

Citizens League
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STATEMENT BY THE CITIZENS LEAGUE
TO THE HEARING OF THE METROPOLITAN HEALTH BOARD
June 20, 1979

Thank you. We appreciate the opportunity to come here this evening to comment on the Report on Long-Range Hospital Planning, with its important recommendations for what this community should now do to reduce excess capacity in its acute in-patient hospitals.

This is basically the conclusion of the major intensive effort at hospital planning that was just getting under way when our Citizens League report was issued in September 1977. Our report made some recommendations for the way in which that process should be conducted, and, looking back on it today, we think there is reason for this community to be proud of the job it has done. The needed "hold" on major new investment in the system was imposed, while the thinking went on about what the size and shape of the future system was to be. The members of the boards of directors of the community's hospitals, who occupied such an important position between hospital management on the one hand and community interests on the other, did -- as we had hoped and suggested -- come into the discussion about these system planning issues, in new and highly constructive ways. In all respects, serious and constructive and responsible discussion has gone on, involving trustees, hospital administrators, representatives of the medical staffs, and the professionals and lay persons involved with the regulation and planning in the public sector.

We would like to make just a couple of comments about what is proposed, here, for the reduction of the hospital system, and then speak briefly to the question of what remains for this community to do, in the continuing effort to exert some effective public policy control over the increasing expenditures on health care and in hospitals.

Conclusions about the Process

We find the process laid out in your plan, for the reduction of the hospital system, to be generally consistent with the principles we recommended in our 1977 report.

Through the discussions of the Viable Hospitals Task Force, and of the trustees' councils, and of the Health Board itself, we think the central concept has been maintained. This is that the job for the public sector is to say -- reflecting and representing the interests of the whole community -- what generally is wanted, in the way of (as everybody says) the size, shape and structure of the system. It is for the hospital community, then, to translate these overall community standards into specific changes -- in terms of beds, services, and institutions. We think this is both an appropriate and effective division of responsibilities.

This assumes, of course, that hospitals, looking at their own individual futures, as they prepare their particular institutional plans under the schedules now set out, will in fact make reductions which, in total, will achieve the Health Board's guidelines. There is, clearly, a question as to what would be done if the reductions that are needed are not in fact made. It is clear to us, too, that this plan does not speak to that question. We are inclined to think, however, that it should not. It will be time enough to deal with that question if and when it actually arises. In the

meantime, the Health Board should proceed with the hospitals on the present, good-faith assumptions.

It does seem to us that a second missing guideline ought to be supplied at this point. It is not clear to us, looking at the sections of this document that relate to specialized services, whether or not the Health Board wants the hospital system to emerge from this restructuring reshaped somewhat more into a pattern of -- in plain words -- "medical centers." It is probably not enough to indicate simply the total amount of capacity, or beds, that ought to be provided for each particular high specialty service. The hospitals need to know, for their planning, how (assuming the Board does in fact care about this at all) these services are to be arranged, relative to each other. Suppose, for example, that the planning covered four high specialty services and the Health Board decided that this community needed no more than four of each. Conceptually, and at the extreme, two different patterns could emerge. There could be 16 hospitals in the community, each with one high specialty service. Or there could be four major medical centers, each containing all of the four high specialty services. We do not presume to say, and we do not know, which of these two, if either, is the right "shape" for the hospital system in this community. It would appear to be an issue on which the hospitals need and deserve some guidance. If the Health Board does have some feelings about whether or not the system here should move rather more toward, or rather more away from, the pattern of "medical centers," it should make this clear before the specific planning about the future of the high specialty services gets under way in the next phase.

Conclusions about the Reduction

In our report in 1977 we drew the attention of the community to a comparison with Seattle/Tacoma: a remarkably similar community, as it appeared, yet one in which the hospital system was not much more than half the size of what we have here in the Twin Cities area. This comparison was examined rather carefully, also by representatives of the Twin Cities area hospitals. We believe it did have a major impact in suggesting the magnitude of the reduction that was both feasible and desirable.

In our own suggestions for the reduction here, the Citizens League committee made a good many allowances for what is both practical and prudent. It suggested the Twin Cities area come about half way down to the Seattle/Tacoma level. The report set this in terms of range, and recommended a cut of "from 1500 to 3500 beds."

The reductions proposed in the document now before us fall, as best we can tell, roughly at or somewhat below the lower end of the range we suggested, and will of course be carried out over a period of several years. We are mindful of the Health Board's decision that the standard for beds in the community will be adjusted, in the future, relative to the demand for bed days of care; and can, therefore, be expected to fall over time if and as the level of utilization continues to fall. Still, from one standpoint, what is proposed is a fairly modest reduction, in what our report regarded as the potential surplus.

We are not disposed, however, to suggest that the Health Board and the hospitals re-start another round of planning, with the object of coming up with a larger proposal for reductions in the system. We accept what is now proposed as a reasonable effort. It is important, however -- so much shrinkage already having taken place in the size of the cut proposed -- that the plan now before us be regarded as the absolute minimum and be implemented without further compromise.

The decision to proceed in the manner proposed does, however, require the Health Board to maintain, one way or another, a tight control on the flow of new investment in the hospital system. The plan stages out over several years the reduction in beds, services and hospital institutions. During this period, great care will have to be taken with investment until the shape of the future system is clear, and until investment decisions can therefore be made with the confidence that comes from knowing that the hospital -- or, more important, the service -- involved is, in fact, going to be a part of the long-term system.

The Remaining Agenda

It is essential for all of us to keep clearly in focus the fact that this is really only the beginning of the beginning, in the effort to deal with the enormous problem of deciding how much we want to spend, as a community and as a state and as a nation, on health care.

We cannot do better at this point than quote exactly the words in the opening pages of our report of almost two years ago:

"Important as this is, (the bed reduction) represents only a first step to deal with the problem. The Twin Cities area should also move aggressively to work a fundamental change in the way health care delivery is organized and financed . . . by encouraging the development of plans in which doctors and hospitals have a built-in incentive, not only to give high quality care, but also to be careful about their costs . . . The key encouragement will come, not from government, but from the private sector, and especially from labor and business, on whom the costs are now falling most heavily."

A next, and promising, area of effort for the Twin Cities community should be on the "demand" side, and the arrangements by which health care is bought and paid for. Up to now, much of the community's effort, and much of the emphasis in our report, has been on the "supply" side. Supply -- hospital beds, hospital services, hospital buildings -- has been the most immediate and most visible form in which the problem of costs and excess has presented itself. It is, quite naturally, where the community would start. But, as we recognized in our 1977 report, it is not the whole of the problem or even the largest part of the problem -- particularly the supply of beds. It is partly in the supply of services. But, even more fundamentally, it is the underlying demand for care, coupled with the system by which this care is so easily paid-for. Our recommendations on this "demand" side which particularly emphasize community efforts to stimulate the growth of alternative health care delivery plans can be found on pp. 24-26 of our report. They were, briefly, three:

- (1) That employers and hospitals should act to encourage the growth of alternative health care delivery plans.
- (2) That the Metropolitan Council and the Health Board should set up a special process for reviewing certificate-of-need requests from alternative health care delivery plans, to give preference to the latter.
- (3) That hospitals with aggressive utilization review programs ought to be given special consideration in both certificate-of-need and in rate review.

More generally, we hope that ways will be aggressively sought-out to encourage all buyers of health and hospital care, both private and public, to reduce utilization and to claim for themselves and for the patients they represent the price reductions made available to the prepaid health care delivery programs. Incentives should be

introduced for insurance premium payers and for companies, and for those who buy health and hospital care with public funds, to stimulate these kinds of "market forces." Little by little, then, as both the first-party and third-party customers become increasingly price-conscious, the community will begin gradually to reduce the aggregate demand for care, and the cost of care -- or, at least of the rate of increase in these costs. This kind of approach, through market forces, is, we think, a better route than for the government to dictate some kind of absolute, fixed limit or "cap" on allowable expenditures. It will be necessary, however, to have some kind of overall community measurement of the kind of progress that these individual actions are making, toward reducing the increase in the cost of care.

Our Recommendations

In looking back at what was said in the 1977 report, and applying it to the current situation, these steps would seem now in order:

1. The Health Board should add to its proposal some indication whether it wishes the hospital community to plan the major high specialty services into a pattern of "medical centers" or not. If the Health Board feels this is not an issue of concern, in the reshaping of the system, it should indicate that, to the hospitals, at an early date.
2. The Metropolitan Health Board and the Metropolitan Council should maintain their control over new investment in the system, during this period until decisions about reduction have been arrived-at, by following the three-part procedure laid out in our 1977 report, for the review of proposals. Longer-term, the Health Board and the Council should review the methods by which capital is secured by hospitals, for expansion. The role of private investors, the role of public authorities in raising capital from private investors, and -- as suggested in our 1977 report -- the potential role of public-tax-supported investment directly in the hospital plant, should all be considered.
3. A program to expand the role of "market forces" in the demand for health and hospital care should now be put together by persons and organizations in the Twin Cities area concerned with the control of costs in hospitals.

One feasible framework for such an effort, though not the only one, is the 'Coalition' proposed to be organized by the community, in the report of the Minnesota Medical Association's Commission on Health Care Costs. An effort to develop new ways to expand further the market-type elements in health care, with particular attention to enlarging the number and type of patients for whom or by whom health care is bought on a price-conscious basis, could be a most useful and important focus of such a 'Coalition.'

We have considered whether such efforts might be weakened by the efforts resulting from the work of the Health Board and the hospital community, to reduce the supply of beds and services over the next few years. In principle, this might be a concern. In practice, however (thinking back to our own findings about the extent of the surplus in this community), we think it likely that enough of the unused capacity will remain in this

system to continue the incentive hospitals have had in recent years to bid for bed-days of care. What is important, as we indicate above, is that the market be made to work in such a way that these price reductions are claimed by other buyers of care, and spread.

4. The Metropolitan Council and the Metropolitan Health Board should monitor and report regularly on the rate of increase in expenditures in hospitals, stated in terms of dollars per capita per year for the resident population.

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We commend you for your effort. We will continue to do our best to work with you closely on the issues that lie ahead.