Hospital Closings—Causes, Consequences, and Responses

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The health care Americans get depends heavily on the kinds of caregivers we've got. The types and locations of our doctors and hospitals strongly influence both the medical services we receive and their costs.

Changes in health care often seem glacially slow, but their cumulative effects are profound. Closings, relocations, mergers, and new construction by 1,200 hospitals in 52 U.S. cities since 1936 have transformed urban health care. Unfortunately, many of these changes will make it harder to assure affordable and high-quality care to all Americans in the years ahead.

In the past 75 years, between 11 and 20 percent of urban hospitals closed each decade. The pattern of closings has been predictable and consistent. Larger hospitals and teaching hospitals have been much likelier to survive. Hospitals in black neighborhoods have been much likelier to close.

In a competitive free market, efficient hospitals would be likelier to survive. That hasn't happened, providing evidence that no such market is present. Hospitals with greater financial endowments are more likely to stay open, regardless of efficiency or public need; this could be called "survival of the fattest."

Travel times to the ER rise because huge swathes of U.S. cities have lost their hospitals. Black Americans are hit hard because they rely on hospital ERs and outpatient clinics for doctors' care twice as heavily as whites. When a hospital closes, remaining physicians in private practice often decide it's time to retire or relocate.

Teaching hospitals' share of urban beds rose from 42 percent in 1960 to 77 percent in 2010. Surviving teaching hospitals have seldom found ways to provide basic services inexpensively. The survivors enjoy greater bargaining power over insurers, which they use to win higher revenues.

Hospitals that have closed typically served disproportionate numbers of minority and Medicaid patients. These patients then choose between going untreated and seeking care at surviving institutions. If these patients move to surviving hospitals, the evidence is mixed on whether they receive better quality care.

Degraded access, higher cost, and mixed effects on quality weren't intended. Rather, they are accidental products of an anarchic hospital system. In health care, anarchy is what results from the absence of either freely competitive markets or competent governments.

The result is that no one's accountable for guaranteeing that the right hospitals and doctors are available in the right places to protect the health of all Americans. Only one state even has a list of vital hospitals. In other rich democracies, employers, unions, and taxpayers unite to pay for hospitals, and they together take some responsibility for providing each hospital with enough revenue to cover the cost of efficient operation. In the U.S., each payer instead scrambles to get the best deal for itself and shift costs to other payers, and only Medicare takes some responsibility for the results.

Decades of hospital closings reflect and reinforce parallel changes among U.S. physicians. Fully two-thirds of U.S. physicians are now specialists, well above their share in other rich democracies. And we have only about one-half as many family doctors per thousand people. Inferior pay and prestige make it hard to persuade more U.S. doctors to go into primary care. Neither governments nor the market has competently addressed this problem.

Lower-income community hospitals find it harder to buy equipment or hire staff that will attract the physicians who will admit profitable patients. They even find it harder to make the costly investments in electronic health records and quality improvements that payers demand.

The long-term drifts toward more expensive hospitals and doctors have helped make U.S. health care the costliest in the world. Our per-person health spending of $7,720 was 225% as great as the average of the world's 25 wealthy democracies in 2008. This year's U.S. health care spending of $2.8 trillion equals almost four times our defense spending.

Why are U.S. costs so high? After all, Americans get less care from hospitals and physicians than do citizens of other rich democracies—nations that cover everyone and live longer.

First, too many of our hospitals and physicians have become too specialized, uncoordinated, and focused on their own financial well-being.

Second, , hospitals, drug makers, doctors, and nursing home owners have used their political power to block effective governmental cost controls. They energetically game the weak and complicated cost controls that have passed.

Third, free market cost controls can't work because, sadly, the market does not function in health care. That's because none of its six requirements can be satisfied. Relying on market forces in health care therefore resembles worshipping a golden calf. Market advocates say that patients must have more financial "skin in the game," so insurance coverage should be cut and patients should be forced to pay much higher deductibles and co-insurance when sick. While lower-income people already have their hearts, bones, pancreases, guts, and other organs in that game, they often find it much harder to ante up thousands of dollars in out-of-pocket payments.

Market advocates push tiered insurance plans that force us to pay more out-of-pocket if we go to costlier doctors and hospitals. With few low-cost community hospitals left in many U.S. cities, tiered networks might mean that urban patients would have to be bused to suburban hospitals if they want to avoid big out-of-pocket payments.

Fourth, by relying on theory and ideology—traditional government regulation and free market competition—we have ignored the main types of cost controls that have actually worked in other rich democracies.

To begin, it's essential to train and retain more family doctors. They will diagnose our problems, coordinate our care, and avoid ineffective over-use of costly services. To get more, we'll have to pay them more. If we paid 300,000 full-time-equivalent family doctors $300,000 yearly, we could drop the average doctor's patient panel in half, to roughly 1,000.

That would give doctors more time to get to know us by listening to us and taking our medical histories, encourage prevention, diagnose ailments earlier, more carefully think through how to treat our problems, coordinate services, and even to take phone calls and e-mails. Yes, $300K

for 300K doctors is a lot of money—$90 billion—but that's only about 3 percent of yearly health spending.

Doctors' clinical decisions control almost 90 cents on the health care dollar. The challenge is to put this money in their hands in ways that allow us to trust them to spend it carefully.

We can do this through a political bargain that gives doctors relief from paperwork and fear of being sued if they take on the job of spending the $2.8 trillion to care for all Americans. This means emphasizing doctors' abilities to be professionals, not businesspeople. It means liberating doctors to think clinically, not financially, by making trade-offs to do as much for patients as resources allow. We can craft parallel arrangement for the nation's 5,000 hospitals, so they will act as fiduciaries for the public, not as profit-maximizers. That would protect and improve our remaining low-cost community hospitals.

Encouraging trade-offs—spending money more carefully—is essential to enabling health care to regulate itself, replacing failed government or market regulation. Making trade-offs overcomes the anarchy that pervades U.S. health care today.

In the real world, pathology is remorseless and resources are finite. After prevention fails, as it inevitably does, health care can extend our lives by avoiding premature death, ease our pain, overcome our disabilities, and offer us greater security and comfort. The challenge is to marshal our vast but finite dollars, doctors, and other resources to win as much medical security as possible. When we do, all Americans can be confident about getting effective, timely, and competent medical care, without worrying about the bill, and without ever worrying about losing insurance coverage.