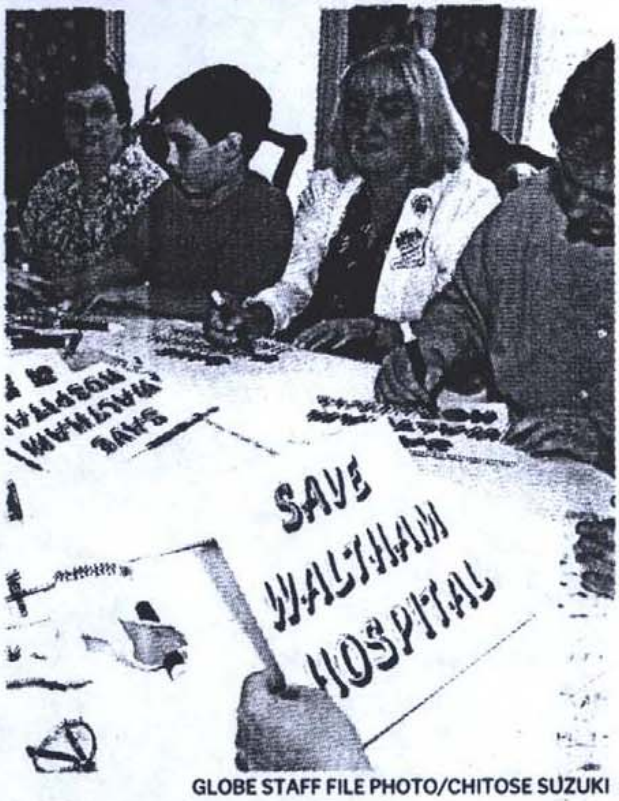
Too many local hospitals on life support

With number of beds halved since 1980, state should alter its closings policy

GLOBE FOCUS 3 MAR. 02



GLOBE STAFF FILE PHOTO/CHITOSE SUZUKI

Community groups are working to save Deaconess-Waltham Hospital.

By Alan Sager and Deborah Socolar

Massachusetts has lost almost half of its hospitals and patient beds. With the state only a flu epidemic or plane crash away from an emergency room crisis and bed shortage, it's time for action.

For a decade, state policy has encouraged hospital closings. This practice stemmed from the belief that too many hospitals led to higher costs. The industry and the state agreed to let market competition decide which hospitals would survive.

Today, however, with no reserve capacity and with baby boomers aging, we are fast reaching the point where patients' lives and safety are in jeopardy. Many cities and towns are nearing a hospital bed shortage, and last year ambulance diversions and emergency room delays hit new highs.

48%
of hospitals in the state have closed since 1960

Public Health Commissioner Howard Koh warns that a bad flu season would spell disaster. This year and last saw mild outbreaks, but Massachusetts can't count on an extended winning streak at flu roulette.

50%
of higher Medicaid payments goes to the 20 most prosperous hospitals

Acting Governor Jane Swift should declare a public health emergency to prevent another closing and to buy time. Legislators should then move to protect all needed hospitals at an affordable cost.

Only 73 hospitals remain in Massachusetts, and 68 have closed since 1960. The state eliminated half of its beds just since 1980, and 15 hospitals are vulnerable. Care Group, owner of six area hospitals, recently announced the closing of Deaconess-Waltham Hospital next month because it is expected to lose as much as $9 million this year. Staff, community groups, and the city are working to find new owners and financing to save the hospital. While laudable, such private deals are complex and easily undermined.

Because stabilizing Waltham is vital, and time is short, staking its future on just one strategy is too risky. A public effort must parallel the private one.

Some state officials and health economists believe that more closings are safe. Others advocate respecting the market. Both views are wrong. Waltham handles 22,000 emergency room visits yearly and provides 43 increasingly scarce psychiatric beds, plus

HOSPITALS, Page D2

Alan Sager and Deborah Socolar direct the Health Reform Program at the Boston University School of Public Health.

New policies needed to prevent a crisis over hospital closings

▶ **HOSPITALS**
Continued from Page D1

standard medical-surgical capacity. If it closes, ambulance travel time will increase, emergency room and inpatient crowding will worsen at surviving hospitals.

Hospitals are not interchangeable parts in a health care machine. They have deep ties to doctors, programs, patients, and communities. Some dislocated nurses, for example, may decide to stop working in hospitals if theirs close, which would worsen the nursing shortage.

Even if a last-minute private rescue saves Waltham, new state policies are needed to forestall other closings. Koh and Massachusetts Attorney General Thomas F. Reilly say that "we cannot afford to lose" another hospital. They are right. Today, many hospitals have no empty beds. Rebuilding hospitals will cost $500,000 to $1 million per bed.

How did this problem develop? For many years, some specialists thought that closing hospitals would save serious money. The state began deregulating hospital payments in 1988, expecting that competition would shut inefficient hospitals.

Deregulation did close hospitals but didn't save money. In 1988, hospital costs per person here were 38.3 percent above the national average. In 2000, after 26 closings, costs were 38.6 percent higher.

One reason closings didn't save money is that excess beds didn't cause high costs here. Massachusetts has been below the US average in hospital beds per 1,000 people since 1988. Also, the 26 hospitals closed since 1988 were smaller or mid-sized community facilities. Massachusetts now leads the nation in reliance on costly teaching hospitals.

After studying the causes of hospital closings in 51 US cities, we found that the market doesn't work. Community hospitals are likelier to close — even though they're more efficient — in part because they lack sufficient physicians. Teaching hospitals and wealthier ones tend to survive.

Genuine free-market competition requires more than theory. It depends on bankruptcies of inefficient producers and replacement by new hopefuls, no dominant buyers or sellers, and good information about price and quality. All are lacking in hospital care, so this market doesn't work. And there's no limit to the hospitals it will close.

Closings and mergers actually foster regional monopolies, which extract high prices from insurers. Massachusetts General Hospital's surpluses totaled $150 million in the past two years while its revenues rose 12 percent ($140 million) last year alone.

But many hospitals are losing money. The Massachusetts Hospital Association blames low revenues, not high costs, a position that raises several concerns:

First, hospitals in this state would need $650 million more yearly to make them as profitable as hospitals are nationally. Who would provide this revenue? Washington and Beacon Hill face deficits. Family health insurance premiums in Greater Boston have already risen 50 percent since 1998.

Second, the association's demand for higher payments to all its members would use up the dollars needed for targeted relief to threatened hospitals.

Third, though many hospitals operate efficiently, the real problem statewide is high cost. Too much care is delivered in costly outpatient departments and teaching hospitals.

In 2000, Massachusetts hospitals spent $3.1 billion more than they would have if they had spent at the national per-person average. The steady drain of patients into expensive teaching hospitals is not warranted or affordable. Patients here use costly hospital outpatient care (instead of office-based physicians) 48 percent more than the national average — even though the state leads the nation in doctors per person. That's 4.6 million extra visits. And Massachusetts trains doctors at three times the US rate.

For a decade, the hospital association has fought proposals to empower state government to identify and protect needed hospitals. It repeatedly claimed that closings were not a problem and that the market would close unneeded hospitals. Recently, though, the association has decried closings and emergency room gridlock — and has won large across-the-board hikes in state Medicaid and free-care payments. Medicaid payments will probably rise by $100 million, or 15 percent, this year and again next year. The 2002 state budget gives hospitals $60 million in free-care relief.

Half the Medicaid increase goes to the state's 20 richest hospitals. While the association talks about closings, its policies channel more public money to its more prosperous and higher-dues-paying members.

Only $15 million was appropriated to provide targeted relief to financially strapped hospitals this year, and Swift plans to freeze all but $5 million. One year's rise in Medicaid payments to Springfield's Baystate Hospital or Mass. General alone roughly equals the $5 million remaining in the distressed hospital fund. Reallocating state dollars to that fund would save needed hospitals today and save money tomorrow.

Government can take several steps to save Waltham now and other vulnerable hospitals shortly:

■ Swift should immediately declare a public health emergency to conserve and stabilize care at Waltham. (Such a declaration was used in 1976 to safeguard residents at a Merrimack Valley nursing home.) Each surviving hospital should be deemed needed unless proven otherwise.

■ Under this emergency declaration, the state should appoint an administrator with expertise in reviving distressed hospitals to run Deaconess-Waltham.

■ The state should back the new administrator with cash from the distressed-hospital fund.

■ The Legislature should provide for hospital receivership, timely detection of hospitals at risk, identification of hospitals and services needed to protect the public's health, and financing for short-term stabilization. (Two years ago, an HMO receivership law helped to protect the Harvard-Pilgrim HMO.)

■ State government should design payment methods that assure each needed and efficient hospital enough money. This means capping revenue generation by powerful hospitals and cushioning money-losing but needed hospitals.

■ To reverse the drift of patients with routine problems to high-cost teaching hospitals, state government should work to enhance quality and promote use of lower-cost hospitals.

Massachusetts has the world's costliest health care — $9 billion above the US average, totaling $45 billion this year. That's double the state budget. Current spending is enough to pay for care for all while stabilizing needed caregivers. Because the market has proved incapable of doing either job, government must act. Otherwise, Massachusetts health care will face meltdown and chaos, with less care for fewer people at greater cost.