

**Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect
the Health of the People**

Testimony on H. 781 and H. 2698

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Disclaimer: As always, we write and speak only for ourselves,
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SUMMARY

We find new evidence on the dangers of excessive hospital closings and bed reductions. With the population's aging, need for hospital beds is likely to outstrip bed availability by early in the next decade, with a great gap by the year 2025. Massachusetts hospital costs are very high, but hospital and bed closings are not effective remedies for these high costs. To minimize the cost of re-building and the dangers of over-crowding and denying care, we urge careful conservation of our state's remaining acute hospital beds.

THE EVIDENCE

- Massachusetts has 77 acute hospitals this year, 39.4 percent fewer than in 1970.
- Conservatively, we project a loss of 12 more hospitals by the year 2005. Recession, a lack of payment increases, or lower hospital use by HMOs would close even more.
- The number of acute care beds in Massachusetts fell from 23,966 in 1970 to about 14,599 beds this year, we estimate— a drop of 39.1 percent.
- We project a continued steady decline to roughly 12,000 beds by the year 2005, and then a leveling out. But continued hospital closings would drop the total even lower.
- Inadequacies in current data collection procedures make it difficult even to learn how many acute hospital beds actually operated or available here in a given year.
- Since 1989, this state has fallen below the national average in acute hospital beds per 1,000 citizens— with just 87.5 percent of the average in 1997.
- Hospital spending per resident here was still 36.5 percent above the U.S. average in 1997. Hospital and bed closings have not eliminated the state's excess costs.
- There is almost no recognition that population aging means rising need for hospital capacity. The rise will not be sudden, when baby boomers hit age 65, but gradual— hospital use by Americans aged 45-64 is nearly double that for ages 15-44.
- Using Massachusetts population projections and national age-specific hospital use rates, we project that the bed supply will soon fall substantially below the need. A conservative measure shows shortfalls of 1,650 beds (12%) by the year 2005 and 4,009 beds (25%) in 2025. Under a more adequate use rate, the shortfall would be 3,063 beds (18%) in 2000 and 9,418 beds in 2025 (44%).
- We hope that these huge shortfalls will not actually materialize. We expect some patients will be denied needed services, some hospitals will become crowded (as has occurred recently), and some hospital capacity will be taken out of mothballs.
- Restoring capacity will be relatively inexpensive if hospitals maintain beds under license and plan for their re-activation. It will be much costlier if it requires extensive rehabilitation to bring delicensed beds up to today's codes— or if closed hospitals or units must be rebuilt, as has been the case with many public schools nationwide.

THE ANALYSIS

- Hospital closings have been over-sold as a way to cut costs. National data show no tendency for higher-cost hospitals to close. Recently, the more efficient hospitals were likelier to close. In a free market, they would be more likely to survive.
- Use of hospital care today is artificially depressed because many prices for hospital care are set well above actual cost. This market failure leaves hospitals under-used for diagnosis, recuperation, and general care. And the average cost of care per day for remaining patients keeps rising, pushing even more patients out of hospitals.
- Hospital closings and mergers are substantially reducing price competition.
- Many public schools that were closed and sold off are now being rebuilt at great cost. To avoid that dynamic in hospital care, beds removed from service should be moth-balled, maintained under license. This would be hard to do if entire hospitals close.
- Excessive hospital closings could bring great harm to patients, including longer trips to emergency rooms, insufficient ER capacity, loss of needed outpatient services, delayed or sub-optimal care, loss of physicians, and insufficient capacity in a major disaster, as well as insufficient beds to serve the state's aging population.
- H. 781 and H. 2698 would require the commissioner of public health to
 - identify which hospitals and services are needed to protect the health of the public
 - identify which hospitals face financial stresses that might force them to close.This legislation also would establish
 - a revolving trust fund to aid needed but endangered hospitals, financed without tax dollars by a one-quarter of one percent assessment on hospital revenue statewide
 - receivership authority to conserve a needed hospital's assets and return it to health.
- Benefits of these steps would include:
 - Hospitals that are vulnerable to closing will have greater chances of surviving.
 - They will be less likely to be forced to sell to for-profit corporations— deals which do not improve efficiency, but do drain substantial revenues away from care.
 - Less likely to merge with larger institutions, hospitals will remain under local control.
 - State government will engage and grapple with the important questions bearing on hospital survival—and with possible answers—to be prepared when a crisis arises.
- We urge that closed beds be maintained under license, in good condition, and that plans for activating them when needed be prepared, tested, and kept up-to-date.
- We also urge a) obliging hospitals to price services in fair proportion to cost, and b) identifying ways to finance the right number of beds in the right hospitals and places.

Hospitals today appeal for more money. That is not a sustainable remedy for the long haul. Massachusetts must seek ways to cover all residents and protect high-quality care without increasing health spending faster than growth in the economy. Protecting and preserving needed hospitals and beds will save money while safeguarding access to care.

INTRODUCTION

Hospital costs in Massachusetts are very high,¹ but closing hospitals or cutting beds are not effective remedies for these high costs.²

In this testimony, we present new evidence on the dangers of excessive hospital closings and bed reductions. We compare the trend in Massachusetts bed availability with the trend in need for care. Need for care will increase steadily in the years to come owing to the predictable aging of our state's population. As a result, we find that need for hospital beds is likely to outstrip availability by substantial amounts early in the next decade. The problem will worsen substantially by the year 2025.

We therefore support this legislation, which calls for steps to identify which hospitals and beds are needed to protect the health of the public, and to stabilize needed hospitals.

We recognize that the steps called for in this legislation are only a beginning. But they are a useful beginning. They deliberately put the Commonwealth back to work on behalf of people who need hospital care. They recognize that the free market is failing in hospital care, and that market forces are therefore not adequate to identify and preserve the hospitals and the bed capacity that our patients will increasingly require in the years to come.

In recent years, many hospitals have closed in Massachusetts. Today, we hear appeals from hospitals for more money—more money from Medicare, and more money from HMOs. That may be a necessary stop-gap to protect vital programs, services, and institutions.

It cannot be an effective remedy for the long haul. Massachusetts already has the world's most expensive health care.³ While more money for business as usual is the first choice of hospitals, doctors, and drug companies everywhere, it is not sustainable. Massachusetts must seek ways to cover all residents and protect high-quality care without increasing health spending faster than growth in the overall state economy.

THE EVIDENCE

1. How many acute care hospitals operate in Massachusetts?

As shown in Table 1 and in the first chart, the number of acute care hospitals in Massachusetts has dropped from 127 in 1970 to 77 this year. That is a drop of 39.4 percent since 1970.

The maps that follow the first chart display the change in the number of acute care hospitals in the Commonwealth between 1970 and 1999. Some of the most recent closings are not yet reflected in these maps.

Conservatively, we project a drop of 12 more hospitals by the year 2005.⁴ That would be a loss of 15.6 percent of today's hospitals, and an overall decline equal to 48.8 percent of the hospitals open in 1970.⁵

If a substantial recession hits in that time, or if Medicare or HMO and insuror payments to hospitals do not rise, the decline could be even greater. And, as we have shown elsewhere, if Massachusetts hospitals or physicians or HMOs adopt use rates that are enforced in the California HMOs deemed by some to employ "best practice," the number of Massachusetts hospitals would plummet even lower.⁶

Table 1

Massachusetts Hospitals, 1970 – 1999, with Projections to 2005

Year	Number of Hospitals	% Change in Hospitals	Cumulative % Change in Hospital
1970	127		
1980	110	-13.4%	-13.4%
1990	97	-11.8%	-23.6%
1995	90	-7.2%	-29.1%
1997	83	-7.8%	-34.6%
1999	77	-7.2%	-39.4%
2000	75	-2.6%	-40.9%
2002	70	-9.1%	-44.9%
2005	65	-13.3%	-48.8%

2. How many acute hospital beds are operated in Massachusetts?

As shown in Table 2 and in the second chart, the number of acute care beds in Massachusetts has also dropped sharply. In 1970, Massachusetts acute care hospitals had 23,966 beds. This has fallen to about 14,599 beds this year, we estimate. This means that fully 39.1 percent of 1970 beds are estimated to have been closed by 1999. We project a continued steady erosion in beds, dropping to roughly 12,000 by the year 2005. The analyses presented here assume the state's bed supply then levels out at about 12,000—but continued hospital closings would drop it even lower.

Table 2

Massachusetts Acute Hospital Beds, 1970 – 1997, with Estimates and Projections to 2005

Year	Number of Beds	% Change in Beds	Cumulative % Change in Beds
1970	23,966		
1980	24,327	1.5%	1.5%
1990	21,008	-13.6%	-12.3%
1995	18,293	-12.9%	-23.7%
1997	15,673	-14.3%	-34.6%
1999	14,599	-6.9%	-39.1%
2000	14,000	-4.1%	-41.6%
2002	13,000	-11.0%	-45.8%
2005	12,000	-14.3%	-49.9%

A major question here concerns what constitutes a bed.

- The American Hospital Association (AHA) data on which we have relied in the past were designed to report beds actually set up and staffed, usually a number lower than a hospital's licensed beds. We believe, however, that many hospitals report licensed beds, making the resulting number a mixed bag of set up and staffed beds and licensed beds.
- The Commonwealth of Massachusetts asks hospitals each year to report their licensed beds at year's beginning and end, and also their weighted average operating beds.⁷ (The latter figure should resemble the AHA's beds set up and staffed measure. But there is some disagreement between the two, apparently because somewhat different types of beds are included in each, and possibly because neither is reported systematically.)

As a result, it is difficult to learn how many acute hospital beds were actually set up and staffed or actually operating in the Commonwealth in a given year, even after the fact. There are even some questions about how many beds were actually licensed in a given year.

Perhaps even more important is the uncertainty about the actual bed supply at any one time. Apparently, no private or public entity in the Commonwealth maintains—or is responsible for maintaining—accurate current records on the number of beds that are available in the Commonwealth. The available information is usually out-of-date and often, despite the best and most conscientious efforts, of somewhat doubtful accuracy.

We suggest that it would be helpful to divide licensed acute care hospital beds into several categories: those actually set up and staffed on a given day; those that can be set up and staffed very quickly (within 24 hours) in event of an emergency; those that can be set up and staffed within one week; and those reserve beds that could be set up and staffed within one to two months. It would also be useful for hospitals to identify delicensed bed capacity that could be returned to use in an emergency. Hospitals should be asked to report these figures every six months.

3. How does the Massachusetts ratio of acute hospital beds per 1,000 citizens compare with national levels?

As shown in Table 3 and in the third chart, the ratio of hospital beds per 1,000 people in Massachusetts had been somewhat above the national average until about 1989. Since then, it has dipped well below the national average.

Massachusetts had 106.2 percent as many hospital beds per 1,000 residents as the national average as recently as 1985. But by 1997, we had fallen to only 87.5 percent of the national average.

Table 3

Hospital Beds per 1,000 People, U.S.A. and Massachusetts

<u>year</u>	<u>USA/1000</u>	<u>Mass./1000</u>	<u>Mass. % of USA</u>
1960	3.6	4.2	116.7%
1965	3.8	4.3	110.7%
1970	4.1	4.6	112.3%
1975	4.3	4.6	106.6%
1980	4.3	4.5	103.8%
1981	4.3	4.5	103.3%
1982	4.3	4.5	103.9%
1983	4.3	4.5	104.2%
1984	4.3	4.5	105.0%
1985	4.2	4.4	106.2%
1986	4.0	4.2	104.6%
1987	3.9	4.0	102.4%
1988	3.8	3.9	101.5%
1989	3.7	3.7	98.8%
1990	3.7	3.6	98.6%
1991	3.6	3.6	99.2%
1992	3.6	3.6	101.1%
1993	3.5	3.5	99.5%
1994	3.4	3.3	96.1%
1995	3.3	3.1	94.5%
1996	3.3	3.0	90.9%
1997	3.2	2.8	87.5%

4. How do Massachusetts hospital costs per person differ from the national average?

In 1997, Massachusetts hospital spending per resident was 36.5 percent above the national average. Indeed, Massachusetts hospital costs have historically been at least 30 percent above the national average. What is remarkable is how high these costs have stayed, relative to the national average, even though our ratio of beds per 1,000 people (see Table 3) fell to only 87.5 percent of the national average in 1997. Clearly, closing hospitals and closing beds has not sufficed to bring hospital costs much closer to the national average.

Table 4

Hospital Costs per Person, U.S.A. and Massachusetts, 1960 – 1997

<u>year</u>	<u>USA \$/person</u>	<u>Mass. \$./person</u>	<u>Mass. % of USA</u>
1960	\$ 31.32	\$ 46.19	147.0%
1965	\$ 47.43	\$ 66.79	140.8%
1970	\$ 93.71	\$ 142.32	151.9%
1975	\$ 177.76	\$ 270.91	152.4%
1980	\$ 335.16	\$ 479.30	143.0%
1981	\$ 390.85	\$ 551.14	141.0%
1982	\$ 448.03	\$ 623.41	139.1%
1983	\$ 492.66	\$ 679.15	137.9%
1984	\$ 517.08	\$ 714.84	138.2%
1985	\$ 542.10	\$ 760.10	140.2%
1986	\$ 578.74	\$ 779.67	134.7%
1987	\$ 621.96	\$ 833.12	134.0%
1988	\$ 681.28	\$ 942.17	138.3%
1989	\$ 739.35	\$ 1,022.20	138.3%
1990	\$ 806.02	\$ 1,082.44	134.3%
1991	\$ 880.80	\$ 1,207.89	137.1%
1992	\$ 960.20	\$ 1,301.82	135.6%
1993	\$1,018.57	\$ 1,408.37	138.3%
1994	\$1,044.98	\$ 1,430.08	136.9%
1995	\$1,071.70	\$ 1,448.28	135.1%
1996	\$1,107.80	\$ 1,449.20	130.8%
1997	\$1,142.50	\$ 1,559.30	136.5%

5. What is the Projected Need for Hospital Beds?

In recent years, there has been much talk of the aging of the population, and of the resulting rise in Medicare costs and need for long-term care. But there has been almost no attention to the rising need for hospital capacity.

This rise will not occur suddenly on the day in 2011 that the first baby boomers hit age 65. Rather, it will take place gradually as more of the baby boomers pass ages 50, 55, 60, and 65—the ages at which rates of use of the hospital increase more rapidly year-by-year. For example, hospital use by Americans aged 45 to 64 is nearly double that for people aged 15 to 44. And baby boomers have certainly begun to age past 45. Further, use rates multiply by an additional 2.5 times among people aged 65 to 74.⁸

This is how we projected the need for hospital beds in the state through the year 2025:

- We employed the most current projections for the Massachusetts population, by age, through 2025.
- We applied the national 1993 and 1996 age-specific rates of hospital use to that projected population.⁹
- We assumed a statewide occupancy rate of 80 percent, well above the actual 1997 rate of 67.3 percent.¹⁰

Table 5

Projected Actual Beds versus Projected Needed Beds, 1995 - 2025

year	projected	needed beds		surplus beds (shortfall)		Shortfall as % of need	
	actual beds	1993 use rate	1996 use rate	1993 use rate	1996 use rate	1993 rate	1996 rate
1995	18,293	21,142	17,990	(2,849)	303	13%	-
2000	14,000	17,063	13,255	(3,063)	745	18%	-
2005	12,000	17,563	13,650	(5,563)	(1,650)	32%	12%
2010	12,000	18,178	14,051	(6,178)	(2,051)	34%	15%
2015	12,000	19,009	14,543	(7,009)	(2,543)	37%	17%
2020	12,000	20,012	15,207	(8,012)	(3,207)	40%	21%
2025	12,000	21,418	16,009	(9,418)	(4,009)	44%	25%

The results raise a number of concerns. As displayed in Table 5 and in the chart on the following page, after about the year 2000, the number of projected beds in Massachusetts falls substantially below the projected need for beds even by the conservative measure of the national 1996 bed use rate.

For example, according to the conservative 1996 rate of use of hospital beds, the Commonwealth will experience a surplus of only 745 beds in the year 2000, and

shortfalls of fully 1,650 beds in 2005, 2,543 beds in 2015, and 4,009 beds in the year 2025.

And employing the more adequate use rate that prevailed in 1993, the shortfalls would be 3,063 beds in the year 2000, 5,563 beds in 2005, 7,009 beds in 2015, and 9,418 beds in 2025.

We hope that these huge shortfalls will not actually materialize.

We expect at least three responses to the aging of the Massachusetts population and the resulting need for more hospital beds. Two of these could mean substantial harm to patients. The third will result in higher costs.

- **First**, some patients who could use hospital care will be denied needed services. A form of bed rationing will prevail. Patients denied care owing to lack of beds will suffer.
- **Second**, some hospitals will become crowded at certain times of the year, especially in the winter. Over the past three winters, clear instances of crowding were reported in the press, as hospitals in Massachusetts reported that they were over capacity.¹¹ Some observers have complained that high costs result from maintaining standby hospital capacity to deal with times of high need.¹² But once beds are built, no further fixed costs are associated with them. The only costs would be that to prepare beds for use and to staff them. These are legitimate variable costs that should be shouldered to provided necessary care.

The possibility of running out of hospital capacity is not mere conjecture. As a worse-than-usual flu season hit several states in December 1997 and early 1998, serious shortages have arisen where hospital capacity—numbers of hospitals, emergency rooms, and beds, as well as staffing—had been cut sharply in recent years. In much of California, central Florida, and elsewhere, hospitals struggled to care for the flood of patients and sometimes resorted to risky stop-gap measures. Among the problems:

- Hospitals in several parts of California, the *Sacramento Bee* reported, obtained the state's permission "to put patients in places other than licensed beds – doctors' offices, hallways, outpatient areas...."¹³
- Los Angeles area hospitals were overflowing. With patients facing long emergency room waits to get beds, hospitals implemented disaster plans.¹⁴ Some began limiting elective outpatient care or using waiting rooms as treatment areas.¹⁵
- One northern California hospital "set up a tent in its parking lot adjacent to the emergency room," which it has "used at least once...for families and visitors, as well as to house equipment," reported the California Nurses Association (CNA).¹⁶
- With nine of Sacramento County's ten hospitals announcing they were at capacity, a state of emergency was declared. Ambulances for two weeks

had to take patients where beds were open, rather than simply using the nearest hospital.¹⁷

- In Nashville, Tennessee, in early January, all hospitals but one were also diverting ambulances from their emergency rooms.¹⁸
- In Florida, hospitals in several counties recently were at or above capacity, with some emergency patients being diverted as far as 30 miles away.¹⁹

The flu upswing was the straw that broke the camel's back in settings where even before it, patients had at times, for example, waited 24 hours in emergency rooms for critical care beds to open.²⁰ As a California hospital industry official acknowledged to the American Hospital Association, "There's no fat in the system to deal with [influenza patients] when this occurs."²¹ The California Nurses Association, which had long warned that cutbacks had reached unsafe levels, called on California's governor to put a moratorium on acute hospital closures and downsizing, and to order the reopening of recently closed facilities.²²

- **Third**, some hospital capacity will be taken out of mothballs. This will be relatively inexpensive if hospitals maintain beds under license and if hospitals plan methods of preparing needed beds for use.²³ It will be much more expensive to increase bed capacity if extensive rehabilitation must be performed to bring previously delicensed beds up to today's codes. It will be even more costly still if closed hospitals or closed units must be rebuilt—as has been the case with many public schools throughout the nation.

THE ANALYSIS

To minimize the cost of pursuing the third response—and the dangers of the first two responses—we urge careful conservation of the remaining acute hospital beds in Massachusetts. Similarly, we also urge that closed beds be maintained under license and in good condition, and that plans for bringing them back into use when needed be prepared, tested, and kept up-to-date.

We strongly suggest that the policy of hospital closings has been unreasonably over-sold as a method of cost containment. We offer several pieces of evidence for this:

First, our studies of hospital closings in 52 cities nationally going back to the mid-1930s have shown that there has never been a tendency for the higher-cost hospitals to close. Indeed, for the decades of the 1980s and 1990s, when more accurate data on hospital efficiency have been available, ***the more efficient hospitals have been more likely to close***. That is, the hospitals that closed had lower costs—measured by average cost per discharge, controlling for case mix—than the hospitals that remained open. The larger hospitals and those with more money in their financial reserves have been more likely to remain open. This is clearly not a case of a free market survival of the fittest; it may well be a case of survival of the fattest.

Second, this evidence reinforces the finding from Massachusetts reported in tables 3 and 4 of this report, that high costs persist in our state even though our beds-to-population ratio has fallen well below the national average.

Third, ***use of hospital care in Massachusetts has been artificially depressed*** by the methods hospitals employ to set prices and by the pricing negotiated between hospitals and many payors. In many instances, hospital prices have been set artificially at levels well above actual cost. (The reasons for doing this include convenience, custom, and payors' preferences.) Payors and clinicians who make care decisions with an eye to price will ignore actual cost because it is not relevant as far as they are concerned. The result is that hospital beds are under-used for purposes of diagnosis, recuperation, and general care. The less expensive patients and patient-days of care are removed from the hospital. Average cost of care per day for the remaining patients rises. Price increases to cover these costs. The result is that still more patients are removed from the hospital. And price rises still higher. Wood and others argue that price and cost must be aligned if prices are to send sensible signals about what care to use in what site.²⁴

But when patients are removed from the hospital, where do they go? What care do they receive? In some instances, they are served in different settings, such as sub-acute facilities, home care, or even observation beds in the hospital. Real costs are re-packaged but they are not reduced.²⁵

The frequent failure of hospitals' prices to match cost is not an esoteric matter of accounting. It is one of several causes of widespread market failure in hospital care. Free markets function well only when prices correspond to costs. This failure prevents markets from functioning well.

Fourth, the many closings and mergers of many hospitals are resulting in substantial reductions in competition among the surviving hospitals. By state policy, price competition is supposed to be the driving force in holding down hospital costs.²⁶ Without competitors, there is no competition. The amount of price competition among hospitals has dropped substantially in many parts of the state—such as Fall River/New Bedford/Wareham, Cape Cod, and large areas of Worcester and Essex counties and greater Boston.

Fifth, we point to the recent struggles experienced by cities and towns throughout the Commonwealth—and indeed throughout the nation—in securing an adequate number of public school classrooms. During the 1970s and 1980s, many public schools were sold off or redeveloped as senior centers, condominiums, and the like. School boards seemed to assume that lower birth rates would prevail indefinitely, just as some health care experts seem to assume today that need for hospital care will drop indefinitely. During the 1990s, many school systems have scrambled to replace the lost capacity by buying portable classrooms, and by acquiring land and building schools to replace those that had been lost.

To prevent this costly dynamic from repeating itself in hospital care, beds removed from service should be mothballed and maintained under license. This is most difficult when entire hospitals are closed, and raises another serious question about any bed reduction strategy that relies heavily on closing entire hospitals.

Sixth, we worry about the consequences of excessive hospital closings for patients. It may be safe to close some hospitals and some beds. But after a time, patients suffer harm. This harm can take many forms:

- longer and therefore more dangerous trips to the emergency room
- lack of adequate capacity in the surviving emergency rooms
- loss of needed hospital outpatient department services
- lack of adequate numbers of inpatient beds, resulting in sub-optimal care or in delays in providing care
- loss of physicians from some communities, as they have relocated to be nearer to the surviving hospitals
- lack of an adequate reserve capacity of hospitals and beds to protect patients in the event of a major disaster like a hurricane or an earthquake
- lack of enough beds to serve the predictable growth in need caused by an aging population

What would these bills accomplish?

H. 781 and H. 2698 have several main provisions:

First, they would require the commissioner of public health to draw up a list of which hospitals and beds and emergency rooms are needed to protect the health of the public. For example: How many beds are required and where should they be located? What emergency room capacity is needed, and what travel times to the ER are considered acceptable?

This would involve several important steps. To begin, it would be necessary to identify all hospitals in the state and accurately inventory their licensed bed capacity, the beds they actually have set up and staffed, and the physical condition of any beds that are licensed and mothballed. A related step would be to identify any reserve capacity—beds that have been officially delicensed but that might be available in an emergency.

Second, they would require the commissioner of public health to identify which hospitals face the risk of financial stress that might force them to close.

Third, if any hospital appeared on both lists, it would qualify for special aid from a revolving trust fund financed by a one-quarter of one percent assessment on hospital revenue statewide. All hospitals would pay into the trust fund and hospitals in need would be aided from that revenue. The aid could include technical assistance to improve hospital management. It could provide cash grants to help a small, stressed, but needed hospital remain open. No state tax dollars would be used.

Fourth, the legislation provides for certain responsible parties, such as the commissioner of public health or the attorney-general, to petition a court to appoint a receiver to conserve the assets of a hospital that is needed to protect the health of the public—with the aim of restoring the hospital to full financial health.

Several good things will result if these steps are taken:

1. Hospitals that are vulnerable to closing will have greater chances of surviving.
2. They will be less likely to be forced to sell themselves to for-profit hospital corporations. Such sales do not improve efficiency.²⁷ They do drain substantial revenues away from hospital care and toward stockholders.
3. Hospitals will be less likely to be forced to merge with larger institutions—to put on gang colors as the price of remaining open.
4. Instead, hospitals will remain under local community control and local management, as long as they are run efficiently.
5. State government will be forced to engage itself with hospital care and health care. Since we cannot trust the automatic pilot of a free market, this is a good thing. The various departments of state government concerned with these matters will become steadily more familiar with the important questions bearing on hospital survival—and

with the different possible answers to those questions. If this is done, state government will be prepared when a crisis arises. Today, too many people argue that only a profound crisis will propel the reforms that U.S. health care vitally needs.²⁸ That is at once profoundly pessimistic and unrealistic. It is pessimistic because it unfairly underestimates our abilities to anticipate problems and plan to confront them in advance. More important, it is wishful thinking. In reality, if a health care crisis hits, it will be too late to prepare. That time is now.

Still, the provisions of this legislation are not, by themselves, adequate to protect and preserve all the hospitals that are needed in Massachusetts.

We urge several additional legislative steps:

1. By legislation, hospitals should be obliged to price all services in fair proportion to cost. No service would cross-subsidize any other. This would much more closely approximate what would prevail in a free market. It would greatly promote efficiency of use of hospital services.
2. Preparation for more effective actions to identify and stabilize all needed hospitals. This will require detailed study and planning. A responsible arm of state government should be charged with building on the assessments proposed here and inventorying the evidence on the number of hospital beds available each year, on the need for hospital care now and in the future, and on methods of financing the right numbers of beds in the right hospitals in the right locations.

NOTES

¹ Alan Sager, Deborah Socolar, and Peter Hiam, *The World's Most Expensive Hospital s: One-fifth of Massachusetts Hospital Costs Appear Unjustified*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 1 February 1991.

² Alan Sager, Deborah Socolar, and Jasprit Deol, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution-- Early Findings from the Massachusetts Hospital Reconfiguration Study*, 2nd edition, 2 June 1997.

³ Solutions for Progress and Access and Affordability Monitoring Project, *Estimates of Health Care Costs in Massachusetts*, prepared at the request of the Senate Committee on Ways and Means, forthcoming June 1999.

⁴ American Hospital Association, *Hospital Statistics*, various years; conversations with individuals at various hospitals; and Massachusetts Division of Health Care Finance and Policy, data from Hospital Cost Reports (form 403, schedule III).

⁵ In these calculations, we count merged hospitals as separate institutions as long as they are located at least one-half mile apart. Thus, Massachusetts General and Brigham and Women's hospitals are considered separate hospitals, while Boston City Hospital and University Hospital are considered one hospital, Boston Medical Center.

⁶ Alan Sager, Deborah Socolar, and Jasprit Deol, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution-- Early Findings from the Massachusetts Hospital Reconfiguration Study*, 2nd edition, 2 June 1997.

⁷ These are reported annually on hospital form 403, Schedule C.

⁸ Alan Sager, Deborah Socolar, and Jasprit Deol, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution-- Early Findings from the Massachusetts Hospital Reconfiguration Study*, 2nd edition, 2 June 1997, p. 43.

⁹ National Center for Health Statistics, Center for Disease Control and Prevention, U.S. Department of Health and Human Services, *National Hospital Discharge Survey: Annual Summary, 1993*, Vital and Health Statistics Series 13, No. 121, August 1995, Table 1; National Center for Health Statistics, Center for Disease Control and Prevention, U.S. Department of Health and Human Services, *National Hospital Discharge Survey: Annual Summary, 1996*, Vital and Health Statistics Series 13, No. 140, January 1999, Table 1. See also http://www.census.gov/population/www/projections/st_yrby5.html.

¹⁰ Calculated from American Hospital Association, *1999 Hospital Statistics*, Chicago: The Association, 1999, table 6.

¹¹ "It was tough to find an empty hospital bed in the Boston area and elsewhere in the state yesterday...." Larry Tye, "For flu and pneumonia, it's been no mild winter," *Boston*

Globe, 11 February 1999. See also Sharon Lynch, "Hospital faces bankruptcy, possible closing," Associated Press, 4 February 1999; and Margaret O'Malley, "Demand Responsible Health Planning," *Gloucester Daily Times*, 26 February 1998. For additional evidence from California, see Kathy Robertson, "After Making Deep Cuts, Hospitals Now Short of Beds and Staff," *Sacramento Business Journal*, 19 January 1998.

¹² See Carol Gentry, "Hospital Closing Prompt Alert: Stop the Bleeding," *Wall Street Journal*, 11 February 1998.

¹³ Dorsey Griffith, "Hospital crisis diagnosis: Cutbacks, shortage of nurses," *Sacramento Bee*, 17 January 1998.

¹⁴ See, for example, David Colker, "Valley Hospitals Packed Due to Rash of Illnesses," *Los Angeles Times*, Valley Edition, 31 December 1997; Lisa Fernandez, "Hospitals Catch the Flu Fever,"; David Haldane, "Annual Flu Outbreak Jams County ER Services," *Los Angeles Times*, Orange County Edition, 3 January 1998; Susan Abram and Julie Marquis, "Flu Season Floods Southland Hospitals With Patients," *Los Angeles Times*, Home Edition, 4 January 1998.

¹⁵ Jon Asplund and Susannah Zak Figura, "Hospitals coordinate services as flu patients crowd ERs," *AHA News*, 26 January 1998.

¹⁶ California Nurses Association, "RNs Urge Declaration of Emergency on Critical Care Crisis," press release, 8 January 1998.

¹⁷ See, for example, Dorsey Griffith, "Hospital crisis diagnosis: Cutbacks, shortage of nurses," *Sacramento Bee*, 17 January 1998.

¹⁸ Jon Asplund and Susannah Zak Figura, "Hospitals coordinate services as flu patients crowd ERs," *AHA News*, 26 January 1998.

¹⁹ Associated Press, "Central Florida hospitals seeing patient increase," *Miami Herald*, 20 January 1998.

²⁰ Ilana Debaré, "Hospital Group Decries Nurses' Strike Plan," *San Francisco Chronicle*, 22 January 1998.

²¹ Dorel Harms, vice president, California Healthcare Association, as cited in Jon Asplund and Susannah Zak Figura, "Hospitals coordinate services as flu patients crowd ERs," *AHA News*, 26 January 1998.

²² California Nurses Association, "RNs Urge Declaration of Emergency on Critical Care Crisis," press release, 8 January 1998.

²³ Some delicensing is required by Massachusetts statute if occupancy rates fall below specified levels. Since no incremental costs are associated with empty beds, it might be useful to amend the relevant statute.

²⁴ Charles T. Wood, "Relate Hospital Charges to Use of Services," *Harvard Business Review*, Vol. 60, No. 2 (March – April 1982), pp. 123-130 (reprint no. 82211). See also

Kong-Kyun Ro, "Incremental Pricing Would Increase Efficiency in Hospitals," *Inquiry*, Vol. 6, No. 1 (March 1969).

²⁵ Uwe Reinhardt, "Spending More through 'Cost Control:' Our Obsessive Quest to Gut the Hospital," *Health Affairs*, Vol. 15, No. 2 (Summer 1996) pp. 145-154; Patrick H. Tyrance, Jr., David U. Himmelstein, and Steffie Woolhandler, "US Emergency Department Costs: No Emergency," *American Journal of Public Health*, Vol. 86, No. 11 (November 1996), pp. 1527-1531; Robert M. Williams, "The Costs of Visits to Emergency Rooms," *New England Journal of Medicine*, Vol. 334, No. 10 (7 March 1996), pp. 642-646; and George Anders, "A Plan to Cut Back on Medicare Expenses Goes Awry; Costs Soar," *Wall Street Journal*, 3 October 1996).

²⁶ Chapter 495 of the Acts of 1991.

²⁷ Jack Needleman, *Nonprofit to For-profit Conversions in Health Care: A Review*, Pioneer Institute for Public Policy Research White Paper No. 5, February 1999.

²⁸ See, for example, Victor Fuchs, cited in Rodger Doyle, "Health Care Costs," *Scientific American*, April 1999, www.sciam.com/1999/0499issue/0499numbers.html.