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MASSACHUSETTS SHOULD PRESERVE EACH HOSPITAL NEEDED TO PROTECT THE HEALTH OF OUR PEOPLE

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Oversight Hearing
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Room A-1

Disclaimer: As always, we write and speak only for ourselves, not on behalf of Boston University or any of its components.

INTRODUCTION

We urge careful and immediate state action to conserve all remaining acute hospitals and beds in Massachusetts. Unless this is done, more hospitals and emergency rooms will close. The results will be increased emergency room diversions, shortages of beds, and skyrocketing costs. As one public official said last year, "Lives are really at risk."

State government must act to protect all needed hospitals because no free market is available to do the job. The alternative to state government action is growing hospital anarchy. Many needed hospitals will close. A few needed but vulnerable hospitals can be saved, like Everett's Whidden Hospital, by a Cambridge Health Alliance riding to the rescue. Still other needed hospitals will conclude that they must cut needed but money-losing services or must sell themselves to for-profit chains as the price of survival—though these steps will often fail to save the hospital.

Waltham Hospital's fight for survival has galvanized long-needed concern and attention. Waltham Hospital should be kept open—and so should each surviving Massachusetts hospital—unless it can be proven that it is not needed. We hope that Waltham Hospital can be rescued, even at the last minute. But we ask that state government get ahead of the curve by anticipating hospital crises and preparing effective and measured responses. Being prepared saves money, saves hospitals, and saves lives.

State government is financially, politically, and administratively competent to protect needed hospitals at the lowest possible cost. Decades ago, when some people thought that closing hospitals would save money, state government lacked the capacity and the political will to do the job. So state government unleashed competition on our hospitals. Competition has proved effective at closing hospitals. Unfortunately, it can close needed hospitals. And, like the Mickey Mouse – Sorcerer's Apprentice in *Fantasia,* it is not able to stop. While state government found it hard to close hospitals, it has the capacity and can find the political will to stabilize each needed hospital.

For too long, state government has acted as if Massachusetts has too many hospitals.

For too long, state government has acted as if a competitive free market for hospital care existed and was competent to pick which hospitals should survive and which should close.

For too long, state government has failed to develop an early warning system to identify which hospitals might experience financial distress, so that the state might move to intervene in a timely manner.

For too long, state government has failed to identify which hospitals are needed to protect the health of the public, so that state government might know which hospitals to protect.

For too long, state government has given hospitals across-the-board spending increases, leaving too little money for the targeted aid that is vital to protecting all needed hospitals.

It is time to do better.

A. SPECIFIC RECOMMENDATIONS FOR ACTION

1. With one-half of Massachusetts hospitals closed in the past 40 years, with growing ER gridlock, and with a looming shortage of staffed acute care beds, ***state government should declare that each surviving acute care hospital is needed to protect the health of the people unless proven otherwise. The burden of proof should be on those who would allow another closing, not on those who would protect their hospital.***

2. The commissioner of Public Health should publicly state that the loss of a needed hospital or emergency room would threaten lives and therefore would constitute a public health emergency, and ***the governor should declare that a threatened hospital or ER closing constitutes a public health emergency.***[1] This would allow state government to act quickly to stabilize any such hospital until a hospital receivership statute is enacted. Steps 1 and 2 constitute the emergency response to the crisis of hospital closings.

3. ***State government should immediately enact and enforce a hospital receivership law.*** That law should empower responsible public officials to petition a court to appoint a receiver to stabilize, conserve, and revive each needed but endangered hospital.

4. The receivership law should be ***accompanied by emergency financial and managerial assistance.*** That assistance should be financed through

a) A dedicated trust fund, whose revenue would be generated by a one-quarter of one percent assessment on acute hospital total revenue statewide. With that revenue likely to equal approximately $12 billion in hospital fiscal year 2002, some $30 million would be raised.

b) Direct state appropriations required to stabilize, conserve, and revive each needed but endangered hospital.

5. To collect the evidence needed to carry out these tasks, the Division of Health Care Finance and Policy, with the support of the Department of Public Health, when appropriate, should be charged with:

a) Identifying any surviving hospitals that are not now needed, and are not expected to be needed, to protect the health of the public;

b) Measuring the revenue needed to finance efficient and high-quality care at each hospital; and

c) Designing an efficient, fair, straightforward, and effective method of regulating hospital revenue in Massachusetts. Available evidence from the state of Maryland should be closely considered.

Several of these steps are incorporated in existing legislation, H. 611 and H. 3541.[2] Originally drafted as preventive measures in 1993, and re-introduced regularly since then, these bills would benefit from some updating and modernization in light of need for speedy responses to the growing emergency facing hospital survival.

Further, state laws adopted in the 1980s have explicitly encouraged hospital closings and bed reductions. For example, some "automatic bed delicensing" is required if occupancy rates drop below specified levels.[3] Since empty beds are not staffed, and because the cost of building them is a fixed or sunk cost, they generate at most tiny incremental costs. And since there appears to be scarce bed capacity to accommodate either emergency surges in inpatient volume or the gradual increases in volume associated with a growing older population, this statutory provision should be replaced by language calling for the mothballing of reserve hospital capacity. Steps 3 , 4, and 5 constitute the short-term response to the crisis of hospital closings.

6. State government should ***prepare to reintroduce hospital rate setting within the next two years***. After so many closings, this is essential to put a floor under the revenue of hospitals with weak bargaining power. And because hospital closings and mergers have resulted in regional oligopolies and monopolies, rate setting is essential to put a ceiling on the revenue of hospitals with strong bargaining power. Finally, rate setting is essential to provide each needed hospital with enough revenue not only to survive but also to deliver high-quality care, so long as that hospital is operated efficiently. Step 6 constitutes the middle-term response to the problem of hospital closings.

B. SUPPORTING EVIDENCE

1. Survival: Targeted state action is essential to protect needed hospitals

Without a competitive market we can trust, only public action can stabilize needed hospitals.

But Massachusetts state government currently lacks the tools to identify which hospitals are needed and to stabilize each needed hospital. The process established by chapter 141 of the Acts of 2000 provides a 90-day notice and for a public hearing, but it does not provide for state authority or money. Further, the hearing's mandated focus appears to be not on whether the hospital should be preserved—and how it should be preserved—but on identifying alternative sources of care—apparently assuming that the hospital will close.

State government must determine which hospitals and which emergency rooms are needed to protect the health of the public. State government still does not know how many beds are set up and staffed currently, and we don't know how many beds could be made available in 24 hours, 48 hours, or one week—in the event of a large-scale emergency.[4]

State government must then develop practical steps to stabilize, conserve, and revive each needed hospital. Recognizing that state dollars are scarce, one essential tactic should be to target state money toward needed hospitals that are in danger of closing.

Only targeted support can stabilize each needed but endangered hospital. ***Targeted support is efficient, providing money where it is most needed. It is the lowest-cost method of saving all needed hospitals.***

When state government plans to pay more money to hospitals, it should carefully monitor where its money would go. When state government increases Medicaid payments across-the-board to all hospitals or when it increases state payments to the free care pool, does the state know how much money goes to which hospitals—and whether these are the hospitals that most need more state money in order to survive and to delivery high-quality care? Generally, state government does not identify how much money goes to each hospital.

One reason for this state failure is that the Hospital Association has been urging across-the-board increases in Medicaid payments and state assumption of free care pool costs as ways to address the problems of hospital closings and emergency room gridlock. After long ignoring and even justifying hospital closings, the Hospital Association appears to have used them—and emergency room gridlock—as pretexts for across-the-board payment increases. Unfortunately, the state money demanded and won by the Hospital Association is not well-targeted. A great deal of it goes to hospitals that are in relatively good financial condition—which may be many of the hospitals with the most powerful voices within the Association.

The Hospital Association insists that Medicaid is not a grant program. But nor is it a program that simply reimburses whatever costs hospitals incur.

Across-the-board financial aid to Massachusetts hospitals, such as increases in Medicaid rates, are very inefficient. Too much of the money goes to hospitals that are in relatively good financial shape. ***Across-the-board payment increases do very little to protect endangered hospitals. They do very little to keep needed emergency rooms open.*** [5]

a) Across-the-board Medicaid rate increases help the more prosperous hospitals

- A 10 percent ($60 million) across-the-board hike in Medicaid rates in hospital fiscal year would have done very little to help financially distressed hospitals.

- Fully $30 million would have gone to the 20 most prosperous hospitals in the state, raising their surpluses by about 15 percent.

- The other $30 million would have gone to the remaining 51 hospitals, lowering their overall deficits by about 25 percent—and leaving them with deficits totaling $90 million.

b) Hospitals that close their emergency rooms more often are in better financial shape.

- In Eastern Massachusetts, twelve hospitals with surpluses in hospital fiscal year 1999 averaged 278 hours on diversion between January and October of 2000.

- But nine hospitals with deficits averaged only 74 hours on diversion during those ten months.

c) Across-the-board Medicaid rate hikes are unfair to hospitals themselves.

- Hospitals now vary enormously in the share of their costs paid by Medicaid, according to data developed by the Lewin Group,[6] so across-the-board hikes perpetuate this unfairness.

d) No one who lives, works, or does business in Massachusetts can afford more money for business as usual in health care.

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.

After targeted support has stabilized all needed hospitals, state government should turn its attention to a durable method of paying each needed hospital fairly. The hospital market is not free and competitive, so Massachusetts cannot trust it to pay hospitals fairly. Today, powerful hospitals extract large rate hikes from HMOs and other private payors. Weak hospitals are not able to garner enough revenue.

In the absence of a free market, state action is essential—and it is clearly feasible. For 25 years, Maryland has used all-payor rate setting to provide fair revenue to each needed hospital. Rate setting puts a ceiling on the revenue of powerful hospitals and a

floor under the revenue of weaker hospitals. All hospitals face pressures to contain cost under this arrangement, because revenue is keyed to the cost of efficient operation.

2. Access

a) "We can't afford to lose another hospital."

- ***Public Health Commissioner Koh has said that "we cannot afford to lose another hospital."*** [7]

b) ER gridlock

- In recent years, the evidence on growing emergency room diversions and gridlock have aroused widespread concern in Massachusetts [8] and elsewhere. [9] Between 2000 and 2001, ER diversions doubled in greater Boston. [10]

- Each hospital closing increases the severity of the ER diversion problem. And many surviving hospitals and ERs are vulnerable. In the northeastern corner of the state, for example, three of the remaining four ERs—at Addison Gilbert in Gloucester, at Hale/Merrimack Valley in Haverhill, and at Cable in Ipswich—are at risk of closing within the next one-two years.

- One of the main causes of ER diversions seems to be a shortage of staffed inpatient beds. Indeed, the shortage of staffed inpatient hospital beds, including ICU beds, while more subtle than the problem of ER diversions, is at least as serious.

- Hospital closings reduce access to emergency room services. They raise the risk of ambulance diversions. They increase travel time and waiting time for ER patients.

c) Half of hospitals lost in four decades

- If Waltham Hospital is allowed to close, Massachusetts will have 72 acute hospitals, 48.9 percent fewer than in 1960.

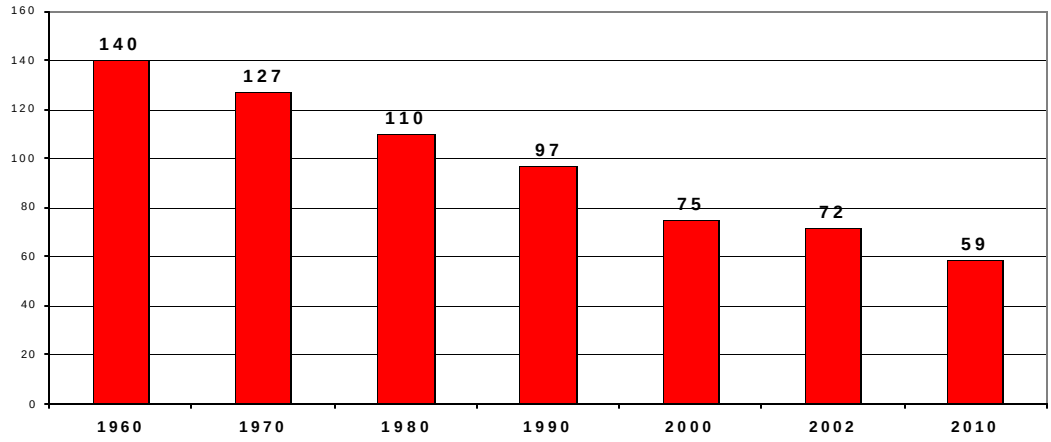
- The rate of closings has accelerated. Twelve percent of the hospitals open in 1980 closed by the end of that decade. But 23 percent of hospitals open in 1990 closed by 2000.

- We project a loss of 13 more hospitals by the year 2010 if state government fails to act to identify and stabilize each needed hospital.

- Clearly, fewer hospitals means less competition among surviving hospitals, and greater upward pressure on hospital prices, other things equal.

- Fully 26 acute care hospitals have closed since 1988, when hospital revenue was effectively deregulated by chapter 23 of the Acts of 1988 (chapter 495 of the Acts of 1991 completed the job).

MASSACHUSETTS ACUTE CARE HOSPITALS, 1960 - 2010



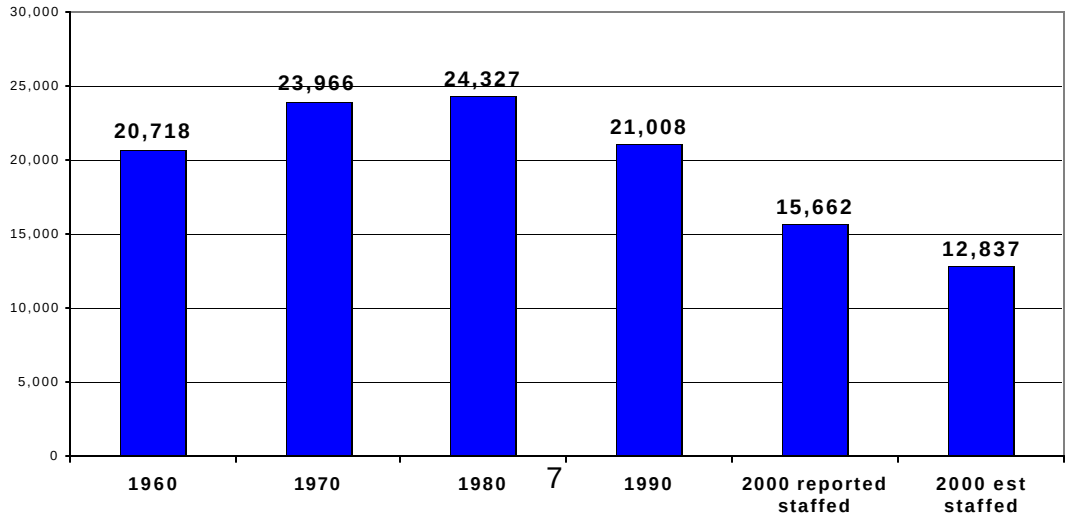
- None of those that closed was a major teaching hospital. Some had quality problems, but these could have been remedied, given the huge supply of competent physicians, nurses, administrators, and other health care workers in the Commonwealth.

- Hospitals located in lower-income Massachusetts communities have been more likely to close. Hospital closings are particularly harmful to lower-income citizens, since they tend to suffer more unmet health care needs.

d) Half of all beds lost in two decades

The recent drop in the number of acute care beds in Massachusetts was much more dramatic than the drop in the number of hospitals. From a high of 24,327 in 1980, beds fell to about 13,000 beds in 2000, we estimate— a drop of 47.2 percent in only two decades.[11]

MASSACHUSETTS ACUTE HOSPITAL BEDS, 1960 - 2000



e) A looming bed shortage

Despite the rapid closing of hospital beds, and the rising need for hospital care, almost public no attention was paid to the looming shortage of hospital bed capacity until recently.[12] Much of the recent discussion has taken place in the context of the shortage of nurses willing to work in hospitals.

The rising need for hospital care owing to an aging population 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.[13]

- ***Almost three years ago, we projected that the state's supply of beds set up and staffed will soon fall substantially below the need.***[14] 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 projected shortfall is 5,563 beds (32%) in 2005 and 9,418 beds in 2025 (44%).[15]

- Even if the drop in Massachusetts hospital capacity slows, and then stops entirely by 2005, the shortage of beds will continue to grow because the need for beds is growing.

- 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.

Exhibit

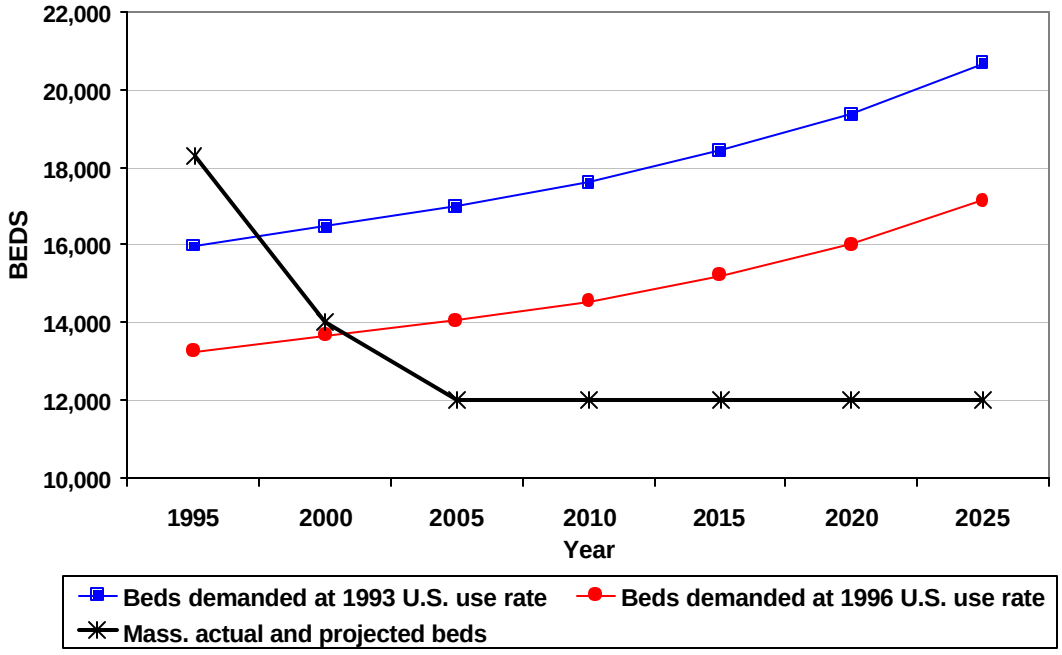
Projected Available Beds versus Projected Needed Beds, 1995 - 2025

	projected	needed beds		surplus beds (shortfall)		Shortfall as % of need	
year	available 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 raised a number of concerns. As displayed in the exhibit and in the chart, after about the year 2000, we found that the number of projected beds in Massachusetts fell substantially below the projected need for beds even by the conservative measure of the national 1996 bed use rate—and even assuming that no more beds are lost after 2005.

The experience of the past two years, with hospitals at capacity at many times and in many places, and with patients backing up in some emergency rooms owing to a lack of inpatient beds on nursing units, suggests that the state did suffer some degree of shortfall, as projected for the year 2000.

IMPACT OF POPULATION GROWTH AND AGING:
PROJECTED MASS. HOSPITAL BEDS AND DEMAND
AT 80% OCCUPANCY AND RECENT U.S. USE RATES, 1995-2025



We expect at least three responses to the looming shortages in hospital bed capacity. Two of these could mean substantial harm to patients. The third could result in higher costs unless the state prepares.

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, as we have seen since several years ago, some Massachusetts hospitals are becoming over-crowded, especially but not exclusively in the winter.[16]

Instances of running out of hospital capacity have become increasingly visible, nationally and in Massachusetts. As a worse-than-usual flu season hit several states in December

1997 and early 1998, serious shortages arose 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 other states, hospitals struggled to care for the flood of patients and sometimes resorted to risky stop-gap measures. For example:

- Hospitals in several parts of California were putting patients needing beds into doctors' offices, hallways, outpatient areas; using waiting rooms as treatment areas; using a tent in a parking lot as a family waiting area; and limiting elective outpatient care.[17]

- Emergency rooms that are closing their doors to ambulances have been a growing problem across the nation for several years[18] – sometimes diverting patients as far as 30 miles away.[19]

Thus, a flu upswing was the straw that broke the camel's back several years ago in many California communities, and elsewhere.[20] A California hospital industry official acknowledged, "`There's no fat in the system to deal with [influenza patients] when this occurs.'"[21]

But in Massachusetts, the upsurge in ambulance diversions of the past two years has occurred without a particularly severe flu season.

And one of the sad lessons understood more widely after this fall's attacks is that, in many areas, the nation's hospitals lack the capacity to accommodate the surge in demand that might arise with a calamitous plane crash, fire, or epidemic.

Some observers have complained that high costs would result from maintaining standby hospital capacity to deal with times of high need.[22] But once beds are built, no further fixed costs are associated with them. The only costs would be those to prepare beds for use and to staff them. These are legitimate variable costs that should be shouldered to provide necessary care.

So, third, another possible response to the collision between growing need and shrinking bed supply is that that some hospital capacity will be taken out of mothballs and more nurses will be hired to staff those beds. Taking capacity out of mothballs 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.

Hiring adequate numbers of nurses will require a hard look at the causes of the recent nursing shortage. To what extent is it attributable to changed working conditions in hospitals, to the difficulty of caring for patients who are substantially more ill, to salaries, and to other factors?

f) Conserving hospital beds that will be needed sooner or later

- Use of hospital beds will rise owing to the greater needs of an aging population, and out of recognition that artificially high prices have held down use of hospital care even when it is less costly than alternatives.

- 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.

- 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.

- Cities and towns throughout the Commonwealth—and indeed throughout the nation—have had to spend a great deal of money to secure an adequate number of public school classrooms. During the 1970s and 1980s, many public schools were sold off or redeveloped as senior centers, condominia, 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 avoid that dynamic in hospital care, beds removed from service should be moth-balled, and maintained under license. This would be hard to do if entire hospitals close. The provision of chapter 23 of the Acts of 1988 calling for automatic de-licensing of beds when occupancy rates fall below a certain level should be repealed.

g) Hospitals are not interchangeable parts in a health care machine

Hospitals, doctors, and patients form complex relationships with one another. These relationships tend not to be of a mechanical nature. Losing a hospital can therefore disrupt patients' long-standing and therapeutic relations with their caregivers.

Losing a hospital also disrupts internal working relationships within the institution.

3. Cost

- Massachusetts hospitals' cost per person in 2000 was 38.6 percent above the U.S. average. Massachusetts hospital spending per person was $1,755.90—highest in the nation—compared with the U.S. average of $1,267.00.[24]

- If we spent at the national average, we would have saved $3.1 billion in hospital fiscal year 2000 alone.[25]

- Hospital closings, long touted as a method of saving money, have failed to reduce Massachusetts hospital costs relative to the national averages. Massachusetts acute hospital beds per 1,000 residents dropped from five percent above the national average to eleven percent below the national average between 1984 and 2000, yet our hospital costs per person in both years were 38 percent above the national average.

Exhibit

Hospital Beds per 1,000 People and Hospital Costs per Person, Massachusetts and U.S.A., 1984 and 2000 [26]

	Massachusetts	U.S.A.	Mass. % of U.S.A.
Beds/1000 people			
1984	4.5	4.3	+4.7%
2000	2.6	2.9	-11.2%
Costs/person			
1984	$715	$517	+38.2%
2000	$1,756	$1,267	+38.6%

- It is clear that while many hospitals and beds have been closed in Massachusetts, hospital costs here have remained high.[27] But excess capacity cannot explain our state's higher than average costs because our capacity is now below the national average. And closing hospitals and cutting beds are not effective remedies for these high costs.[28]

- Some consultants to the hospital industry and others have tried to explain away the $3.1 billion excess costs of Massachusetts hospital care in 2000.

- But there is a big difference between statistical explanations of high costs and concluding that those high costs are affordable and appropriate in the real world.

- Recognizing the high costs associated with the steady drift of hospital care into teaching hospitals, the majority report to the Massachusetts Health Care Task Force strongly recommended directing more hospital care to lower-cost hospitals. But unless lower-cost hospitals are kept open, it will not be possible to direct any care to them. The Finance Working Group has said that no additional community hospitals should close.[29]

- Each hospital closed since 1988 has been a community hospital.

- Massachusetts leads the nation in the share of our inpatients served in costly teaching hospitals.

- As has been found with public schools, the cost of building new hospitals is much greater than cost of retaining a reasonably modern hospital. The current estimated low-side capital cost of opening a new hospital of 200 beds is $100 million, or $500,000 per bed.[30] This can be expected to continue to rise substantially.

4. Market failure

Most Americans prefer to rely on a free market to solve problems whenever possible. But a free market is not always present. Hospital care is one of the areas in which the main foundations for a trustworthy competitive free market have been eroded by mergers and closings, by the lack of effective price competition, and by the high barriers to entry into the hospital market. A number of pieces of evidence support this contention.

In a free market, the more efficient hospitals—those with lower costs—would be more likely to remain open. Unfortunately, there is no evidence that the more efficient hospitals are more likely to survive.

Our studies of hospital closings in 51 cities nationally going back to the mid-1930s show that lower-cost hospitals have been more likely 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 teaching hospitals and those with more money in the bank and in investments 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.

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—for example, charging an average daily price for hospital inpatients means that low-cost recuperative days are extremely over-priced. (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.

Further, the less expensive patients and patient-days of care are removed from the hospital. But with fewer patients to cover the hospital's fixed costs, the average cost of care per day for the remaining patients rises. The price is increased to cover these costs. Higher prices spur insurors to remove still more patients from the hospital. And price rises still higher.

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. [31]

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.

State policy is still relying on price competition as the driving force in holding down hospital costs.[32] But 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, the Connecticut River valley, Berkshire County, Worcester County, Essex County, and greater Boston.

Owing to closings and mergers, surviving Massachusetts hospitals enjoy increasing bargaining power against HMOs, insurance companies, and other private payors. The result will be more revenue to surviving hospitals and higher costs to all who live, work, or do business in Massachusetts.

The high cost of building a new hospital, and the regulatory barriers to entering the hospital market, will make it hard to build new hospitals that could compete by offering lower prices. And it is clear that no functioning free market exists in hospital care—one that can be trusted to hold down costs, to keep open efficient hospitals, to assure an adequate supply of hospital beds for the long haul—or even to protect the emergency rooms we all need.

When economics fails—when the free market fails—the choice is between anarchy and careful government action.

Some will say that governmental action means politics. They are right. A greater government role means more politics. That is no longer an option. The real choice is between good politics that protects high-quality care at all needed hospitals at the lowest possible cost, and bad politics that makes irresponsible decisions. Given the importance of our health care, and the enormous reservoirs of competence in our state, our legislators and public officials can and must make good political decisions.

Two years and one month ago, Massachusetts state government used a new receivership law to help preserve Harvard Pilgrim Health Care. That was an important demonstration that state government can act constructively and successfully in health care.

Preserving hospitals—actual caregivers—may be even more vital than preserving insurors, the organizations that move money in health care. And indeed, state government provided financial assistance to help preserve Quincy Hospital a few months before its involvement with Harvard-Pilgrim.

But many other needed hospitals have closed. And many more will close in the years ahead without stabilization, reform, and adequate financing. Some observers may imagine that losing a hospital affects only a few communities. They are wrong. Our

state has lost so many hospitals that each additional closing will shake many other hospitals, communities, and regions with ER diversions and bed shortages.

Each potential loss of a hospital must now be everyone's concern. Action delayed until a hospital is on the verge of closing will be too little and too late. So state government should declare that all surviving hospitals are needed unless proven otherwise. It should act to protect each needed hospital. And it should act now, before more hospitals and more health care slip over the edge.

NOTES

[1] Mass. Ann. Laws chapter 17, section 2A (2001) states that "Upon declaration by the governor that an emergency exists which is detrimental to the public health, the commissioner may, with the approval of the governor and the public health council, during such period of emergency, take such action and incur such liabilities as he may deem necessary to assure the maintenance of public health and the prevention of disease."

[2] Two bills introduced in the 2001-2 legislative session, H. 611 and H. 3541, 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.

[3] Chapter 111, Section 51, *Massachusetts General Laws.*

[4] 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. This should be a number lower than a hospital's licensed beds. We believe, however, that many hospitals

report licensed beds to the AHA, making the AHA's reported numbers of beds set up and staffed a mixed bag of licensed beds and set up and staffed 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.[4] (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 hospitals do not report systematically.)

One result is that, even after the fact, 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. There are even some questions about how many beds were actually licensed in a given year.

The difficulty is made even greater by the lack of current knowledge about the present year's actual bed supply. Apparently, no 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, and within 48 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 month.

[5] Alan Sager and Deborah Socolar, Many Massachusetts Hospitals Have Financial Problems, and These Must Be Addressed, but an Across-the-board Medicaid Rate Increase Is Not an Effective Solution, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 18 December 2000, http://dcc2.bumc.bu.edu/hs/accessandaffordability.htm.

[6] This evidence was reported to the Finance Working Group, Massachusetts Health Care Task Force, on 29 August 2001.

[7] This statement was made at a meeting of the Finance Working Group, Massachusetts Health Care Task Force, 30 May 2001.

[8] Larry Tye, "ER Crisis Hits Close to Home for Officials," *Boston Globe*, 21 May 2001.

[9] Peter Gosselin, "Amid Nationwide Prosperity, ERs See a Growing Emergency," *Los Angeles Times,* 6 August 2001; and Linda Brewster, Liza S. Rudell, and Cara Lesser, "Emergency Room Diversions: A Symptom of Hospitals under Stress," *Issue Brief No. 38,* Center for Studying Health System Change, May 2000.

[10] Michael Lasalandra, "BU Prof. [Eugene Litvak] Offers Solution for Hospital ER Crunches," *Boston Herald,* 9 January 2002.

[11] Source: American Hospital Association, *Hospital Guide Issue* and *Hospital Statistics,* various years. For 2000, we estimated beds set up and staffed by taking the average daily inpatient hospital census of 10,912 and allowing for an average 85 percent occupancy rate across all services, yielding an estimated 12,837 beds set up and staffed. Hospitals are supposed to report beds set up and staffed to the American Hospital Association but many or most apparently report the number of licensed beds, typically a much greater number. Use of the artificially high denominator of 15,662 beds is what accounts for the apparently—and artificially—low statewide occupancy rate of 69.7 percent.

[12] See Alan Sager, Deborah Socolar, and Jasprit Deol, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 June 1997, p. 43; and Alan Sager and Deborah Socolar, "Massachusetts Hospital Costs Per Person Have Risen Much Faster Than the National Average, 1997-1998,"16 December 1999. See also Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," testimony to the Joint Committee on Health Care, Massachusetts General Court, 20 May 1999.

[13] 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.

[14] Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," testimony to the Joint Committee on Health Care, Massachusetts General Court, 20 May 1999.

[15] 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. 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.

Occupancy rates were calculated from American Hospital Association, *1999 Hospital Statistics,* Chicago: The Association, 1999, table 6, and American Hospital Association, *2002 Hospital Statistics*, Chicago: The Association, 2001.

[16] "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.

[17] Dorsey Griffith, "Hospital crisis diagnosis: Cutbacks, shortage of nurses," *Sacramento Bee*, 17 January 1998. Jon Asplund and Susannah Zak Figura, "Hospitals coordinate services as flu patients crowd ERs," *AHA News*, 26 January 1998. California Nurses Association, "RNs Urge Declaration of Emergency on Critical Care Crisis," press release, 8 January 1998. Kathy Robertson, "After Making Deep Cuts, Hospitals Now Short of Beds and Staff," *Sacramento Business Journal,* 19 January 1998. See also, for example, David Colker, "Valley Hospitals Packed Due to Rash of Illnesses," *Los Angeles Times*, Valley Edition, 31 December 1997; Susan Abram and Julie Marquis, "Flu Season Floods Southland Hospitals With Patients," *Los Angeles Times*, Home Edition, 4 January 1998.

[18] See, for example, Dorsey Griffith, "Hospital crisis diagnosis: Cutbacks, shortage of nurses," *Sacramento Bee*, 17 January 1998. 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 Debare, "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] See Carol Gentry, "Hospital Closings Prompt Alert: Stop the Bleeding," *Wall Street Journal,* 11 February 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] American Hospital Association, *Hospital Statistics,* 2002 Edition, Chicago: The Association, 2002, tables 3 and 6.

[25] This is calculated by taking the difference between Massachusetts and U.S. hospital spending per person in 2000 ($488.90) and multiplying it by the Massachusetts population of 6,349,000. The product is $3.1 billion.

[26] Authors' calculations from American Hospital Association, *Hospital Statistics,* Chicago: The Association, 1985 and 2002, and from U.S. Bureau of the Census data.

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

[28] 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.

[29] Statement by Stuart Altman, Co-chair, Finance Working Group, FWG meeting of 16 January 2002.

[30] This assumes 1,200 gross square feet per bed, which is at the low range for new community hospitals today, and a construction cost of $250 per gross square foot, yielding a total construction cost of $60 million for 200 beds. It also assumes $40 million for equipment and furniture, architecture and engineering, planning and development, contingencies, and pre-opening financing. Estimates have been provided by an industry source.

[31] 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; 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).

[32] Chapter 495 of the Acts of 1991.