

CITIZENS LEAGUE  
530 Syndicate Building  
Minneapolis, MN 55402

June 20, 1983

STATEMENT TO THE METROPOLITAN HEALTH BOARD

MADAM CHAIRMAN, MEMBERS OF THE METROPOLITAN HEALTH BOARD, AND THE METROPOLITAN COUNCIL

We as a metropolitan community have come a long way in our effort to control rapidly rising health care costs. This report, PRESCRIPTION FOR CHANGE: BALANCING COMPETITIVE, COMMUNITY AND REGULATORY FORCES IN TWIN CITIES HEALTH CARE is, in many ways, the long awaited progeny of a difficult labor. What it represents, above all else, is that the metropolitan community not only recognizes that it must do something about the problem or spiraling health care costs but that it is in fundamental agreement about what needs to be done.

THIS REPORT THEN REFLECTS A BROAD BASED COMMUNITY CONSENSUS ABOUT THE STRATEGY TO EMPLOY TO CONTAIN COSTS.

That consensus did not exist two years ago. At that time the community was steeped in conflict and controversy. While we stood together on the need to do something about the problem, we were divided as a community about what to do. The debate became one of means, not ends.

Clearly the community had a choice. It could have pursued a largely regulatory strategy. It could have attempted to let some hospitals "die on the vine" by using the certificate-of-need mechanism. The Health Planning Board wisely chose to avoid that course of action. Pursuing that strategy would only have plunged the community into further controversy and division. Following that course would ultimately have meant allowing the issue to become bogged down in the courts -- an outcome that would have done little to achieve the Health Planning Board's or the community's ultimate objectives.

The Health Planning Board opted for another, and we think better, course of action. It chose a hybrid strategy of competitive and regulatory forces to combat the problems of a dysfunctional market and excess capacity. It chose a balanced approach between these two policy extremes.

We commend you on your decision. It is beyond doubt a courageous move on the part of the Health Planning Board. We recognize that the decisions it involved for you were difficult and that ultimately they required that you give up the certificate-of-need mechanism in the best interests of the community. This report reflects the Health Planning Board's willingness to put the higher community good before other interests.

It seems to us that your decision carries national significance. At a time when Health Systems Agencies are being forced to redefine their role and strategic approaches to controlling costs, your action can help to pave the way for others to follow.

The decision of the Health Planning Board to pursue this new strategy should be seen for what it is -- an effective community compromise. The Health Planning Board has given up the option of using regulatory forces to pressure providers out of the market. In return, it has gained new ways and new partners to help it accomplish meaningful change.

Providers have been given a reprieve from regulation but now must face the rigors of a marketplace buttressed by the joint efforts of government, business and labor.

This report raises another critical issue: Who should implement this report? We are aware that there are some in the community who, with the abolition of certificate-of-need will want to relegate the Health Planning Board to "the back seat." That is not our view. We see the Health Planning Board taking a more proactive role than ever, in the following areas:

- The release of price information. The Health Board has already made a good start on this area by releasing hospital charges for Medicare patients.
- Assisting in the interpretation of price information. As helpful as it is for the Board to encourage the release of price information, that is not enough. The Board should help the public understand what the data mean. Why are prices higher at some hospitals than others? How much cross subsidization or service is occurring? Are the differences in prices legitimate? We hope that eventually the Board's "Consumer Guide to Hospital Care" will contain such information. As providers compete for market share, consumers will look to you for guidance.
- Provide information on the quality of care at various institutions. The Board should not shy away from this area. Do mortality rates differ at various institutions for highly technical procedures? Are there legitimate reasons for these differences? Should consumers be made aware that their risk increases if a hospital does not perform an adequate volume of highly specialized procedures? What about infection rates? Incidence of iatrogenic occurrences?
- Help businesses, employee organizations and government become cost-effective purchasers of health care. If the competitive strategy is to work at all, businesses and government must redesign their benefit packages for their own employees as well as the indigent. Neither entity as yet is well prepared to do this. Neither, for the most part, is even aware of how to do it. The Health Planning Board must become much more active in this arena. It should work first with the larger employers and then with others. Redesign of benefits for government employees and the indigent should also be a high priority. There are many good ideas on how to do this in your report. There are some useful concepts in our 1981 report, "Paying Attention to the Difference in Prices: A Health Care Cost Strategy for the 80's." Competition as a strategy will only become effective when utilization begins to shift towards rewarding cost-effective providers.
- Assure that the ensuing competition is fair. Do Health Maintenance Organizations have a competitive advantage in the marketplace? Do new providers have an opportunity to emerge? Should nurses be allowed to compete with physicians in the delivery of some kinds of care? Are there barriers in the present reimbursement systems which preclude such competition? Should they be removed?

- Take a more proactive legislative role. Clearly, this report represents a milestone in the thinking of the Board and the community at-large. Should not the Health Planning Board begin immediately to line up legislative support for its recommendations? We think it should and pledge to work with you to see that many of these recommendations are seriously considered by the Legislature.

In addition to these roles, we would see one other. As we stated in our 1981 report, "some public body with an interest in regional health care cost containment ought to determine when, and under what circumstances, tax-exempt financing for new construction should be granted." Clearly municipalities have no such incentive. There is growing concern over the amount of tax-exempt financing occurring today. This issue deserves closer examination in the years ahead.

There is also an additional set of questions which go beyond the scope of this report but which are relevant to the MHPB's future. For most of its life, the Metropolitan Health Planning Board has been principally concerned with health care which occurs in hospitals. We would not suggest that the Health Board de-emphasize that portion of the health care system, particularly at this critical juncture in our region's evolution. But we would suggest that the Board's emphasis on cost containment be expanded to include long term care and other areas of health care. Important issues are now appearing in those arenas. To what extent is health care always consistent with the medical model? What have been the consequences of treating the acute care and the long term care systems differently? Should policy thinking between the two now be integrated? If so, should the basic framework and approach behind this report be applied to long term care as well? What will be the consequences of the state's moratorium on long term care beds at a time when the state's nursing homes have better than a 90% occupancy rate and new federal reimbursement mechanisms encouraging Diagnostically Related Groups (DRG's) loom large on the horizon? Will DRG reimbursement force hospitals to discharge elderly patients sooner? Where will discharged patients go who still need substantial care in a system with high occupancy and long waiting lists?

Will the Veterans Hospital System seek to enlarge its role in the region's health care system by expanding further into long-term care? Would that kind of separate system be a wise move for the region, the elderly, and the elderly veteran?

These are important questions. They represent the next vista of health care issues. We think that the Metropolitan Health Planning Board should be prepared to address them.