CITIZENS LEAGUE REPORT

No. 155

Minneapolis General Hospital Future Status

March 1963

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FINDINGS AND RECOMMENDATIONS ON THE FUTURE STATUS AND CONTROL OF MINNEAPOLIS GENERAL HOSPITAL

Prepared by the

General Hospital Committee

Citizens League of Minneapolis and Hennepin County

Approved by the

Board of Directors

March 20, 1963

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** Disagrees with Recommendation #1-D(2)-(a)&(b) and Findings #21, 22, 23 & 28; takes the position that cost should be allocated uniformly throughout the county.

Citizens League
545 Mobil Oil Building
Minneapolis 2, Minnesota

REPORT TO: Board of Directors

FROM: General Hospital Committee, James R. Pratt, Chairman

SUBJECT: Findings and Recommendations on the Future Status and Control of Minneapolis General Hospital

RECOMMENDATIONS

1. We urge enactment of legislation during the current session of the Minnesota State Legislature which would:

A. Transfer to the County administrative and financial responsibility for public programs providing:

(1) Hospital and medical care for the poor.

(2) Hospital and medical care for the medically indigent.

B. Transfer to the County responsibility for assuring adequate emergency care service for residents of Hennepin County.

C. Authorize the County to provide for these services by utilizing public or private facilities or both.

D. Allocate the cost of public hospital and medical care services for the poor and the medically indigent in the following manner:

(1) Capital costs for construction or rehabilitation of public hospital facilities to be levied uniformly throughout the County.

(2) Operating and maintenance costs in providing these services to be allocated:

(a) To Minneapolis, based on the proportion of the total annual cost attributable to care of Minneapolis residents.

(b) To suburban Hennepin County, based on the proportion of the total annual cost attributable to the care of suburban residents. This levy could be accomplished either by a uniform levy throughout suburban Hennepin County or by assessing each municipality in suburban Hennepin County on the basis of the proportion the assessed value of its property bears to the total assessed value of property in suburban Hennepin County.

(c) A uniform levy throughout Hennepin County for the proportion of the total annual cost attributable to the care of non-residents.

E. Provide that construction or major rehabilitation of any public hospital facilities shall be accomplished in accordance with the provisions of Minnesota Statutes, Sections 376.01 through .06, with the single exception that the bond issue could be presented to the voters at a general, a primary or special election. Under these provisions, the County is authorized to issue bonds for the construction of public hospital facilities if the proposed bond issue is approved by the voters of the County. The majority required for approval would be a simple majority of those voting on the question.

2. We do not regard the issue of which level of government most logically should administer public relief programs as so interrelated with the issue of responsibility for public hospital and medical care programs that they must be considered together. Neither do we regard the need for a decision on the proper placement of administrative responsibility for public relief programs as even remotely as urgent as the need for a prompt decision on the question of proper assignment of the responsibility for administration of public hospital and medical care services. Therefore, we urge that the two issues be separated and considered on their own merits and that priority be given to resolving the issue of proper placement of administrative responsibility for public hospital and medical care services.

3. We urge county officials, once the County acquires the responsibility for the administration of public hospital and medical care services, to proceed without delay in initiating the necessary steps which will lead to the earliest possible determination of the future status of the physical plant at MGH.

4. We believe it is incumbent upon and therefore urge the leadership of the voluntary hospitals in Hennepin County to provide the community with their best professional judgment on the question of whether the services presently provided by MGH could in the future be provided as adequately in some other way than through the continued operation of a public general hospital. If these leaders believe that this community has an alternative to the continued operation of a public general hospital, then they should undertake immediate steps to make public this viewpoint and they should proceed promptly to formulate the specifics of such an alternative.

FINDINGS

A. Public Hospital and Medical Care Services

Condition of the Physical Plant at Minneapolis General Hospital

1. We concur fully with the generally accepted view that the physical plant at MGH is badly in need of either major rehabilitation or total replacement. Its major structural deficiencies result from a grossly inefficient layout of facilities for patient services and the absence or insufficiency of certain facilities and accommodations commonly provided in any modern hospital. A new or rehabilitated physical plant at MGH would, in addition to providing important intangible or psychological benefits, enable either the provision of the same quality of patient service at less cost or an improved quality of service without a corresponding increase in the cost.

2. We have now reached the point where the basic decision on the future status of MGH can no longer be postponed. Assuming the continuation of a public

general hospital, a very sizable amount of money must be spent, either by undertaking major rehabilitation of the present physical plant or abandoning it in favor of construction of a new public hospital. Before any commitment is made for so substantial an amount of public funds, it is imperative that the basic question of determining the future status of and control over MGH be resolved.

3. Leading Minneapolis city officials have stated repeatedly during recent weeks that MGH will be closed unless it is transferred to the County. Different closing dates have been predicted, the latest being at the end of the 1963-64 fiscal year. This date would be prior to the convening of the next regular session of the State Legislature. These threats to close MGH are doubtless designed, at least in part, to precipitate a crisis attitude and, thereby, a prompt decision on the basic question. However, many persons have become concerned over what gives every appearance of being the imminent closing of MGH. Any prolonged continuation of the prevailing attitude of uncertainty will adversely affect the morale of MGH employees, will make it more difficult to attract highly-qualified interns and residents, and could produce harmful results which might take years to overcome. The best way to assure that this does not occur is to reach a prompt decision on the future status of MGH.

4. We do not find the physical condition of MGH such as either to endanger the safety nor preclude the proper medical treatment of its patients. Even if the determination on the future status and control of MGH were to be made now, it would be several years before rehabilitated or replacement facilities would be available. If MGH can continue for several years during a transitional period, then we see no justification whatsoever for the precipitous closing of MGH within the next year or two. If and as it is closed, the closing should be phased into the orderly transition as replacement facilities become available.

5. The general view of those experienced in the field of hospital construction is to prefer as sounder and more economical the replacement of the existing physical plant at MGH with a new hospital, rather than undertake its major rehabilitation. We have made no effort to weigh the merits of these two alternatives. Instead, we urge and assume that a competent hospital consultant will be engaged to provide guidance before a final determination is made on which of these two alternatives should be followed.

Future Need for a Public General Hospital

6. No one, to our knowledge, contends that the voluntary hospitals as now constituted are equipped to handle adequately the services presently provided by MGH. Nor have we heard anyone urge that MGH be closed because (1) its services are no longer needed by the community, or (2) the quality of medical care provided at MGH is substandard. On the contrary, there appears to be universal agreement that MGH is providing excellent medical care, in fact that the quality of the care provided is receiving well-earned national acclaim. Based on the facts we have been able to develop, we subscribe fully to these viewpoints. We doubt seriously that there would be any thought whatsoever of closing MGH if the condition of the physical plant were such that relatively minor maintenance would be required during the next several years.

7. We would regard it as totally unsound to abandon a system of providing medical care for the poor and indigent through operation of a public general hospital -- a proven system which has produced excellent results over a period of many years -- with no more than a general hope or even an assumption that these services could be provided equally adequately and economically in some other way.

Before the method of providing these services through operation of a public general hospital should be discontinued, convincing evidence should be required demonstrating that (1) the services now provided by MGH can be provided equally well in some other way, and (2) the transition could be accomplished in an orderly way and without serious disruption of the present high level of service. . . . Thus far, no proposal of any kind has been offered suggesting any feasible alternative to the continued operation of a public general hospital. Until or unless such a proposal is presented, we should, indeed must, base decisions on the assumption that these services will continue to be provided through use of a public general hospital.

8. We have been disappointed at the inability or the unwillingness of the leadership of the voluntary hospitals to provide the community with its professional judgment on the question of whether the services presently provided through a public general hospital could be provided equally well without the continued operation of a public general hospital and, if not, to clearly so state. The failure thus far of most of these leaders to express their professional viewpoint on this basic question has contributed substantially to the uncertainty, which in turn has made it exceedingly difficult to reach a prompt determination of the question of the future role in our community of a public general hospital.

9. The voluntary hospital system, as presently constituted, could not in our opinion provide as adequately the services now provided by MGH. We pass no final judgment at this time on the question of whether these services could at some future date be provided equally adequately without the operation of a public general hospital. We would welcome specific proposals from the leadership of the voluntary hospitals within what we regard as the following essential limitations: (1) Concentration of most, if not all, of the services now provided by MGH in one or a few centrally located general hospitals. (2) Close affiliation between these one or a few centrally located general hospitals and the University of Minnesota, from the standpoint of providing basic staffing and in conducting medical teaching and training programs. (3) A close working relationship between these one or a few hospitals and the University Hospital with even more intensive use of University Hospital in providing certain of the services now provided by MGH.

10. Based on the facts we have been able to develop, there appears to be no possibility that the University Hospital alone either could, or would, provide the services now offered by MGH in such a way as to serve as a substitute for a city or county general hospital. On the contrary, present University Hospital and University Medical School spokesmen have publicly disavowed any interest in serving in this capacity.

11. No specific estimates of the cost of construction of a new public hospital to replace MGH are available. The cost will depend, to an important degree, on the size and bed capacity of any such hospital. However, there appears to be general agreement that the cost could range from a figure as low as $10 million to upwards of $18 million. Before such a substantial commitment for the expenditure of public funds is made, the most careful assessment possible should be made of the factors and trends likely to influence the future use of a public general hospital. This type of appraisal must of necessity take into consideration the future of University Hospital, the other public general hospital in our community. Among those factors or trends likely to result in decreased use of public hospital facilities and services are: (1) The continually higher standard of living in this country, resulting in a proportionately smaller number of persons generally defined as poor or medically indigent. (2) The increased likelihood that the federal government will be entering into or expanding prepaid and/or free medical programs for those over 65, with the guarantee that the recipients will have the right to choose their

own doctor. (3) The continued steady growth of prepaid medical care coverage. (4) The trend toward shorter duration of hospitalization resulting from increased medical knowledge. (5) More effective control and treatment of contagious diseases. However, there are also certain other offsetting factors likely to result in increased use of a public general hospital. Among these are: (1) The constantly increasing number of emergency cases and the certainty that this trend will continue. (2) The increased emphasis on outpatient treatment provided by a public general hospital. (3) The growing need for psychiatric and geriatric care, particularly for the kind of cases unwanted in private institutions. (4) An expected continuation of the population growth in suburban communities. (5) The psychologically greater attraction of new and modern public hospital facilities.

12. We believe the proper role of a public general hospital in providing service for the poor and medically indigent should be to meet the requirements under generally favorable economic conditions. Any additional requirements resulting during adverse economic conditions should be met through use of voluntary hospitals.

13. Based on the facts we have been able to develop, the trends we can foresee, and on our view of the role which a public county hospital should play, we can see no justification for constructing at this time a new public hospital with inpatient bed capacity in excess of that presently available at MGH. In fact, there are solid reasons for holding the inpatient bed capacity at an even lower figure than at present. Two areas of service, based on recent trends, which might require expanded facilities are emergency service and outpatient care.

Present and Future Users of a Public General Hospital

14. Under present MGH operations, the vast majority of its patients are intended to be, and actually are, residents of Minneapolis. Use of MGH by suburban residents is confined principally to two services: (1) Providing emergency care treatment while the suburban resident is in the central city. These services are now or can be charged fully to the patient or to the municipality of his residence, if he is not able to pay. (2) Outpatient treatment of suburban residents at the psychiatric center at MGH. However, this program is administratively separate from other MGH services and is financed exclusively by the county and state. . .Suburban residents, along with those in the entire metropolitan area, and perhaps in the entire state, are recipients of one important benefit from MGH for which they make no direct payment. Through the excellent teaching and training program at MGH, highly qualified doctors are attracted from other states, and statistical data indicate that a substantial proportion of these doctors who take their training at MGH become practitioners in this area. Based on the facts we have been able to develop, there is no assurance -- in fact, it is unlikely -- that these same doctors would be equally interested in coming to Minneapolis to train at voluntary hospitals.

15. No specific plan has been presented by those who propose transferring MGH to the County which details the type of service which would be provided and for whom by a new county general hospital. However, though certain services provided to suburban residents by a county general hospital would be quite important and highly beneficial, it seems reasonable to conclude that at least for the next decade or more central city residents would continue to represent the substantial majority of the inpatient and outpatient load at a county general hospital. There appears to be general agreement, and with considerable logic, that any new county public hospital would be located within the city of Minneapolis and, in all likelihood, in reasonably close proximity to the downtown area and the University Hospital. If so, it seems highly likely that the vast majority of cases requiring emergency care which occur in suburban communities -- certainly the less serious cases -- would continue

to be treated by suburban voluntary hospitals, rather than being brought a considerably farther distance into the heart of the central city. Without question, the most influential factor which dictates the conclusion that central city residents will continue to be the principal users of services provided by a public general hospital is the disproportionately high percentage of persons eligible for its services who now live, and likely will continue to reside, in the central city.

Administrative Responsibility

16. Based on likely future developments in the area of providing hospital and other welfare services for the poor and the medically indigent, and certainly from the standpoint of the most efficient and economical administration of these services, it would be clearly beneficial, both to residents of Minneapolis and of suburban communities in Hennepin County, to have the County assume administrative responsibility for public hospital and medical services, including the supervision and control over any public hospital facilities.

17. If it should prove politically impossible to attain during the current session of the State Legislature the transfer to the County of responsibility for administration of public hospital and medical services -- and we wish to make it crystal clear that we believe such a transfer should take place at this time -- we cannot reject as totally implausible the continued operation of a public general hospital by the City of Minneapolis. We are not convinced, for example, that Minneapolis can fulfill its legal obligation to provide public hospital and medical services to its own residents as adequately and more economically by discontinuing use of a public general hospital. Minneapolis public officials should carefully review all relevant factors from the standpoint of its own enlightened self-interest before reaching any irrevocable decision to close MGH.

Finance and Allocation of Costs

18. The proposed transfer to the County of responsibility for hospital and medical care services and also the public relief program would, without question, result in a substantial increase in taxes to suburban taxpayers. The exact amount of this increase cannot be determined, since it will depend on the rules of eligibility and the level of services the County decides to provide. We do know, however, that the cost paid for by taxes of operating MGH during 1963 has been budgeted at $3,808,074. If MGH were a county hospital and the cost paid for by county taxpayers on the same basis as other county services, suburban taxpayers would pay approximately 35% of the total cost. This would amount to a 5.9 mill increase for suburban taxpayers. The 1963 estimated expenditures for the Minneapolis public relief program is $2,981,000. If this program were a county program with the same basis of taxation as other county services, suburban taxpayers would pay an additional 4.1 mills during 1963. The capital cost of constructing new hospital facilities has not been estimated specifically, but an estimate in the neighborhood of 1.2 - 1.5 mills each year over a 20-year period would seem defensible. The total of these increases for suburban taxpayers amounts to at least 11 mills. This represents, for example, a tax of approximately $23 on a suburban home with a market value of $20,000.

19. This substantial increase in the tax burden on suburban taxpayers would occur without a corresponding increase in the use of these services by suburban residents. Although the benefits to suburban residents from a county general hospital would be greater than at present, these benefits probably will increase no more rapidly than the rate at which suburban residents are paying an increasing share of total county taxes. For the reasons discussed under Findings #14 and #15 of this report, it appears reasonable to conclude that during the coming decade or more, central city residents will continue to make substantially greater use of these services than will be the central city's share of the financial burden if the

cost is levied uniformly throughout the county. Stated simply, the tax obligation which would be assumed by suburban residents resulting from the proposed transfer of these programs is likely to be far greater than the direct benefit to suburban residents.

20. As a general rule, we favor the practice of levying uniformly among similar taxpayers within the geographical boundaries of the unit of government which provides the service. The first and essential question to be answered when considering a proposed transfer of a governmental function or service is whether the function or service properly should be performed by that unit of government. If the answer to this question is yes, then the cost of the service should be allocated in accordance with the allocation of costs of the principal other governmental services provided by that unit of government.

21. Unfortunately, the situation in Hennepin County requires, at least for the present, some deviation from or further refinement of the general principle discussed in Finding #20. It is contended, with considerable validity, that a number of important governmental services are not now being performed by the proper unit or level of local government, resulting in an inequitable allocation of the tax obligation to pay for for these services. Examples might include, among others, public hospital and medical care services, the public relief program, sewage collection and disposal, providing major park and open space facilities, library service, water distribution, courts, etc. Unfortunately, most of these services represent conflicts between central city taxpayers and those residing in suburban communities. These important conflicts make it impossible, and justifiably so, to consider any single governmental service in a political vacuum.

22. Formulating the criteria or standards on which to base recommendations for allocating the cost of a county-administered public hospital and medical care program has been one of our most difficult tasks. These criteria have been developed with three main objectives: (1) Assuring fair and equitable treatment of both central city and suburban taxpayers, (2) Enhancing the prospects of favorable action on this issue during the current session of the State Legislature, and (3) Enhancing, or at least not discouraging, the prospects for early and constructive solutions to other important issues involving the interests of central city and suburban residents.

Following are the criteria we have used in developing our recommendations and our conclusions on each criteria:

A. So substantial a shift in the relative tax burden between central city taxpayers and those in suburban communities in Hennepin County as would result from the proposed transfer of these services to the County should be avoided in the absence of a rather clear showing that one or more of the following conditions exists:

   (1) General unfairness in the total tax burden between the central city and the suburbs.

   (2) The proposed tax shift is accompanied by a somewhat corresponding increase in the benefits received.

   (3) The proposed tax shift is coordinated with a somewhat offsetting shift involving other governmental services.

(4) The proposed tax shift is part of a coordinated long-range plan to assign each local governmental service to its most logical unit or level of government, and assessing the cost of each service uniformly among similar taxpayers within the geographical boundaries of the governmental unit.

B. It would seem reasonable to impose on those proposing the substantial tax shift the burden of proof in demonstrating that any or all of these conditions exist. After listening to spokesmen representing both the central city and suburban communities, we have reached the following conclusions with respect to these conditions:

(1) No satisfactory evidence has been presented to justify the conclusion that on balance central city taxpayers are bearing a disproportionately higher share of the tax burden than are residents of suburban communities in Hennepin County.

(2) As we have stated previously in this report, the increased tax burden on suburban residents would be substantially greater than the direct benefits accruing to suburban residents.

(3) Most central city political leaders have evidenced no willingness whatsoever to consider proposals involving other governmental services where a somewhat offsetting tax shift would occur. The position, for example, of most central city political leaders on such issues as sewage collection and disposal facilities and county parks is indicative of the fact that this condition does not exist at the present time.

(4) We see no indication that most central city political leaders are interested in integrating this issue into a coordinated long-range plan to assign governmental services to the most logical unit or level of local government.

23. Since none of the conditions discussed in Finding #22 appears to exist, and until such time as one or more of these conditions do exist, the cost of providing public hospital and medical services should be allocated essentially on the basis of the use of these services by the residents of the central city and by those of suburban communities in Hennepin County. We believe allocating the cost of these services on the basis of benefits received, as between the central city and the suburbs, should be followed with two exceptions:

A. The capital costs of constructing or rehabilitating public hospital facilities should be financed by a uniform levy on the residents of the entire county. Any other method of allocation might well complicate the ability to issue bonds. In addition, we find considerable merit in allocating on a uniform basis the costs of providing facilities which will be used by residents of the entire county for many years after the bonds are paid off.

B. The cost of providing public hospital and medical care for non-residents of Hennepin County should be paid for by a uniform

levy on the residents of the entire county. It would seem unfair to place the entire financial burden of caring for non-residents on either the central city or the suburbs.

24. The County has no authority to issue bonds for any purpose other than as provided under Minnesota Statutes, Sections 376.01 through .06. These sections authorize the County to issue bonds for the construction of a public hospital if at a general election a majority of the voters of the County voting on the question approve the proposed construction program. With one exception, this existing authority appears to be reasonable and sufficient to allow the construction of a new county public general hospital if and when the County Board deems it advisable. The exception to which we refer is to broaden the existing authority to allow submission of the bond issue at a general, a primary or a special election.

25. By proceeding in accordance with the authority granted under Minnesota Statutes 376, two important objectives would be accomplished. First, the referendum procedure would compel county officials to present to the voters a careful and specific plan for the construction of public hospital facilities, as well as for the services which it would provide. Second, the referendum process would give the leaders of voluntary hospitals in this area an opportunity, to the extent they might desire it, to present a specific alternative plan for providing these services. Should the voluntary hospital leadership come forth with a specific plan that appeared to be able to provide comparable service at less cost to the taxpayer, then the proposed public hospital construction program would either never be presented to the voters at all or it likely would be rejected by the voters. On the other hand, should the voluntary hospital leadership fail to present a convincingly workable alternative or should it concur in the viewpoint that services can better be provided through use of a public general hospital, we are convinced that the voters of the county would give overwhelming support to a carefully prepared and presented construction program.

B. The Public Relief Program

26. We do not regard the issues of administrative responsibility for providing public hospital and medical care services and administrative responsibility for public relief programs to be so interrelated from an administrative or any other standpoint that they must, or even should, be considered together. We are at this time faced with an urgent need to determine which unit of government should assume administrative responsibility for public hospital and medical services for one very basic and simple reason -- the physical plant at Minneapolis General Hospital is in such condition that a prompt decision is imperative on whether to rehabilitate it, replace it with a new hospital, or abandon the hospital in favor of providing such services through the voluntary hospitals. We can see no similar urgent need for making this type of decision on the issue of administrative responsibility for handling the public relief program. It would certainly seem preferable, and perhaps imperative, to consider these two issues separately on their own merits, rather than combining them into a single proposal. Any other course of action is exceedingly likely to jeopardize the prospects for for favorable action on the more urgent of the two issues. Such a result would be most unfortunate and unnecessary.

27. Based on what we can foresee as the likely future trends, and certainly from the standpoint of sound administrative practice, the county rather than the municipality or township is the most logical unit of government for the administration of the relief program in Hennepin County. Two important advantages

which we believe would occur under a county system are: (1) More uniform standards of eligibility for recipients throughout the entire county, and (2) Considerably less duplication of effort by public employees and, therefore, greater efficiency and economy in administration of these programs.

28. Should administrative responsibility for public relief programs in Hennepin County be transferred to the County, we would urge that the cost be allocated between the central city and the suburbs on the basis of the residence of recipients. We reach this conclusion for the reason we have urged essentially the same method of allocating the costs for public hospital and medical care services.

SCOPE OF REPORT

The Citizens League's Board of Directors, in authorizing the project covered by this report in September, 1962, directed the General Hospital Committee to report its findings and recommendations on the most desirable future use of Minneapolis General Hospital. The Board of Directors, at that time, called our committee's attention to specific proposals recommending that Minneapolis General Hospital become a county hospital and that responsibility for providing public hospital and medical care for the indigent be transferred to the County.

This report contains our recommendations and findings on the following issues which are directly related to the question of determining the most desirable future use of Minneapolis General Hospital:

1. Condition of the physical plant at MGH.
2. The future need for a public general hospital.
3. The users, both present and future, of a public general hospital.
4. Administrative responsibility for providing public hospital and medical services.
5. Allocation of the cost of providing public hospital and medical services.
6. Administrative responsibility for public relief programs.
7. Allocation of the cost of public relief programs.
8. The interrelationship, if any, of administrative responsibility for providing hospital and medical services and administrative responsibility for public relief programs.

COMMITTEE MEMBERSHIP

A total of 38 Citizens League members participated in the deliberations of the General Hospital Committee. Of these 38, 23 reside in the City of Minneapolis and 15 in suburban communities in Hennepin County. Most committee members had a close working familiarity with the Minneapolis General Hospital problem prior to their membership on our General Hospital Committee. The committee membership consists, for example, of two former members of the Minneapolis Board of Public Welfare, a former hospital administrator, several University of Minnesota staff offi-

cials closely associated with the hospital field, a suburban health officer, a member of the CLIC committee which formulated the recommendations which were reviewed by our committee, a number of voluntary hospital board members, and a number of doctors and medical officials.

The subcommittee, which was assigned the task of formulating the general viewpoints of the full committee into specific findings and recommendations, was selected on the basis of assuring representation of the various informed viewpoints on this issue, both from the standpoint of residence and professional background. Subcommittee members included Charles Clay, attorney and member of the Citizens League Board of Directors; Mrs. Howard Conn, former member of the Minneapolis Board of Public Welfare; Dr. C. J. Ehrenberg, on the staff at Northwestern Hospital; Dr. Ellen Fifer, suburban health officer; Walter S. Harris, Jr., who served on the CLIC committee dealing with the General Hospital problem; Dr. E. J. Huenekens, former member of the Minneapolis Board of Public Welfare; James R. Pratt, chairman of our General Hospital committee and a member of the Citizens League's Board of Directors; Dr. Joseph W. St. Geme, Jr., instructor in pediatrics and microbiology at the University of Minnesota; Owen B. Stubben, former administrator of the Glen Lake Sanitarium and former deputy administrator of the public hospitals in Denver and Philadelphia; and Wheelock Whitney, Mayor of Wayzata and a member of the St. Barnabas Hospital Board and of the newly-formed Regional Hospital Council.

The committee was assisted on a staff basis by Verne C. Johnson, the League's Executive Director, and Clarence Shallbetter, League Research Assistant.

COMMITTEE PROCEDURE

The General Hospital Committee held its first meeting on November 5, 1962, and has met on a weekly basis since that time. During this period, the full committee has held 14 different meetings. In addition, the subcommittee met on three different occasions, for a total of more than ten hours of deliberations. Naturally, much additional work was done between meetings by committee members on an individual basis and by the League staff.

The committee attempted to avail itself of all the experienced viewpoints on this complex issue before it reached its own findings and recommendations. During the course of its work, the committee had the benefit of presentations by Minneapolis Mayor Arthur Naftalin; MGH administrator John Dumas on four separate occasions; Dr. Robert Barr and several members of the State Department of Health; Dr. Robert Howard, Dean of the University of Minnesota Medical School; County Commissioner Richard O. Hanson, Chairman of the County Board; Mayor Kenneth Wolfe of St. Louis Park; City Manager Warren Hyde of Edina; Ray Amberg, Administrator of the University of Minnesota Hospitals; and Vance DeMong, Administrator of North Memorial Hospital. In addition to formal presentations by these persons, other leaders were consulted on a personal contact basis. Also, all the written material available on the issue was distributed to committee members.

In the development of specific findings and recommendations, the subcommittee reviewed three drafts before presenting its thoughts to the full committee. The full committee then considered and suggested changes on three additional drafts. Thus, it would seem reasonable to conclude that the recommendations and findings contained in this report have been developed after careful consideration and with extensive active participation by members of the committee.

BACKGROUND AND RECENT DEVELOPMENTS

During the past fifteen years, various consultants, public officials, citizens organizations and others have made extensive studies in trying to reach long-range conclusions on the future status of Minneapolis General Hospital. Almost all of these studies have focused on two critical aspects of the problem: (1) The poor condition of the physical plant at MGH, and (2) the almost constant shortage of financial resources to operate the hospital and finance medical services provided by MGH on an adequate basis.

In 1947, Long and Thorshov, architects, made a comprehensive investigation of the physical plant at MGH, which concluded with a recommendation for a partially new and enlarged facility to meet the anticipated population and caseload growth. In 1950 MGH was studied as part of a total hospital plan for Hennepin County. The study was undertaken by James A. Hamilton and Associates. The report of this firm recommended that MGH become a regional hospital center on a considerably expanded basis. The Citizens League itself has made comprehensive studies of MGH, first in 1953, and again in 1958. The 1953 League report stated, "In view of the amount of unused bed space, rearrangement of existing space and not construction of new space appears to be the answer. . . With the possible exception of the outpatient building, remodeling as outlined above is feasible to provide adequate -- though not perfect -- facilities for many years to come. Considering carefully what has been done since the war, what must be done this year, and what may reasonably be foreseen in the next ten years, the cost resultant of such remodeling is far preferable to the abandonment of existing facilities and construction of a new acute hospital at this time." The 1958 League report concerned itself primarily with the financial crisis which then faced MGH. That report recommended that MGH be transferred to the County but that conversion to a county system of responsibility for poor relief administration should not be tied in with transfer of the hospital. The 1958 report contained the following statement: "When the time comes, however, for decision on major replacement of physical structures of the hospital, this fundamental problem should be reviewed by responsible community leaders. It must be considered and decided, and the decision carried through, essentially by the same group who have planned and sparked the United Hospital Fund, plus local government officials and the leaders of the University of Minnesota Hospitals, which also have a stake in the future of General Hospital."

The most recent proposals were formulated by a Citizens Committee on General Hospital appointed by the Minneapolis Capital Long-Range Improvements Committee. In a report dated October 17, 1961, that committee recommended that MGH become a city-county or county hospital in the fullest sense. The report also indicated that a new hospital building should be built, unless competent professional advice indicates that rehabilitation of the present structures is a realistic alternative. This report was followed by recommendations of a special task force on Minneapolis General Hospital, also appointed by CLIC, which reaffirmed the findings of the Citizens Committee on General Hospital in a written report dated July 10, 1962. This task force expanded the Citizens Committee report by adding the recommendation of transferring to the County responsibility for public relief programs in Hennepin County.

These proposals of the CLIC committees have undergone extensive community scrutiny during recent months. The proposals have tended to obtain support from community organizations vitally interested in preserving Minneapolis General Hospital. However, in fairness, it should be stated that most of these groups have not reviewed the detailed recommendations, particularly the provisions dealing with financial allocations of costs. In general, suburban political leaders have opposed

these recommendations, although the strongest criticisms have been leveled at the contemplated shift in taxes which would result from transfer of these services to the County.

The Minneapolis City Council, Mayor Naftalin of Minneapolis, and the Hennepin County Board of Commissioners have all given official support to the recommendations to transfer to the County responsibility for public hospital and health services and the poor relief programs. These proposals have been drafted into bill form and are now reaching the hearing stage before the Hennepin County Legislative Delegation.

THE PRESENT SYSTEM IN HENNEPIN COUNTY

An appropriate way to describe briefly the present system of handling the various welfare programs in Hennepin County would be to divide these programs into three general categories. These three areas would include: (1) The categorical aid programs. (2) Public relief programs, and (3) Public hospital and medical care for the "medically indigent."

The so-called categorical aid programs are those welfare programs which have been established by the state and federal governments and for which the County has been designated as the administrative agency to carry them out. The federal government and the state government finance approximately two-thirds of the total cost of these programs, with the county financing the balance of the cost. These programs include the Old Age Assistance program, Aid to Dependent Children, Aid to the Disabled, Aid to the Blind, and a few other miscellaneous programs. The County administers these programs through the County Welfare Board, with the County having very little discretionary authority on such issues as the level of benefits or the eligibility of recipients.

Public relief programs in Hennepin County are on the so-called "township basis." The majority of counties in Minnesota have the county public relief program, including Ramsey County. In Hennepin County, each municipality, such as Minneapolis, and unincorporated area is responsible under state laws for providing assistance to the poor. In Minneapolis, this program is administered under the direction of an appointed Board of Public Welfare and under the general financial control of the Minneapolis City Council. Suburban communities have banded together to form two separate suburban relief agencies, through which relief programs are administered in suburban Hennepin County. Each municipality assumes the entire cost of providing poor relief benefits to its residents. These benefits include such items as direct cash payments for living expenses, food, clothing, medical care, etc.

The third welfare program is that of providing public hospital and medical care for persons defined as "medically indigent." A "medically indigent" is generally defined as an individual who is not on direct relief, but who is unable to pay his hospital or medical bill. The criteria for eligibility is established by the local governing body which handles this program. Minneapolis requires its medically indigent to use the services provided by MGH and, according to its records, about 70% of the patients treated at MGH are classified as medically indigent. Suburban Hennepin County residents who cannot pay their hospital or medical bills are generally referred to the University of Minnesota Hospital. Procedurally, contact is made with a member of the Hennepin County Board of Commissioners and, if found to be eligible, the patient is referred to University Hospital by the County Commissioner contacted. In addition, County Commissioners refer to University Hospital a substantial number of Minneapolis residents who are classed as medically indigent. For

example, during the year 1961 just over 51% of the medically indigents referred to University Hospital by the County Board were residents of Minneapolis, and just under 49% were suburban residents. There appears to be no precise written regulations defining these medically indigent persons referred to University Hospital by County Commissioners. However, it is our understanding that any one who is on public relief in Minneapolis is required to go to MGH and is not referred to University Hospital.

Minneapolis General Hospital is run by the City of Minneapolis and is under the direct control of the Minneapolis Board of Public Welfare. In general, MGH performs the following services: (1) Medical and hospital care for the poor who are residents of Minneapolis. (2) Hospital and medical care for patients referred to it by other welfare agencies, in particular the County Welfare Board. (3) Hospital and medical care for individuals who come to MGH, usually as the result of admission on emergency, and who are able to pay the full charge for their care. (4) Hospital and medical care for the medically indigent residents of Minneapolis. (5) Emergency service. (6) Care for patients with contagious diseases. (7) Training and teaching programs for doctors and nurses. (8) Psychiatric treatment for Hennepin County residents under a program financed exclusively by county and state funds.

DISCUSSION OF MAJOR FINDINGS AND RECOMMENDATIONS

(This section, which is being prepared separately in the form of an appendix to this report, contains a detailed discussion and amplification of the major findings and recommendations contained in this report. In the interests of making the broadest possible distribution of the findings and recommendations contained in this report, and in order to make these findings and recommendations available to the community at the earliest possible date, the discussion sections are not attached hereto. They will be made available to anyone upon request.)

EXPLANATION OF LEGISLATION PROPOSED IN RECOMMENDATION #1

(See Report, Page 2)

Our recommendations urging transfer to the County of administrative and financial responsibility for public programs providing hospital and medical care for the poor and for the medically indigent require action by the Minnesota State Legislature. We believe it is imperative that the necessary legislation be enacted during the current session.

Administrative Responsibility and Control

At the present time Hennepin County is under the so-called "township system of poor relief." This means that each municipality in Hennepin County is charged with both the administrative and financial responsibility for providing assistance to the poor. This responsibility includes the obligation of providing hospital and medical care for those receiving direct relief payments. Under our proposal, the County would assume the sole administrative and financial responsibility for providing hospital and medical services for these people. The municipalities would cease to have any authority in this area, and all recipients would deal directly with the County. All rules and procedures would be established by the County, and the municipalities' role would be narrowed to providing assistance to the poor other than hospital and medical services.

Under our proposal, the County likewise would assume the sole administrative and financial responsibility for providing tax-supported hospital and medical services to the "medically indigent." The municipalities would no longer have any authority in this area. This exclusive authority must be vested in the County in order to assure maximum use of a county public general hospital and to assure coordinated use between the county public hospital and the University of Minnesota Hospital.

Under our proposal, the County would assume the obligation of assuring adequate emergency care service for residents of Hennepin County. At present, there is no obligation on any governmental unit to assure provision of this service. It is true that Minneapolis has provided emergency service over the years through MGH, but Minneapolis has the discretion to discontinue this service, as in fact they have indicated will be the inevitable result unless MGH is transferred to the County. We regard it as important that some governmental unit be responsible to assure adequate provision of this vital service, and we believe the proper governmental unit is the County. However, the legislation should obligate the County to assure adequate emergency service in such a way as to allow the County to have discretion as to whether this service should be provided through a public hospital, the voluntary hospitals, or both.

Allocation of Cost

Under our proposal, two cost items would be levied uniformly throughout the entire county. These would include (1) capital costs for construction or rehabilitation of public hospital facilities, and (2) costs attributable to tax-supported hospital or medical treatment provided to non-residents of Hennepin County.

All other costs of operation and maintenance in providing tax-supported hospital and medical services would be allocated, as between the central city and the suburbs, essentially on the basis of benefits received by residents of each.

There would be only two levies for these costs -- one on central city taxpayers and the other on suburban taxpayers. Thus, the taxpayers of each municipality in suburban Hennepin County would assume the same proportion of the total cost which is allocated to the suburbs as any other taxpayer in any other municipality who has property which has the same assessed value. We wish to make it clear that each municipality in the suburbs would not pay in accordance with the benefits received by its own residents. This approach would greatly simplify the administrative record keeping.

We envision that in allocating the proportion of the total cost of operation and maintenance as between the central city and the suburbs the experience of the previous year would be controlling. Each year the allocation would be reviewed and revised, based on any new evidence of differing benefits. Records would be kept in sufficient detail to assist in documenting the reasonableness of the cost allocation. These records would not be for the purpose of accumulating an exact total of each service provided to each patient. Such a procedure would be unduly complicated and is unnecessary. If any municipality questioned the reasonableness of the allocation as between the central city and the suburbs, it could contest the allocation as being arbitrary through established court procedures.

We have reviewed these recommended administrative procedures with several persons experienced in this field, including staff members at MGH, and without exception they concur in the view that they pose no great difficulties from an administrative standpoint.

Authority to Issue Bonds

Our proposal recommends use of existing authority granted to each county to issue bonds for the construction of hospital facilities. The one legislative change which would be required is to broaden the existing authority so that a proposal to issue bonds for construction or major rehabilitation of public hospital facilities could be submitted to the voters at either a special or a primary election, as well as at a general election. The present restriction, requiring that the referendum be presented at a general election, might work an unnecessary hardship, particularly in view of the fact that the next general election is in a presidential election year. We are aware of no other referendum procedures which limit submission to a general election only and can see no justification for this type of limitation for the issuance of bonds for proposed construction of public hospital facilities.

The County has no other authority to issue bonds, even with referendum approval. Requiring referendum approval is the rule in Minnesota, rather than the exception. For example, all school districts and most municipalities throughout the state are required to obtain approval by the voters before issuing bonds for major construction proposals. Even the Minneapolis Special School District has such a requirement for all bonds in excess of approximately $2,000,000 each year.