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July 31, 1980

TO: The members of the Metropolitan Health Board and
the Metropolitan Council

SUBJECT: Summary statement by the Citizens League on Phase III of the
Metropolitan Hospital Plan

1. The Phase III "designations" represent an expected and useful step in the continuing effort to deal with the problem of excess capacity in the hospital system of the Twin Cities metropolitan area.

It has been understood since the adoption of the plan a year ago, that the process would begin with the reduction of beds, and move on to the reduction of whole specialty services. The process has simply now arrived at that point.

The document is now specific as to particular hospitals. Very clearly, as a corollary of indicating which services at which locations would be designated to continue, it indicates which services at which locations would be "designated" not to continue. It seems to us this is not an inappropriate thing to do. In the whole effort to identify the elements of capacity that need to be reduced, it would probably be unrealistic to expect, or to ask, individual hospitals to propose the elimination either of their own services, or of services belonging to other hospitals.

2. At this point, however, the process of capacity reduction is likely to encounter great controversy, and considerable resistance.

Decisions about the retention, or closing, of particular high-specialty services greatly affect the future viability of individual hospitals, and would be perceived to do so. They also raise important policy questions about the future shape and structure of the region's hospital system in total. From both the system and the project points of view an intense debate can be expected. From here on, the going is likely to be extremely difficult.

It is important, therefore, at this point to continue to remind ourselves that the effort is required by the continued existence of a very large and very real problem, in the level of, and the rate of increase of, health care and hospital expenditures. In every nation that has made health care now substantially free to its citizens, some form of 'restraint' is essential. Normally, this begins with some form of concern with the 'supply' of services and facilities.

3. If the plan is to succeed in reducing capacity, the Health Board and the Metropolitan Council should begin to encourage the competitive and market forces now working in the same direction.

Action only on the 'supply' side will not be sufficient. There will need to be an effort to restrain 'demand', as well.

Too much discussion in the community recently has suggested that these two approaches are antithetical: that the region must follow one strategy or the other. We reject this notion. The two strategies are, as the Citizens League argued in its basic report, "More Care About the Cost in Hospitals" in 1977, complementary. They reinforce each other. It is time for the Health Board, in its own interest, to add this dimension to its present effort.

We would offer you today suggestions in two areas:

- A. You should try to secure two changes (which we recommended to you in our statement last fall) that would tend to recreate something more like a 'market' for hospital capital.

This would supplement your regulatory efforts through Certificate of Need, to slow the flow of new investment into the hospital system. This should be a basic part of your strategy. It is very hard, as we are now seeing, to get facilities out of the system, once they have been constructed. In this field, as in so many other fields including health care itself, prevention is an easier strategy than repair!

This is important also because the issue is not only the number of beds, or the number of specialty services, or the number of hospitals. The underlying issue is, as we have said on so many occasions, the number of dollars: the level of expenditure, and the rate at which it is increasing.

The specifics we put in front of you last fall would, we think, work to discourage new facilities, by increasing their cost or by increasing the risk to the persons who finance them. Specifically:

- * You should work for an amendment of the 1978 Minnesota law that made hospital and health care facilities fully eligible for tax exempt financing under the state's Industrial Development Revenue Bond Act.

The new amendment should require the concurrence of the HSA -- that is, of the Metropolitan Health Board and the Metropolitan Council -- as well as the concurrence of the municipality in which the proposed facility is located, to secure the below-market-rate credit for financing. Our reasoning was simple: the use of the public credit is justified in the law on the grounds that the facilities in question represent something the community has determined it needs more of. So, for example, these bonds have been used to finance the installation of pollution control equipment in industry. There would not seem to be a case for their use precisely in an

area where public planning and public policy has determined that facilities are in over-supply.

- * You should prepare for every bond prospectus on a major hospital facility the statement on "bond holder risks".

Such a statement appears in each prospectus. Traditionally however it is quite generalized, making no reference to the particular situation in the region in which the proposed hospital is to be located.

Your statement should disclose fully, and with concrete references to real developments in the Twin Cities metropolitan area, the plans, trends and policies in existence that are in fact working to reduce the utilization of health care and hospital facilities.

- B. You should begin exploring intensively, as a part of the overall effort at expenditure restraint, particular actions that might be taken by the Health Board and by the Metropolitan Council to support the forces now working in the local health care marketplace to lower the demand for hospital services and facilities.

This will help you defend against the charge, which may very well be justified, that your current effort is attacking really the less important dimension of the expenditure problem. The charge, in other words, that what is really important is not the under-utilization of facilities and services, but rather their over-utilization.

It will also guard against the criticism, perhaps also justified, which might come from the community of persons interested in the strategy of competition . . . that reducing excess capacity without restraining demand will simply re-create a "seller's market" in hospital care, driving up prices.

Very quickly, here is a list of such items which you might reasonably explore and on which you might develop supportive actions. They do not represent policy recommendations by the Citizens League: they are simply, at this point, things which we have heard about, and have begun to think about. We will be considering them further in a special task force over the next few months.

- * In the private sector, how can the practice of purchasing medical/hospital care on a price-conscious basis be further and more rapidly expanded?

The market for prepaid care has been developed, to date, pretty much within large employee groups. The next frontier would seem to be to break through to offer this kind of service to persons who happen to work for small employers. Some kind of "brokering" or "packaging" entity may be needed, to work with the aggregations of small employers or multi-employer associations.

- * Certainly, how can this practice be extended within the public sector?

Much of the exhortation to be careful about expenditure in the health

care system has been coming from government. Surely government should follow its own advice, as a large purchaser of health care itself. There is now under discussion in the Twin Cities area a major demonstration to do something like this, with the Medicaid program. The HSA should explore how it can be helpful.

- * You should look to see what more can be done, simply with the posting of prices, to make people involved more conscious of the cost of the system.

More information is available about the prices charged, and how they relate to costs, than is widely published. Consumers can be made more sensitive. Insurance companies -- and the regulatory agencies who approve rate increases -- could be made more sensitive. Doctors could be made more sensitive.

We've been made aware, for example, that when major loan agreements are being negotiated, federal law requires that a complete statement of all expected costs be laid out fully in advance of the decision to enter into the loan. Something like this might be done, on a voluntary basis.

- * You might explore the usefulness of changing the fundamental way in which hospitals are now paid for their services.

An interesting question arises: If, as we are so often told, the real customers of the hospital are the doctors, why should not the bill for the hospital services be sent to the doctors? Or, perhaps put more precisely: through the doctors, for reimbursement. This would, if nothing else, accomplish the objective mentioned earlier, of consolidating at one point the total cost -- medical and hospital -- for care rendered in hospitals.

- * Or you might think, alternatively, about a very different question we have heard raised: which is, whether this objective of consolidated responsibility could better be achieved by making doctors fundamentally responsible for hospitals, and their development and operation.

This opens up, of course, a very large question, reaching as far as the continued existence of the present system of governance of hospitals, through their Boards of Trustees separate from their medical staffs.

But the problem is certainly large enough, and the other answers are certainly elusive enough, that even ideas that appear at the moment to represent a fairly radical change ought to receive some discussion.

We stress, again: these are suggestions for your consideration. The important point is for the Health Board and for the Council to begin finding something under this general heading of demand-restraint to complement and support its current efforts through planning and Certificate of Need regulation.