HEALTH CARE

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Imprudent AND impatient

Are hospitals closing too fast and for insufficient reason?

BY ALAN SAGER AND DEBORAH SOCOLAR

In 1970, Massachusetts had 127 acute-care hospitals. Today it has 81 – and the push to close hospitals is accelerating. Although it's hard to predict where it will stop, at least one national pattern of use suggests that Massachusetts may end up with 55 or fewer hospitals statewide.

This trend wins much applause. Many people blame our high health costs largely on having too many hospitals and expensive-to-maintain hospital beds. For 10 years, state government has encouraged closings as its main hospital cost-control strategy. Nationwide, proponents of closings claim that a free market's invisible hand will make sure that only the inefficient and unneeded facilities close, while essential hospitals survive.

But is it safe to close so many hospitals? Does it save money? Can the market be trusted to judge how many and which hospitals should survive?

Despite the conventional wisdom, there is increasing evidence that we are going too far in removing hospitals from our medical landscape – and that, in the end, patients will pay the price for mistakes made in the name of cost-cutting. There is even evidence that, contrary to what we've long been told, closing hospitals does not save money after all.

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One problem is that today's inevitably unfree health care market often closes the wrong

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Alan Sager and Deborah Socolar are co-principals in the Access and Affordability Monitoring Project at the Boston University School of Public Health.

Imprudent and *anti*-patient

■ **HOSPITALS**

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hospitals.

For example, it's not the costly, inefficient hospitals that are being weeded out. Those that closed between 1980 and 1990 had slightly lower costs per patient than those hospitals that survived. Granted, the hospitals that have closed since 1990 have been slightly costlier, but the gap is far smaller than advocates of closings imply. In short, it's survival of the fattest – hospitals with dollars in the bank – not necessarily the most efficient.

Many needed hospitals close. National evidence shows that urban hospital closings are likeliest in poor communities and those with more black and Latino residents, where unmet health needs are already greatest. (Think of Lynn Hospital, St. Margaret's Hospital in Dorchester, and Burbank Hospital in Fitchburg.)

Communities suffer when hospitals close, often losing all outpatient care, and even many physicians in private practice. Travel times to emergency rooms rise.

And when hospitals close, nearly one-third of their patients disappear from hospitals, at least for a time – perhaps because people lose trusted physicians and hospitals. Many Gloucester residents, for example, say they would never travel to a hospital that is not in tune with their community's culture. Hospitals are not interchangeable parts.

Still, proponents of closings argue, it is essential to cut health care costs, and that means we must close hospitals. But there is a serious flaw in their argument: Having fewer hospital beds does not automatically mean lower costs.

Consider that Massachusetts in 1995 had 5.5 percent fewer hospital beds per person than the nation. Yet analysis of American Hospital Association data indicates that, in that same year, our hospitals spent $1,448 per resident, or $377 above the national average. So excess beds cannot explain high costs here.

The idea that closing hospitals, or using them less, saves money also ignores some simple economics. For example, quicker discharges don't cut costs much because the expensive care (such as surgery) usually is given soon after admission; thus, reducing a stay from eight days to four saves only a tiny share of the overall cost of a patient's hospitalization.

And reducing the size of hospitals by, say, closing a wing that had unoccupied beds does not save much by itself. Laying off the staff that once tended to those beds does produce savings, but most hospitals do that automatically when beds are unoccupied.

Indeed, looked at another way, trends in spending and bed numbers suggest that hospital downsizing can raise costs here. The same may be true nationally, as economist Uwe Reinhardt recently noted. How can this be? Consider:

Hospital care may be more efficient than alternatives (although some patients prefer those alternatives). For example, while a hospital nurse can easily care for several recuperating patients at once, home care requires much travel time and a health professional's one-to-one attention, which is necessarily more expensive. Unless hospitals are full, building new surgi-centers and sub-acute units and buying equipment for patients' homes mean added health spending.

But, despite a lack of evidence that closing hospitals will cut medical costs overall, the practice is likely to barrel ahead. Just since 1990, eighteen Massachusetts hospitals have closed.

Competition requires competitors. Closings yield monoplies, which mean higher prices, reduced responsiveness to patients, and – inevitably – government regulation.

And which hospitals will survive? A look at recent history provides some clues, assuming the same forces remain at work.

Hospitals more likely to survive in Massachusetts from 1990 to 1997 included those with more beds, higher financial reserves per patient, and higher operating margins. They tended to be farther from Boston and in higher-income communities.

But, amid current trends, no hospital would be immune from the pressures to close or downsize. Suppose Massachusetts residents were to use hospitals at the same reduced rate that the average US health maintenance organization mandated two years ago. That would mean that patients here would use only 9,600 hospital beds – roughly half as many beds as were available in 1995. This translates into about 55 hospitals. (See map.)

Further, if our residents were, at the behest of their HMOs, directed to use hospitals as sparingly as patients of some HMOs in California, demand would drop dramatically to just 4,300 beds. That translates into about 15 or 20 hospitals.

There is no evidence such use rates are safe. Indeed, Massachusetts has never assessed effects of past closings on costs or the public's health.

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When will people agree that too many hospitals have closed and that government action is needed? When we reach 60 hospitals? 30? 15?

Many towns recently turned schools into condominiums. Now, to educate baby boomers' children, they must build new schools. Soon, if too many hospitals close, communities will face rebuilding those. The cost of new construction would be prohibitive. Even reopening closed hospitals requires costly updating to meet safety codes.

Announcement of a hospital closing often comes too late to analyze need for the hospital or take steps to save it. Closing a needed hospital simply because of bad management punishes its community.

Mergers and for-profit chains cannot be counted on to save needed hospitals. When two hospitals merge, often all acute services close in the poorer community. And for-profit chains, less tolerant of low financial margins, tend to close hospitals more aggressively than nonprofit owners.

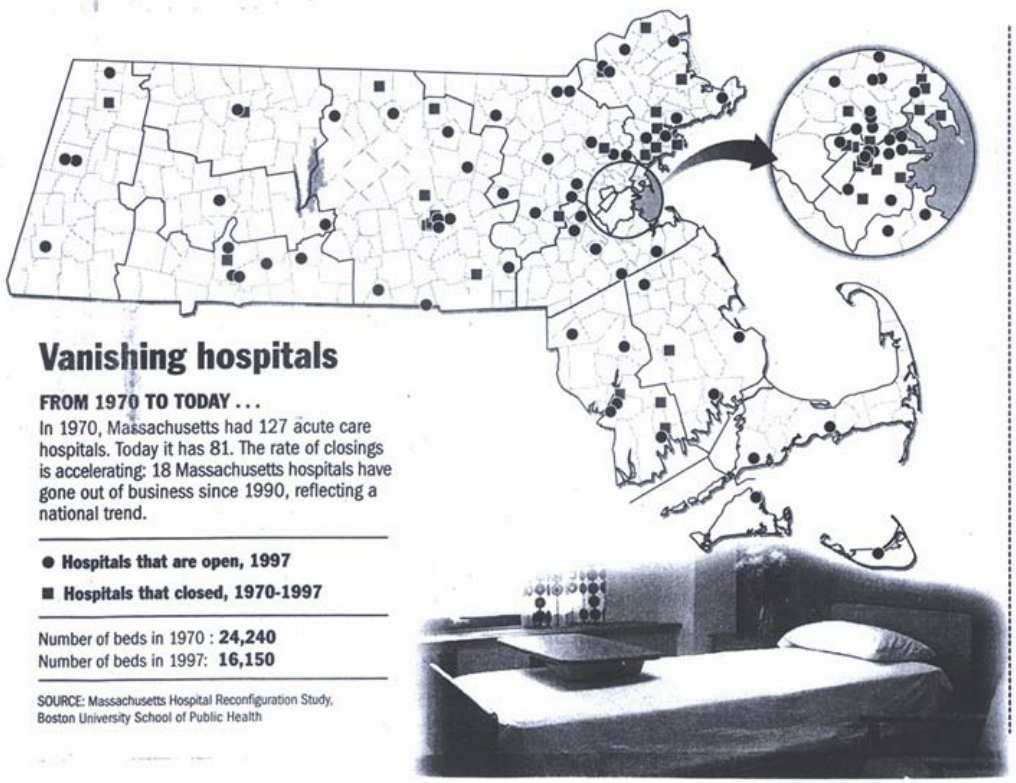
Hospitals are not sinners or saints. They are only vital. So it is equally vital to learn how many are needed before it's too late. Yet so far, neither hospitals nor their association have spoken up to protect themselves or their communities.

What can be done? The state, through legislation under consideration, could help stem the tide of closings. It could help identify needed hospitals and, if they are vulnerable, help protect them financially from pressures to close. This would, of course, require money – but it could be raised by collecting a modest contribution from all of the state's acute care hospitals.

Such measures could help prevent catastrophe now, buying time to devise rational, long-term financing for needed hospitals and health care in Massachusetts.

Instead of rushing to close hospitals, the bias should be toward conservatism, because the medical injunction to "first, do no harm" applies as much to those who set health policy as to individual physicians.

Jasprit Dosi compiled data and prepared maps for the Massachusetts Hospital Reconfiguration Study.



Vanishing hospitals

FROM 1970 TO TODAY . . .

In 1970, Massachusetts had 127 acute care hospitals. Today it has 81. The rate of closings is accelerating: 18 Massachusetts hospitals have gone out of business since 1990, reflecting a national trend.

● **Hospitals that are open, 1997**

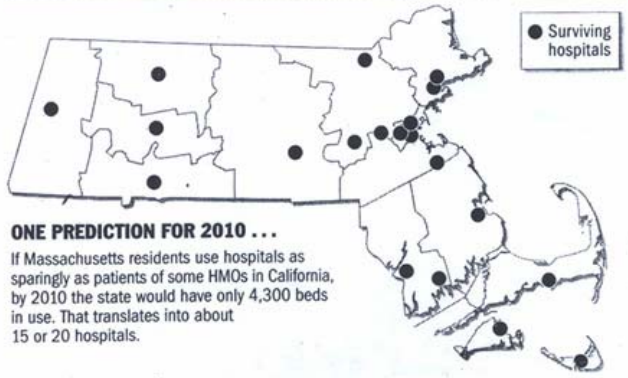
■ **Hospitals that closed, 1970-1997**

Number of beds in 1970 : **24,240**
Number of beds in 1997: **16,150**

SOURCE: Massachusetts Hospital Reconfiguration Study, Boston University School of Public Health

A LOOK AHEAD to 2002 . . .

If Massachusetts residents use hospitals at the same reduced rate that the average US health maintenance organization mandated two years ago, by 2002 the state would have only 9,600 hospital beds in use. This translates into about 55 hospitals.



ONE PREDICTION FOR 2010 . . .

If Massachusetts residents use hospitals as sparingly as patients of some HMOs in California, by 2010 the state would have only 4,300 beds in use. That translates into about 15 or 20 hospitals.