals in the inner cities will continue to decline.

c. Health care is not easily accessible to significant groups in the community -- We have used "accessible" to refer to the opportunity an individual or a family has to get preventive care or disease treatment even when providers are physically located nearby. Typically, everyone is "on his own." The ethics of the medical profession prevent reaching out to offer care. The medical society and the specialty boards offer some guidance to the quality of a provider. But we doubt these are well known. No provider has anything more than perhaps a moral commitment to accept any individual or family as a patient. And, again, few institutions accept responsibility or are, in fact,

organized to provide care that is either comprehensive for all varieties of illness or continuous over a period of time. Typically, an individual seeks out a physician when he finds himself ill. Typically, too, he is expected and obliged to make his own contacts and arrangements for each type of illness; that is, he must arrange separately for dental care, for eye care, for care of his children, for obstetric care, perhaps for nursing home care for elderly persons in the family, possibly for mental care. Emergency care is most readily available simply by picking up the telephone. And, beyond this, each individual must make his own arrangements for the financing of his health care -- again, separately, in many cases, for dental care, for routine family care, for nursing home care, and for major illness. Physicians do, of course -- out of their knowledge of the system that exists -- refer patients to the offices where they can get the care they need. But the problem remains for some individuals, less sophisticated, to "get in" to the system in the first place.

d. Where will money be "saved"? -- It has been argued vigorously before this committee that much expanded programs of health maintenance and early diagnosis would produce real savings -- perhaps in greater productivity, or reduced loss of income by the individual. Granted: It may not reduce the bill for the health care provided . . . . just as the benefits of fire protection involve an increase in the expenditures of the Fire Department. The real savings occur in private accounts and in "losses" prevented. We find the system organized, however, to respond best to episodic illness, and least well to these long-term needs for health maintenance. The explanation seems to be, in major part at least, that the insurance system evolved since the Depression has tended to pay for episodic care rather than for prevention and maintenance.

3. *Cost is in many ways the central problem. It is increasingly a public problem, because the increases arise out of basic defects in the way the system is organized and financed, and more dollars do not, at present, necessarily produce better services.*

a. Prices are rising rapidly -- Cost indices for almost all elements of medical care are rising faster than price levels generally and at accelerating rates. Noticeable upturns in rates occurred after the introduction of Medicare in 1965. Broadly, two strategies have been discussed before the committee to deal with the cost problem. One aims at providing expanded resources to families to meet health care bills principally by increasing the coverage under federal health insurance programs. The other would propose to limit, if not reduce, the real costs that go into the health care bills by reorganizing the method in which health care is delivered and financed.

b. Some cost increases appear fully justifiable -- A number of persons appearing before the committee testified that the higher medical and hospital bills today reflect in large measure improvement in facilities and services over the 1930's, 1940's, or even the 1950's. Further, we heard evidence that a substantial part of the increase in prices has gone to upgrade the compensation for nurses, interns, residents, and paramedical personnel that were, by almost any standard, underpaid in both private and public hospitals, through most of our history.

c. Most of the cost problem lies basically in the absence of incentives for the most efficient utilization of services and facilities--We would not want to see

a system of finances that scanted resources for health care, nor one that set up incentives to sacrifice quality for economy. But, by the same token, the committee has been presented with much testimony indicating that new and different ways of furnishing high-quality health care at relatively lower cost are possible and are not being implemented because, under present financing arrangements, no incentive exists to do so. Specifically, the committee has heard that:

* The health care system is encouraged to continue to put resources into treatment for existing health defects and emergencies, rather than into health maintenance programs that might prevent illness.

* There continues to be an emphasis on treatment in acute hospital facilities (granted that some hospitals are beginning to contain "gradations" of intensive-care beds, minimum-care beds, etc.) which are the most expensive to build and operate, rather than in lower-cost, extended-care or home-care programs and facilities.

* Expensive facilities and services tend to be developed in each separate institution, largely because they are desired, and not always because they are needed or -- when built -- fully utilized.

* Many services and procedures continue to be performed by highly-trained (and therefore expensive) personnel, when they could be delegated to competent paraprofessionals.

* Unnecessary admissions and unnecessary services continue to be encouraged by present insurance arrangements.

d. Inadequate restraints exist on the incurrence of costs -- The essential situation that exists in the health care system has been described for the committee by a number of witnesses, among whom there is no disagreement. It has been well summed up in a quote from the Somers' book:

> "In no other realm of economic life is repayment guaranteed for costs that are neither controlled by competition nor regulated by public authority, and in which no incentive for economy can be discerned." (Medicare & the Hospitals, by Anne & Herman Somers)

These are the essentials of the so-called "cost pass-through" as we have come to understand it:

* The doctor is the point in the system where the demand for the use of resources originates. Out of his professional judgment, he orders certain services provided and manpower utilized in the interest of the patient's care. In a more basic sense, he also "orders" equipment bought and facilities built. We have found considerable testimony, moreover, that the doctor is under some considerable pressure to utilize services and facilities, even where, in his judgment, adequate care could be provided at lower cost. The doctor is aware of the problem of cost and may try consciously to reduce utilization. But he is to some extent in the marketplace, and he cannot be insensitive to demands from his patients that they be admitted to a hospital if this is required under their insurance coverage. Nor can he be unaware of the possibility of malpractice suits

arising from any refusal to prescribe services or treatment. Since he incurs no direct cost to himself in calling resources from the system, it is understandable that he tends to make decisions in ways he might not if there were countervailing incentives -- negative or, better, positive -- working toward economy.

* The hospital also exercises few restraints. Hospitals, too, are in a real sense in the marketplace. They cannot be insensitive to the requests of their medical staff for the addition of facilities and equipment, and they can now, because of the quite rapid and almost universal extension of hospital insurance plans, be reimbursed for the costs they incur in providing whatever patient care is requested. Hospitals are not unmindful of the effects of additional facilities and equipment on their average daily charges. But it appears this pressure tends more to lead to maximum occupancy of facility and utilization of services, once provided, than to a discouraging of their construction or installation in the first place.

* Insurance programs, both the commercial carriers and the non-profits, tend, on the whole, to think of themselves as intermediaries. They do not find that they have been given the social responsibility for controlling costs in the health care system generally. While they do resist conspicuous abuses, while they do exert considerable pressure for voluntary restraint and while Blue Cross and Blue Shield and some commercial carriers are beginning now to pay for (and some employers beginning to buy) diagnostic care out-of-hospital, they also--in the end-- tend to pass the costs along in the form of increases in the premiums charged broadly across the whole population they serve. The federal Medicare program -- while adding to the dollar demand for care -- has not changed this basic situation.

* Public regulatory authority, finally, even to the extent it does control increases in the rates, tends to ask no questions about whether the costs incurred by the carriers are in any sense justified or not.

We do not see here a picture of "wrongdoing." Every party in the system takes the system as he finds it, and none, in truth, has been given any charge to be responsible for the system as a whole. In the absence of such overall control, or new incentives in the system, cost increases continue to pass through substantially unrestrained at any point.

4. *Special adjustments may be needed to preserve and expand the medical education program as patients are increasingly free to elect care outside the traditional training institutions.*

a. A strong training program must be maintained -- Hospitals in Minnesota, and Hennepin County General Hospital in particular, have been outstanding physician training centers. This has upgraded the quality of the health care in the community, and the evidence is considerable that it has materially augmented the supply of doctors that remain to practice in the community. A major consideration in the planning for the future of all the health care institutions ought to be the impact of decisions on our ability to maintain strong and growing training programs in these institutions over the long run.

b. Characteristics of a sound training program -- We find two elements principally that produce an outstanding training program:

* A flow of patients that combines a full range of serious medical problems with good opportunities for the resident to observe the work being done and to carry responsibility for patient care.

* A fulltime, high-quality staff, salaried by the institution, dedicated to teaching and therefore providing residents-in-training substantial responsibility for patient care.

c. There is a need to expand teaching situations -- The demand for medical manpower is growing. Medical schools are expanding their enrollment. More teaching opportunities for residents will be required. Apparently, not many more can be accommodated on the patient load in existing institutions. General Hospital does not propose to increase significantly in size. It appears to us, therefore, that the community need for medical manpower now involves serious efforts to develop quality teaching situations in private institutions.

d. Changes in health care will affect medical training -- Changes in one element of the health care system -- as for example, changes in the financing of health care, or the change in flow of patients associated with the transfer of General Hospital from city to county jurisdiction -- have already produced changes in the pattern of training in institutions in the Twin Cities area. Additional changes at various points in the system can reasonably be expected to have similar effects on the training program in the future. Specifically, the committee has been made aware of the following:

* The number of undergraduate medical students is being increased considerably in Minnesota. The University of Minnesota is enlarging its enrollment; Mayo Clinic is developing a national medical school here; a new medical school may appear in St. Paul.

* The internship, as we have known it -- originally a one-year "apprenticeship" before a doctor went out to practice -- is disappearing. Students will move directly into specialized residency training upon graduation. Family practice is appearing as a new specialty.

* The public, teaching hospital may not continue almost automatically to receive the most desirable number and variety of teaching cases. Indeed, in a basic -- although admittedly long-run -- sense, the effort by the County dramatically to improve the health levels of its traditional population may diminish the attractiveness of this group for the teaching program. Meanwhile, with the growth of the urban area and the change in the character of the population of the central city, changes also appear in the pattern in which births, and accidents, occur . . . and the hospitals to which obstetric cases and emergencies tend to be taken. University of Minnesota Hospitals appears to have been substantially affected in recent years by such basic changes . . . by new hospital construction in cities out-state; by changes in the system of financing which upset the old incentives for rural county boards to send patients in to the University; and, to some extent, by the transfer of General Hospital from Minneapolis to Hennepin County jurisdiction, which reduced the referrals

from the County Commissioners to the University. St. Paul-Ramsey Hospital has taken steps to broaden its patient base by opening to private patients. How far General Hospital is immune from such changes is not clear.

* Voluntary hospitals are now aggressively trying to develop teaching programs. A house staff of residents is important to the availability and, therefore, quality of care in these hospitals. Several of the hospitals are, therefore, trying to develop opportunities that will attract residents for their training. This means hiring fulltime doctors and directors of medical education. It also means trying to get affiliation with the University, and it involves efforts to bring into the hospital a flow of patients seeking medical care from the institution. But, because this is expensive, and because a number of elements must be put together almost all at once, hospitals are making only fairly slow progress into teaching programs -- and at considerable expense. One critical element, too, appears to be the attitude of doctors who have patients in these hospitals on conventional fee-for-service arrangements. The committee has heard different, and sometimes conflicting, testimony about the prospect of such private patients being available for the training program.

* Pressure for economy may impair the present financing of postgraduate training. Oversimplified, but essentially . . . the programs in both the public and voluntary hospitals for the training of interns and residents -- their salaries, and the salaries of the fulltime directors of training -- are paid for partly out of gifts to the hospital from philanthropists interested in encouraging education programs, and partly out of charges buried in the bills to patients for their hospital care. Very little, if any, money comes to any hospital directly from the state government or from the University for postgraduate medical education. As efforts are made to reduce expenditures on in-hospital care, and as (and if) private support is increasingly difficult to secure, new sources of support will need to be found. Direct state appropriations are usually proposed as the answer . . . and in the 1969 session the Minnesota Legislature did take additional steps in this direction. It will be asked to do more in 1971. But there is concern that -- given increasing pressures on the state budget -- this will not be a sufficiently productive source. (Somewhat the same situation exists with respect to the training of nurses and other paraprofessionals, as hospitals look toward the phasing-out of hospital-supported -- which means patient-supported -- schools of nursing . . . and as the job of educating these allied health professionals is taken up by the public vocational schools, junior colleges and state colleges.)

e. Much-expanded planning of medical education is now required -- All these changes suggest to us that, increasingly in the future, there will be a need for larger and more difficult choices and policy decisions in the management and expansion of the program of postgraduate medical education. Some broadening of the program to involve the voluntary hospitals more fully seems both inevitable and desirable, as the need for medical manpower grows and as "charity" patients disappear. But this must come as an addition to, and not at the expense of, the programs presently existing in the public hospital. The decisions will be, in part, as well, related to decisions about the future pattern of patient care and hospital facilities.

PLANNING THE PUBLIC HOSPITAL AND THE HEALTH CARE SYSTEM

1. *Medical science and health insurance have changed both the work and the clientele of the public hospital. Yet because of its essential features the institution remains critical in the health care system, and must be preserved.*

a. Hennepin County General Hospital is more than just a hospital -- No real understanding of the health care system is possible when one focuses solely on buildings. Viewed as buildings, hospitals look remarkably alike, except perhaps for their age. Hospitals must be seen in terms of the programs that operate within them. Such a view underlies the dramatic differences between Hennepin County General Hospital (HCGH) and others in the community. Most hospitals are extensions of a doctor's office . . . a central building to which a number of doctors assign those of their patients they deem too ill to be treated, or find it to inconvenient to treat, at their homes. Some care — particularly nursing care -- is available at these hospitals. Hospitals have for some time had pathologists, directors of physician training, anaesthesiologists, etc. on their staffs. And some are, most recently, beginning to provide (by hiring doctors or moonlighting residents, or by "pooling" arrangements within their medical staffs, as at Methodist Hospital) medical care in their out-patient and emergency rooms, even into the night. This significantly expands the role of the hospital as a point of access into the system for care. But HCGH is essentially a doctor as well as a hospital . . . and a round-the-clock, multi-specialty institution. Its most prized resource, we have been told repeatedly, is its "house staff" of medical residents -- supervised by the staff of fulltime doctors, and aided by volunteer doctors from the community -- organized to provide care in all specialties, at all hours. This is what makes it possible for residents of the county simply to appear at the door of this "hospital" and be confident they will receive the care they need. This is fundamentally why HCGH (and Minneapolis General Hospital before it) developed as the institution which served the poor in the community who could not -- or chose not to -- get their care from a private physician: HCGH is a public doctor. And precisely because it is this combination of doctors and patients (patients who have come to the institution as their doctor and not to an individual physician) HCGH has developed as an outstanding institution for the training of doctors. Patients, without resources, got care, General's salaried team of doctors could concentrate on patient care and training, interns and residents were attracted by the opportunity to take responsibility for the care of these patients, under the supervision of HCGH's staff, and the private doctors of the community contributed substantial amounts of time to assist both in patient care and in the training -- and, possibly, to learn, themselves, as well.

b. Powerful trends are changing its traditional role -- One of the principal tasks of the public institution, traditionally, was to serve as the center for the care and treatment of epidemic disease. Since the end of the polio epidemic in 1952, this function as a "contagion hospital" has virtually disappeared. At the same time, the tremendous and very rapid changes taking place in the financing of medical care are tending to reduce the role of the public hospital as a "charity" hospital. We find most knowledgeable health professionals expecting that these programs of medical insurance will be extended in the relatively near future over most of the population. This does

not automatically mean -- and appears not to have meant so far, in the experience of HCGH -- that patients who can now go anywhere for care will no longer voluntarily elect the public hospital. But we do find, listening to others describe their projected programs for health care, that a number of hospitals -- public and private -- in the Twin Cities area are now affirmatively interested in serving those that have been the traditional clientele for HCGH in the past. And this does suggest to us that Hennepin County General Hospital is moving increasingly into a period when patients will be attracted, not because it is the only place they can get care, but because they find there some type or quality of medical care that is superior to what is provided at other public institutions or private physicians' offices to which they could freely go.

We see Hennepin County General Hospital, then, as an institution faced at the same time with new demands for service and with a new need to be competitive in the marketplace. It is this dilemma . . . the need for change and the uncertainty of the future . . . that lies at the heart of the planning decisions about the future programs and facilities of HCGH.

c. The new emphasis on better health-care delivery suggests its future role -- The key contribution to be made by HCGH in the future is likely to have less to do with what diseases are treated, or who is cared for . . . and more to do with how care is organized, delivered and paid for. HCGH comes into this period of growing concern about the cost and accessibility of care as essentially a single organization, a team of doctors and allied specialists, highly oriented to service, providing all major services -- out-patient and in-patient -- day or night, at a single point of entry for the patient. It is, moreover, part of a larger organization which is responsible -- in the case of welfare patients, at least -- not only for acute but also for long-term care.

d. The county hospital is responding to this new demand by proposing a "complete system of care" for its constituency -- The planning unfolding in Phase III following the September 1969 referendum has emphasized the role of HCGH in providing new directions in the method of delivering health care. Specifically, the "concepts" for the new program developed by the hospital staff and consultants involves:

* Improved accessibility and availability of care, through the location of facilities in the neighborhoods where its primary patient group resides.

* An emphasis on prevention and health maintenance . . . a shift from the concept of "treating the sick" to "keeping people well" . . . emphasizing multi-specialty care to the family unit, and reaching out affirmatively with programs of education that promote the use of health care services.

* Increased use of out-patient facilities, partly at the central site but particularly in the neighborhoods where facilities and services are now lacking.

* Increased use of extended-care facilities.

* New arrangements for maintaining continuous responsibility for the patient as he moves from early diagnosis through care and treatment . . . as he

moves, in other words, through the entire range of facilities until he is "restored" to full health.

2. *The County's planning has not yet adequately resolved -- or, in some cases, addressed itself to -- a number of the key issues raised by the changes in (and the need to change) the health care system.*

   a. The future "service" population for the County's program has not been defined -- The consultant's report (Appendix J-2) specifically assumes that, "Of the indigent population in the County, one-third are categorical aid recipients, and 20% of this group will use Hennepin County General Hospital, while two-thirds are medical relief patients, all of whom will use Hennepin County General Hospital." We find the consultants and the County substantially alone in this belief that the category of medically indigent will not be significantly reduced by extended public medical/hospital insurance programs in the relatively near future.

   b. Insufficient emphasis on restricting in-patient beds -- The only specifics that have emerged from the planning suggest that the County is projecting an enlargement in the size of its hospital in the course of the first-phase revision (from 400 to 500 beds) with a second-stage expansion beginning almost immediately afterward that will raise the total acute beds to about 600. It is not clear to us that this reflects a sufficiently high priority assigned to the question -- where, again, the County can lead importantly by example -- of reducing costs in the community. Nor does there appear to be anything in the County's proposal that -- alternatively -- would provide some expansion of HCGH's in-bed capacity by drawing on some beds presently existing or projected in the private hospital community.

   c. Little so far clearly furthers the grouping of facilities into larger, more specialized, medical centers -- All the "concepts" provide for the task forces to consider co-location or sharing of facilities, but nothing is available at this point to indicate that the County proposes to take the lead in grouping together a sufficient mass of facilities really to change the pattern of planning and development in this community -- as proposed in the 1950 plan* -- from one of substantially free-standing, self-contained institutions to a pattern of genuine medical centers.

   d. Attention is not being given to new incentives for efficient utilization through changed arrangements for the financing of medical care -- Again, little in either the specific proposals or in the "concept plan" indicates this is under consideration, although the County is aware of the developing federal legislation and of the interest being expressed in "health maintenance organizations" elsewhere in the community. Our belief is that this is regarded, at present, as politically inexpedient to consider.

   e. Inadequate attention is being given to changed governance -- It appears assumed that HCGH will, and should, continue to be administered directly by the County Board of Commissioners. There are no indications in the concept plan that alternatives, and experience elsewhere in the transformation of the traditional public hospital into some kind of quasi-public or non-profit corporation, are being explored. Dissatisfaction continues, too, with arrangements for participation by the users of the hospital in the management

* See pp. 36-37

of its program. Some steps have been taken to increase the involvement of "consumers," but controversy remains over the extent of their involvement at the Pilot City Health Center, in the work of the advisory committee considering the new program, and on the committee which assists in the management of the hospital itself.

f. No financing plan has been presented -- Rough estimates given to this committee suggest the per-bed cost of a hospital of the size and nature the County proposes (500 beds initially) will run from $50,000 to $60,000. This seems confirmed by the statement of the County in its letter to the Metropolitan Hospital Planning Agency (MHPA) indicating the Commissioners will use the full $25 million from the bond issue for "the immediate new central hospital facility." Nor is it clear whether all the facilities needed even at the central facility will be constructed within this total: Indications are that the nurses' quarters and the research buildings, at a minimum, will be retained from the present hospital plant, and that even some of the bed facilities -- perhaps the annex building, or a part of it -- will also be kept in use for a period of time. In approving the three-block land acquisition to the east and south of the present site June 9, the Commissioners saw and approved no proposed layout of buildings. The capital levy authorized -- currently producing about $650,000 a year -- will apparently be continued. This represents about one-third of the levy that will be spread to retire the $25 million in bonds. It is not clear how the money would be raised to acquire or to construct and equip the primary care centers. Nor, apparently, is anything provided for the construction or acquisition of long-term care facilities.

3. *The specific decisions required -- about facilities, about programs, about patients and about relationships -- are complicated for the County by the way in which these same questions are currently opening for virtually every health care institution in the community.*

a. A rebuilding program involving something approaching a quarter of a billion dollars is being discussed . . . carrying implications for significant changes in the whole pattern of health care delivery -- Little is settled at this point, but the committee has come to understand that active discussions are in progress involving the replacement or substantial rebuilding of:

* Hennepin County General Hospital
* University Hospitals
* VA Hospital (possibly related to University)
* Swedish Hospital
* An expansion in the western suburbs, either by a Northwestern/Abbott satellite or by the expansion of Methodist and/or North Memorial
* Deaconess Hospital, either in connection with a rebuilding of the MMCI or in cooperation with Fairview in the Bloomington-Burnsville suburban area.
* Northwestern/Abbott, in the "Bakken Plan" for MMCI
* Mount Sinai Hospital, in the "Bakken Plan" for MMCI
* Children's Health Center

Much the same picture occurs in the St. Paul area:

* St. Paul Children's Hospital may be relocated and rebuilt.
* A study by the Associated Capital Hospitals (Children's, Miller, St. Joseph's and St. Luke's) could lead to realighment of services, including suburban development.
* Riverview and Divine Redeemer Hospitals have sponsored a study which recommended a new hospital in Eagan Township on the site of the major Dayton commercial center to be developed about 1975.
* The White Bear area is showing greater interest in a local hospital.

"All hospitals," the Metropolitan Hospital Planning Agency said in a projection of bed demand in June, 1970, "will be reshaped in the coming decade."

b. <u>These capital investments represent, really, only the visible tip of the iceberg: An even more important question is the cost of operation to which the pattern of capital facilities will commit us</u> -- We have learned that acute care facilities cost more to build than longer-term facilities. But we have also learned that the biggest savings appear to come in operations. Typically today, for example, the community will spend every two years or less, to run a hospital, what was spent to build it. We are talking, for example, about spending (with federal aid, and without considering $20 million for the cost of money borrowed) just over $30 million to construct a new General Hospital. The annual budget of the hospital, currently, is about $17 million. This is, fundamentally, why capital facilities must be so carefully -- and cooperatively -- planned to take maximum advantage of the opportunities for shared services and facilities.

c. <u>Few of the institutions have -- nor has the community as a whole -- any clear sense of direction with respect to the organization, structure and financing of the health care system of the 1970's and '80's</u>.

* <u>Hennepin County has no settled plan</u> — The consultant had originally recommended the (planning) Phase III be completed prior to the referendum. The County's decision was, however, to lay this over until afterward. The staff advisory committee and its various task forces are now at work. The "concepts" paper was approved by the Citizens Advisory Committee, July 1. But specifics about role, program and facilities have not yet been committed.

* <u>University Hospitals is at a major fork in the road</u> -- Serious concern appears to exist within the University about the flow of patients . . . particularly the "mix" of patients to University Hospitals. Broadly, it now appears University Hospitals must move, in one of two directions: Toward a much more aggressive and competitive service role in the state and in the metropolitan area; or toward a much altered arrangement in which a substantial part of its educational program moves out into private and other community hospitals, with University Hospitals itself becoming a set of highly specialized research and educational institutes. They hope to take the first course. An Acting Vice President of Health Sciences has been appointed, bringing all of the University's health training programs together for the critical next stage of the long-range expansion to be developed. Legislative action will be required, and may not come until 1973.

* The private "complexes" are not yet real medical centers -- Of the three medical centers organized over the past five years, only one is well on its way toward the full and formal merger of its hospitals' boards and medical staffs. In the others, some sharing of support services has been achieved . . . and the beginning of sharing in clinical services. It seems fair to say, however, that the member hospitals have not yet settled into specialized roles within the larger grouping in a way that would permit these to be called really integrated hospital centers. We do recognize a new effort is under study within the MMCI. This could result in the complete replacement, and possibly even the relocation, of all the major institutions in the Minneapolis Medical Center. The task forces are now expected to complete their work in late summer or early fall.

* As Children's Health Center enters the system, important questions arise about the relations in pediatric care involving CHC, the University, Gillette State Hospital, General Hospital and the private institutions.

* VA Hospital has proposed to Washington that funds be allocated for a new facility. Its administrator does not believe remodeling a hospital is economic. A decision is presumably still some considerable time away. But discussions -- with the University and perhaps with others -- about site, are under way.

* The state hospital system, after 20 years of developing mental in-patient institutional facilities, is now reversing direction, and its medical director is raising the possibility that the facilities might be closed out entirely, and the care of mental patients transferred to local health care institutions as essentially an out-patient responsibility.

* Medical, as well as hospital, institutions are changing . . . with a continued trend toward single or multi-specialty groups and with the Hennepin County Medical Society's proposed new "foundation" about to introduce major new arrangements for the review of physician care and charges.

* Widespread and fairly intense interest exists in exploring the concept of a new option in arrangements for paying for medical care . . . that is, for adding to the present system -- in which a patient pays fees after receiving services -- a new arrangement in which the patient pays a fixed sum in advance and the medical practitioner undertakes, in return, to provide whatever care is required. The American Rehabilitation Foundation here has been deeply involved in the development of this proposal nationally, and its endorsement by the national administration. Something like this is involved around the family practice program at the University. The idea is incorporated into the Model Neighborhood program in Minneapolis, and it is under active consideration by other private medical groups and insurance organizations in the area.

4. *It is proving impossible to resolve the issues raised, under the existing planning arrangements.*

Disagreements are quite real, even if not visible, not only over what should

be done in the development of the community's health care system, but also over the way in which decisions ought to be made.

a. Public mechanisms for health and hospital planning are themselves in transition, and hampered in their ability to offer leadership.

* The state Comprehensive Health Planning (CHP) agency, created as a result of 1966 federal legislation, is new and tends to defer on less-than-statewide matters to the regional Comprehensive Health Planning agency.

* The regional CHP agency -- which will be a Metropolitan Health Board, set up by and under the Metropolitan Council -- was agreed-on only in May, 1970, after a two-year study, and will not have its members and staff until the late summer of 1970.

* The Minnesota Department of Health prepares and maintains a state hospital plan, but in responding to requests from hospitals for the federal Hill-Burton financial assistance it administers has tended to rely -- for the Twin Cities area -- on the local, voluntary hospital planning agencies.

* The Legislature is only beginning -- in first steps for the support of post-graduate medical training at its 1969 session, and in committee work during the current interim -- to acquaint itself with the issues involved.

* Public opinion -- because the issues in the health care system have been so largely kept within the community of professionals -- has not become capable of providing an informed check on, or input to, the decisions that need to be made.

b. Conflicting interests prevent decisions from being made among the hospitals themselves -- The long and close relationship between Hennepin County General Hospital and the voluntary hospitals (and the University) has been, at the same time, cooperative and competitive. This can, perhaps, only be felt, rather than seen. But it has been apparent to our committee. And the competitive aspects of the relationship have been the source of the trouble that has existed -- and intensified since formal planning began, following the referendum -- between HCGH and the other hospitals. It is one thing to "work with" all hospitals, under an agreed-on plan; it is another to "plan with" all hospitals when decisions involve the status and prospects of institutions and individuals in the health community in a major way. For all kinds of reasons, most hospitals would like to be great hospitals. And to be great, most hospitals feel they need what the General has: A high-quality program of post-graduate training, in which the staff of fulltime residents attracts (particularly emergency) patients, and in which these patients in turn attract young doctors in training. These are valuable assets for a hospital . . . emergency patients, young doctors in training, and the specialized equipment with which they can work. And because they are scarce, they are competed-for.

Efforts made to resolve the future roles and programs of HCGH jointly with the voluntary hospitals, therefore -- whether through the formal Metropolitan Hospital Planning Agency (MHPA), or in an informal way with the other hospitals individually -- have been essentially frustrated. The MHPA contracted and paid for the major portion of Phases I and II of the study of HCGH. Its

involvement in the detailed planning phase was in fact solicited by the County. Yet relationships have not been entirely happy. The voluntary hospitals are seen as, and see themselves as, in some senses competitors of the General. The other hospitals tend to feel HCGH planning does not fully acknowledge their accomplishments or the intentions, in care and in training. HCGH, for its part, is concerned about its programs -- educational programs, particularly -- under cooperative arrangements that fragment its services. And it views the MHPA -- made up, as it is, predominantly of other hospital representatives -- as not a disinterested body. It does not observe other hospitals ceding to the agency the authority to decide whether they shall or shall not build or expand. In truth, formal communication between the agency and a hospital about institutional plans does not always occur even when the plans are in the early stages of internal formulation. Given the essential makeup of the agency, this behavior is predictable, from the standpoint of any individual hospital. But the effect -- from the point of view of the community as a whole -- is that many opportunities for sound, orderly development . . . by "getting out ahead of the game," so to speak . . . are lost.

5. *An impartial and orderly framework for planning and decision-making should be developed promptly. Until it can become effective, the County should avoid as many irrevocable commitments . . . and remain as flexible in its options . . . as possible.*

a. Facilities decisions ought not to be made first -- Generally, buildings ought to be shaped around programs. But, as we have pointed out, HCGH -- because it is so affected by the actions of others, whose decisions at this point it cannot see clearly -- cannot know with great certainty what its programs will be, five, ten or fifteen years hence. Thus it should develop its physical facilities so as to leave it maximum freedom to move in different directions, as trends come clearer.

b. Planning must proceed on several different "levels" -- Not all decisions about the future programs and facilities of HCGH can appropriately be made by any single planning agency. Rather, certain decisions are appropriate for agencies with certain levels of jurisdiction. Where a particular level is missing, it should be filled in. Specifically, we see decisions occurring at these levels:

* Statewide. HCGH operates, for example, kidney dialysis units at centers throughout Minnesota. Decisions about the future of this program will relate to the programs of the University and to hospitals in other cities . . . and are appropriately handled by the statewide Comprehensive Health Planning agency.

* With "all hospitals" in this urban community. HCGH was not meant, we think, to be a "total care center" in the sense that every service and facility should be duplicated within its own walls and/or program. Rather, it is specialized within a larger medical/hospital system. Decisions need to be made in the County and in the Twin Cities area about which specialized facilities HCGH is to provide . . . and where it is to use facilities provided by others.

* With hospitals physically adjacent. A special relationship will -- inevitably, and not undesirably -- exist as a result of direct physical

proximity, and the special opportunities for shared services and facilities this creates. Decisions on parking facilities, or steam plants, or joint laboratories or surgical suites or out-patient departments, are appropriately made directly with these co-located institutions.

* Internal. Some services and facilities need not and will not be shared or specialized at all. For these decisions, the present single-institution planning is appropriate.

Broadly, of these four "levels," we believe it is the second and third that are, currently, missing . . . in relation to the issues raised about the future of HCGH.

RECOMMENDATIONS

Our Objective

Utilization of facilities and services in our hospital and health care system must be dramatically improved, if adequate care is to be made available in this community. This must become the central objective.

Three opportunities now exist to take significant steps toward this objective, locally.

One lies in the imminent decision by Hennepin County about the planning of facilities for its new General Hospital . . . which it has been this committee's principal charge to review. We believe it is now possible -- and, indeed, imperative -- for the General, while still working with all hospitals, to work with its immediate neighbors for the planning and development of a large and truly integrated hospital center, which could establish a new pattern of enlarged opportunities for sharing and economies in the development of the hospital system in this entire community.

The second is in the current re-making of the mechanisms for hospital and health-care planning, and the new ability this will afford the community to reach decisions about the sharing of programs and facilities among all hospitals in the community as a whole, which the institutions -- public with private, and private with private -- have not been able to reach among themselves. It offers a new chance, too, to begin exerting the kind of pressure on the overall bed supply that is an admittedly crude and negative, but necessary, tool to force improved utilization.

The third, and most basic is in the growing concern about the importance of, and the growing interest in, introducing innovative ways of affecting costs . . . new and positive incentives for doctors and hospitals to use resources most efficiently . . . as an alternative to the control of costs through direct, administered regulation.

Specifically, we recommend:

1. *The Hennepin County Commissioners should enter into new planning arrangements jointly with representatives of the Swedish/St. Barnabas group for the development of a complete medical/hospital center.*

   a. The present plan for developing the site adjacent to the present hospital grounds appears well-supported.

      The essential arguments in the preceding pages, for the development of Hennepin County General Hospital in close relationship to a larger grouping of medical/hospital facilities could apply, of course, to any of the several "complexes" that have appeared in central Minneapolis in recent years. And, in fact, all three major complexes did in 1968, at the invitation of the consultant to the County, make proposals for the development of HCGH jointly with their own institutions. No real response was made to these proposals . . . the County simply stating that it would work with all hospitals and would plan to rebuild "at or near its present location."

We have not attempted an evaluation of the three proposals made in 1968. We have observed that development of the new facilities on land adjacent to the existing site does offer a number of advantages:

* The hospital would remain relatively centrally located with respect to the residence of its major patient groups, which exist in and around downtown, on the near north side, and on the near south side.

* Public transportation -- which is critically important for a number of patients -- is, and is likely to remain, relatively better at this site.

* Major savings in construction cost would be possible, by continuing to make use of those buildings in the existing facility that remain in acceptable condition. Specifically, the nurses' residence, the research building, and perhaps even a part of the "annex" could remain in use for a period of time. Also, a more "staged" transfer from the old to the new facilities should be possible.

* This location conforms most closely to the County Board's declared intentions. The consultant recommended, and the Board in August 1969 agreed, that the new facility should be "at or near the present location." Planning has proceeded on that assumption, culminating June 9, 1970, with the Board's decision to acquire the blocks immediately east and south of the present site. (See map in appendix.)

b. <u>The object now must be to take maximum advantage of the opportunities presented by the concurrent development of the new HCGH and the hospital center with which it has been effectively co-located.</u>

The new site is contiguous to St. Barnabas Hospital, and the newly-completed "joint facility" which links it to Swedish Hospital. Organized as the "Metropolitan Medical Center", the two institutions make up the most fully-integrated hospital center which has appeared in the community up to this time. Complete, formal merger of the two corporations -- including boards and medical staffs -- is to be accomplished in the summer of 1970. Decisions about centralization of many services and facilities will be made shortly after that. Additional construction is to follow, and may involve a substantial loan or grant of public funds through the Hill-Burton program: Swedish Hospital has a "place in line" for 1971, which it will presumably bequeath to the new, successor corporation. A consultant for planning the merged facility is to be retained during July 1970.

The County and these voluntary hospitals must not proceed with their projects independently. Rather, the object must be to ask: "How, together, can we make the maximum use of the community dollars all of us will be investing?" More than coordination is required. The policy boards, medical staffs, administrators must be jointly involved, with their planning consultants and architects, in a new and formalized planning framework, given the specific assignment to study and report on the areas in which shared services and facilities are desirable and possible.

c. <u>We believe the following areas can profitably be explored:</u>

* Power plant and laundry. Our understanding is that both these facilities

have recently been newly constructed by Swedish and St. Barnabas, with substantial excess capacity -- enough to carry HCGH loads.

* Basic supporting services: laboratories, x-ray facilities, cobalt therapy facilities, food preparation facilities, record-keeping, personnel, purchasing, etc. Significant efficiencies may lie in these areas, particularly through the use of new technology.

* Clinical facilities. This is, we recognize, the most complex and difficult area. But we consider it essential that the possibilities for joint development here -- pediatrics, central kidney dialysis unit, central psychiatric unit, perhaps a central set of surgical suites -- be thoroughly explored.

* The education of nurses and other allied health professionals. Also, residential facilities for nurses and others in training.

* Physician education. We believe incorporation of the HCGH into a larger hospital center need not impair, and might well enhance, the program of medical education. Responsibility of HCGH staff for its patients can, and should be maintained. Efforts of Swedish/St. Barnabas to develop a medical education program can be added to the program at HCGH, to the benefit of both.

* Central out-patient facilities. This should be stressed, in the HCGH reconstruction. New techniques, and technology, for the screening and diagnosis of patients should be included. Swedish and St. Barnabas have been planning to close their own, separate emergency departments: The opportunity exists to merge these also with the facilities of HCGH.

* Extended care facilities. The fundamental effort to reduce the use of facilities and personnel associated with acute in-patient beds, which are the most expensive, requires efforts both to treat patients without admitting them to the hospital, and, if they have been admitted, to move them as rapidly as possible to facilities that can be built and operated at lower cost. HCGH should have such a longer-term care facility available -- preferably close to its central facility, so care can be extended to patients rapidly in an emergency. This need not mean the County must construct such facilities new: The joint planning may well reveal that the existing Swedish Hospital, or part of it, would be available, and appropriate, as an extended-care facility.

  We are aware there is a substantial number of ECF beds presently unoccupied in other hospitals in the area. We do also understand, however, that the under-utilization of these beds results primarily from complications in the regulations affecting insurance reimbursements for extended care patients . . . and emphatically does not suggest that ECF beds could not or should not play a far greater part in a reorganized health care system. Here, again, HCGH -- because it does not presently depend exclusively on reimbursement from third-party insurers -- can pioneer in new patterns of care.

* Acute-care beds. We believe that, as the three institutions plan and develop the new hospital center, the number of acute beds -- which are the

most expensive to build and to operate -- ought not to increase beyond the 1300 presently at this site. What the Twin Cities area needs is not more hospital beds. Central Minneapolis, in particular, needs to reduce its historic concentration of beds, as a result of the population decline and the gradual development of the ring of suburban hospitals. If the planning does, as we recommend, emphasize out-patient and extended-care facilities, the need for acute in-patient beds should -- relatively -- decline still further. There is always the possibility that programs may expand. But beds ought not to be built in anticipation of demand. Until new incentives to restrain utilization can be developed, sound planning policy suggests a deliberate effort to maintain a healthy pressure on the bed supply, and the publicly-owned hospital should lead the way in exercising self-restraint in the building of beds. Planning for this hospital center should, therefore, aim at or near the present total.

Within the hospital center we hope will result from the joint planning, some facilities and services may be developed by one institution and used by the other. It is inappropriate, therefore, we concluded, to talk in terms of "the size" of any hospital individually -- or of General's size in particular. Rather, we felt, the question of bed size should occur at the level of the center as a whole. There does remain, however, an important distinction, from the County's point of view, between the number of beds it <u>needs</u> and the number of beds it <u>needs to build</u>. The whole effort to plan jointly, and to look at maximum utilization of the resources of all three existing institutions, carries with it the possibility that some beds might be made available for General Hospital from the stock presently in the Swedish/St. Barnabas complex. (We assume the abandonment of the 394 acute beds in the obsolete, existing facility. Utilization of some of these beds on a temporary basis might be appropriate, but any long-range use is clearly inconsistent with the concept of replacing a deteriorated physical facility, with its high cost of maintenance.)

2. *Issues about services to be shared and specialized at the community-wide level, which cannot be resolved successfully in negotiations between and among HCGH and the voluntary hospitals, should be resolved by the areawide hospital and health planning agency.*

Some services cannot be established within every hospital or hospital center, but must be specialized at the community or metropolitan level. In some cases these services are best provided by the public hospital and used by others. In other cases, they should be provided by community hospitals, and used by HCGH. To date, clear decisions about these "programmatic relationships" have not emerged from the planning process, or from the bi-lateral negotiations between the County and other hospitals. In part, this appears due to the fact that the programs in question involve interests in conflict among the institutions, and cannot easily be resolved except by a planning or decision-making agency sensed by all to be a disinterested party.

We have not thoroughly evaluated the specific issues -- about makeup, powers, staffing and organizational relationships -- involved in the transition now under way from a private, hospital planning agency to a public, health planning agency . . . although we have carefully followed the development and implementation of the proposal to designate the Metropolitan Council as the areawide

"comprehensive health planning agency." Our recommendations apply regardless of the form in which the planning agency exists at any particular time: We believe the job of developing proposals for the solution of the issues we cite should be continued, now, by the Metropolitan Hospital Planning Agency, and should be picked up and carried on by the Metropolitan Council and its subordinate Metropolitan Health Board.

Specifically, we recommend the areawide planning agency:

a. Concentrate on four major issue areas re HCGH and other hospitals:

* Super-specialty services and facilities, such as radiation therapy, heart surgery, organ "banks," transplant facilities, etc.

* Emergency services.

* Out-patient programs, including mental health and alcoholism, as well as the pattern of ambulatory care centers.

* Post-graduate medical education. The principal issue here appears to be whether any number of the patients of HCGH should or can be housed in specialized facilities located outside and away from the central facility of HCGH itself. This question has been presented most specifically with respect to pediatrics . . . in proposals that the County use pediatric beds to be developed by Children's Health Center. In large part, this appears to depend on physical proximity.

b. Concentrate its work on the early development of specific and positive proposals for the resolution of other particular, and pressing, community issues.

Very large and extremely complex issues have been raised by the changes taking place in the private hospital community and at the University of Minnesota, as well as in the public hospitals -- including the VA Hospital. Unfortunately, action cannot and will not wait for the completion of a community-wide comprehensive plan. Decisions must, and will, be made . . . hopefully improved and made more comprehensive, year by year, as basic studies and plans are completed. Among the most compelling are:

* The future role in direct patient care and service of the University of Minnesota Hospitals, with particular relation to HCGH and St. Paul/Ramsey Hospital.

* Coordination of pediatric services. We are impressed with the contribution a Children's Health Center can make to the community, properly integrated into service and training programs. As it develops, however, the agency overseeing the growth of the hospital system must prepare and carry out a plan and program for the consolidation of beds in the small, scattered pediatric units into the center. Beds thus closed should not be diverted to other uses without approval of the planning agency. Teaching programs will need to be affirmatively encouraged there, so a staff of residents will be available to help with patient care. And orderly planning must begin for the on-going financing . . . at least to the extent that research and educational costs are not likely to be recovered out of patient revenues.

* Future plans for service in the western suburbs of Minneapolis, with particular attention to the individual plans of Methodist, Abbott/Northwestern Hospitals, and North Memorial Hospital.

* Possibilities for the expanded use of medical assistants and other allied health personnel to relieve the shortage of doctors and nurses and to provide services at relatively lower costs.

To become effective in the community, the planning agency must become involved in these particular issues. We believe it should -- and can -- do so even before a plan is completed and even before it is armed with a power to veto construction projects. Its potential strength lies in the combination of the professional understanding of health and hospital planning available to it and its impartial representation of the public interest . . . and in its ability to develop , early, imaginative yet realistic proposals that will exert authority by virtue of their good sense and practicality.

3. *Hennepin County should continue to develop HCGH (viewed as a health care program, and not as a building) as a new option in the community . . . an alternative method of receiving and paying for health care . . . potentially available to any resident.*

a. We envision a pluralistic, not a "unitary" system -- Proposals to "rebuild" the health care system should not mean the total change from present arrangements to some new way of providing and financing care . . . but rather the introduction of some new ways, in addition to and in healthy competition with the methods which exist at present.

b. HCGH should lead by example -- We do not believe the talk about the County "taking leadership" in health care should mean -- or does mean, or could mean -- the County dictating to others what their roles and programs are to be. Experience with the mental health program (where the County has been given authority to plan for both public and private facilities) does not suggest the County intends to dictate to other providers. At the same time, we find widespread agreement that -- given the troubles in the health care system -- it is appropriate and desirable . . . indeed, imperative . . . that the public programs "lead" by trying to set new directions. Specifically:

* Family-centered care should be extended into the neighborhoods. We do not see clearly precisely how many neighborhood facilities might be developed, or how they would be staffed or related to other hospital or medical facilities. These questions exist particularly with respect to the poverty area on the south side of Minneapolis. Nevertheless, a strong demand appears to exist for bringing primary care closer to the areas where the people live, and the County should be encouraged to bring forward its specific proposals for service.

* Comprehensive care should be made available and accessible. It should offer a patient a single point of contact with an organization that will take responsibility for providing him with a full range of medical specialties, at any time of day or night.

* A spectrum of facilities for continuous care should be provided. The effort to de-emphasize in-patient care requires efforts to develop not only out-patient care but also various types of facilities . . . intermediate-care beds, long-term beds, nursing homes, boarding homes, and private home-care programs where the lighter staffing patterns can help reduce costs. New arrangements will need to be made by the County's health-care organization to follow individual patients through this system of facilities.

c. For this new and improved health care delivery system really to be effective as an example in the community, it will need to be opened to a representative, if limited, cross section of residents.

As we have explained, many patients now -- and, we believe, more in the future -- are not medically poor, and do not have to come to the public hospital, as the "poor" originally did have to come. Increasingly, they will be simply residents of the county, with money to pay their bills, who -- because they like its facilities or its "supermarket" approach to giving care -- freely choose to come there. We like this free-choice principle, and welcome its extension. There will be no basis, we believe, for the County's distinguishing among residents . . . at least among those who express a desire to come, who can pay, and who are willing to participate in the training program. We think the County must not, as a matter of policy, limit admissions to individuals from a particular social, racial, economic, or geographic group. This seems to us an essential part of its commitment to "a single system of care." If the new medical/hospital program does succeed in attracting not only the previously undoctored patients but also some who now decide they prefer the County's approach to the traditional system, then the stimulus to change in the private sector is likely to be much increased.

d. The County should fully explore the basic arrangements by which the hospital is governed . . . and new arrangements which may be needed and desirable.

Certainly, on the governance side, there should be a re-examination, in the course of the present planning, of the role of the users of the hospital in decisions about its policy and operations. Consumers have recently been better represented both on the advisory committee planning the new program and on the board operating the Pilot City neighborhood health center. But they remain badly represented on the older, so-called "advisory board" to which the Commissioners apparently intend to delegate much, if not most, of the operating policy and program responsibility. Beyond this, there is the larger question about direct ownership and operation by county government itself. We do not see here the same financial and political difficulties that have set up pressures elsewhere for the transfer of the public hospital into some kind of quasi-public or nonprofit corporation . . . certainly, at least, not since the transfer to county jurisdiction in 1963. Yet there is a trend toward this change in ownership, which may be related to the ability of the institution to take new directions, and we believe the question should be raised and explored.

e. New financing arrangements should encourage General Hospital to be more efficient.

With the disappearance of medical indigency, the hospital will be earning

more -- indeed, most -- of its income. The possibility then arises that it might simply bill the Welfare and Relief Departments directly for the remaining patients who lack some form of third-party coverage. We believe the County should explore this possibility . . . and, beyond this, the possibility of having the General sell its care for patients as a "health maintenance organization." The County would then provide a fixed sum of money per capita, out of which the General would undertake to give whatever care might be required. This would require the General to review the basis of its charges . . . specifically, to include -- as must other hospitals -- a charge for the cost of capital. Education costs, on the other hand, may have to be subtracted. Many questions exist. But we believe the change should be strongly explored.

4. *The Metropolitan Comprehensive Health Planning Agency -- to improve the utilization of health resources -- should be armed with authority to control the growth in bed supply . . . but should devote its efforts primarily to developing new and positive incentives that will encourage providers to seek out innovative ways of delivering health care.*

We have found many individuals and groups deeply concerned about the problems of the health care system . . . about its rising cost, and about its failure to deliver service effectively to all. What more than anything else frustrates their efforts at change, we have come to believe, is the existing arrangement for financing health care . . . which now simply offers no reward to the doctor or hospital sincerely trying either to economize on expensive resources or to reorient activity from the episodic care of illness to the maintenance of good health in families. We believe it is critical that efforts be made to introduce these "rewards": They will work more powerfully, over the long run, to encourage greater economy and better care, than will the prohibitions and orders of some public regulatory commission. Specifically, we recommend:

a. <u>The 1971 Minnesota Legislature (in the absence of franchising legislation for the state as a whole) authorize the Metropolitan Comprehensive Health Planning Agency to regulate the expansion of hospital beds in the seven-county area.</u>

Beds are not the central issue in remaking the health care delivery system, but control over their expansion may well be the most feasible and necessary -- even if a crude -- device for encouraging change toward better utilization. Though the costs tend to be hidden, it is very expensive for the community to maintain an over-supply of hospital beds. Almost 40 per cent of expenditures for medical care go to hospitals -- exclusive of construction costs. It seems clear that, with roughly five beds per thousand population, the Twin Cities area today has -- <u>even under present definitions of need</u> -- more hospital beds than it requires. Metropolitan Hospital Planning Agency studies indicate that, taking together beds now existing and those "in the pipeline," virtually no additional construction can be justified through 1975.

And the present standard may be excessive. Ahead of us, certainly, lie important changes in medical practice: New programs of preventive care, new efforts to provide treatment on an out-patient basis, and -- through the Hennepin County Medical Society's proposed Foundation -- new ways to review and control utilization. These and other efforts to reduce the in-patient days of care strongly suggest that -- in planning the physical expansion of the hospital system -- a target should be established below the present 4.9 beds per thousand.

Proposals modeled on recent New York legislation are now being considered here for requiring something like a "certificate of public convenience and necessity" before a hospital expansion could take place. On balance, we believe this power would be useful. But some cautions are necessary. This "veto" authority is not an end in itself . . . and is no substitute for positive well-formulated proposals as to what ought to develop. It ought not to be used to hold back the redistribution of beds that should continue to take place as population shifts within the metropolitan area. Finally, these kinds of negative constraints may not produce change in the system as rapidly as the positive inducements represented by the new economic incentives afforded under the proposed health-maintenance-organization plans. In the long run, economic incentives may prove a more effective regulatory tool than administrative regulation.

Wise and effective use of the franchising power will depend on the ability of the comprehensive health planning agency to secure from health care institutions the data about patients, days of care, procedures, costs, etc., required to provide a sound base of information for planning and decision-making. Legislation should empower them to make the necessary studies and to secure the necessary data.

b. The Metropolitan Comprehensive Health Planning Agency should:

* Promote the fullest use, here, of any new program established by federal legislation -- on either a regular or demonstration basis -- providing for the purchase of care for Medicare and other recipients from "health maintenance organizations." There is a variety of organizations with both the interest and the potential, in terms of manpower and facilities, to enter into a contract for the provision of health care to a specified population group. This would include private multi-specialty facilities which now operate on a "prepaid" basis; the larger private clinics which now operate on conventional payment arrangements; the new family-practice clinic at the University of Minnesota; local medical society "foundations" and, probably, the two county hospitals themselves. Other buyers, beyond public welfare agencies, could be large business organizations which have by now contracted to finance virtually all of their employees' health care on conventional payment arrangements.

* Make special efforts to develop this new arrangement for some part of the population for which a county welfare office is responsible. It should be possible to establish a plan under which individuals whose care is now fully paid by the County would be offered an opportunity to be served by a "health maintenance organization" that had contracted to provide care at an agreed-upon per capita yearly charge. Discussions should be pursued . . . specifically with Hennepin County and with its health program, but with other counties as well, as interest is expressed.

* Clear away legal barriers. Our understanding is that, although there are organizations in the community selling health care on a prepaid basis, all questions have not been resolved about the kinds of organizations that can engage in this form of medical practice under existing Minnesota law. Similarly, existing legal definitions of who may practice medicine may

still exist that would prevent or impede the movement toward the expanded use of nurses and other allied health personnel. The Metropolitan Comprehensive Health Planning Agency should undertake to clarify this question, and to propose amendments as required.

* Conduct studies of the costs and quality of services under alternate arrangements for delivering care. The extent of savings under the proposed new arrangement for financing care -- and the quality of care delivered -- have been matters of considerable dispute. It will be important to have good figures on both.

WORK OF THE COMMITTEE

General Hospital (then Minneapolis General Hospital) was one of the first subjects studied by the Citizens League after its formation in 1952 . . . and the League's interest in the program and facilities of the institution has continued up to the present. In 1962-63 a Citizens League committee was active in the issues concerning the transfer of the hospital from city to county jurisdiction. When the proposal came from the County for a reconstruction of facilities, in 1969, the Board of Directors formed a special committee to review the issues involved in the referendum proposal. That committee, which did recommend approval of the $25 million bond issue in September 1969, recognized, at the same time, that the real job of planning the future program and facilities of the hospital still lay ahead. . . . and recommended to the Board that a Citizens League committee be continued through this planning period.

This committee -- to study the planning of the new Hennepin County General Hospital in a rapidly-changing health care system -- began meeting on November 19, 1969. There were 30 meetings of the full committee -- most of them 2½-hour evening sessions . . . which, for a number of members, began informally with dinner ahead of the meeting and continued informally for an hour or more afterwards. In addition, there were six meetings of a Steering Committee appointed to prepare draft recommendations.

In the course of its work the committee was most fortunate to have an opportunity to meet with individuals who are both knowledgeable and influential -- in decisions about General Hospital and in decisions about the health care system, both locally and nationally. Those who were good enough to come and share their thoughts and opinions with the committee included:

Frank Rarig, Executive Director, Wilder Foundation, St. Paul
Dr. Ellen Z. Fifer, Health Planning Director, State Planning Agency, St. Paul
John Yngve, (then) Chairman, Hennepin County General Hospital Advisory Board
Donald B. Ardell, Comprehensive Health Advisory Committee, Metropolitan Council
Dr. Theodor Litman, Medical Sociologist, University of Minnesota
Dr. C. A. Smith, Minneapolis Health Commissioner
Allin Karls, Director of Research, Minnesota Blue Cross
John Turner, Group Health Department, Northwestern National Life Insurance Co.
Carl Platou, Executive Vice President, Fairview Hospital Association
John Dumas, Executive Administrator, Mount Sinai Hospital
David Bjornson, Associate Administrator, Swedish/St. Barnabas Joint Facility
James Stephan, James A. Hamilton & Associates (hospital consulting firm)
Dr. R. B. Raile, Medical Director, Hennepin County General Hospital
C. Thomas Smith, Coordinator of Health Sciences Planning, University of Minnesota
Dr. Richard Ebert, Chairman, Educational Policies Committee, & Director, Department of Medicine, University of Minnesota
Dr. Lyle French, Chief of Staff, University Hospitals
Mrs. Jo Turner, Pilot City Health Center
Dr. Charles McCreary, Minneapolis Health Department, & Minneapolis Model Neighborhood
Everett Sherman & Al Brosius, Honeywell, Inc.
Dr. Helen Knudsen, Director, Hospital Services Division, State Health Department
Dr. Arnold Anderson, Director, Children's Health Center
James G. Miles, President, Children's Health Center

Booz-Allen-Hamilton (consultants to Hennepin County Board of Commissioners) represented by: Dr. Lawrence Wilsie, Dr. Roy Perkins, William Loving and Richard Storey
Dr. Paul Ellwood, Executive Director, American Rehabilitation Foundation
Dr. Donald Freeman, Chief of OB-GYN Service, Hennepin County General Hospital
Dr. Richard Anonsen, Chairman of Board, Hennepin County Medical Society
Dr. John LaBree, Director of Medical Education, St. Mary's Hospital
Dr. Lowell Weber, Minneapolis Internist
Thomas Cook, Executive Director, Hennepin County Medical Society
Dr. Robert ten Bensel, Hennepin County General Hospital
John Westerman, Director, University Hospitals
Earl E. Bakken, President, Medronic, Inc.
Lloyd Detweiler, Director, Medical Center, Vancouver, British Columbia

In addition, the committee was most grateful to have had the continuing attendance and assistance of Paul Vogt, Director of Health & Hospitals, for Hennepin County, and Donald Van Hulzen, Executive Director, Metropolitan Hospital Planning Agency.

In addition to its detailed study of decisions about General Hospital and the local health care system, the committee tried regularly to follow the evolution of hospital and health planning in the metropolitan area -- which was under way at the same time in a task force established by the Metropolitan Council. The committee was also kept current with developments in the national debate over new programs of health insurance. By the end of the work, the badge of a regular member was a book of minutes and background materials some three inches thick.

A total of 36 members participated actively in the work of the committee. They are: Richard J. FitzGerald, Chairman, Harold Adams, Carl A. Appelquist, A. A. Aronson, Charles H. Clay, Mrs. John Coe, Richard Dechert, Richard Dethmers, Henry Doerr IV, Mrs. Joy Drummond, Leo J. Feider, Mrs. David Graven, D. J. Gubrud, Dr. Kristofer Hagen, Dr. Seymour Handler, John G. Harrison, Roger T. Johnson, Leroy Knuthe, William Kreykes, Ray Lappegaard, Dr. Walter McClure, Ann Meissner, Victor E. Miller, William Pearce, Dr. H. F. R. Plass, Robert Provost, Dr. Thomas Recht, Dr. Robert Scott, Richard Slade, Robert Spano, Gary Specker, Dr. Norman A. Sterrie, J. R. Stirrat, Harry Sutton, Everett J. Swanson, and Senator Kenneth Wolfe.

The committee expresses its particular thanks to Vera Sparkes of the Citizens League staff, who serviced the projects efficiently, and frequently on short notice, with the materials and the drafts of reports needed for its discussions.

The committee was assisted by Ted Kolderie, Executive Director, and Calvin W. Clark, Research Associate.

BACKGROUND

Preface

A very substantial book would be required to describe both the essential elements and the specific details of the health care system in a metropolitan community like the Twin Cities area. Such a volume would be immensely useful. It is, however, beyond the scope of this report. What will be attempted here, therefore -- as a supplement to the "policy" discussion of the preceding pages -- can be only the briefest overview of some of the main features, and historical developments, in the hospital and medical system, in Hennepin County General Hospital, and in the recent efforts toward the orderly planning of hospital and health facilities. We will try, for the more interested reader, to indicate where additional information may be obtained.

Hennepin County (and Minneapolis) General Hospital

The hospital, as a program, began in 1886 when the City Council took over responsibility for the care of the "sick poor" who -- prior to that -- had been cared for partly from the charity of private citizens. Fairly quickly afterward, the small staff of the "City Physician" was supplemented by volunteers from the doctors of the city. And -- though the hospital declined to locate near the campus -- cooperation with the University of Minnesota Medical School was established by 1900.

The physical structure developed -- one building at a time, over the years -- at the corner of Fifth Street and Portland Avenue in downtown Minneapolis. The first of the present yellow brick buildings was begun in 1901. The hospital was expanded rapidly, largely as a result of epidemics of diphtheria, scarlet fever, typhoid fever, influenza, pneumonia and tuberculosis.

These contagious diseases began a marked decline in the 1920's, due largely to improved treatment of the water supply and inoculation of school children. These changes marked the first major point of reappraisal of the hospital and its future role. The decline in demand for beds that resulted from the control of these diseases was offset, however, by the growth in demand that resulted from the growing financial hardships of the public after 1929. During the Depression, too, the City began what became a permanent policy of deferring maintenance and capital improvements at the institution.

The long-range questions about the future role of the hospital were forgotten temporarily, during the polio crises of the 1940's.

But in 1947 the period of formal reappraisal -- which is, in a sense, still continuing -- began with an architectural study looking toward modernization and expansion for the rapid population growth expected to take place. The plan proposed at that time called for the expansion onto the block south of the present hospital, and for an institution of about 900 beds in size. It was studied again, by the Citizens League in 1953. That study concluded that, in view of the amount of unused bed space, a rearrangement and remodeling of existing space, rather than new construction, appeared desirable. A further report in 1958, arising out of the City's persistent concern over the financing of the institution and its deteriorating physical condition, concluded again that efforts must be made to "retain General Hospital as an institution providing out-patient and acute hospital care for the indigent, and

emergency and contagious care for all." That report also recommended that the hospital be transferred to county jurisdiction. No decision was reached on the physical structure.

Another committee was assembled by the Capital Long-Range Improvements Committee of the City Council late in 1960. All the elements of the situation which still confronts the community began to be apparent at that time. The implications of the growing programs of public welfare and medical assistance were coming clear. The 1960 census returns had just been reported, showing the first downturn in the city's population. And the results of the United Hospital Fund were apparent in new construction and expansion of the private hospitals in the community. (Interestingly, the City at that time felt severely burdened financially by an operating cost of the hospital that amounted to about $4.5 million a year — or about $3 million a year net to the City, after deducting income from patients' fees.) The committee reaffirmed again the need for preserving the essential elements of General Hospital, underscored again the grossly substandard condition of the physical plant, and recommended that the programs of the hospital be expanded to serve all residents of Hennepin County, with the institution becoming truly a county or city-county facility. It leaned in favor of constructing a new facility, rather than remodeling the old one, but recommended that the size of the institution be reduced from about 450 beds to one of "not more than 400 beds."

This report, submitted in October, 1961, was further reviewed by a second committee appointed by the City Council -- which in July, 1962, reaffirmed all the foregoing recommendations, and looked specifically to the 1963 session of the State Legislature for action.

Legislation was enacted in 1963 . . . transferring administrative responsibility to the Hennepin County Commissioners. A small levy was provided, for the first three years, to investigate the feasibility of a new hospital and to conduct preliminary planning. A one-half mill levy was provided to carry on necessary replacement and improvement projects. The County was permitted to acquire facilities for a new hospital following approval by the voters at a referendum.

One more architectural survey of the existing facility was completed, following the County's assumption of responsibility for the hospital at the start of 1964. It, too, concluded that the existing hospital should not be remodeled, but should be replaced. The major question then remaining was -- again -- the persistent question of the feasibility and desirability of continuing Hennepin County General Hospital . . . and the nature of its role and programs, if continued. In 1967 the Planning Agency for Hospitals in Metropolitan Minneapolis took the lead in developing a contract with a consultant, to appraise the programs and services provided by this and other hospitals; to project future requirements for services that might be provided by General Hospital; to look at alternative ways of meeting the need for programs provided by General Hospital; and to recommend a preferred method of carrying out the Hospital's responsibilities. It was also to prepare long-range plans for the development of Hennepin County General Hospital, including objectives, programs and services, location and facilities, costs and methods of financing, and a staged program of action. This study, paid for jointly by the planning agency and by the County, was completed in December 1968, reviewed by a Citizens Advisory Committee, and endorsed early in 1969, and a $25 million bond issue to acquire facilities for Hennepin County General Hospital was submitted to the voters in a referendum in September, 1969. It was endorsed by a vote of almost 9 to 1.

A Sketch of the Area's Hospital System

In the area surrounding Hennepin County General Hospital -- which the Metropolitan Hospital Planning Agency refers to as the "west metropolitan area" -- there are 16 general acute hospitals with a total of just over 6,000 beds — medical-surgical, obstetric, pediatric and psychiatric. This leaves out the other kinds of beds in long-term care facilities -- nursing homes, etc.

The general acute hospitals, in turn, can be divided into two groups. The first are the governmental hospitals -- the Veterans Administration at Fort Snelling, the University Hospitals, and Hennepin County General Hospital. Together these have over 2,000 beds, or about a third of the total. Second are the 13 "voluntary" hospitals with about 4,000 beds. These are private non-profit corporations. For-profit operations in the hospital area have been discouraged for some years by the State Department of Health, and the last of the existing such operations disappeared a few years ago. These voluntary hospitals can be grouped, in turn, into four suburban hospitals -- Fairview-Southdale in Edina, Methodist in St. Louis Park, North Memorial in Robbinsdale, and Glenwood Hills in Golden Valley -- and nine central city hospitals. The central city hospitals are further subdivided in terms of the hospital groups or complexes that have been emerging over the last five years. All but one -- Eitel Hospital, near Loring Park in Minneapolis -- is now affiliated with one or another of the major groupings. The first of these is: Minneapolis Medical Center, Inc., which includes Mount Sinai, Northwestern, Deaconess, Children's Health Center and Kenny Institute, roughly between 22nd Street and 27th Street on Chicago Avenue. The second is the West Bank Medical Center, which includes Fairview and Saint Mary's Hospitals, just across the river from University Hospitals on the main campus. The third is the Metropolitan Medical Center, made up of Swedish and St. Barnabas Hospitals, just east of Hennepin County General Hospital in downtown Minneapolis. The remaining hospital -- Abbott -- is still physically located on First Avenue South, but has recently merged organizationally with Northwestern Hospital. In all, the suburban hospitals account for about 22% of the total general acute hospital beds in the community; the central city hospitals for about 46% (the remaining third, as indicated earlier, is represented by the governmental hospitals).

Broken down another way . . . about 70% of the total beds are medical-surgical, about 10% obstetric, about 7% pediatric, about 9% psychiatric. In 1969, beds were used to about 80% of capacity, which is generally very good. There is, however, a good deal of variation, both among the different institutions and among the services within any given hospital. Overall, the occupancy rate has come up over the last six years. Generally, obstetrics and pediatrics show the lowest occupancy rates.

Generally, for a major metropolitan area, this area has a relatively large number of comparatively smaller hospitals. The range is from the VA Hospital, with just over 1,000 beds, to Eitel, with 129 beds. Six of the hospitals have fewer than 300 beds, eight have between 300 and 400, and only three (University, VA, and St. Mary's) have more than 400. This fact, together with the increasing specialization of medicine and the need for large volume facilities to achieve economies of operation, are major factors pulling the hospitals of the Minneapolis area together into complexes.

Projections of bed needs, made by the Metropolitan Hospital Planning Agency regularly since 1967, indicate that the four-county west metropolitan area essentially now has -- or has approved, and "in the pipeline" -- as many beds as it will need through 1975. There would appear to be a likely over-supply of pediatric beds --

although this depends on the rate at which Children's Health Center opens its new beds, and the extent to which existing pediatric beds are closed as a part of the consolidation into Children's Health Center. This situation with respect to the adequate, or more than adequate, supply of general acute hospital beds is a source of much of the basic problem in hospital planning in the area: How can additional facilities be made available in the developing suburban portions of the area without seriously overbuilding the total bed supply for the community? Put another way, the question would seem to be, how can there be a gradual phasing out of some of the beds in the central part of the area where the population has been declining? A number of the very small hospitals that once existed in central Minneapolis have closed during the last 20 years. The extent to which this may continue into the future is not clear.

Questions about the supply of beds relate directly to the way in which hospitals are financed. This issue was well summarized in the introduction to the planning agency's report on the proposed Heritage Hospital in Bloomington in October, 1969:

> "Most hospital services are financed by third-party payers . . . that is, governmental or private insurance which spreads these costs broadly throughout the community and reimburses providers on a cost or cost-plus basis. The hospital reimbursement structure in Minnesota almost guarantees that any hospital service covered by health insurance will be a financial success, regardless of whether or not such additional services are needed. Everyone pays, regardless of who the users are, regardless of whether the use is appropriate, and regardless of whether the service is efficiently or inefficiently provided."

Of the private third-party payers, Blue Cross is the largest. It is also the only one that pays on the basis of total cost: That is, it relates the hospital's total budget to its total days of patient care and arrives at a total per diem rate. Blue Cross then pays the per diem rate for all of the days of care provided to its subscribers. Put another way, this means Blue Cross does not pay specifically for the services and facilities used by patients. Commercial insurance plans, on the other hand, pay the charges for services rendered to particular patients up to the dollar limit of the policy.

There are also large public third parties which buy large quantities of medical care from hospitals -- particularly Medicare and Medicaid. These programs currently are buyers of care only for persons over 65, and for a number of low-income persons in certain welfare categories -- AFDC, blind, etc. There is a third public program -- general relief -- that is a buyer of medical care, but in the Minneapolis area its purchases are limited to University Hospitals and Hennepin County General Hospital.

A very high proportion of the hospital bills in this area are paid by the so-called third parties. What is known as private pay -- out-of-pocket expenses covered directly by the patient -- account now for less than ten per cent of total hospital revenues in the area.

Hospitals -- though perhaps the most conspicuous physical feature in the health care system -- are by no means the only major element. In addition to the "general acute hospital," there are a number of less-intensive-care facilities which -- although not commonly owned by the same organizations -- may be considered part of the "system." There are, first of all, the extended-care facilities, many of them built

by hospitals in recent years, which provide accommodations for patients who are past the critical stage of their illness and who can care for many of their own needs. Some housekeeping help and some nursing care is provided. There are also, of course, the "nursing homes" -- primarily, but certainly not exclusively, for the aged -- which are, in fact, a very large part of the system and which account for by far the largest share of the Welfare Department's purchases of health services. Some of these are -- like hospitals -- non-profit corporations, frequently with religious or charitable affiliations, but many -- unlike hospitals -- are private for-profit enterprises owned either by independent businessmen or by large, and in some cases, national organizations.

A number of other health facilities and services exist in the public sector. Programs operate in both the city and suburban public schools, and for students at the University of Minnesota. The City of Minneapolis and a number of the larger suburbs maintain public health departments. Services, separately in the city and in the suburbs, exist to provide full-pay, part-pay, or non-pay home nursing service. There are rehabilitation services for people who need to learn to speak after losing their voice box due to cancer, for persons with breathing problems, and for children or adults physically disabled by injury or disease. There are immunization clinics, family planning clinics, and clinics -- both public and private -- to help expectant mothers care for the arrival of their children. A concise and useful directory of these and other services is prepared and made available by three voluntary organizations: The Minnesota Heart Association, the Hennepin County unit of the American Cancer Society, and the Respiratory Disease Association of Hennepin County.

The question of the organization of medical -- that is, doctors' - practice is beyond the scope of this study and this report. It is, however, related at several points to a discussion of hospitals. For the voluntary hospitals are, essentially, extensions of the individual doctor's practice . . . places to which patients are sent by the doctors for examination or treatment beyond what can be given in the doctor's office, and the hospital, from another point of view is essentially responsible only for its own doctors' (that is, the doctors on its medical staff) patients. These doctors, in turn, are organized in various ways. They may be general practitioners working by themselves, or they may be specialists working by themselves, or they may be working in a group with other doctors of the same specialty, or they may be doctors working in a multi-specialty group.

Doctors are, of course, free to locate their offices where they choose . . . and in this community in recent years a significant shifting in the pattern of doctors' office locations has been under way. Most of the information about this was supplied to the committee by Dr. Theodor Litman, a medical sociologist at the University of Minnesota, who is completing a detailed analysis of the location and re-location of doctors' offices in the area. His study has clearly identified a heavy movement of doctors out of the central city into the suburbs. This same pattern has been seen earlier in other major areas, particularly in Chicago. In large part this seems to be related to the location of doctors' residences and to their understandable desire to minimize travel time. Currently, about a third of all doctors in the Minneapolis area live in Edina. Major concentrations of doctors' offices have been appearing around the suburban hospitals, particularly the Southdale Medical Center and near Methodist Hospital in St. Louis Park. There have been substantial gains, also, around North Memorial Hospital, and in Golden Valley, largely around the psychiatric clinic. The areas experiencing a loss of doctors' offices are particularly the north side of Minneapolis, the lower south side, and even the University area in

southeast Minneapolis. Partly in response to this, hospitals in the inner city have also been encouraging the construction of new doctors' office buildings next door to themselves. One is now open across from Swedish-St. Barnabas, another is contemplated near Fairview-St. Mary's, and one or more are under discussion farther south on Chicago Avenue near the Minneapolis Medical Center, Inc. This trend is much less pronounced, to date, in the St. Paul area, largely, Dr. Litman believes, because the real suburban hospital development on the east side of the metropolitan area has not yet started.

More and more, medical care is also being provided at the hospital for persons who simply appear there, rather than being sent or brought in by a physician. Some of the hospitals have hired off-duty interns and residents in training at the public hospitals. Some have begun to hire doctors -- full or part-time -- on their staffs to man the "emergency" and out-patient rooms during the evening. And Methodist Hospital has adopted the so-called Pontiac Plan, under which the doctors on its medical staff, in effect, agree to take turns spending an evening or a week-end day at the hospital to take care of whatever "walk-in" traffic appears. The Hennepin County Medical Society maintains a service for persons in the community who need care and do not have a personal physician to whom they can go. This is available day or night simply by calling 339-1411.

Private -- and Public -- Hospital Planning

Except for the governmental institutions, community hospitals are independent and private organizations. And, in the strictest sense, their decisions about the expansion of facilities and programs might be considered their own business . . . with no concept of community-wide hospital planning admitted. And, certainly, for many years the hospitals were financed by private charity, rather than by charges to insurers, and little sense of community planning did exist.

Planning requirements came, however, with the Hill-Burton program of public assistance for hospital construction, which began in 1946. The Minnesota State Department of Health was required -- in the course of administering this grant program -- to keep and maintain a plan for hospitals and related health facilities. Since the primary focus on the Hill-Burton program for almost the first twenty years of its existence was, however, on rural Minnesota, this program did not initiate hospital planning within the urban areas or within the Twin Cities metropolitan area in particular.

A first -- and privately financed -- effort in this direction came about 1949, in connection with the postwar effort to respond to the need for additional hospital facilities in Hennepin County, and the felt need for some planning for such a large and expensive community-wide program. The Minneapolis Hospital Research Council was organized by a group of businessmen concerned that the building programs being developed by the various hospitals were being prepared substantially without reference to each other or to the overall needs of the community. The Council -- representative of individuals and firms who would be expected to contribute substantially to the capital funds campaigns for the different hospitals -- retained the consulting firm of James A. Hamilton & Associates to study the present and future hospital requirements of the community. Their report was completed in June, 1950, as "A Hospital Plan for Hennepin County."

It represented a dramatic break with the past pattern in which hospitals had been built and rebuilt. Essentially, it proposed that in the course of adding a

large number of beds to the community supply, there be a "grouping" of hospitals with each other . . . and within this grouping a real effort to begin developing particular institutions as specialists in certain health services and facilities. The principal such grouping was to be known as Hennepin Hospital Center, and was to be made up of 12 hospitals, five of which would be located at a central site on the east side of downtown Minneapolis. A second grouping was proposed centered around Mount Sinai Hospital, in which the hospitals would be related only organizationally. Some other hospitals would continue to operate as separate community hospitals. And the plan contemplated, with the postwar movement of people into the suburbs, the first substantial hospital construction outside the city: One additional to the south or southwest; one to the west in St. Louis Park; and one to the northwest, serving those suburbs. The principal feature of the Hennepin Hospital Center proposal was the proposal to centralize in a new corporation, owned by the member hospitals, fourteen specific services -- from accounting and statistics to radiology and nursing education. The whole plan was advanced one more stage, to a report in January 1952, detailing a specific program and plot plan for the "Hennepin Hospital Center." But the Center Corporation, established in September 1950, with eight member hospitals, never actively functioned, and it became apparent that -- particularly with the loss of several key individuals from the leadership of this center -- the ambitious plan actually could not be carried out.

The need for additional facilities remained, however, and was eventually met through the successful efforts of the United Hospital Fund. This "round" of expansion and modernization of the community's hospital system went forward without any concurrent effort to reshape the roles of the various institutions into a more integrated kind of community hospital system.

In the late 1950's the growing concern with rising hospital costs and with the over-utilization of hospital beds, which in turn led to additional pressure for construction, stimulated a number of conferences and a growing interest in efforts to bring the bed supply under some kind of overall, planned control. Out of this came a program by the U. S. Public Health Service to support the organization of voluntary planning councils in the major metropolitan areas, to study the existing supply and the need for the expansion of hospital beds and other facilities. A PHS grant was made to the Minnesota Department of Health in 1960, for a three-year period, to study the need for and to promote the creation of areawide hospital planning activities in Minnesota.

This effort bore fruit first in St. Paul. An editorial in the St. Paul Dispatch in July, 1961, said:

> "The recently-completed study of St. Paul's hospital facilities in relation to community needs is a significant step toward maintaining the best possible health services at the lowest practical cost. Area planning for hospitals, including coordination of services is essential. This has long been recognized in theory, but too seldom acted upon in practice . . . Forthcoming construction of the new $16 million Ancker Hospital is a key factor. Since planning for this institution began, questions have been raised as to what kind of operation would best fit St. Paul's overall needs. This discussion, in turn, has led to self-examination by the other hospitals . . . One important conclusion already reached is that when present construction plans are completed, no additional general hospital beds will be needed

until 1970 . . . Pinpointing the overt deficiencies brings up the logical question whether different hospitals should not make different contributions of particular services supplementing one another. This would be more efficient than for each institution to attempt to make itself self-sufficient in all aspects of costly medical technology. . . One of the strong arguments advanced for locating the new Ancker between Miller and St. Joseph's Hospitals was the possibility of sharing and coordinating facilities and services. The Ancker location finally adopted is not as well suited to this purpose, but nevertheless there continue to be opportunities for coordinated services if all, or several, hospitals cooperate."

A Metropolitan St. Paul Hospital Planning Council was formed in 1962.

In the Minneapolis area, development of a similar council was sparked principally by the announcement in 1963 that the Hill-Burton program intended to make available $2 million for the construction of a "satellite" by Fairview Hospital in Edina. Discussions continued during 1963, and the Planning Agency for Hospitals of Metropolitan Minneapolis (PAHMM) was organized in mid-1964.

PAHMM came on the scene in the middle of a second controversy over the proposed construction of a second small hospital in the northern suburbs -- a 150-bed hospital in Fridley -- by the North Suburban Hospital District. St. Mary's Hospital indicated at the same time it was considering plans for a slightly larger hospital in New Brighton, about three miles away. Another small hospital had recently been completed, serving Anoka and Coon Rapids. The fledgling planning agency intervened in the dispute and recommended against the Fridley Hospital. The North Suburban Hospital District did proceed, however, in cooperation with Glenwood Hills Hospital.

The two local planning councils proceeded independently until about 1966, when the staffs were merged into a single staff serving both agencies. Then in 1969-70 the separate boards were abandoned and the commitment to proceed with a single board on a fully metropolitan basis was adopted.

At this point a whole new line of thinking about planning in the hospital and health care area enters the picture. Before discussing this new thrust briefly, it would be well review the essential philosophy and strategy of voluntary hospital planning. This is not the place where anything like a full-scale review or evaluation of voluntary planning could be attempted, but it is important to convey an essense of this approach as a basis for understanding the new direction that will be taken in the future, and the policy issues the change presents for the Twin Cities area at this time.

The voluntary Metropolitan Hospital Planning Agency in the Twin Cities area counts as members all, or virtually all, of the general acute hospitals of the Twin Cities area. The Veterans Administration Hospital does not belong. Its major objectives are to promote the coordination of existing hospital services and influence the future growth and development of these services and facilities. It works through two major programs: First, the operation of an information system which centrally collects and reports data about the utilization of hospital beds and about patients discharged daily from each of the member hospitals; second, the review and evaluation of proposals from the hospitals for the construction or reconstruction of facilities and the addition of major services. Policy-making authority is vested in a board of

directors. The board is advised on professional and technical matters by a hospital advisory committee, composed of medical and administrative representatives from each member hospital. Typically, a special "study committee" is formed as each major building proposal is brought to the agency for review and comment.

Over the past six years the MHPA has encouraged closer coordination of services among neighborhing hospitals in the central cities and the development of more efficient long-term out-patient, rehabilitation and specialized services particularly suited to the needs of the older and lower-income populations of these areas. Short-term acute services most needed by younger populations have been endorsed for suburban hospital growth. Efforts have been made to make sure that the suburban expansion comes in units of a size that assures economies of scale necessary to support a broad range of community health services. Also, the agency took the leadership in initiating the study that has led to the proposal for new facilities for Hennepin County General Hospital.

Given the makeup of the agency, success must rest on a desire, on the part of the hospitals, to put community needs above their own institutional aspirations, and to establish the measure of community needs through a consensus developed within the hospital and health care community. The powers of such agencies are derived from the member hospitals who voluntarily submit to a "discipline of consent" exercised by the board. Powers are expanded as consensus is achieved, as mutual trust and confidences are established, and as competence and effectiveness are demonstrated. These powers are heavily dependent on community recognition and support, particularly through the media. And they are, therefore, intangible and easily dissipated. The initiative in planning typically rests with the individual hospital: The hope is that, if the areawide planning agency is strong and has achieved a consensus on its "guidelines" for a desirable hospital system, the individual institutional planning will be strongly influenced thereby. The major influence of the planning agency is on the distribution of beds and the size of the total bed supply -- and to a lesser extent on the distribution of specialized service programs. Typically, the planning agency reacts to a proposal submitted by an individual hospital . . . measuring it against such guidelines for a desirable hospital system as it has been able to establish. While the staff and members of the review committees are likely to be aware of the plans and aspirations of other hospital institutions, the process does not -- on the motion of the agency -- raise at one time the specific projects of several hospitals proposed to be built over a period of several years in a given part of the Twin Cities area. The influence of the agency, therefore, is strongest in giving direction to change, rather than actively promoting change. Its recommendations are also voluntary: If the individual hospital chooses not to abide by the comment of the agency, there is little effective action that can be taken short of terminating the hospital's membership in the planning agency.

One of the key issues since 1963, and for a number of years into the future, is the struggle over the relationship between convenience, cost and quality in the hospital system. These issues were raised by the development of Fairview-Southdale Hospital, by the construction of the two small hospitals in the northern suburbs, and by the proposal for a small for-profit hospital in Bloomington in 1969. The study committee report on the latter (the so-called Heritage Hospital proposal) stated the issue this way:

> "The desire for convenience encourages each community or small section of the metropolitan area to want its own hospital. This could lead to the

development of many small hospitals. Each small hospital would be able to deliver routine uncomplicated care but none would be able to provide a broad range of sophisticated and difficult care. This type of development would not contribute to the education and training of needed health manpower. It would not meet the community's needs for comprehensive care. It is economically unsound because it seriously fragments and squanders health resources. And it is counter to the trend toward more sophisticated and specialized services which depend on economies, qualities and opportunities of scale. Therefore, we believe that convenience must be only one of several factors that governs the development of hospital services.

"Nevertheless, we are concerned about convenience in looking to the future. There will be tremendous changes, and new development to serve our rapidly growing metropolitan population. The major share of this new development will be suburban, but a health hospital system will not grow if we disregard the roots of that system which are in the central cities. During the past five years planning has moderated the growth of all hospitals in order to correct the over-development of central city hospitals. Today, the system is in better balance and is more fully utilized. Although costs are high, and increasing each year, they are less than they would have been without this planned development. During the next five years, PAHMM's Policy Guidelines, if followed, will help improve our already good hospital care system. The addition of short-term hospital beds will be concentrated at existing suburban hospitals. By 1975, the system should be well balanced, reasonably convenient and capable of delivering high quality comprehensive services. After 1975, but perhaps sooner, there will be justification to provide more convenient hospitals at new sites. One obvious area for a new hospital is southeastern Bloomington or Burnsville. Other likely areas of need include western and northwestern suburban areas of Hennepin County. The 1970 census will provide the needed statistical base for outlining when, where, what type and how much hospital service should be provided in each area."

The contributions of voluntary planning through the 1960's have been important . . . and it may be, as proponents of this model suggest, that the public does tend most to remember its failures, rather than its successes. It is also -- as its proponents recognize -- limited. Its ability to shape or enforce change is restricted to those areas where a broad consensus among hospitals exists. And the freedom of hospitals to participate, or not to participate, depending upon the particular issue at the time, weakens the whole process. Also, the whole credibility of an agency supported by existing hospitals may be questioned when it reviews the plans of new organizations which are not members of the agency. Some of the proposals reviewed by the voluntary planning agency in the Twin Cities area, and not endorsed, were not built. But the proposed Heritage Hospital was forestalled by a decision in the municipal government of Bloomington, and not on issues related directly to health policy. Also, the decision by North Memorial Hospital in 1969 to proceed with the installation of beds in three floors "shelled in" earlier, beds specifically not approved by the planning agency, demonstrates that a hospital can, when it pleases, move unilaterally with considerable impunity.

It was these problems with voluntary planning, in part, together with the rise of a whole new set of concerns that ran well beyond hospital problems, that led to

the so-called "Comprehensive Health Planning" proposal which passed into federal law late in 1966. Some fundamentally different ideas were introduced by this legislation . . . that the concern must be with health broadly and not exclusively with hospitals; and that health care is to be increasingly regarded as an issue for the public, and not for the health care providers alone.

The law which packaged together a number of grant-in-aid programs in the health area required the creation of a comprehensive health planning agency, both at the state and at the "local" level. At the state level, the Governor designated the State Planning Agency to perform the function. But the failure of the law either to specify what was meant by "local" or to indicate clearly who was to resolve the question led to a dispute that ran for better than a year in the Twin Cities area. Eventually the Metropolitan Council undertook to apply to the Public Health Service for a "developmental grant" to study the way in which comprehensive health planning should be established in the Twin Cities metropolitan area. The study was funded for a two-year period, beginning in September 1968. A 25-member advisory committee charged to recommend an organization, work program and financing for the Twin Cities area was not appointed and put to work until April 1, 1969. But it moved rapidly, once created, and brought its proposals to the Metropolitan Council in March 1970.

Its basic recommendation was that the Metropolitan Council itself be designated as the areawide Comprehensive Health Planning (CHP) agency . . . with the function actually to be carried out by a Metropolitan Health Board administratively independent but legally part of the Metropolitan Council. With some adjustments, this was adopted by the Metropolitan Council late in the spring. The first members of the board -- a majority to be citizens and consumers, rather than providers -- were to be appointed in July 1970. Discussions are under way to determine the relationship of the Metropolitan Hospital Planning Agency and its staff to the new Metropolitan Health Board, and to handle the transition so the areawide planning agency -- whatever its form -- does not lose its involvement in the critical hospital and health planning issues currently before the community.

The next stage in planning seems almost certain to be the stage in which formal powers are introduced. Broadly, two models are being discussed . . . which may be used separately, or in combination, at various locations at various times.

The first essentially involves the denial of funds for construction to hospitals that build without planning agency approval. This model obviously worked in a primitive sort of way in communities, and at times, where hospitals depended heavily on contributions from charities and local business firms who were sensitive to planning considerations. Once the financing of hospitals, and particularly of the capital costs of hospitals, passed out of the stage of direct public giving and into the stage where it was provided by third-party insurers, the operation of this "penalty" model became more difficult. In Michigan, however, Blue Cross reimbursement to hospitals has been indirectly tied to local areawide planning for a number of years. Hospital beds made available against the recommendation of local planning agencies are considered non-participating beds and are reimbursed by Blue Cross at a fixed daily rate substantially below total charges or costs. The Blue Cross board does retain the final decision on these matters, but, in practice, has almost always accepted the recommendation of the planning agency. With the growing role of federal public financing of health services, more and more attention is shifting to the idea of denying Medicare or Medicaid payments to hospitals that build outside the approvals of comprehensive planning agencies. Legislation along this line has developed in

California and has been under consideration in several eastern states and in the national Congress. This approach, it should be noted, discourages but does not forbid construction by individual hospitals.

The other model now being actively discussed would essentially require a hospital to get a "certificate of public convenience and necessity" before any construction, reconstruction, or addition of major defined services. This regulation would be set up by legislation and would be mandatory. Decisions to grant or to withhold "franchises" to existing or new hospitals would be related to areawide planning. It now seems likely that legislation along these lines will be presented to the 1971 Minnesota Legislature. Whether this franchising power will be vested in the local or state CHP agency, or in some local or statewide regulatory board before which the planning agencies will argue their case, is a major question yet unresolved.

A Basic Alternative to Regulation: The Health Maintenance Organization

A growing school of thought argues that it would be a disaster for public policy in the health care area to move, now, down the road of direct regulation of hospitals and other providers of health services. The infant health planning organizations cannot begin to cope with the size, skills and complexity of the health care industry . . . or, if it could, a huge public administrative bureaucracy would have been built for the purpose. The "regulatory" route is, therefore, infeasible and undesirable . . . and is, in any event, unnecessary.

In much the same way, this school of thought argues that public policy oriented primarily toward providing dollars to individuals for the purchase of health insurance or health care is also undesirable. Rather, it is argued, sound public policy should aim at the reconstruction of the way in which health care is organized, delivered and financed . . . so that the system itself -- without direct public regulation -- will be responsive to the problem of cost and to the efficient distribution of health services.

The key concept involves the creation of what is now called a "health maintenance organization," in which the incentives on doctors and hospitals are specifically devised to encourage them to concentrate on keeping the patient healthy and to seek out and put into use the most efficient methods for doing so. The "HMO" would be an organization . . . a multi-specialty medical group owning or having access to a full range of health care facilities -- from out-patient centers to acute hospitals to extended-care facilities to nursing homes. Some group of patients -- whether a collection of persons and families enrolling individually, or the employees of some large government or business organizations -- would contract with the HMO for the provision of whatever care they and their families would require in the course of a year . . . that is, for "the maintenance of their health." The HMO would contract to provide this care in return for payment of an agreed-upon number of dollars in advance. In essence, the patient is then able to get, at a single "point of access", all the care he and his family require . . . with the organization taking responsibility for providing whatever high quality, specialized facilities or personnel is required. The HMO in turn gets a sum of dollars paid in advance . . . and gets to keep whatever portion of this advance payment is left over after care is provided as required. This sets up the essential incentive -- for the HMO to improve utilization of expensive personnel and facilities, and to make efforts toward out-of-hospital and preventive care, so that its expenses in the treatment of illness are reduced and a larger number of dollars is left over, either to invest in new programs or facilities or to distribute as rewards to the members of the organizations themselves.

Medical care, thus, would tend to become relatively more the province of organizations -- and, indeed, in some cases, national organizations. From the point of view of the individual this would be not unlike the delivery of, say, automobile insurance through large nationwide organizations . . . which contract for an annual fee, in advance, to provide specified services to the policyholder, and which maintain in all parts of the country personnel who -- at a phone call from a policyholder in distress -- will provide for him whatever professional or technical services he may require. This situation in the insurance industry may be contrasted with the present situation in the health "industry" . . . where, at present, a family that finds itself moving to a new home in another metropolitan area leaves behind the various elements of one health care system it has carefully assembled over the years in the form of its pediatrician, its dentist, its eye doctor, its obstetrician, etc.; and must begin in its new city assembling the various elements of this system all over again.

This kind of an arrangement for health care, if broadly adopted, it is hoped and expected, would cure the fundamental problems of cost, accessibility and availability of care far better than any of the other "solutions" being discussed.

Organizations of essentially the type now proposed are not new. They have existed in the east since at least the 1930's and have reached probably their greatest prominence on the west coast in the health care programs developed during and after the war as an outgrowth of the health programs set up by the Kaiser organizations for their employees. A small plan of this sort has existed for a number of years in the Twin Cities area. Except, perhaps, on the west coast, their growth has not been spectacular. They have been bitterly fought and impeded in a number of areas by other elements of medicine -- because of the challenge which their essential principle represents to the traditional approach . . . which involves the delivery of care by individuals, not organizations; and in which the provider collects his fee for the particular service provided, rather than contracting to provide care for an amount agreed on in advance. The attack has been on their performance, as well as on their philosophy. But proponents contend that a number of the plans, at least, deliver comprehensive and high-quality care which involves the use of only something like two beds per thousand population . . . as contrasted with four, five or more beds per thousand population in cities where health care is delivered on the traditional basis. (The Twin Cities area currently has about five beds per thousand.)

This is not the place for a review of this long controversy. The facts of particular interest have to do with the growing interest that is, manifestly, being expressed now by insurance companies, by the government, and by organized medicine itself in some moves toward the delivery of health care through some form of HMO.

For example, the Health Insurance Association of America in November 1969, in a broad report recommending changes in the programs of its 313 member companies to help control rising costs, proposed that insurance companies follow closely developments in this area and be prepared to conduct experiments to determine the proper relationship of insurance companies to the health maintenance organizations. The report said:

> "There is considerable opinion today that prepaid group practice contains the possibility of bringing about improvements in the health care field, that it can result in more efficient use of available manpower, that it can improve the access to care, that it can tend in the direction of more

expeditious use of less costly forms of care, and that it can thus minimize the inevitable increases in the overall cost of care. It is important that insurance companies do not place themselves in a position of impeding any such sound development."

Perhaps most important, however, is the proposal made within the national government in March 1970 that from hereon federal health insurance programs be used to restructure the health care industry into a more efficient pattern. In a statement on March 25 then-Secretary of Health, Education, and Welfare Robert H. Finch said:

"The federal government is spending over $10 billion this year to buy health care for the aged and the poor under the Medicare and Medicaid programs. This is double what was estimated when these programs were enacted in 1965, just five years ago. In another five years, given the present trend, the cost will be at least $20 billion. We are not getting our money's worth. The aged and the poor are not getting all of the care they need.

The average citizen loses on two counts:

-- He is paying an increasing share of taxes to support this expenditure, without seeing the desired results for it.

-- He is paying higher medical bills in part because his government has increased the demand for medical service without increasing the supply and without improving the operation of our fragmented and inefficient health care industry. . .

The question is not one of placing blame but of recognizing our difficulties and acting on them.

Medicare and Medicaid were built on the traditional arrangements for organizing, delivering and paying for care that prevailed when those programs were enacted. They placed added and unanticipated stress on a health system which was fragmented, and unprepared to respond. . .

There have been encouraging responses. Medical societies are beginning to experiment with offering services to the poor at guaranteed annual rates and reviewing the practices of theirm members to prevent abuses. Medical schools are looking for ways to expand their enrollment and develop paramedical workers. The new generation of medical students is involving their schools in the problems of the inner-city and the rural poor. Hospitals are establishing satellite health centers in neighborhoods that have had no facilities and are expanding out-patient services in order to keep people out of the hospital. Insurance companies are going beyond their traditional role of paying bills to concern themselves with problems of providing health services.

But these efforts are still few and scattered and they have brought into starker view the size of the job before us. . . .

Our goal must be to reverse the process of growing expenditures without corresponding increases in health care. This means working toward a system where the doctor is rewarded financially for keeping the patient healthy

where the hospital is rewarded for efficiency and can invest cost savings in improved services, where the doctor and hospital together are rewarded for efficient use of manpower, and, where the health consumer, the individual or the federal government, has a choice between competitive alternatives when he buys health care.

As the biggest purchaser of health care in the world, the federal government has an obligation to encourage development of a more responsive health care system for the nation. It will be a long process, but we must atart now.

We are pleased that the House Committee on Ways and Means and the Senate Committee on Finance have begun hearings in this important area. We propose the following steps, as outlined this week by Under Secretary John G. Veneman in executive sessions of the Ways and Means Committee.

-- To initiate a series of measures, some of which have already been announced, aimed at controlling the costs of Medicare and Medicaid and encouraging better distribution of health facilities.

-- To begin redirecting our Medicare and Medicaid expenditures, through the use of health maintenance contracts, toward developing an increasingly efficient and competitive health care industry that can serve all Americans better. . .

We are asking for authority, under the Medicare and Medicaid law, to enter into health maintenance contracts guaranteeing health services for the elderly and the poor at a single fixed annual rate for each person served. . .

In the case of Medicare, the patient will be entitled under such a contract to all of the usual Medicare services plus preventive services. The contract price will be negotiated in advance at an amount less than the Social Security Administration presently pays for conventional Medicare benefits in the locality.

Similarly, under Medicaid we are seeking authority for the states to offer to the poor the option of securing services under such health maintenance contracts. . .

The cornerstone of this new option in federal health purchasing will be the opportunity for consumers to choose between alternatives. The ultimate goal will be to give every beneficiary of these programs a choice between obtaining services from a health maintenance organization or arranging for them in the usual way from individual doctors and hospitals. . .

Through such legislation we hope to accelerate the coming of a new era of diversity and competition for health care in the U. S., based on informed consumer choices and private incentives that operate within the framework of government safeguards.

More than 5 million people in the U.S. are presently getting medical care under arrangements which include financial incentives to keep the patient health and out of the hospital. Virtually all members of a county medical

society in Oregon have joined together with local hospitals to provide health maintenance contracts for the poor. In a newly-developed model community, a distinguished medical school and an insurance company have teamed up to build a health maintenance organization for the entire population of the community. One of the country's largest corporations has sponsored for many years a non-profit foundation which now guarantees comprehensive health services at a fixed annual charge for almost 2 million persons.

The kind and variety of arrangements which are possible go far beyond these beginning efforts. Some health maintenance organizations may be large corporations. In contrast, a group of doctors may elect to combine for this purpose for part of their time and continue their conventional medical practice as well. An existing hospital may combine with its medical staff to form such an organization, or it may develop arrangements with others and subcontract its services at a fixed rate.

We recognize that health maintenance organizations do not now exist in every American community. In fact, some states have laws prohibiting the practice of medicine in this fashion. We propose to use the economic leverage of the federal government to encourage the states to remove these barriers. It is the goal of this Administration to encourage a more efficient medical care system and the proposals the Administration is making today would stimulate physicians to align themselves into groups to practice more efficiently. The process may take many years, but we need to begin now to build into our health industry the seeds of continuing renewal."

MEDICAL CARE EXPENDITURES

Medical care in the United States costs $60.3 billion, or 6.7% of the gross national product (GNP) in 1969. This represents a fivefold increase since 1950, when the expenditure on health care was $12.1 billion, or 4.6% of the GNP. Of this increase, 50% is attributable to price increases, 19% to population increase and 31% to other factors, including increased use of services and new technologies.

The increase in medical care costs has recently been accelerating. From 1965 to 1969 there has been an increase of 64.5%, from $38.9 billion to $60.3 billion. During the first six months of 1970, the monthly increase in health care costs has reached an all-time high.

The marked increase in health care expenditures nationally is also reflected in the increased cost to the individual living in the Twin Cities metropolitan area. A large private insurance company shows the following rate increases for a typical group health plan in Minneapolis over the last five years:

I. Plan Used For This Study

Special Basic Major Medical
$3,000 of Full Area Hospital
$20,000 maximum per individual
80/20 co-insurance
$100 calendar year deductible - zero deductible all hospital charges
Maternity - $350, Switch

First dollar coverages

Surgical $600 Schedule A
Hospital Medical $5 per visit 120 times
X-ray and Laboratory $100 non-scheduled
Supp. Accident benefit $300

II. Rates for Above Plan (Monthly)

	'66 Basis	'67 Basis	'68 Basis	'69 Basis	'70 Basis
Employee	$ 9.65	$10.20	$11.42	$13.36	$15.90
Dependent	18.92	19.99	22.39	26.18	31.17
Percentage Increase over Previous Year *		6%	12%	17%	19%
Total Percentage Increase 1966-70					65%

* Percentage increases shown are for the Minneapolis area and do not necessarily reflect overall company increases.

Appendix II

1970 BUDGET

HENNEPIN COUNTY GENERAL HOSPITAL

BUDGET		
OPERATING COST		$ 15,643,893
UNIVERSITY OF MINNESOTA HOSPITAL SERVICE		525,000
MENTAL HEALTH CLINIC		816,245
TOTAL		$ 16,985,138
LESS:		
PATIENT REVENUE	$ 8,574,000	
MISCELLANEOUS INCOME	772,875	
OPERATING CARRYOVER	600,000	
STATE AID-MENTAL HEALTH CLINIC	408,123	10,354,998
AMOUNT REQUIRED FROM TAXES ON PROPERTY		$ 6,630,140

	CITY OF MINNEAPOLIS	SUBURBAN HENNEPIN CO.	ENTIRE HENNEPIN CO.
PERCENT OF UNRECOVERED PATIENT COSTS-1968	77.87	11.42	10.71
TAX REQUIREMENT FOR OPERATING FUND APPORTIONED ON 1968 UNRECOVERED COSTS	$ 5,162,890	$ 757,162	$ 710,088
CAPITAL AND PLANNING LEVY			650,000
AMOUNT REQUIRED FROM PROPERTY TAX	$ 5,162,890	$ 757,162	$ 1,360,088
LESS: PERSONAL PROPERTY TAX REPLACEMENT & ESTIMATED DELINQUENT TAX COLLECTION	423,687	27,207	83,433
NET AMOUNT REQUIRED FROM PROPERTY TAX LEVY	$ 4,739,203	$ 729,955	$ 1,276,655
ASSESSED VALUATION	$378,800,000	$437,600,000	$816,400,000
AT 98% COLLECTION, ONE MILL EQUALS	$ 371,244	$ 428,848	$ 800,072
MILL RATE	12.77	1.71	1.60
ADD BACK COUNTY-WIDE RATE	1.60	1.60	
MILL LEVY REQUIREMENT	14.37	3.31	

Appendix III

PAYMENTS FOR CARE OF HENNEPIN COUNTY WELFARE DEPARTMENT RECIPIENTS IN HOSPITALS - 1969

H O S P I T A L	In-Patient Beds			Welfare $			Welfare Cases		
	#	% of Total	Rank	$ (000's)	% of Total	Rank	#	% of Total	Rank
Hennepin County Gen. Hosp.*	394	6.3%	8	$1,388	23.2%	1	2,478	19.1%	1
University of Minnesota*	693	11.1	1	521	8.7	3	367	2.8	14
Swedish + ½ shared	407	6.6	5	230	3.9	9	927	7.2	5
St. Barnabas + ½ shared	342	5.5	10	221	5.7	10	647	5.0	9
Asbury	111	1.8	17	36	0.6	18	66	0.5	17
Deaconess	254	4.1	13	185	3.1	12	650	5.0	8
Kenny Rehabilitation Inst.	58	0.9	18	45	0.8	17	25	0.2	18
Mount Sinai	273	4.4	12	691	13.6	2	1,386	10.7	2
Northwestern	400	6.4	7	193	3.5	11	489	3.8	11
Fairview--Fair. Southdale	614	9.9	2	455	7.6	5	1,125	8.7	4
St. Mary's	519	8.3	4	346	5.7	7	888	6.8	6
Abbott	307	4.9	11	152	2.6	14	402	3.1	13
Eital	129	2.1	16	66	1.1	16	271	2.1	15
Glenwood Hills	385	6.2	9	450	7.5	6	616	5.1	
Methodist	406	6.5	6	157	2.6	13	459	3.5	12
North Memorial	553	8.9	3	464	7.8	4	1,306	10.1	3
Mercy	140	2.2	14	18	0.3	19	48	0.4	17
Unity	139	2.2	15	106	1.8	15	129	1.0	16
Out of County				254	4.2	8	620	4.7	10
TOTAL				$5,980			12,949		

* Includes physicians' fees

Appendix IV

PURCHASE OF HOSPITAL CARE BY HENNEPIN COUNTY WELFARE DEPARTMENT RECIPIENTS -- 1964-1969

VOLUME BY YEAR

HOSPITAL	1964		1965		1966		1967		1968		1969	
	$	#	$	#	$	#	$	#	$	#	$	#
HCGH*	$731	1,410	$ 844	1,517	$1,040	1,959	$1,104	2,244	$996	2,549	$1,388	2,478
Univ. of Minn.*	---	---	---	---	99	143	270	289	359	335	521	367
Swedish	412	913	509	965	482	985	217	936	277	996	230	927
St. Barnabas	189	449	218	518	200	524	107	554	171	679	221	647
Asbury	33	97	36	102	31	101	56	134	115	218	36	66
Deaconess	262	609	312	714	280	682	151	729	167	746	185	650
Kenny Rehab.	---	---	---	---	---	---	---	---	16	20	45	25
Mount Sinai	484	928	577	1,063	568	1,140	410	1,261	502	1,421	691	1,386
Northwestern	180	301	173	323	182	358	133	427	208	542	193	489
Fairview-Fairv-Southdale	316	771	401	946	439	1,144	317	1,062	392	1,108	455	1,125
St. Mary's	215	531	294	700	343	833	228	842	274	1,013	346	888
Abbott	138	249	144	312	145	282	72	334	195	593	152	402
Eitel	119	300	163	339	123	897	70	299	55	308	66	271
Glenwood Hills	143	398	173	805	175	426	214	534	319	631	450	666
Homewood	10	34	8	24	---	---	---	---	---	---	---	---
Methodist	147	371	188	405	186	381	83	446	133	512	157	459
Minnetonka	3	5	---	---	---	---	---	---	---	---	---	---
North Memorial	255	615	360	784	405	887	263	1,105	344	1,247	464	1,306
Mercy	---	---	---	---	---	---	---	---	---	---	18	48
Unity	---	---	---	---	---	---	---	---	---	---	106	129
Out of County	---	---	---	---	---	---	---	---	---	---	250	620

* Includes Physicians' Fees
$ in thousands

Appendix V

PURCHASE OF HOSPITAL CARE BY HENNEPIN COUNTY WELFARE DEPARTMENT RECIPIENTS - 1964-1969

Hospital	Beds - 1969 #	Beds - 1969 % of Total	% of Total Volume by Year: 1964 $	1964 #	1965 $	1965 #	1966 $	1966 #	1967 $	1967 #	1968 $	1968 #	1969 $	1969 #
Hennepin County General	394	6.3%	19.9%	17.7%	19.2%	16.6%	22.1%	19.3%	29.9%	20.2%	22.0%	19.1%	23.2%	19.1%
University of Minnesota *	693	11.1	-	-	-	-	2.1	1.4	7.3	2.6	7.9	2.6	8.7	2.6
Swedish + ½ shared	407	6.6	11.3	11.4	11.6	10.6	10.3	10.8	5.9	8.4	6.1	7.7	3.9	7.2
St. Barnabas + ½ shared	342	5.5	5.1	5.6	4.9	5.6	4.2	5.1	2.9	5.0	3.8	5.3	3.7	5.0
Asbury	111	1.8	0.9	1.2	0.8	1.1	0.5	1.0	1.5	1.2	2.5	1.6	0.6	0.5
Deaconess	254	4.1	7.1	7.6	7.1	7.8	8.1	6.7	4.1	6.6	3.6	5.8	3.1	5.0
Kenny Rehab.	58	0.9	-	-	-	-	-	-	-	-	0.4	0.2	0.8	0.2
Mount Sinai	273	4.4	13.2	11.6	13.1	11.6	12.1	11.2	11.1	11.4	11.1	11.0	13.6	10.7
Northwestern	400	6.4	4.8	3.8	3.9	3.5	3.9	3.5	3.6	3.8	4.6	4.2	3.5	3.8
Fairview - Fairview SD	614	9.9	8.6	9.7	9.1	10.4	9.3	11.3	6.7	9.5	8.7	8.6	7.6	8.7
St. Mary's	519	8.3	5.9	6.7	6.7	7.7	7.3	8.2	6.3	7.6	6.1	7.8	5.7	6.8
Abbott	307	4.9	3.8	3.1	3.3	3.4	3.1	2.8	1.9	3.0	4.3	4.6	2.6	3.1
Eitel	129	2.1	3.2	3.8	3.7	3.7	2.6	8.8	1.9	2.7	1.2	2.4	1.1	2.1
Glenwood Hls.	385	6.2	3.9	5.0	3.9	4.5	3.7	4.2	5.8	4.8	7.0	4.9	7.5	5.1
Homewood	-	-	0.3	0.4	0.2	0.1	-	-	-	-	-	-	-	-
Methodist	406	6.5	4.0	4.6	4.3	4.4	4.0	3.8	2.3	4.1	2.9	4.0	2.6	3.5
Minnetonka	-	-	0.1	0.1	-	-	-	-	-	-	-	-	-	-
North Memorial	553	8.9	6.9	7.7	8.2	8.6	8.6	8.7	7.1	9.9	7.6	9.6	7.8	10.1
Mercy	140	2.2	-	-	-	-	-	-	-	-	-	-	0.3	0.4
Unity	139	2.2	-	-	-	-	-	-	-	-	-	-	1.8	1.0
Out of County	-	-	-	-	-	-	-	-	-	-	-	-	4.2	4.7

* Includes Physicians' Fees

ABOUT THE CITIZENS LEAGUE . . .

The Citizens League, founded in 1952, is an independent, non-partisan educational organization in the Twin Cities area, with some 3,600 members, specializing in questions of government planning, finance and organization.

Citizens League reports, which provide assistance to public officials and others in finding solutions to complex problems of local government, are developed by volunteer research committees, supported by a fulltime professional staff.

Membership is open to the public. The League's annual budget is financed by annual dues of $10 ($15 for family memberships) and contributions from more than 600 businesses, foundations and other organizations.

(July 15, 1970)

YOU ARE INVITED . . .

to join the Citizens League

- Serve on a CL Research Committee
- Receive the CL News
- Attend CL Community Leadership Breakfasts
- Become better informed on public affairs
- Help provide financial support for the League's program

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Family* $25.00 ☐ . . . $30.00 ☐ Regular student . . . . $ 5.00 ☐

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