Why Is Primary Care Like the Weather?

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Thanks for inviting me to speak with you.

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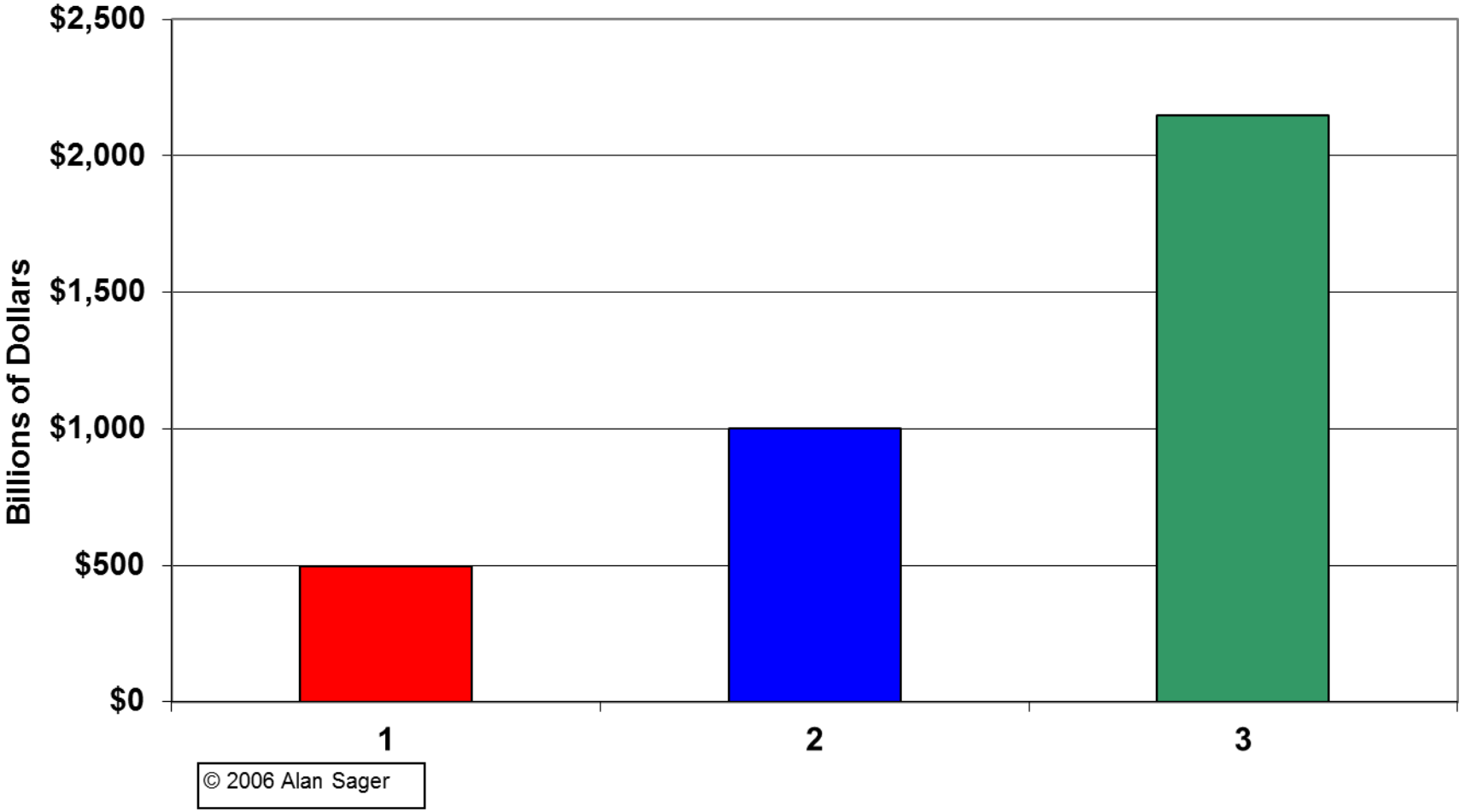
How big?

Which is health? Education? Defense?



Six points

1. Primary care is vital
2. The shortage is real
3. Nothing tried so far has worked well enough
4. Why not?
5. We can do much better
6. A barrier to progress

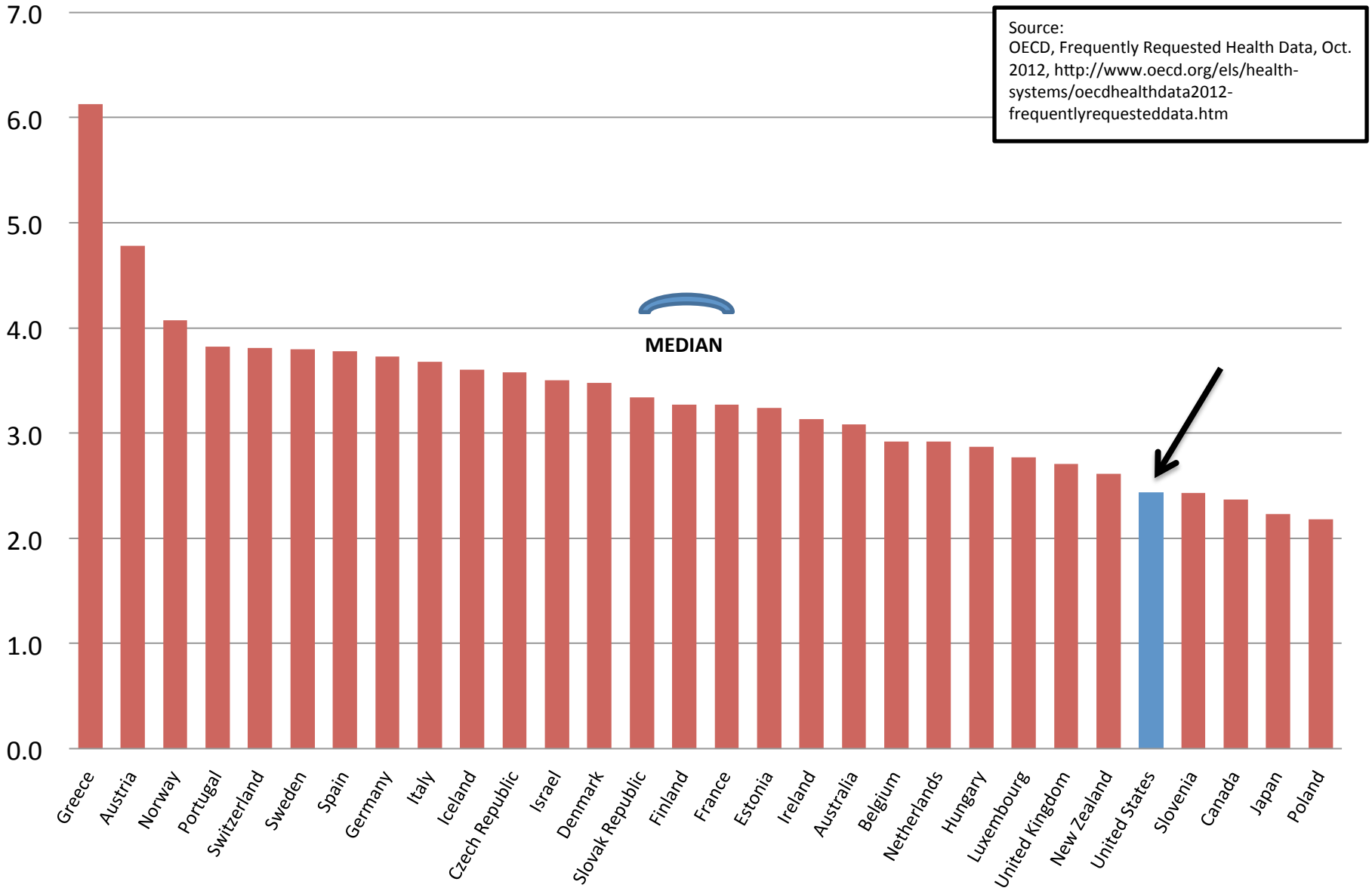
1. Primary care is vital

- Adequate and well-distributed PCPs are a foundation for better, more accessible, and more equitable care at lower cost
  - The health care we get depends heavily on the caregivers we've got
- Bedrock of trust and competence – a personal relationship with a good doctor is even better than a good EHR!
- Coordination and continuity
  - Especially for people who are very ill or disabled, who can destabilize very quickly
  - Primary care – the sun whose gravity keeps fragmented medical care from flying off into space

2. The U.S. PCP shortage is real

- International differences
- PCP share of U.S. physicians falls steadily
- Shortage much worse in many states
- Even bigger differences within states
  - Rural
  - Urban
  - Racially

Physicians per 1,000 People, 30 Rich Democracies, 2010

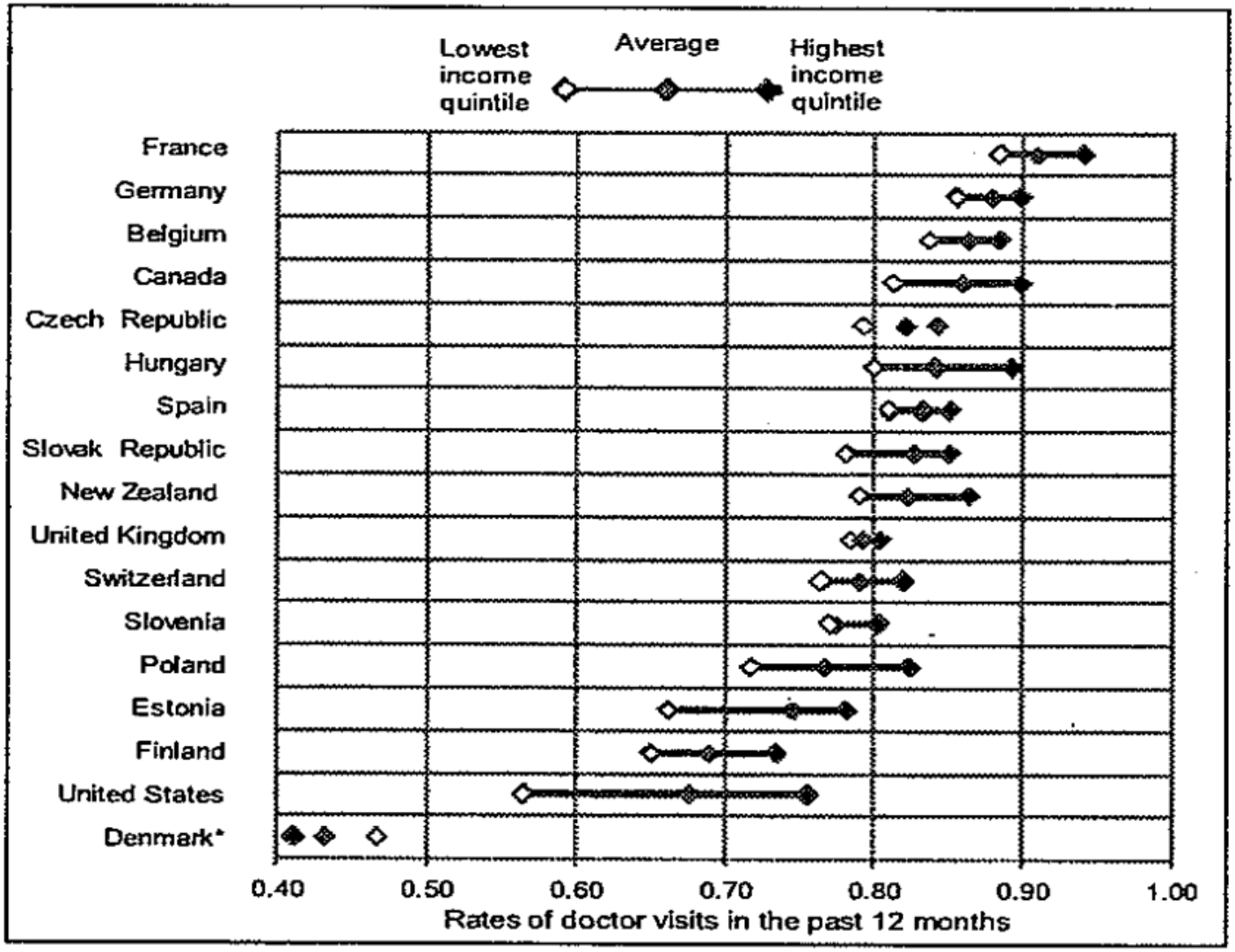


U.S. – OECD PCPs/1,000 People

	U.S.	OECD – 30-nation median
Practicing physicians/ 1,000 people	2.4	3.3
Share in primary care	1/3	1/2
PCPs / 1,000 people	**0.8**	**1.6**

Source: OECD, Frequently Requested Health Data, October 2012, http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm; Health United States, 2011; and various estimates of PCP share in other nations.

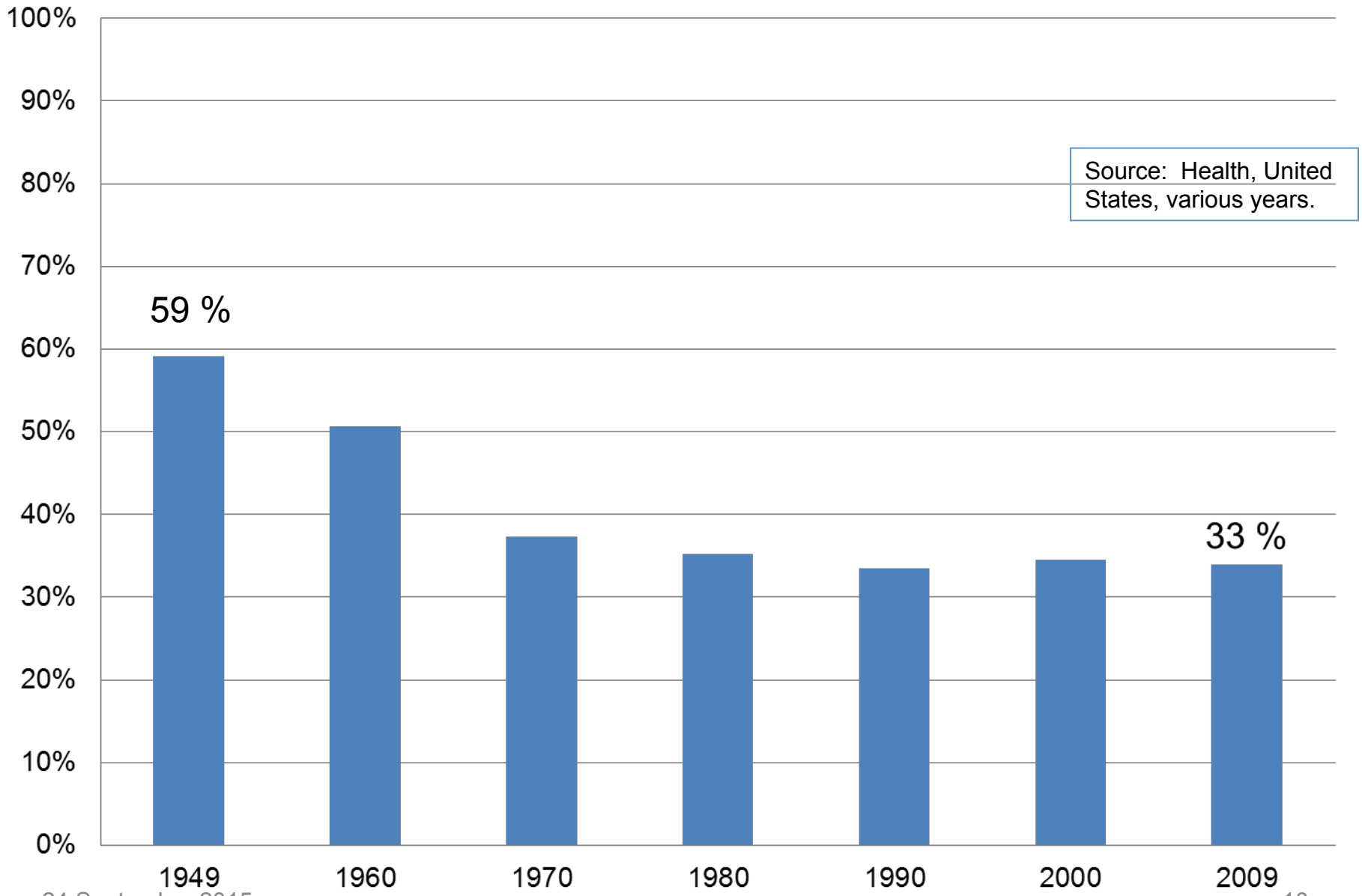
Figure: Needs-adjusted Probability of a Doctor Visit in Last 12 Months, by Income Quartile, 2009 (or latest year)



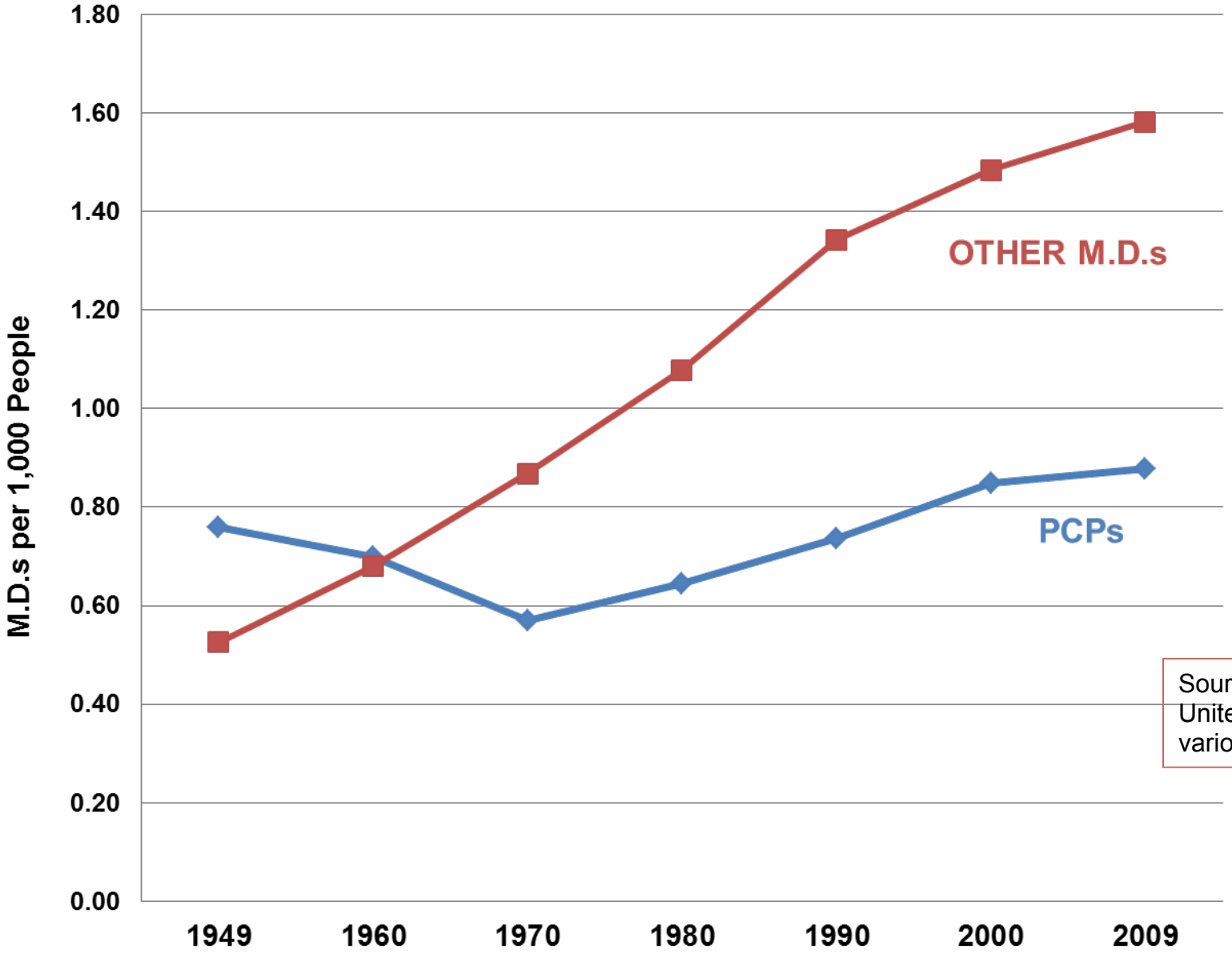
Note: Denmark reports three months of data only.

Source: Marion Devaux and Michael de Looper, *Income-related Inequalities in Health Services Utilisation in 19 OECD Countries, 2008-2009,* OECD Working Papers, No. 58, 2012, p. 17.

PCP Share of Active U.S. M.D.s, 1949 - 2009

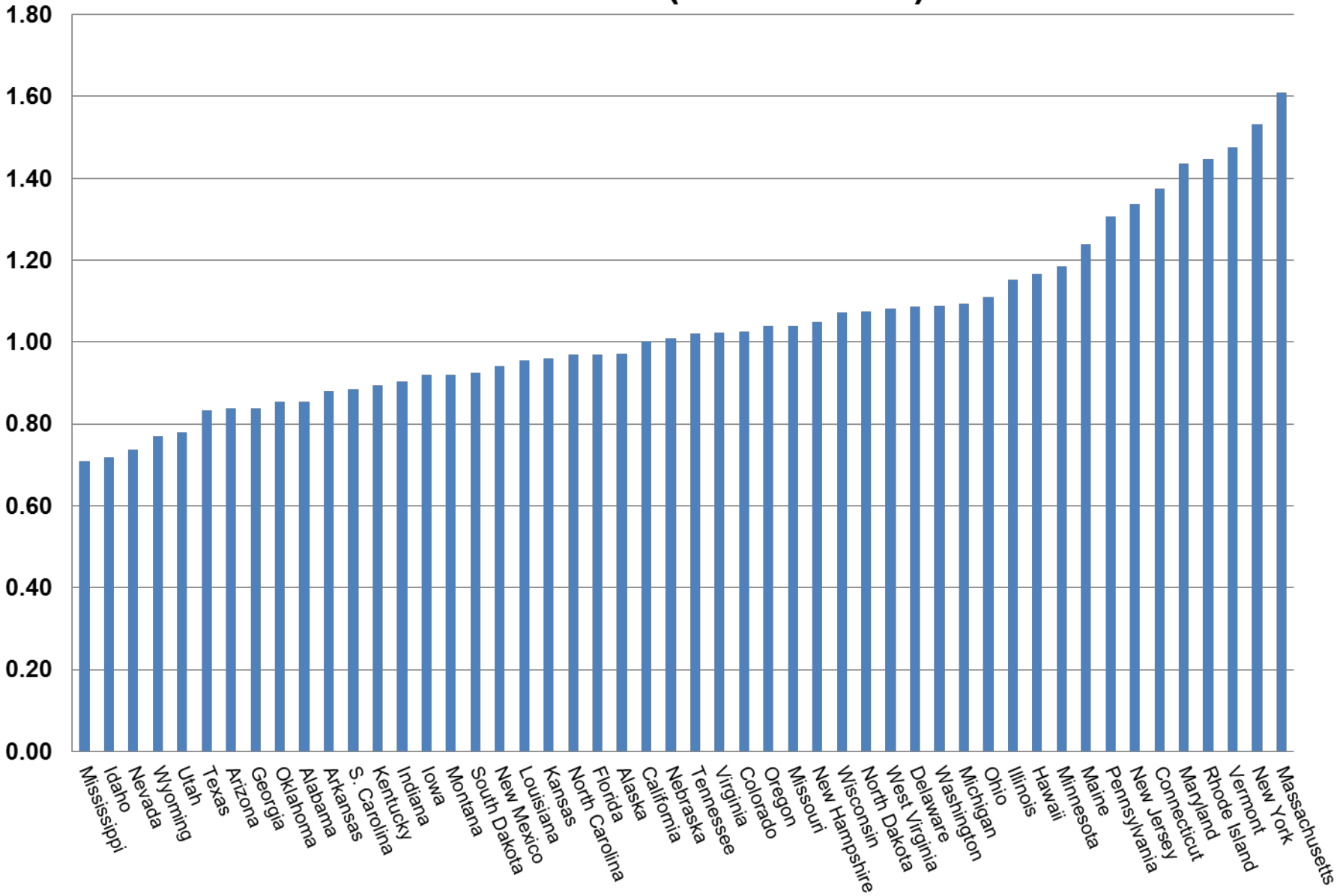


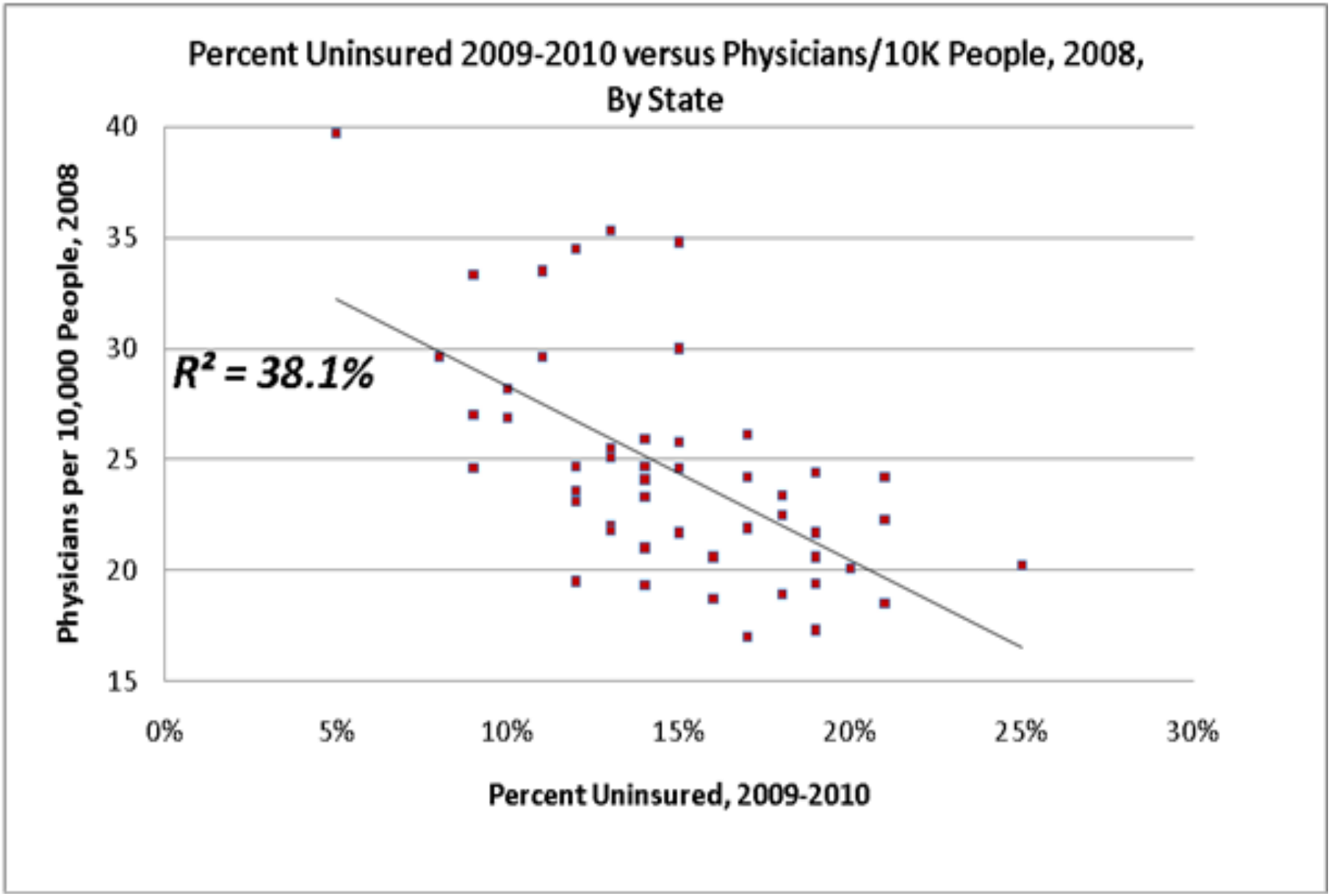
U.S. PCPs and other M.D.s per 1,000 People, 1949 - 2009



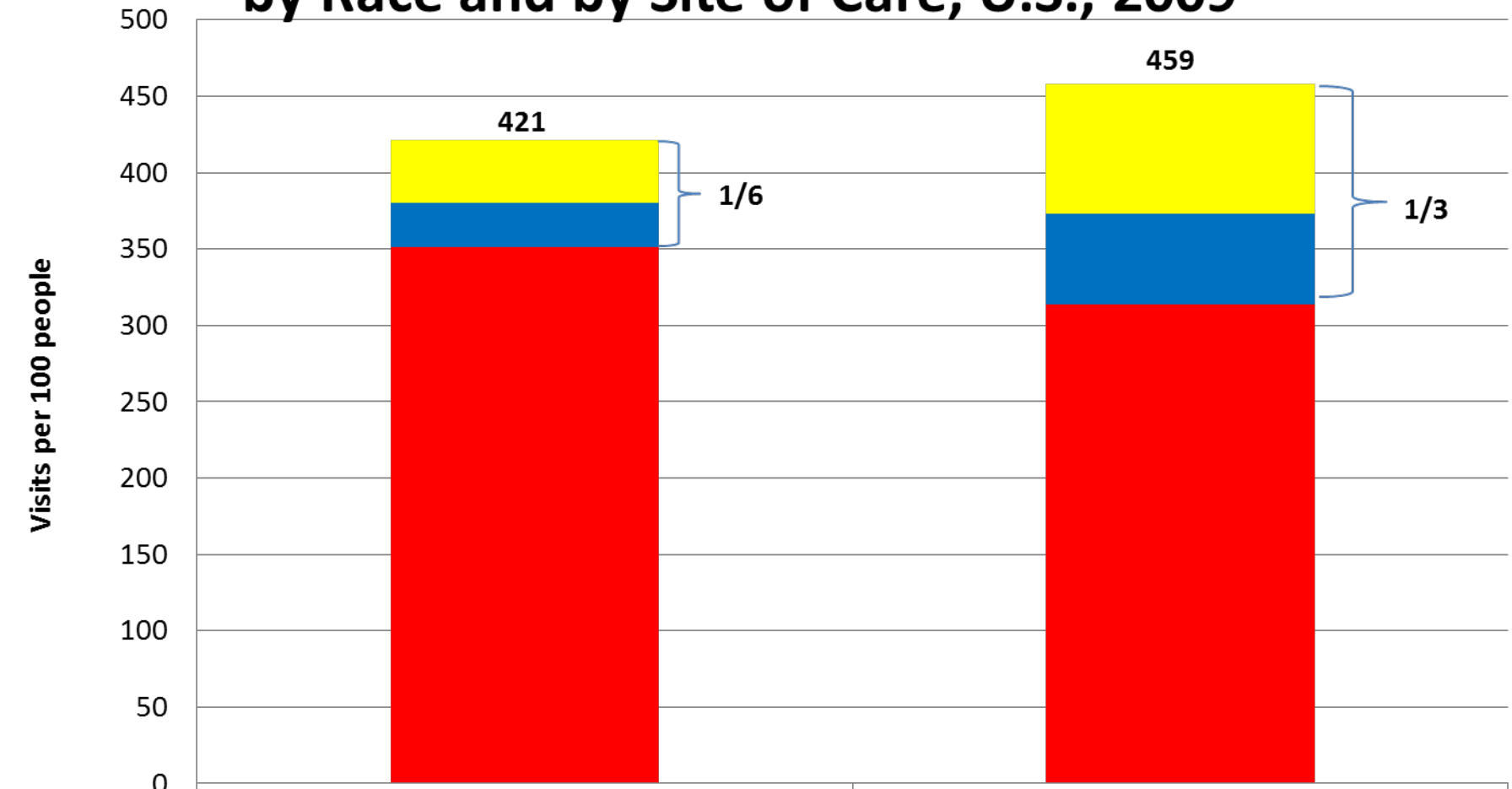
Source: Health, United States, various years.

Patient Care PCPs per 1,000 People by State, 2003 – 2005 (M.D. + D.O.)





Physician Visits per 100 People, by Race and by Site of Care, U.S., 2009



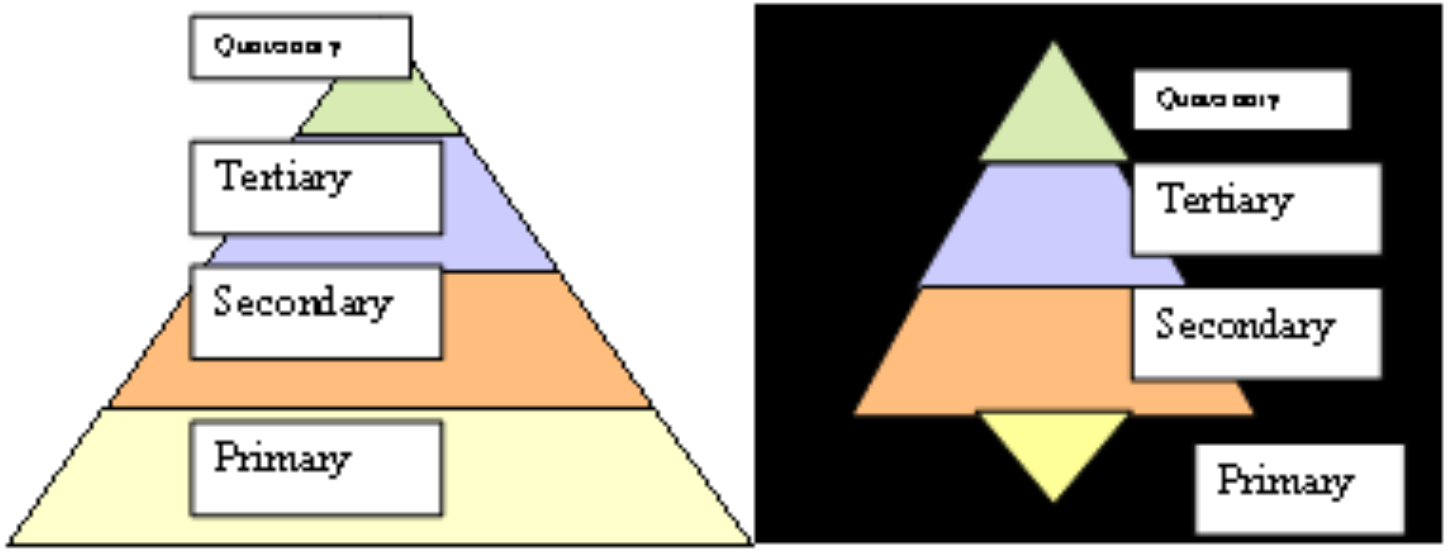
	white	black
ER	41	85
OPD	29	59
MD office	351	314

Source: *Health United States, 2011*, Table 96, age-adjusted.

The inverted primary care pyramid

Chart X: the traditional health care pyramid, resting on a broad and solid primary care base.

Chart Y: Today's inverted primary care pyramid, in which growing pressure and disruption are imposed on primary care doctors by health care delivery and financing.



3. Nothing tried so far has worked well enough

a. **Pretend** growing PCP shortage isn't a problem
- There's always the ER
- Specialists can/do provide primary care—quality of PCP and specialty care may suffer

b. **Expand** CHC capacity + enlarge NHSC + forgive some of some doctors' debts

c. **Try** RBRVS formula to re-balance cognitive/procedural fees

d. **Ignore** the problem

e. **Imagine** HMOs (or ACOs) require more gatekeepers → higher pay to more PCPs

f. **Build** patient-centered medical home to offset PCP shortage
- NPs or PAs or teams could substitute for many PCP visits
- MD/DO works at top of license, could make more money

g. **Deride**: Who needs one-class PCP care?
- Walk-in clinics, in pharmacies and elsewhere
- Urgent care centers
- Free-standing ERs

h. **Ignore** the problem some more

i. **Talk** about it, especially when seeking new medical schools from legislatures
- But focus on "doctor shortage" not on what kinds are needed
  → Big, indiscriminate rise in U.S. graduates is under way

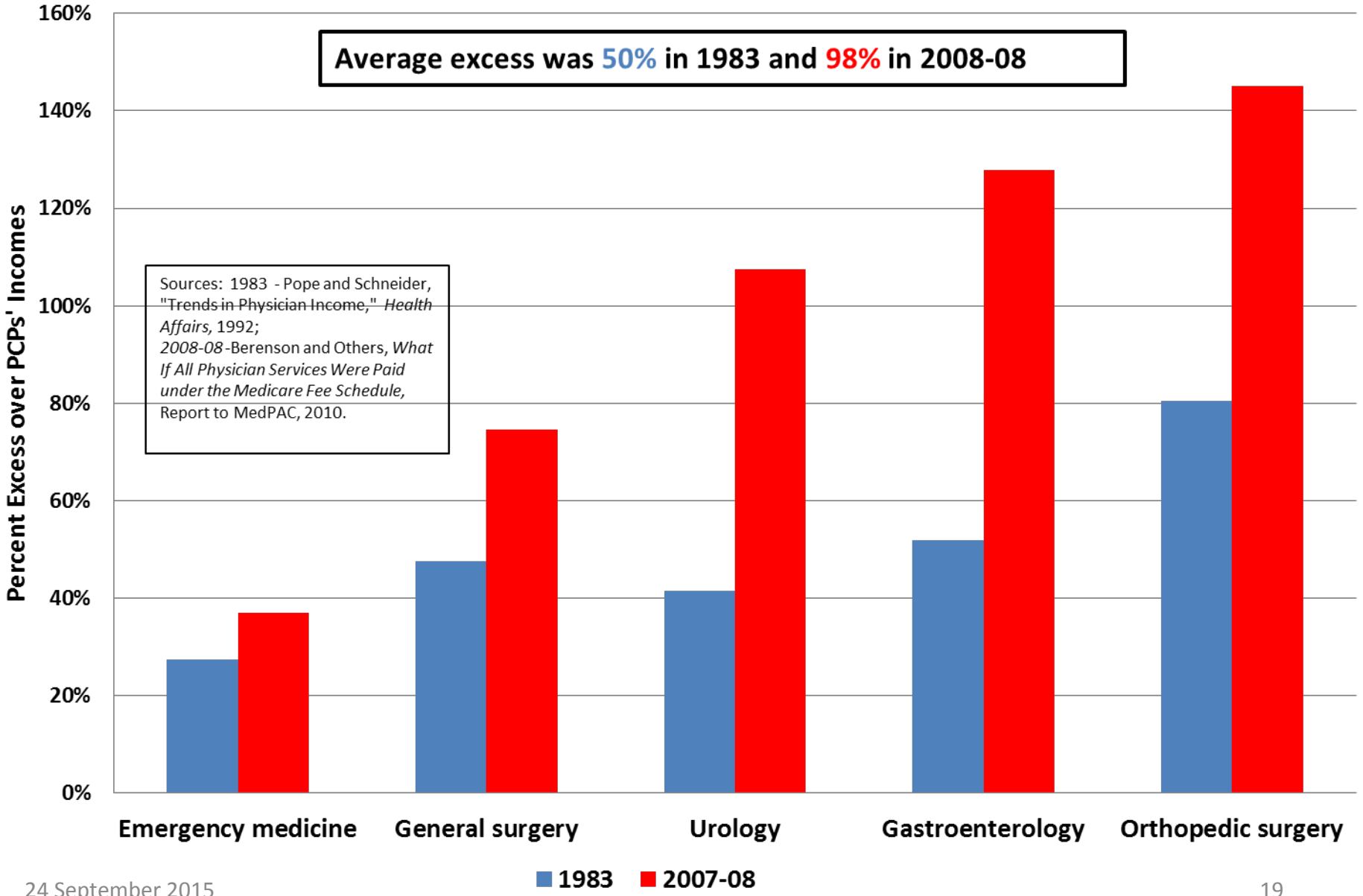
PCP shortage: Causes, remedies

Causes	Past/current remedies	Others nations' remedies	Potential US remedies
Low PCP incomes	PCMH = hierarchy. Boost PCP M'caid fees to Medicare levels. ACO → market for PCPs.	Calibrate FFS to attain target incomes. FFS + capitation → target. 10% of premium $s to PCPs	300K FTEs * $300K. All payers pay same price for same care. Hike PCP % insurance. (But "docs overpaid")
High costs of billing, EHR	Sell practice to powerful protector providing capital	Simplify billing	One price. Build trust
Specialists set Blue Shield fees, dominate RUC	More PCPs on RUC. Re-evaluate time estimates for procedures. ACOs → limit specialist income	Cap specialists' numbers and incomes since hospitals set slots and pay from hospital budgets	ACO → cuts demand for specialists and their incomes.
High debt	NHSC, forgive loan		Tuition-free schools mean $0 PCP debt
Low prestige	Teaching CHC. PCMH → PCP=internal consult.	Recognize value of relation with trusted PCP	Med school faculty may not deride PCPs
Need know breadth/depth	ACO → better coordination with specialists	More PCPs/smaller panels. Good access to specialists.	Smaller panels allow time to do the job.
Stunted empathy		Political commitment	Many can't find PCP
Weak access	M'care, M'caid, ACA	1 payer or all pay same price	
Weak cost		1-payer manifests political	Weak economy

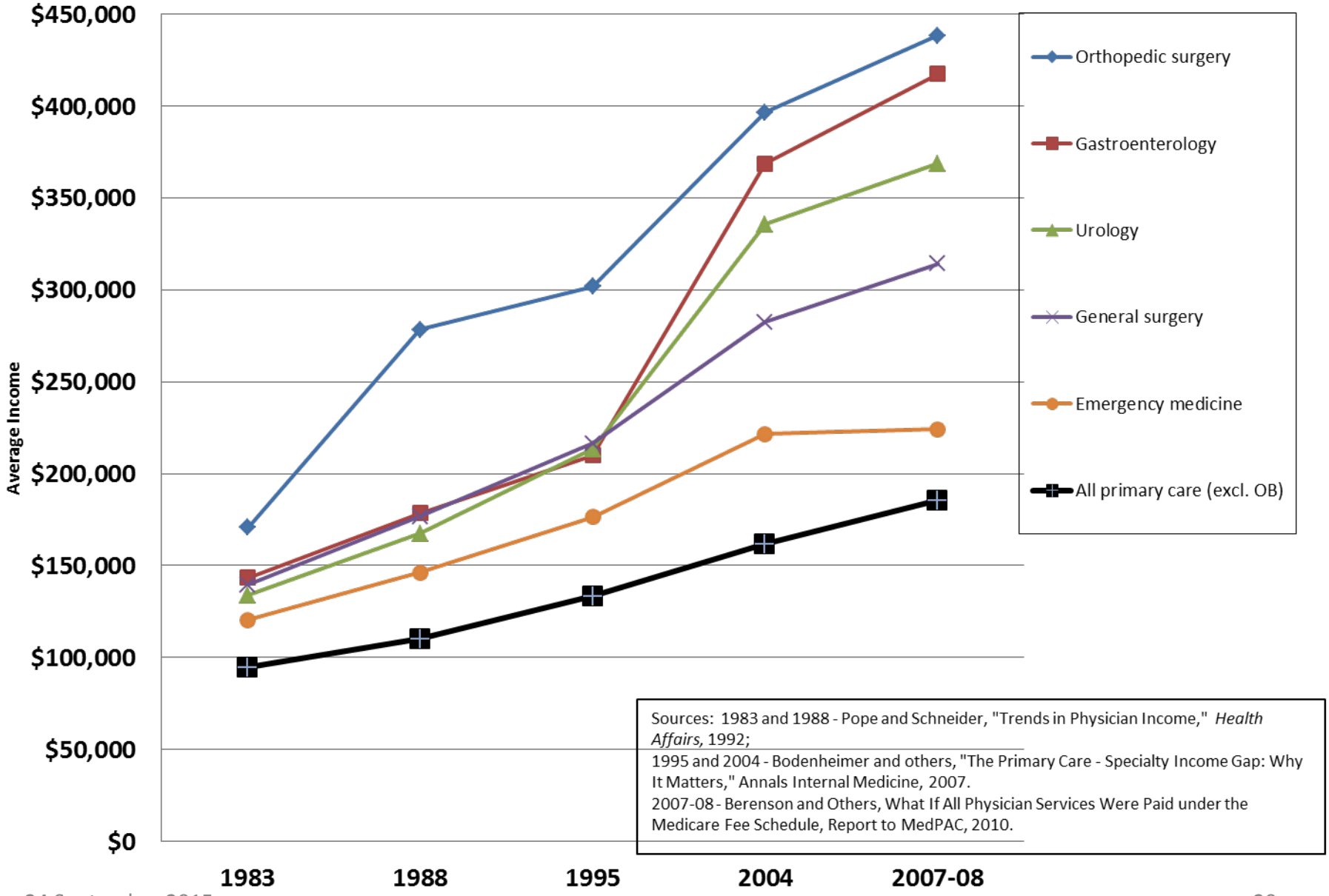
4. Why not?

a. Income gap
b. Prestige gap
c. Primary care is very hard work
d. Stunted empathy + rampant myths
e. Cumulative erosion of urban community hospital care in many areas
f. Little sustained attention to physician configuration
g. No functioning market + no competent government = **?**
h. Haven't tried what works elsewhere
i. Very weak political commitment to finding solution

Five Specialties' Average Incomes - Percent Excess over PCPs' Incomes, 1983 and 2007-08



Average Income, PCPs versus Five Specialties, 1983 - 2008



Expand CHCs + NHSC, + lower debt

- Income matters much more than debt
- Suppose average academic debt rises to $250K

  = 365 days' gap in before-tax income between orthopedic surgeon and PCP
- PCP incomes so low that many PCP residencies unfilled

Hope RBRVS will re-balance fees, incomes

- Some initial success but surgeons, others worked in Congress to cut fee shift in half
  - Now, we fight about the formula instead of incomes—methods instead of aims
  - Hard to win since RBRVS is zero-sum game
  - PCPs outnumbered numerically and politically
  - Time to perform procedures commonly over-stated, shifting income further away from PCPs
- Hospital-based proceduralists retain free capital
  - Use hospitals' machines, ORs, nurses to earn incomes, but don't pay for them
- Medicaid very low payer in many states

Prestige gap

- Medical school faculty – role model shortage
  - "You're too good for primary care"
  - One response: Teaching health center program
- Prestigious teaching hospitals train few PCPs
- Rise of hospitalists means PCPs have less contact with in-hospital physicians
- Diagnosis widely believed to rest less on accumulated wisdom, history, physical exam
  - Rely more on better imaging, labs than in past

Is primary care hardest job in medicine?

- Need great breadth + depth of medical knowledge
- Need enjoy science + relationship
  - Do medical schools enroll enough students who like both?
- Memory, history, physical exam inform diagnosis and treatment
  - Not all imaging, labs, referrals, EHRs
- Hours of self-limiting illnesses + staying alert to grave, acute problems
- Rising panel size, long hours, lots of unpaid paperwork

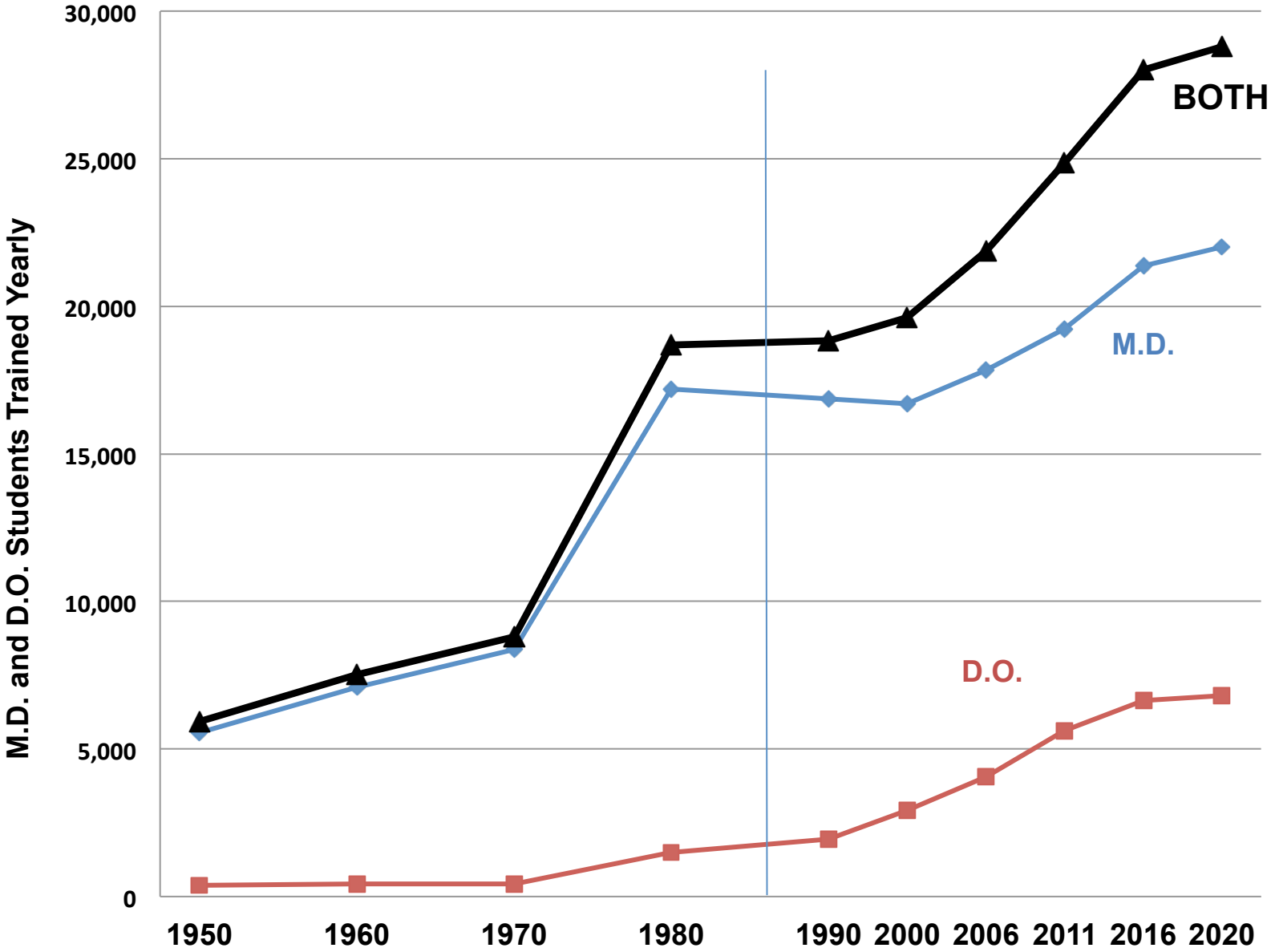
Stunted empathy + rampant myths

- **"It's not my problem"**
  - **Not one influential American now lacks a PCP or fears future lack**
- Ranting against "inappropriate and costly use of the ER"
  - Symptom, not cause
  - No one goes to ER if has a better choice
  - Fragmented care is costly; providing it in ER is no more costly
- Prevention fantasies – behave better and live forever
  - "It's your fault you got sick, anyway"

Too little sustained attention to physician configuration

- How many doctors? what kinds? where?
- Sixty years of too few doctors – too many – too few – too many.
  - Never have right number
  - Despair. We're too dumb to get it right
- Imagine that "health care market" will elicit right number of right types of doctors in right places
- Belief that training more U.S. medical school grads will push U.S. doctors into primary care

M.D. and D.O. Students Trained Yearly, 1950 - 2020



Results may surprise

- PCMH and its MD/DO/NP/PA/RN++ teams may reduce pressure to train more PCPs
- More USMGs combined with no or small increase in residencies will displace IMGs from residencies
  - Hospitals may try to convert unfilled PCP residencies to specialist/procedure-performing
- But, because IMGs had been much likelier to fill PCP residencies,
- Result could be fewer PCPs trained yearly

ANARCHY

= no functioning market + no competent government

a. <u>Free market fantasies</u>

– None of the 6 requirements for market are satisfied in health care

– Some assert that competitive free market justifies low PCP incomes

  - Why no movement to market-clearing PCP income?
  - Little attention to discriminatory payments by Medicare, Medicaid

– Some hope that patient-centered medical home will boost PCP incomes and use team of caregivers to cope with PCP shortage

b. No competent government action, either

- Weak political pressure to boost PCP supply
- Formula-driven RBRVS can't generate fair PCP incomes
- Specialists outnumber, out-gun PCPs
- Hope to recycle HMO as ACO to boost PCPs' importance
- Imagine capping Medicare-financed residencies will cap specialist residents
- Implementing dozens of ACA provisions + SGR impasse take attention from PCP shortage
- ACA's higher fees are good start, but temporary
  - Medicare 10% bonus much too little, $700M/year * 5 years
  - Medicaid offers $11B in 2 years, but very hard + slow to implement
- Debt, deficit, hollowed economy, SGR fix, and endemic political fights probably mean few new dollars for PCPs

Don’t just stand there

- Absent
  - Functioning market or competent government
  - Political commitments to cover all + cut cost
- Resort to gimmicks
  - EHR “meaningful use”
  - Boost patient out-of-pocket payments “underinsure”
  - Disease management “don’t call us; we’ll call you”
  - Primary prevention “no blame, but it’s your fault”
  - Reverse financial incentives, “reward value, not volume”

Weak political commitment

- Many mechanisms could be used to boost PCP incomes, supply, location where needed
- But so what?—If the political commitment to adequate PCP supply and pay is weak.
- Is this inevitable?

Where do other nations find that commitment?

- When all are insured, people seek care
  - So PCPs must be available to assure access
    - And all payers pay same prices → access equity
- Long-standing caps on salaried hospital-based specialists and residents
  - Usually paid from hospital's capped budget
  - Remaining medical graduates will be PCPs
- Health spending capped
  - Recognition that PCPs help contain cost

How we might find that commitment

- Maybe, PCP shortage has begun to hit some influential people—this will worsen
- If ACA really does cover lots more people
  - And previously covered people face longer waiting times
- If today's cost control bubbles pop loudly
  - Boosting out-of-pocket payments bankrupts
  - ACOs could go the way of HMOs
- If PCPs' value shines through
  - Coordination and continuity
  - Cost control, appropriate care

5. We can do much better

a. Budgets in three watertight compartments, and PCPs manage them all – risk-free
b. Help physicians—especially PCPs—cut expenses
c. Try mechanisms that work in other rich democracies
   - Cap specialist residencies
   - Create real budgets for all needed hospitals and pay hospital-based specialists from those budgets
   - Raise PCP incomes
     - Move incomes of PCPs back in line with specialists
     - 300K * $300 = change the work and change the pay

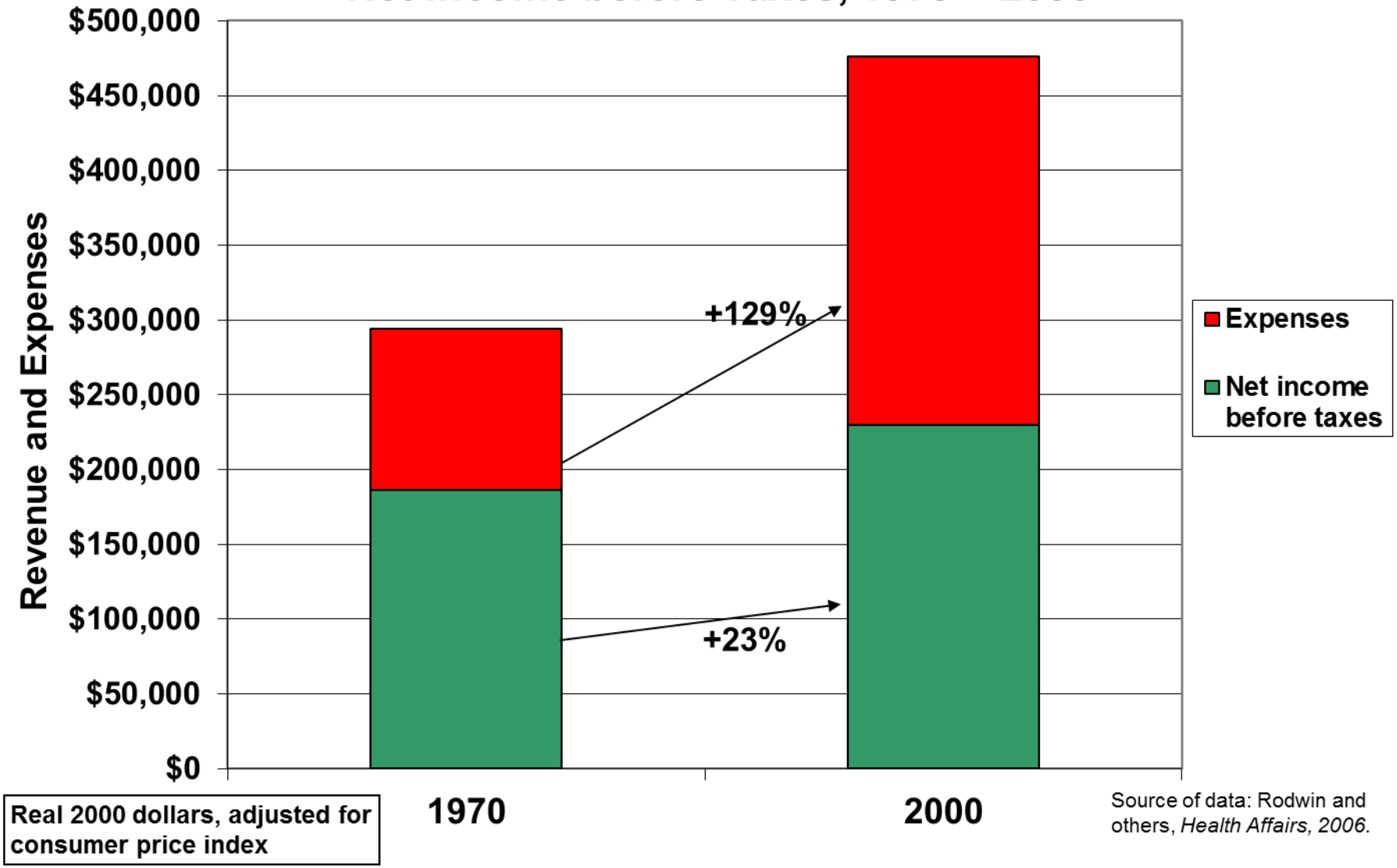
Groups of 10-20 PCPs manage 3 separate budgets, risk-free

- 3 budgets, each in own watertight compartment
  - One to pay PCPs
  - One to pay other physicians
  - One to pay hospitals' variable costs, LTC, meds, other
- PCPs manage all 3 – can only be paid from first
- PCPs must expend dollars in other 2 budgets, but can't exceed budgets, and can't benefit from under-spending → trustworthy financial neutrality
- 20 PCPs @1,000 patients * $6,000/patient = $120M
  - Need substantial managerial and decision support

Help PCPs cut expenses

- **(Valuable tool, since great majority of Americans think doctors are over-paid)**
- **U.S. physicians' practice expenses grew 5.5 times as fast as net incomes, 1970 – 2000**
  - Many practice expenses are clinical
  - But many others are administrative, stemming partly from complexity associated with multiple payers, rules, formularies, co-pays
  - And many others stem from payer-doctor mistrust perceive to arise from physician financial incentives
- Cutting administrative costs requires cutting complexity and mistrust

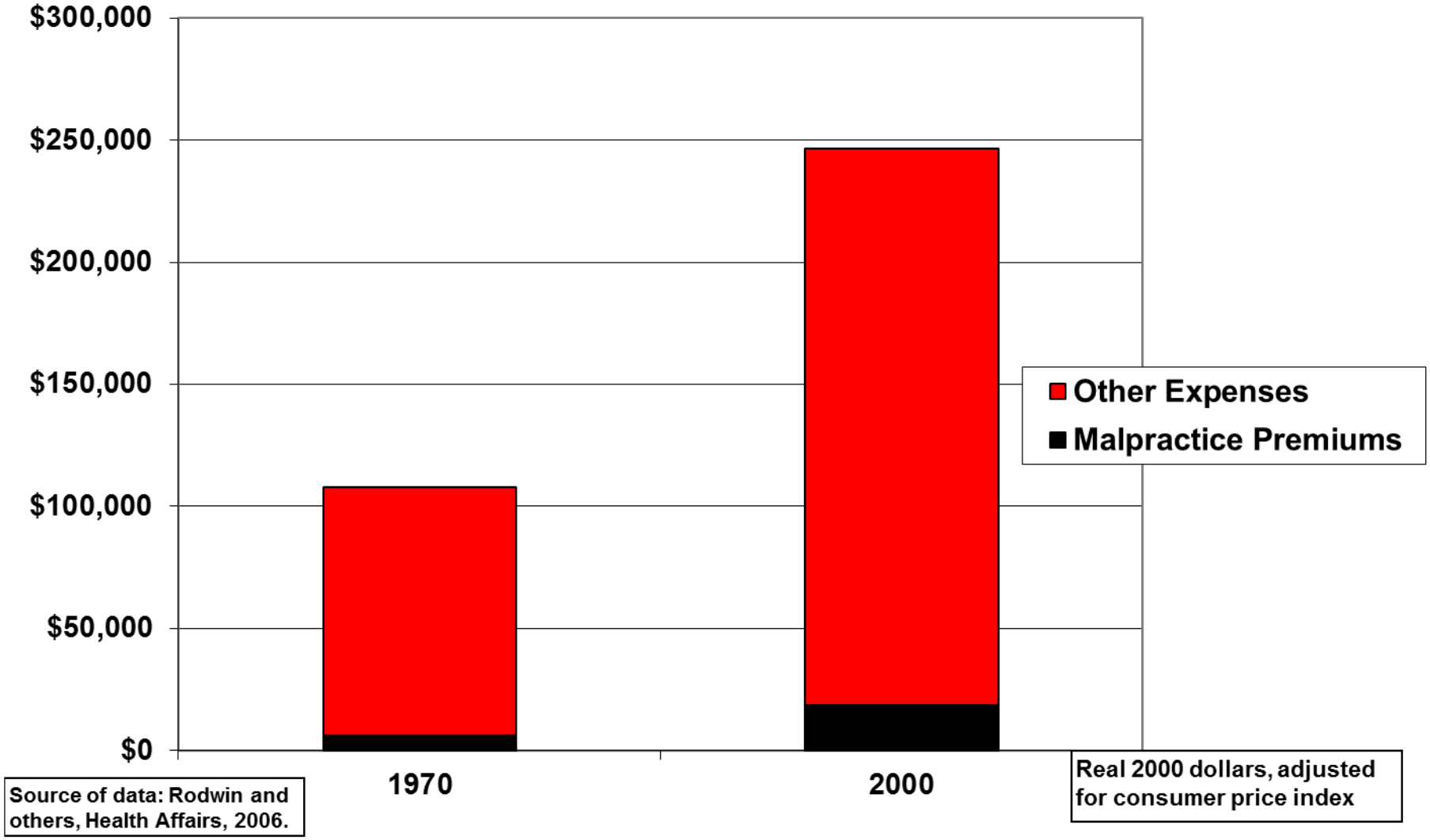
U.S. Physician Average Gross Income, Expenses, and Net Income before Taxes, 1970 + 2000



Real 2000 dollars, adjusted for consumer price index

Source of data: Rodwin and others, *Health Affairs, 2006.*

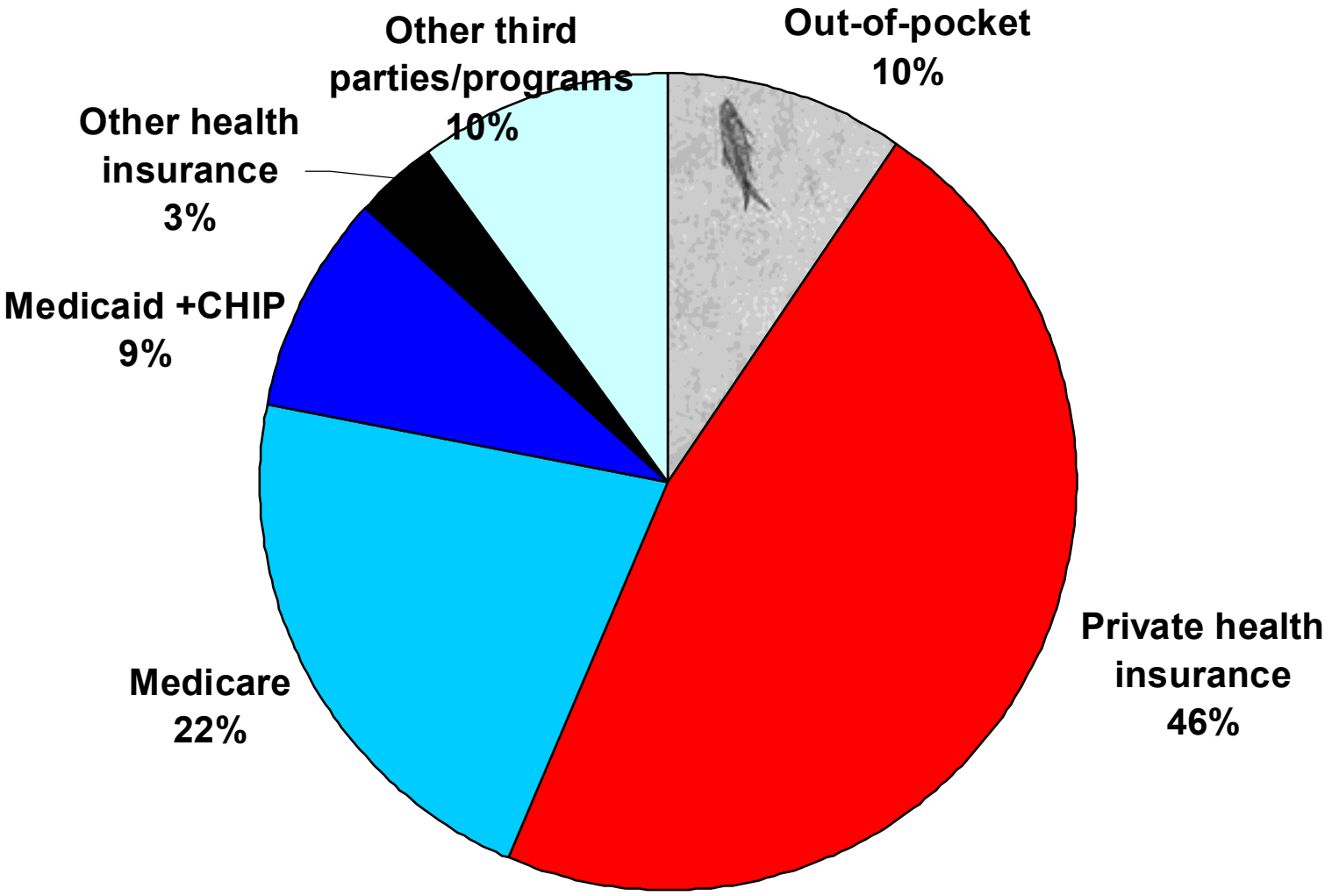
U.S. Physicians' Average Malpractice Premiums and Other Expenses, 1970 + 2000



Will ACOs boost PCPs' incomes?

- **Absolute** = dollar incomes of PCPs might rise
  - If ACOs needed more PCPs than are now available
  - And bid up incomes in order to attract more
- **Relative** = dollar incomes of specialists might fall
  - If they have less to do in ACOs
    - If ACOs work to suppress some low-value services provided by specialists
  - Or are paid less
    - If demand for specialists falls, cutting incomes

Sources of Revenue to Finance Physician and Clinical Spending, 2009



Channel more physicians into PC

Use residency limits + surge in U.S. medical graduates to direct greater share of doctors into primary care

- Medicare can't pay for more residencies unless Congress acts
  - Leverage!
- Will Congress try to use this leverage to induce teaching hospitals to train more PCPs?
  - If so, will teaching hospitals manipulate "PCP training" to train specialists?
- Any value without narrowing PCP income gap?

Pushing the PCP – specialist income gap back down to its 1983 level—or below

- In 1983, the 5 specialties examined earlier had a mean income of 50% above the PCP mean
- By 2007-08, the excess had risen to 98%
- Suppose we restored the 2007-08 gap to 50%

  = boost mean 2007-08 PCP income from $185,000 to $235,000, a rise of $50,000 (27%)

  - For about 275,000 PCPs, the rise would cost $13.8 billion annually, or 0.50% of annual health care spending
- Instead, suppose we cut the 2007-08 gap to 25%

  = boost mean 2007-08 PCP income from $185,000 to $282,000, a rise of $97,000 (52%)

  - Cost: about $27 billion annually, or 1.0% of yearly spending

Concrete steps to cap the gap

- Annual loan forgiveness for PCPs working in under-served area or if Medicaid share of patients exceeded a certain level (only affects those with outstanding debt)
- Adopt "all-payers pay same price to PCPs"
  - As would prevail in functioning free market
  - Prices set to provide target income to PCPs
- Encourage other states to adopt Rhode Island health insurance commissioner's requirement that private insurers direct 10% of premium revenue to PCPs (varying impacts across states)

300,000 * $300,000

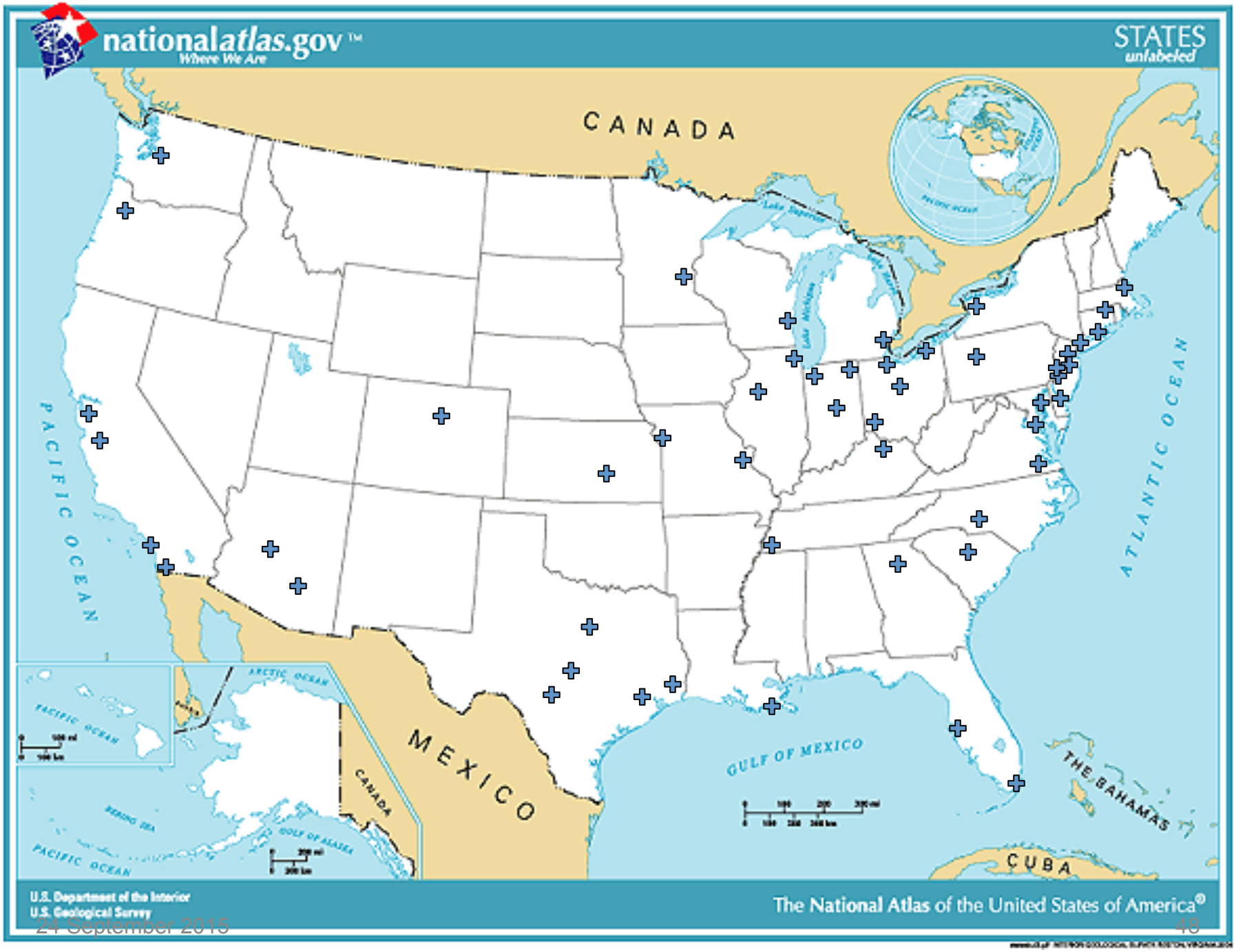
- Pay 300,000 FTE PCPs $300,000 annually
  - Net income before taxes
  - Total cost is $90 billion, or 3.1 % of total health $2.9T
  - Incremental cost < $45 billion
  - < $150 / American
- Drop panel size to about 1,000 – concierge for all
  - Old-fashioned alternative to patient-centered medical home's team model
  - Time for phone calls, e-mails, chronic care case management, health education
  - Over time, attract more physicians to primary care
  - Need for many more PCP residency positions
  - Divert many new USMGs from specialties

6. A barrier to progress

- Cumulative effects of urban hospital closings make practice environment more hostile to PCPs, especially practicing privately
  - Fewer places for community physicians to admit patients
  - Weaker infrastructure for practice
  - Growing dominance of larger, costlier, and more geographically remote hospitals

OVERVIEW

A. The terrain
B. Identifying the hospitals that are likelier to close
C. Why do hospital closings matter?
    Access, Cost, Quality
D. Stabilizing hospitals that are needed
   – By patients
   – By their physicians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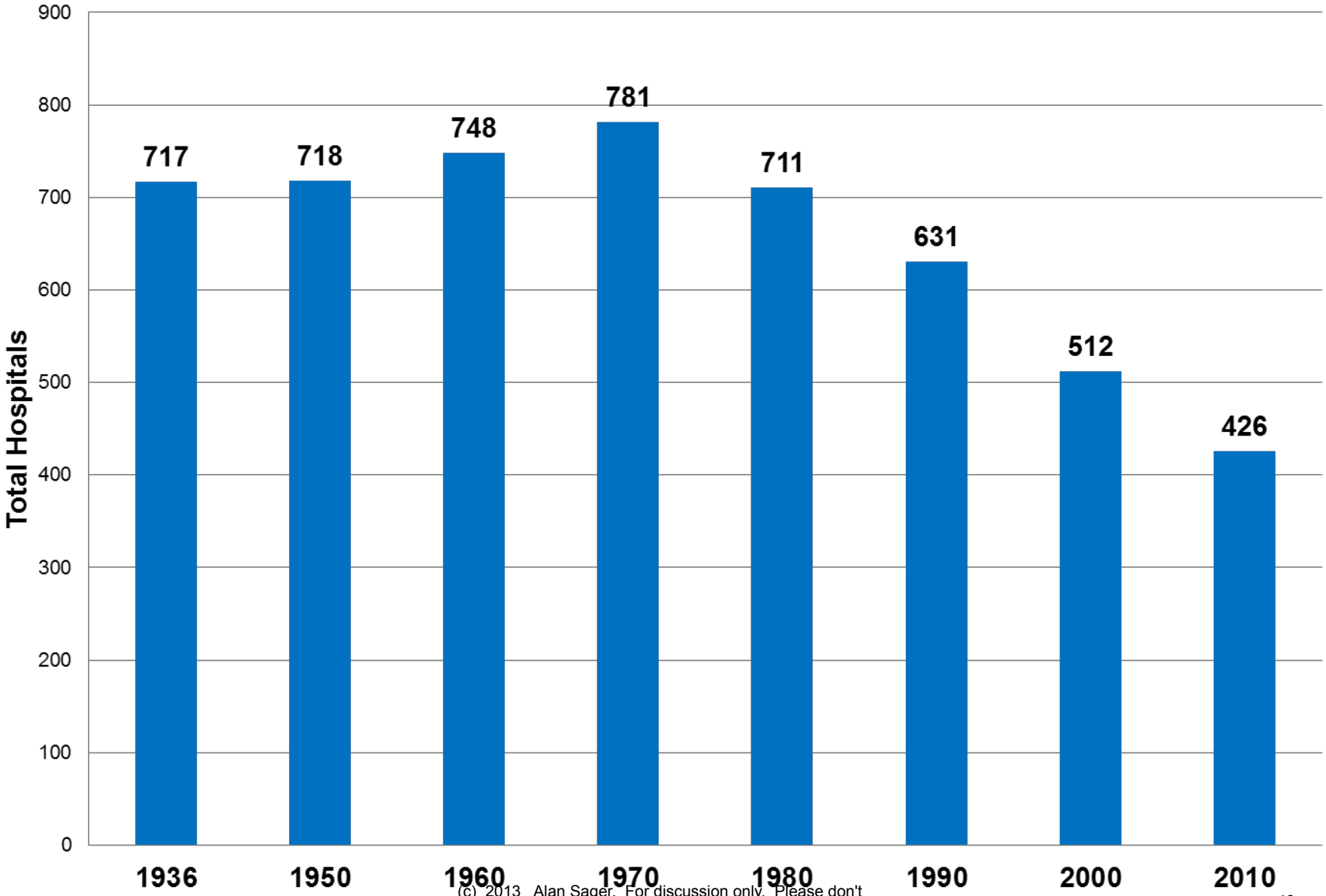
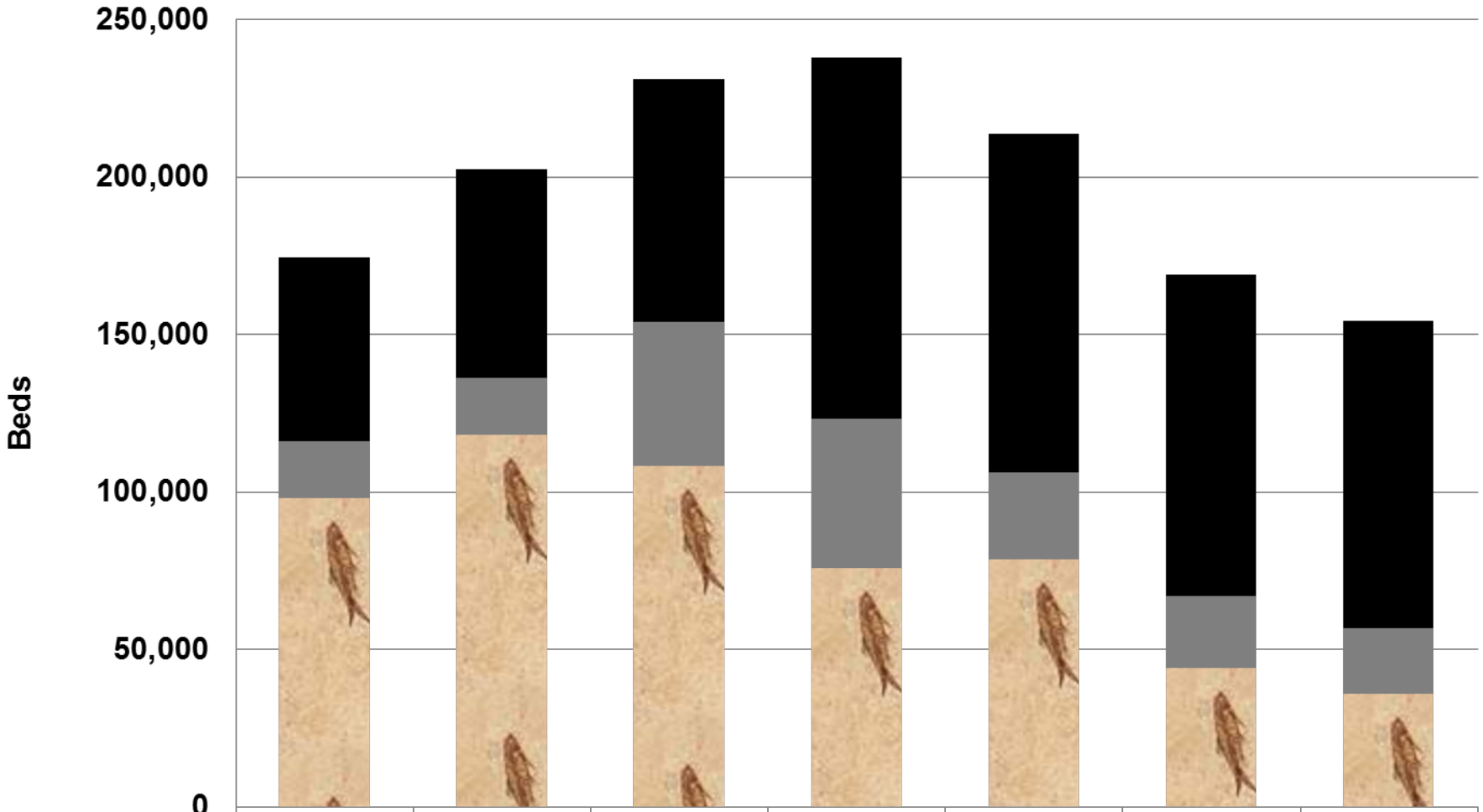
Total Study Hospitals, 52 Cities, 1936 - 2010



Beds by Medical School Affiliation, 52 cities, 1950 - 2010

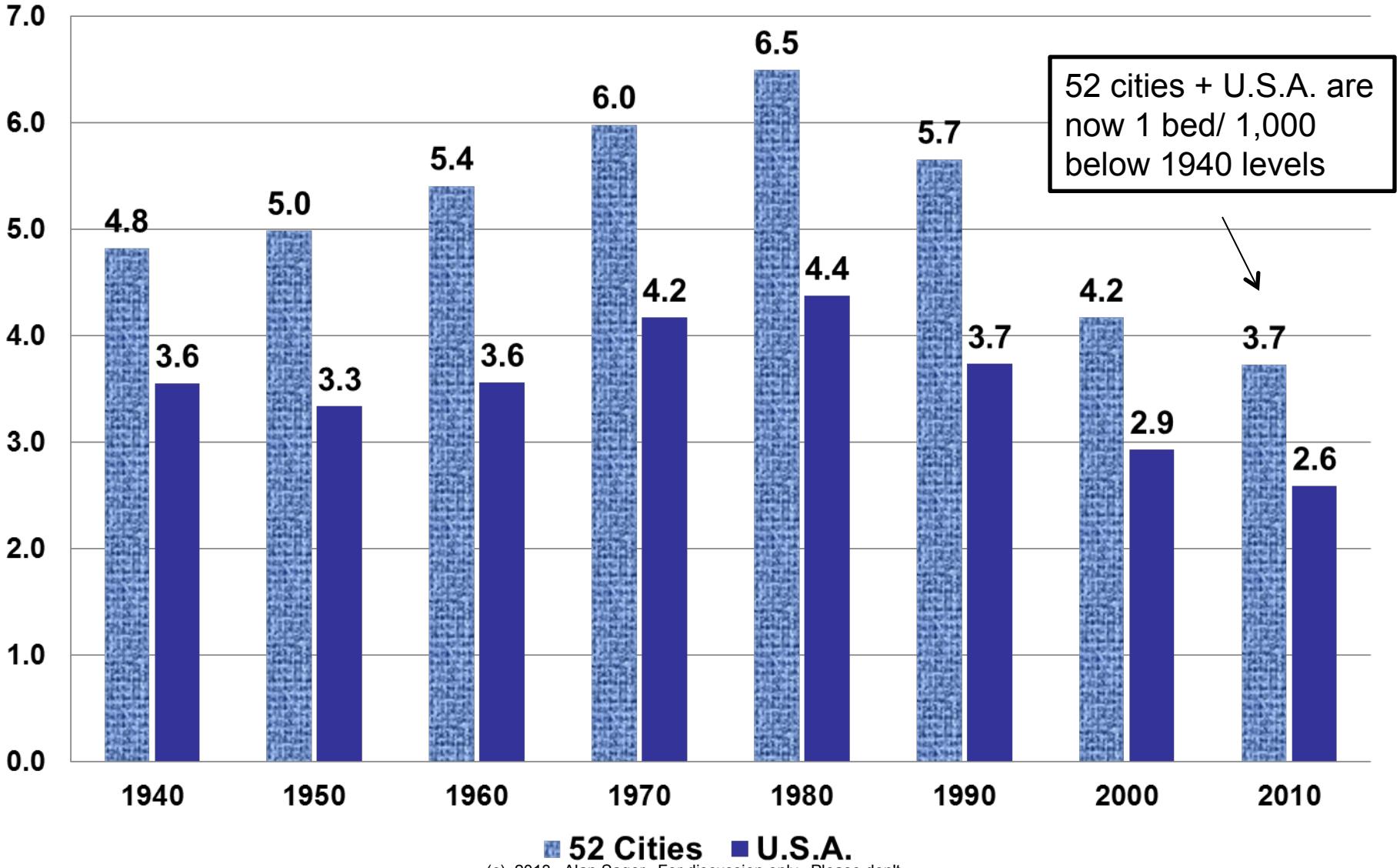


	1950	1960	1970	1980	1990	2000	2010
Major teaching	58,468	66,372	77,174	114,913	107,420	102,030	97,622
Minor teaching	17,948	18,098	45,645	47,442	27,554	23,012	20,986
Non-teaching	98,236	118,210	108,382	75,772	78,731	44,063	35,915

Hospital Closings/Relocations and New Hospitals, by Decade

Period	At Start	Closing	% Closing	Survivors	New	End	Change	% Change
1936-50	709	75	11%	634	79	713	4	1%
1950-60	713	81	11%	632	110	742	29	4%
1960-70	742	90	12%	652	122	774	32	4%
1970-80	774	153	20%	621	90	711	-63	-8%
1980-90	711	130	18%	581	50	631	-80	-11%
1990-2000	631	122	19%	509	3	512	-119	-19%
2000-2010	512	87	17%	425	1	426	-86	-17%

Beds per 1,000 People, 52 Cities and U.S.A., 1940 - 2010



B. Which hospitals are likelier to close

Do rich hospitals deserve to be rich?
(Sometimes)

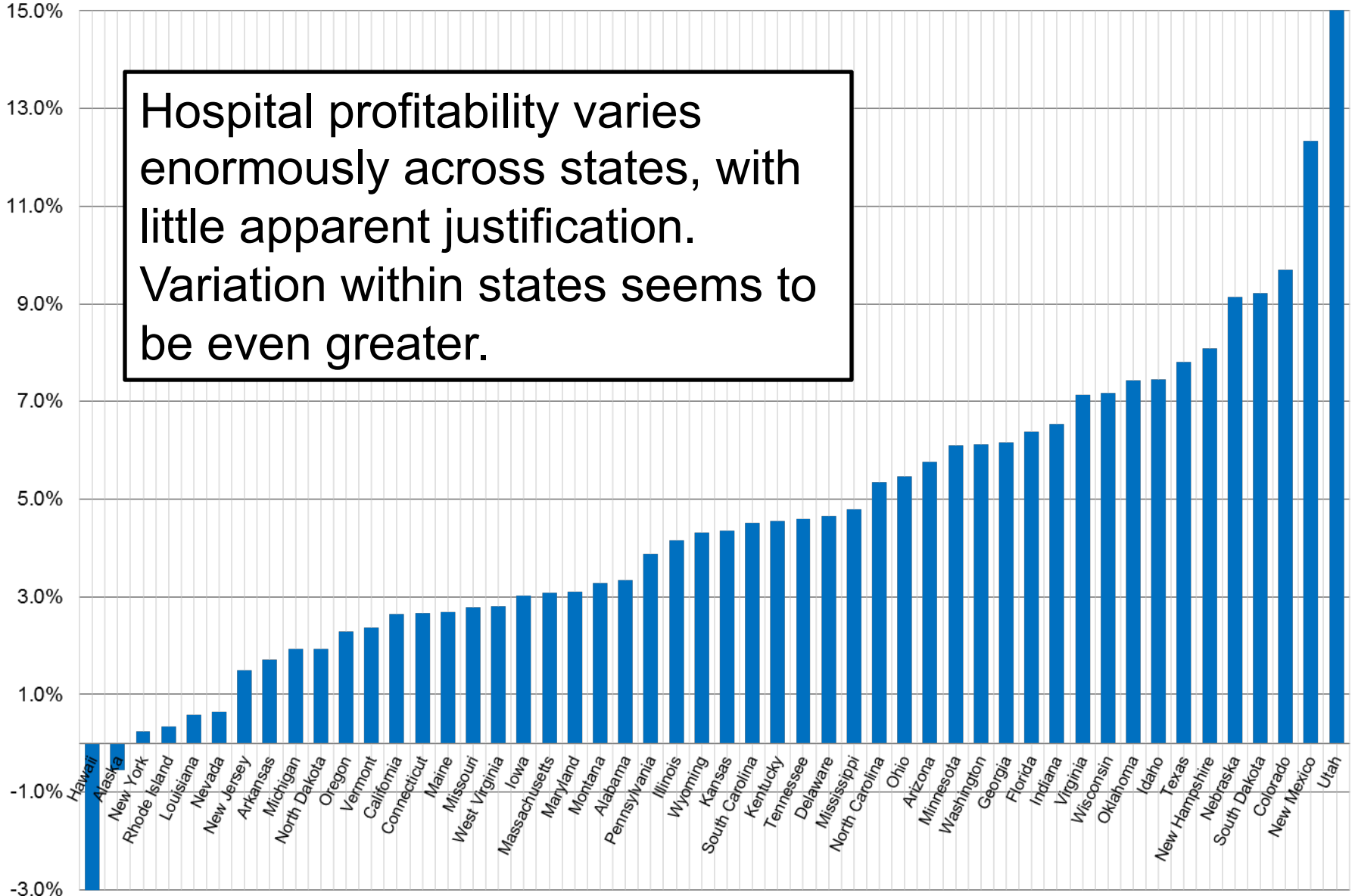
Rich hospitals

- Lots of privately insured pts.
- Located in high-income area
- Treat profitable diagnoses
- Lots of doctors, many salaried
- Efficient? (No evidence)
- Endowment, gifts
- Market power to boost prices
- Reputation? Attract patients
- More political power
- Fair reward by real market? OR self-sanctification – profits without honor?

Poor hospitals

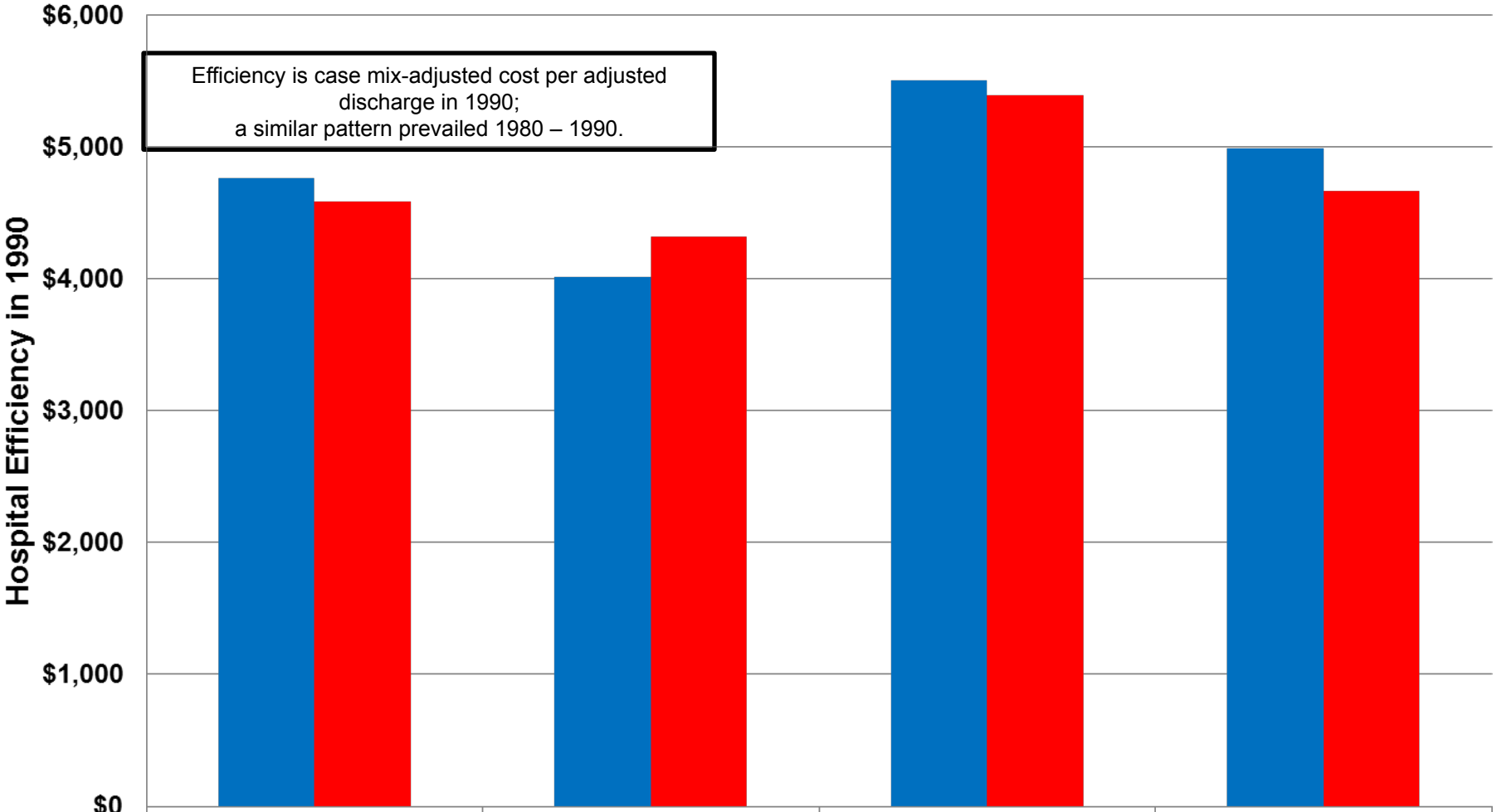
- Lots of Medicaid, uninsured
- Located in Black area
- Many unprofitable diagnoses
- Vanishing private doctors
- Weak management?
- Lack money to renew capital
- More competitors/low prices
- Poor perceived quality
- Usually less power
- Game is rigged?
- Self-blame

Statewide Hospital Operating Margins, 2009



Hospital profitability varies enormously across states, with little apparent justification. Variation within states seems to be even greater.

Hospital Efficiency in 1990 by Medical School Affiliation in 1990 And Survival until 2010



	non-teaching 1990	minor teaching 1990	major teaching 1990	All hospitals 1990
open 2010	$4,766	$4,012	$5,504	$4,986
closed 2010	$4,585	$4,319	$5,387	$4,663

WHAT PREDICTS MAJOR LEAGUE BASEBALL TEAM RELOCATIONS, 1950 – 1970?

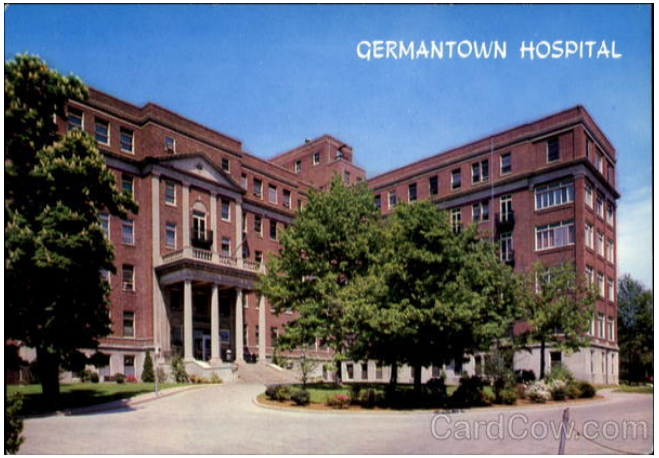
- Not attendance
- Not place in standings
- Not age of stadium

✓ Race of residents living nearby

Closed Brooklyn Hospitals

Shibe Park, Philadelphia

Mt. Sinai



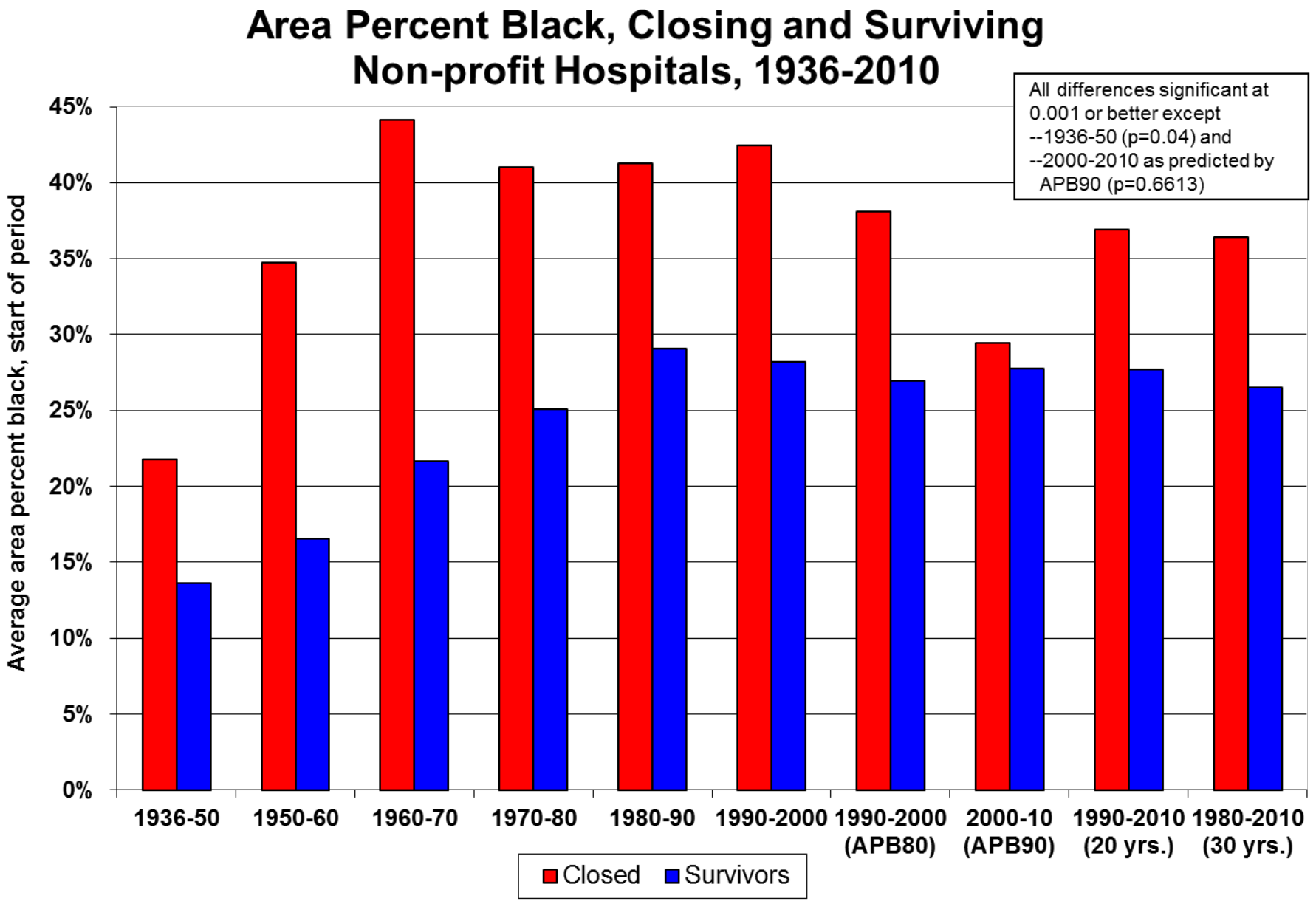
Presbyterian

Hospital of Women's
Medical College

Northeastern

Braves Field, Boston

The wrong team left town. "Survival of the fattest."


Area Percent Black, Closing and Surviving Non-profit Hospitals, 1936-2010
All differences significant at 0.001 or better except --1936-50 (p=0.04) and --2000-2010 as predicted by APB90 (p=0.6613)
Average area percent black, start of period
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
1936-50
1950-60
1960-70
1970-80
1980-90
1990-2000
1990-2000 (APB80)
2000-10 (APB90)
1990-2010 (20 yrs.)
1980-2010 (30 yrs.)
Closed
Survivors

Predicting hospital closings, 1990 - 2010

Predictor, 1990 values	Significance
Beds	0.000
Hospital fund balance / adjusted daily census	0.000
Occupancy rate	0.004
Area percent black	0.008
Hospitals within 1 mile	0.034
Case mix-adjusted cost / discharge (efficiency)	0.637
Operating margin	0.679

Model C-statistic = 0.819

Predicted Chance of Hospital Closing, 1990 – 2010

(Mean hospital – as function of mean 1990 characteristics)

Independent Variable	β Estimate (coefficient)	Values for mean hospital	Prediction for mean hospital
Intercept	-2.190	1.000	-2.190
Beds	0.005	328.7	1.772
Area percent black	-0.010	28.7	-0.298
Occupancy rate	1.948	66.1	1.288
Hospitals in 1 mile	-0.168	1.2	-0.202
Fund balance/adjusted cen	0.004	$134,183	0.573
Case mix-adjusted cost/dis	0.000	$6,462	0.090
Sum			1.033
Exponential value of sum			2.810
Predicted probability of survival			73.8%
Predicted probability of closing mean hospital			**26.2%**

Model C-statistic = 0.819

Predicted Chance of Hospital Closing, 1990 – 2010

(At-risk hospital – predicted by riskiest quartile values of variables in 1990)

Independent Variable	β Estimate (coefficient)	Riskiest quartile 1990 values	Prediction for hospital in riskiest quartile
Intercept	-2.190	1.000	-2.190
Beds	0.005	176.0	0.949
Area percent black	-0.010	45.4	-0.472
Occupancy rate	1.948	57.0	1.111
Hospitals in 1 mile	-0.168	2.0	-0.336
Fund balance/adjusted census	0.004	$33,508	0.143
Case mix-adjusted cost/discharge	0.000	$4,769	0.067
Sum			-0.729
Exponential			0.482
Predicted probability of survival			32.5%
Predicted probability of closing hospital in riskiest quartile			**67.5%**

Model C-statistic = 0.819

Chance of Closing between 1990 and 2010 Rises as Beds Fall and as Area Percent Black Rises

		Beds, 1990				
			Higher quartile	Mean	Lower quartile	
Area Percent Black, 1990		600	433	329	176	100
Lower quartile	5%	6.1%	11.8%	21.9%	38.9%	49.0%
Mean	29%	7.7%	14.6%	26.4%	44.9%	55.1%
Higher quartile	45%	9.0%	16.9%	29.9%	49.2%	59.4%
	75%	11.8%	21.7%	36.7%	56.9%	66.5%
	99%	14.7%	26.2%	42.7%	62.9%	71.8%

Of the 548 non-public hospitals with 50 or more beds that were open in 1990, 193 (35%) closed by 2010. Chance of closing was calculated from mean 1990 values of all variables except Beds and APB.

Predicted Chance of Hospital Closing, 1980–2010
(Mean hospital – as function of mean 1980 characteristics)

Independent Variable	β Estimate (coefficient)	Values for mean hospital	Prediction for mean hospital
Intercept	-3.441	1.000	-3.441
Beds	0.004	324.2	1.452
Area percent black	-0.011	29.7	-0.324
Medical school affiliation	0.329	0.7	0.002
Occupancy rate	2.681	0.8	2.038
Hospitals in 1 mile	-0.190	1.6	0.000
Fund balance/adjusted census	0.010	$56,470	0.544

Sum	0.271
Exponential value of sum	1.311
Predicted probability of survival	56.7%
Predicted probability of closing mean hospital	43.3%

Model C-statistic was 0.824.
Of 608 non-public hospitals with 50 or more beds in 1980, 291 (47.9%) closed by 2010.

C. Why do hospital closings matter?

The health care we get depends heavily on the caregivers we've got.

Access

Cost

Quality

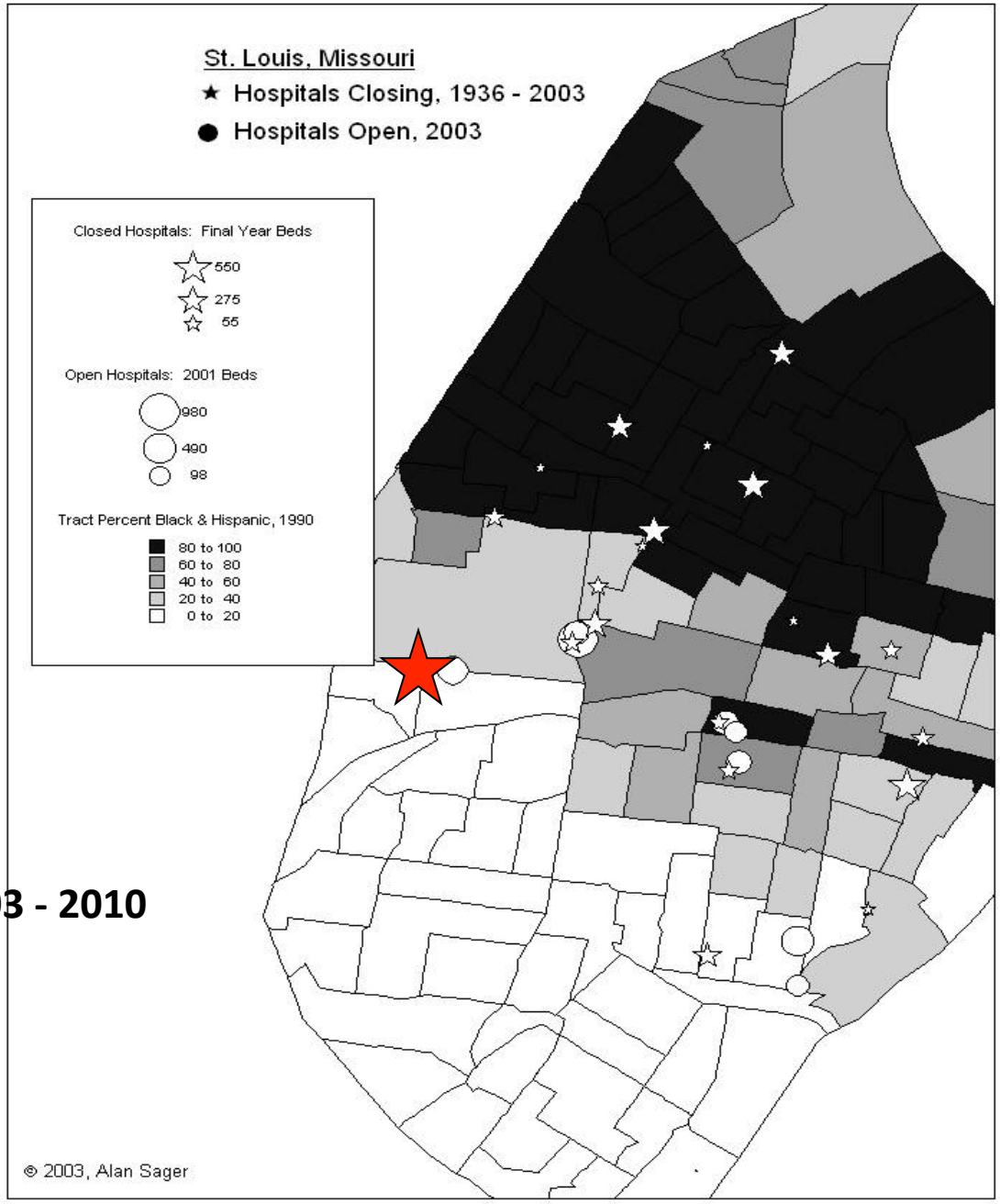
So what?

- Don't patients just vote with their feet, avoiding low-quality or unresponsive hospitals?
- How can a hospital be needed if it's losing $
- Do we really need many hospitals?
  - Won't community health centers substitute?
  - Won't we live forever if we lose a little weight?

- Consider access – cost – quality → →

ACCESS – inpatient

- Cumulative loss of access grows over time, as large expanses of many U.S. cities lose their hospitals→ "medical wastelands"
  - 45% of 774 open in 1970 had closed by 2010
  - 3/5 closed in areas >60% black in 1990
- Risk of putting too many beds in too few baskets: Katrina/NOLA, Sandy/Manhattan
- Consider changes in St. Louis, Detroit, Washington, D.C., Baltimore, or Cleveland
- 30% of inpatient volume displaced by closing is lost initially, and only gradually reappears



Closed 2003 - 2010

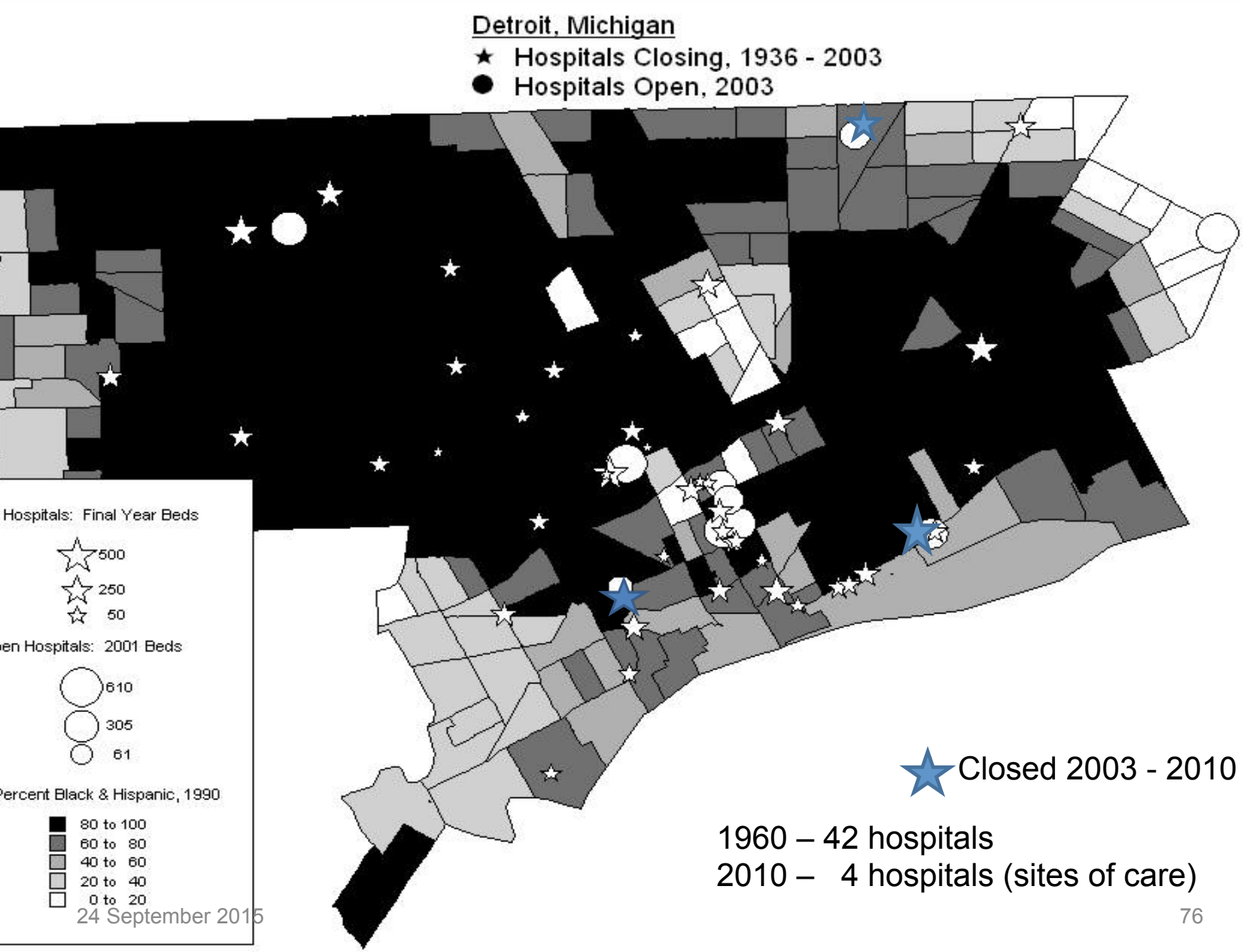
Sportsman's Park, St. Louis

17014 Homer G. Phillips, St. Louis, 1933 - 1980

De Paul

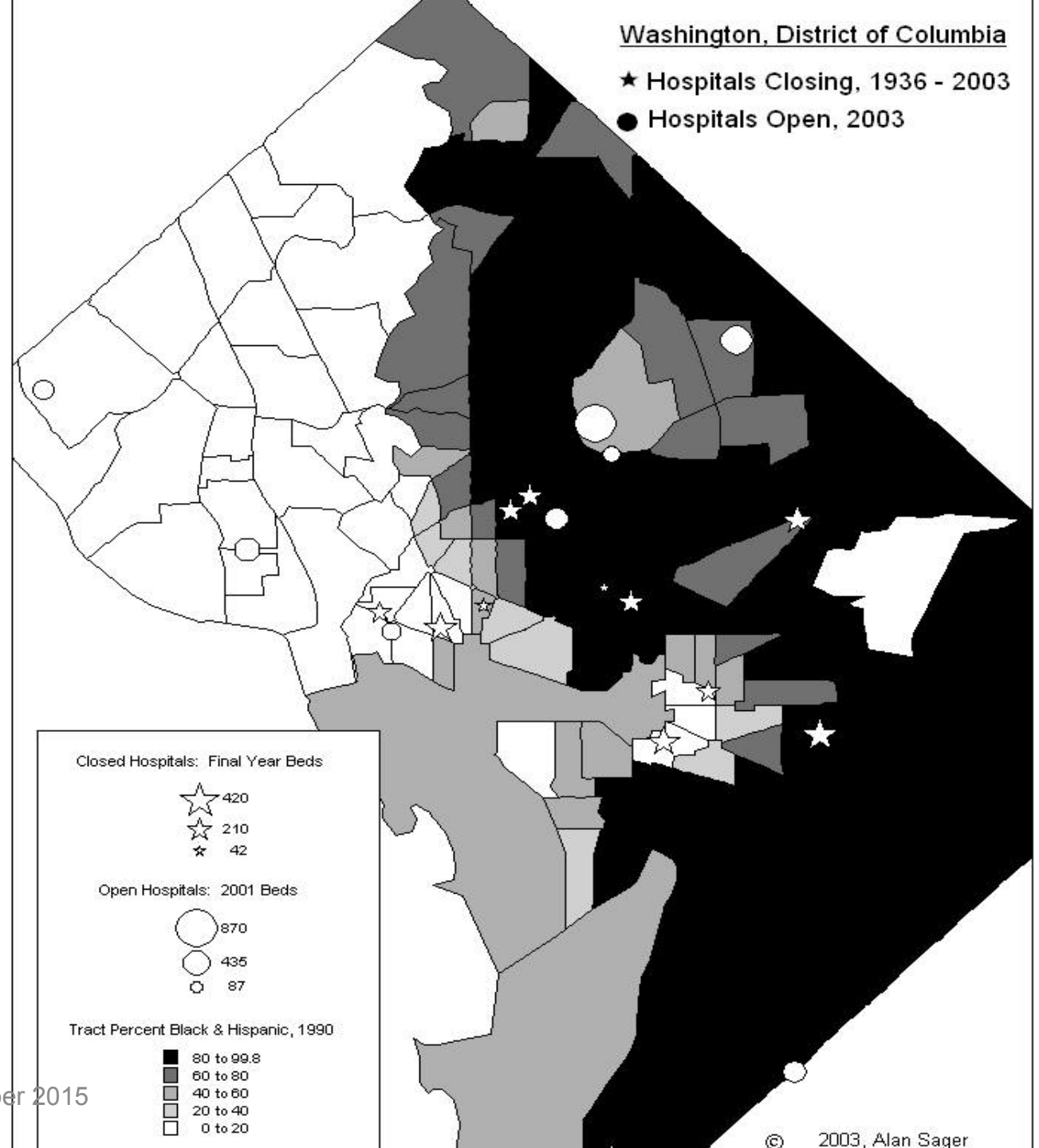
Evangelical Deaconess

Missouri Baptist


Detroit, Michigan
Hospitals Closing, 1936 - 2003
Hospitals Open, 2003
Hospitals: Final Year Beds
500
250
50
en Hospitals: 2001 Beds
610
305
61
Percent Black & Hispanic, 1990
80 to 100
60 to 80
40 to 60
20 to 40
0 to 20
Closed 2003 - 2010
1960 – 42 hospitals
2010 – 4 hospitals (sites of care)

8057 Detroit Riverview, - 2008

8054 Southwest Detroit Hospital, 1974 - 1991


Washington, District of Columbia
★ Hospitals Closing, 1936 - 2003
● Hospitals Open, 2003
Closed Hospitals: Final Year Beds
420
210
42
Open Hospitals: 2001 Beds
870
435
87
Tract Percent Black & Hispanic, 1990
80 to 99.8
60 to 80
40 to 60
20 to 40
0 to 20
© 2003, Alan Sager

Griffith Stadium, Washington, D.C.

Eastern Dispensary

18007 D. C. General, 1846 - 2001

Sibley Hospital (old)

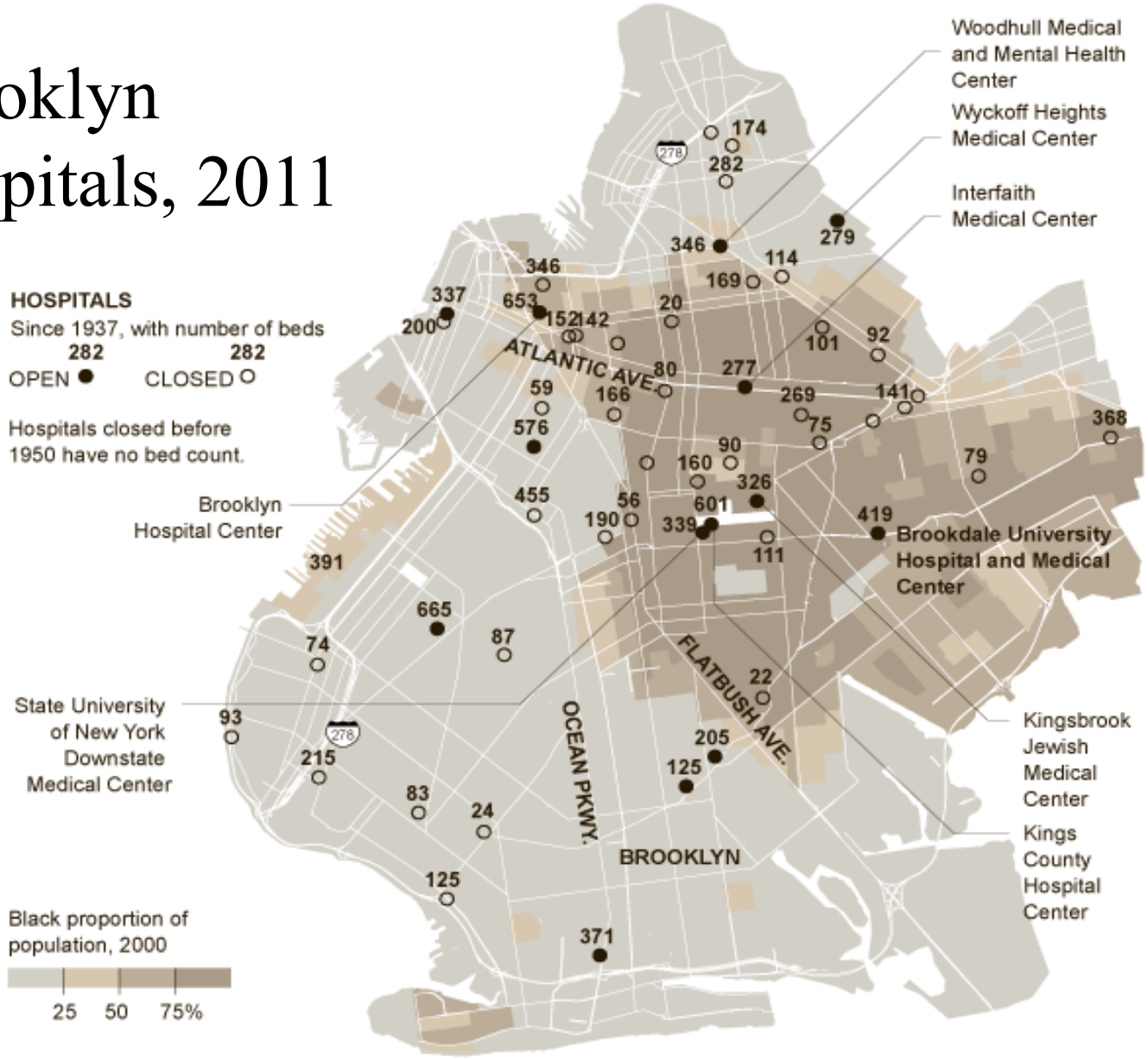
Garfield Memorial Hospital

Brooklyn

"The effort to reduce costs by cutting capacity has often meant closing smaller hospitals. Those hospitals are more likely to be in minority areas. Five hospitals in Brooklyn are now in peril, putting pressure on Kings County, State University of New York Downstate and Woodhull medical centers, the public hospitals."

—Nina Bernstein, "Seeking a Cure for Troubled Hospitals in Brooklyn, *NYT*, 9 Nov. 11

Brooklyn Hospitals, 2011



N.Y. Times, 9 Nov. 2011

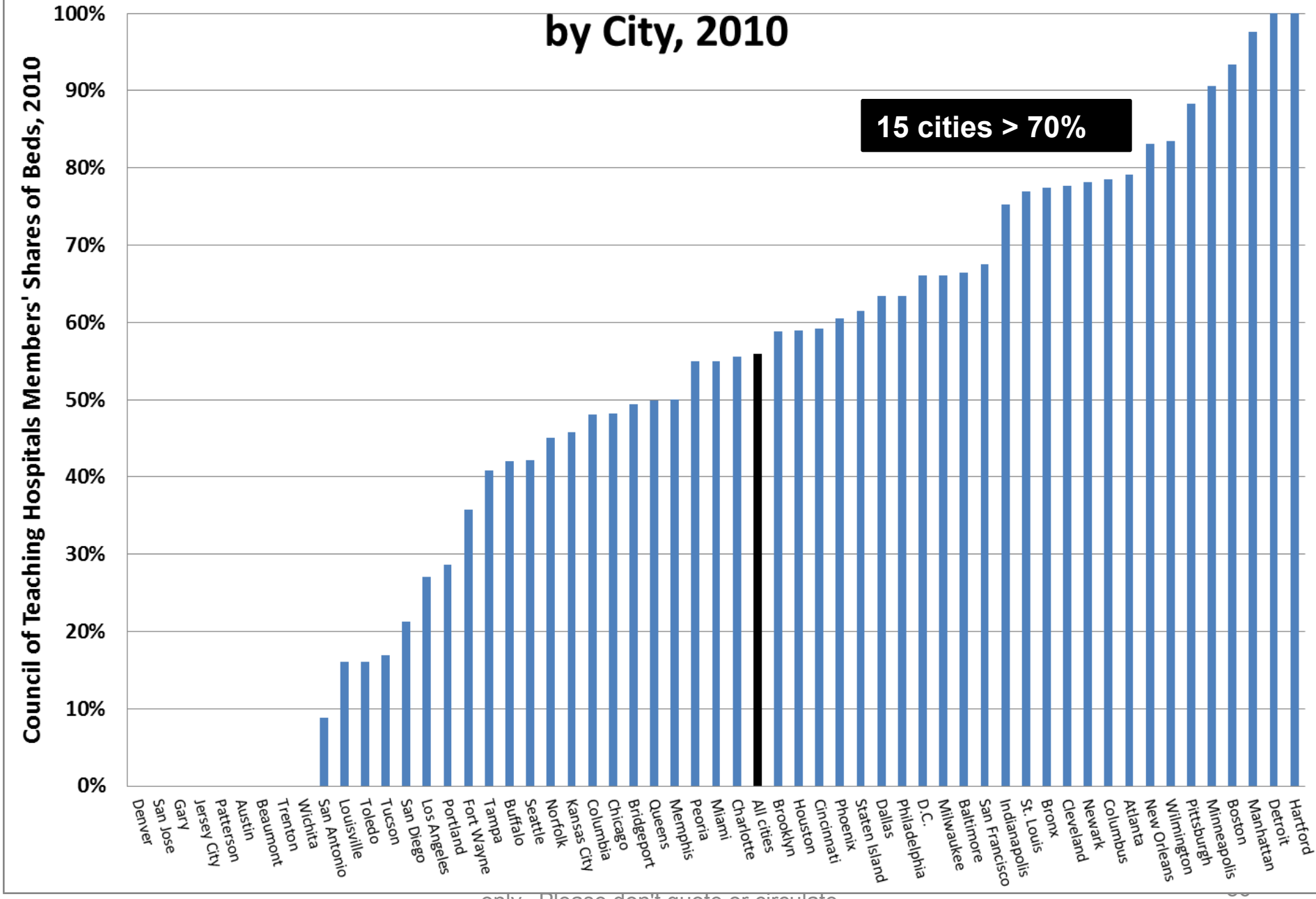
How Much of 1990s' Care Capacity Survived to 2010?

	Closing	Surviving	All	Closing % of All
Beds	43,040	167,227	210,267	20.5%
Admissions, total	1,389,756	6,138,392	7,528,148	18.5%
Admissions, Medicare	407,537	1,676,125	2,083,662	19.6%
Admissions, Medicaid	321,768	1,210,903	1,532,671	21.0%
Outpatient visits, total	14,293,329	62,323,207	76,616,536	18.7%
Emergency visits	3,765,315	14,747,054	18,512,368	20.3%
Non-emergency visits	10,528,014	47,576,153	58,104,168	18.1%

COST

- Fewer hospitals → fewer competitors → less price competition → higher revenue for surviving hospitals → enables them to incur higher costs.
- Slight/moderate tendency, decade after decade, for the more efficient—the less expensive—hospitals to close
- Teaching hospitals' growing share of most cities' hospital beds (great variation x city!)
  - 44% in 1950
  - 77% in 2010
- Major COTH teaching hospitals' share rises from 46% in 1970 to 56% in 2010 (also great variation by city)
- Growing tendency to care for our lower-income urban patients in the world's costliest teaching hospitals
  - Puts added cost pressure on Medicaid

COTH Major Teaching Hospitals' Shares of Beds, by City, 2010



QUALITY

- Were many closed hospitals effectively segregated racially and unequal in quality?
- If so, closing of heavily black non-teaching hospitals and relocation of their patients to large teaching hospitals might → more integrated, mainstream care, boosting quality.
- But
  - Do patients with routine problems get good care in large teaching hospitals that focus on complex problems?
  - And is care at integrated teaching hospitals racially neutral?

D. Stabilizing needed hospitals

CASE FOR INTERVENTION - 1

1. We lack a free market that could to weed out the inefficient hospitals.
2. Even if we had a free market, it could only ratify purchasing power and doctor location—both maldistributed today.
3. Racial link with closings is very troubling.
4. Bed shortages loom in many areas.
   - Average hospital census nationally now about 530,000—could easily rise substantially in coming decades.

CASE FOR INTERVENTION - 2

5. Cost of replacing closed beds has surpassed ~ $1M → $2-3M for LAC-USC!
   - $1-2-3 billion / 1,000 beds

5. Hospital today is usually worth more than promises tomorrow, especially when its survival depends on organizing needed care (DC General, Brooklyn examples).
6. Jobs matter.
7. Burden of proof should shift
   - No hospitals should be allowed to close without proof that they are no longer needed to protect the health of the public.

ACTION STEPS

1. Identify needed hospitals likely to close

- Which hospitals (and ERs) are needed to protect the health of the public, today and tomorrow.
  - ✓ What types of hospitals and where should they be located?
  - ✓ Only one state has such a list.
  - ✓ Which hospitals are required to help attract and retain needed doctors to each locality?
- Identify hospitals that are needed but likely to close in time to intervene
  - ✓ Track financial ratios annually
  - ✓ Use long-term predictive model

ACTION STEPS - 2

2. Raise public awareness of the risk to a needed hospital
   - Trustees and CEOs deny problems until it's too late
   - They often act as if they thought, "If we can't save this hospital, we would be embarrassed if someone else did it."
   - They often believe that hospitals that can't compete in the market deserve to close.
   - They claim that going public would only undermine the hospital prematurely

ACTION STEPS - 3

3. For temporary protection
   - Enact state hospital receivership law, allowing officials or citizens to petition a court to take control of a hospital and stabilize its finances.
   - Or urge governor to declare that closing Hospital X constitutes a "public health emergency," allowing state to seize control of needed hospital and stabilize it.
   - Underpin either legal step with short-term financial relief through state trust fund financed by 0.25 percent of each hospital's revenue, → about $500 million yearly in U.S.
   - Consider mothballing instead of delicensing.

ACTION STEPS - 4

4. To durably protect each needed hospital, establish all-payer rate setting to guarantee enough money to sustain efficient, high-quality operation
   - In a free market, each payer would pay the same price
   - Without a free market, only a public structure can protect each needed hospital, regardless of its teaching status, neighborhood demographics, or endowment

Finally

1. The care we get depends heavily on the caregivers we've got
2. Our hospitals continue to become
   - Bigger, costlier, and more specialized
   - More geographically maldistributed
   - Merged together + owners of doctors' practices
3. Changes not legitimized by free market or intentional government action
4. What can we do to get the right hospitals and doctors in the right places?