The Survival of Lachine Hospital

Alan Sager, Ph.D.
Professor of Health Policy and Management
Director, Health Reform Program
Boston University School of Public Health

Montreal

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This talk rests in part on years of work with my fellow-Health Reform Program director,

Debbie Socolar, M.P.H.

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Structure of the talk

- A look at Quebec health and hospitals
  - Spending patterns
  - Fair and rational decision-making
  - Correlation of means and ends
  - How many hospitals and beds are needed?
- Lessons from U.S.A. hospital closings
  - New York State
  - Detroit
  - 52 cities

Quebec Health and Hospitals in Canadian Context

- Spending patterns
- Hospitals and beds, teaching and total
- Hospital closings

Quebec’s health and hospital care

In the face of financial difficulties, Quebec has done very well in providing health care to all people at low cost. This should be recognized as an extraordinary achievement.

1. Health spending per person in Quebec is about 11 percent below the Canadian average. (But health spending is about the same share of the economy.)

2. General hospital spending per person in Quebec is about 9 percent below the Canadian average.

3. Quebec's lower hospital spending per person is striking, since

4. Quebec does have 21 percent more beds per 1,000 people than the nation as a whole and

Quebec’s health and hospital care

5. Teaching hospitals--usually costlier--contain 38 percent of Quebec's general hospital beds (versus 30 percent for the nation).

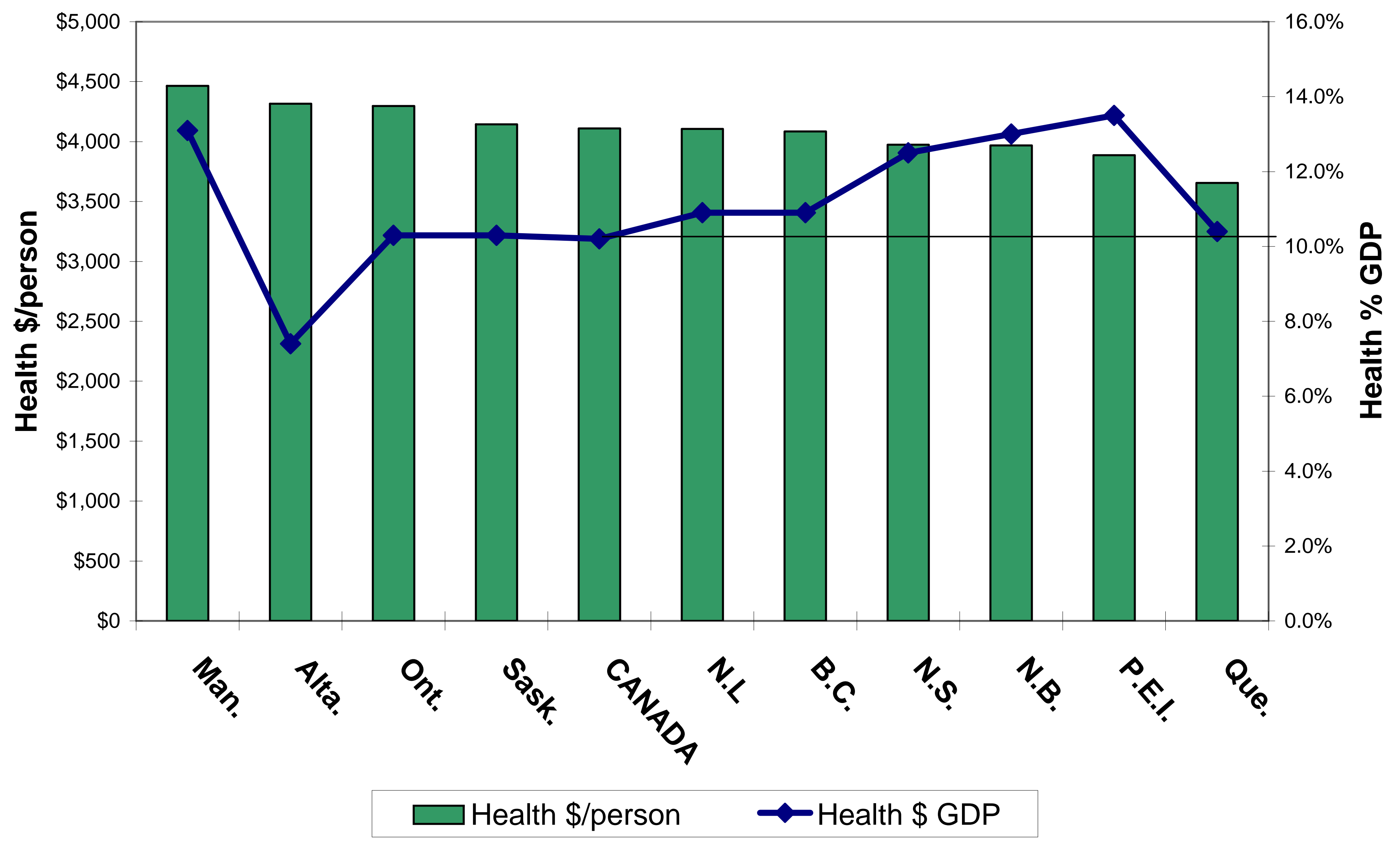
6. Therefore, it seems unlikely that closing smaller and usually lower-cost community hospitals in Quebec will be a good way to save money and help to shape more affordable care in Quebec for the future.

7. This is reinforced by allegations that, over the years, the decision-making about which Quebec hospitals should be closed has been criticized as unreasonable and unfair.

Quebec and Canada Compared

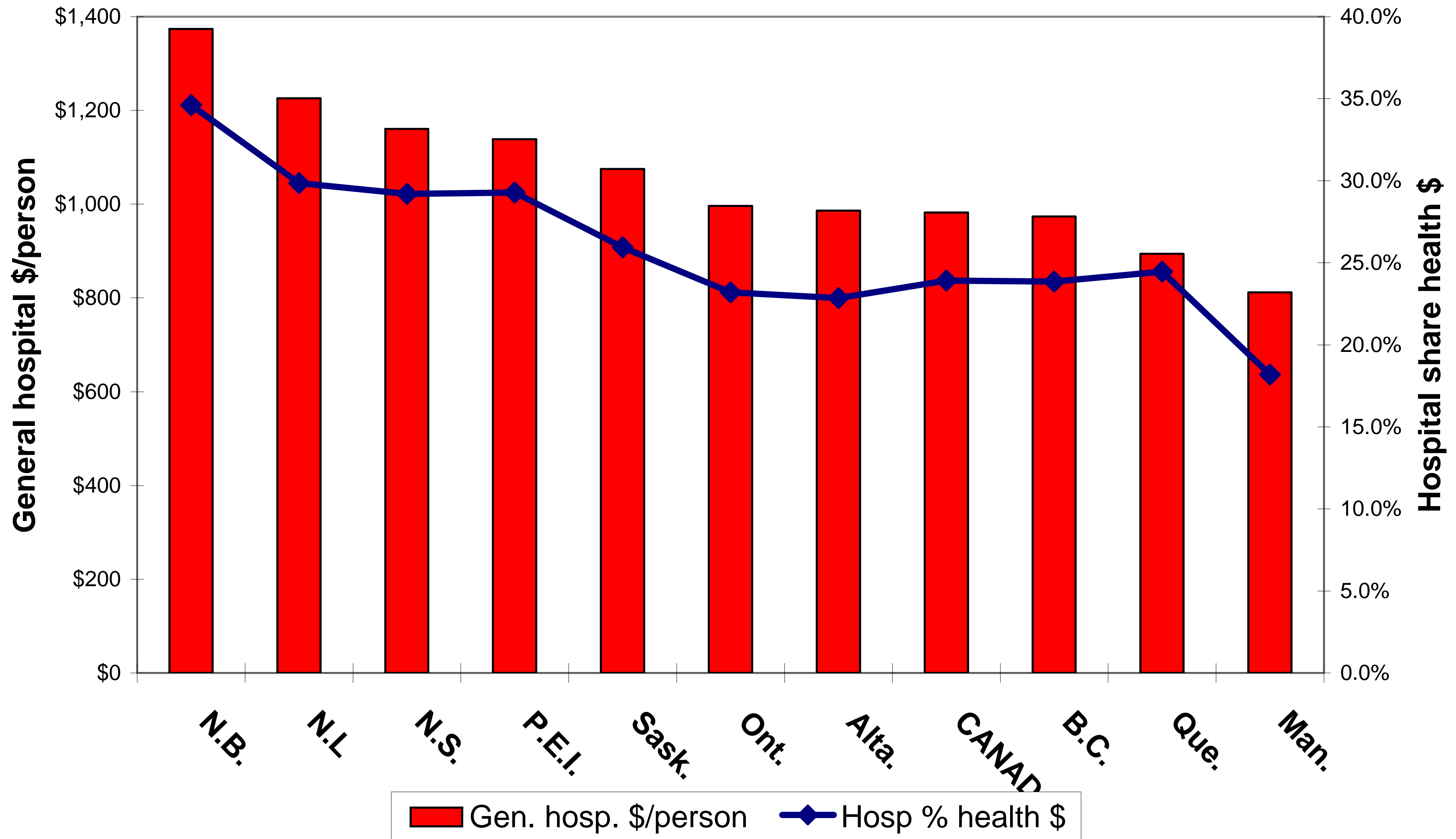
2004—	Quebec	Canada	Que/Can
Health $/person	$3,656	$4,109	89%
Health % GDP	10.4%	10.2%	102%
Gen’l hosp $/person	$894	$983	91%
Gen’l hosp % health $	25%	24%	103%
Gen’l hosp beds/ 1,000	3.4	2.8	121%
Teaching % beds	38%	30%	127%
Teaching % hosp $	52%	42%	122%
Gen’l hosp $ per bed	$266K	$355K	75%
Tchng hosp $ per bed	$357K	$498K	73%

Health Spending per Person, 2004, and Share of GDP



Health spending in Quebec

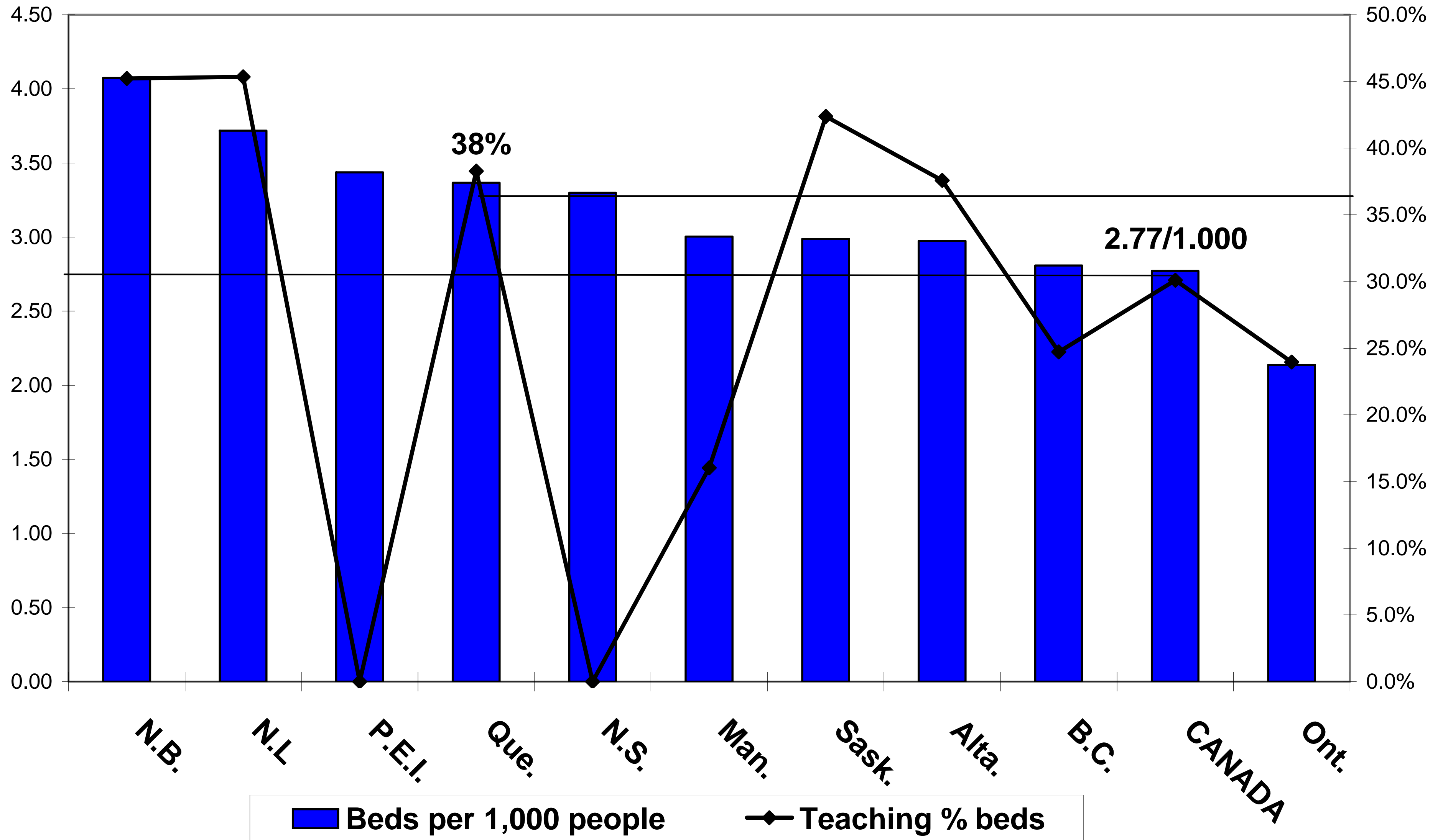
- Health spending per person in Quebec is the lowest in Canada, about 11% below the nation’s
- Yet health spending in Quebec as a share of GDP is very slightly above the nation’s



General Hospital Spending per Person and
Hospital Share of Health Spending, 2004
General hospital $/person
Hospital share health $
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
N.B.
N.L
N.S.
P.E.I.
Sask.
Ont.
Alta.
CANAD
B.C.
Que.
Man.
Gen. hosp. $/person
Hosp % health $

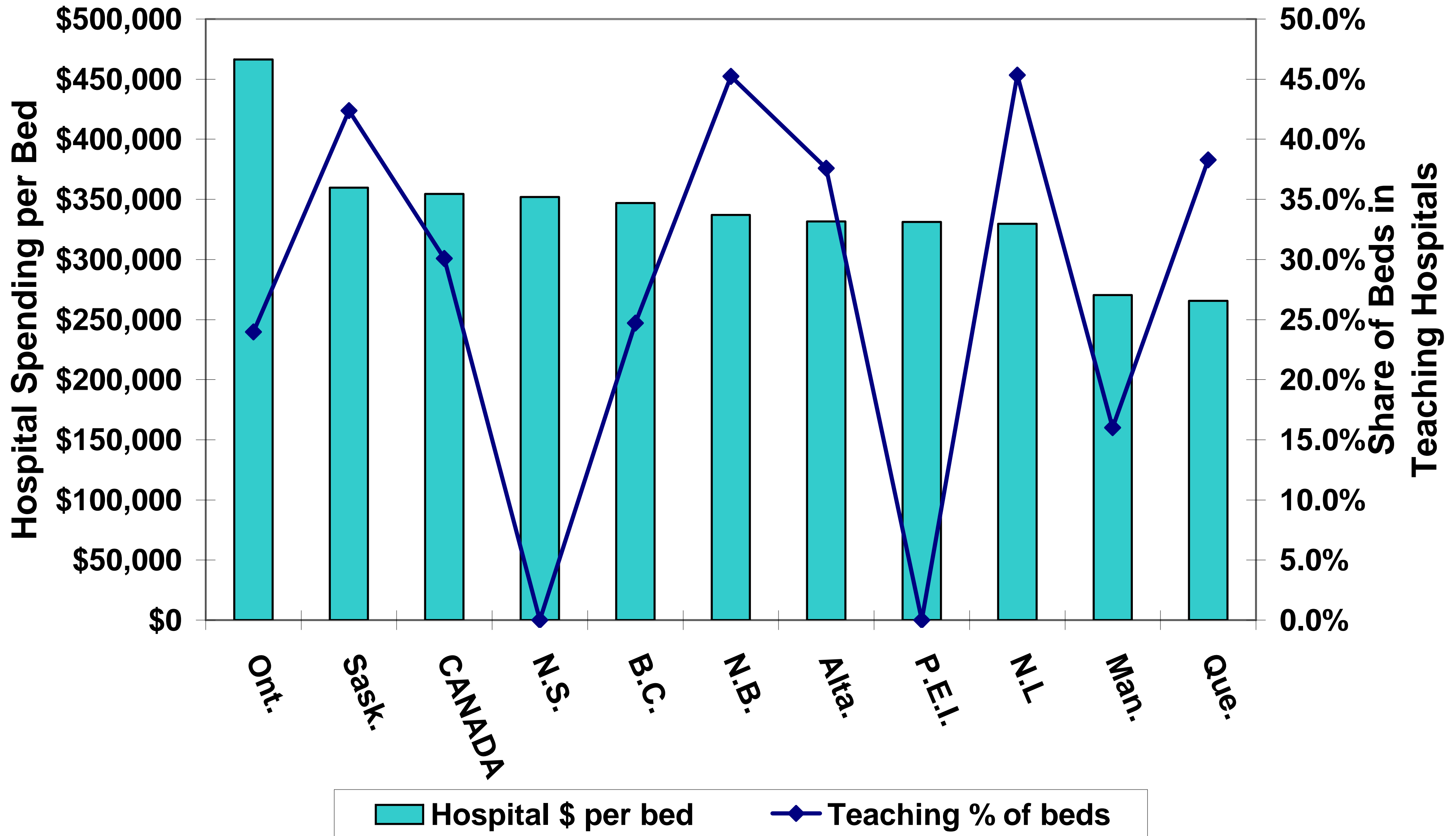
Hospital spending per person

- Hospital spending per person in Quebec is second-lowest in Canada
- Quebec hospitals' share of the health dollar is very slightly above the national average


Total Hospital Beds per 1,000 People and
Teaching Hospital Share of Beds, 2004
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
38%
2.77/1.000
N.B.
N.L
P.E.I.
Que.
N.S.
Man.
Sask.
Alta.
B.C.
CANADA
Ont.
Beds per 1,000 people
Teaching % beds

Beds and teaching hospitals

- Quebec has one-fifth more beds per 1,000 people than does Canada as a whole
- Quebec's teaching hospitals have 38 percent of the province's beds
- That share is about one-quarter above the national average

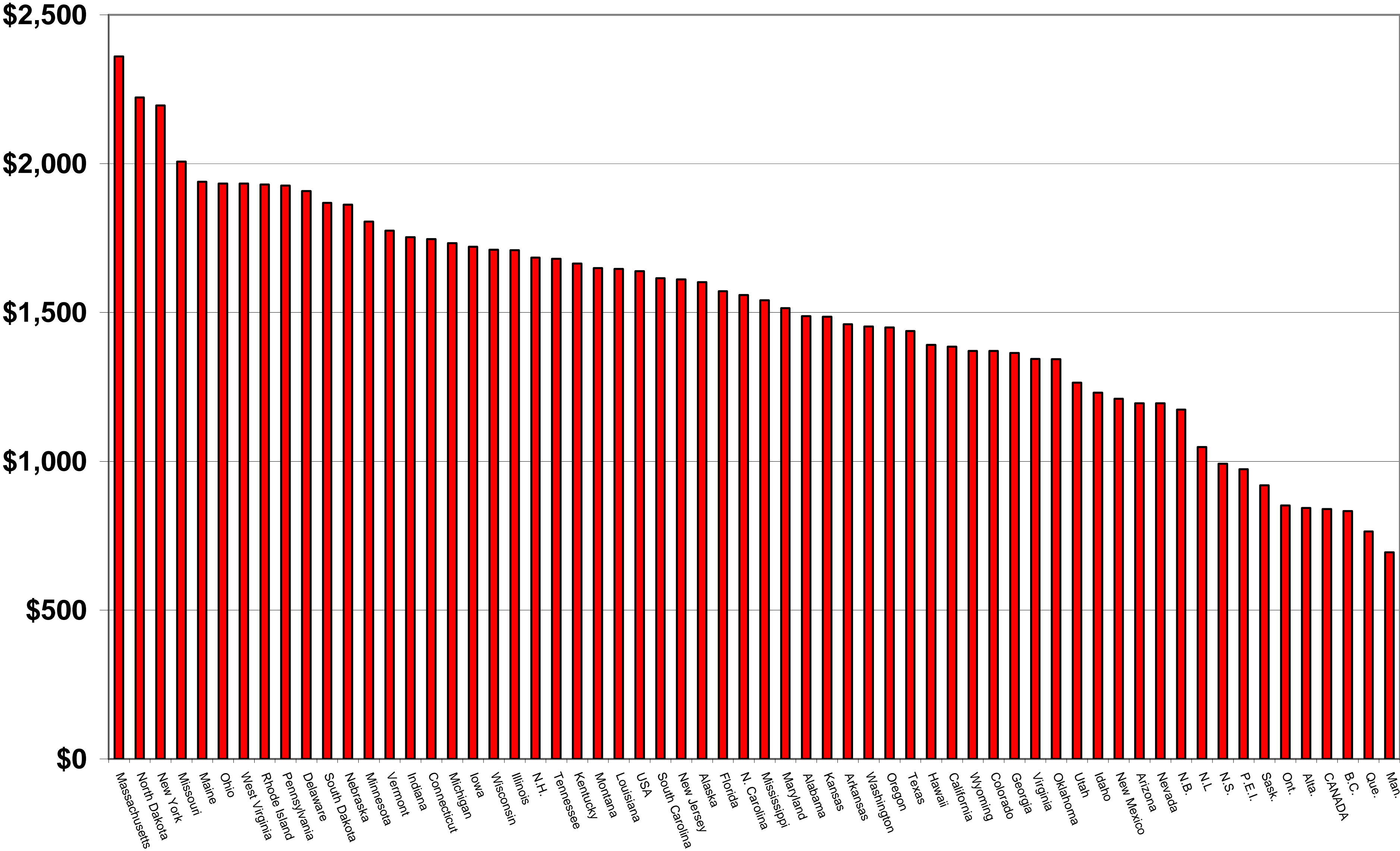


Spending per Hospital Bed and
Share of Beds in Teaching Hospitals, 2004
Hospital Spending per Bed
$500,000
$450,000
$400,000
$350,000
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
Share of Beds in Teaching Hospitals
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Ont.
Sask.
CANADA
N.S.
B.C.
N.B.
Alta.
P.E.I.
N.L
Man.
Que.
Hospital $ per bed
Teaching % of beds

Spending, beds, and teaching

- Quebec’s hospital spending per person is second-lowest in Canada
  - Is this spending adequate?
- Quebec is fourth-highest in hospital beds per capita
- Spending per bed is therefore lowest in the nation—25 percent below average.
- And Quebec is one-quarter above the national average in costly teaching hospitals’ share of beds
- This is a recipe for relatively intense competition for scarce dollars
  - Among teaching hospitals
  - Between teaching hospitals and community hospitals
- This competition may not always be fair

Hospital Costs per Person, U.S. and Canada, 2004



Inter-province/state comparison

- Quebec has the second-lowest hospital cost per person in North America
- Massachusetts’ and New York’s hospital spending per person were three times as great as Quebec’s
- Hospital cost per person in the most costly Canadian province is below that of the least costly U.S. state

Review of Hospital Closings in Montreal

Phil Nolin, February 2001 report

- Procedural flaws—criteria made public belatedly
- Unwillingness to accept expert testimony
- Application of narrow statistical criteria
- "extremely questionable" scientific validity
- Two weeks' consultation (two years in Toronto helped to cut teaching hospitals from 6 to 2)
- "No good deed goes unpunished:" length-of-stay rises when ambulatory care substitutes for use of beds, but this rise punished the hospital.
- Consideration of licensed beds, not beds actually staffed and ready for use

→ Nolin's review parallels critiques of closings in Detroit and in New York State.

Facts or fantasies

- Nolin suggests that, a decade ago, the process used to close hospitals was defective, and so were the evidence and analysis employed
- Is this happening again?
- Does it make sense to close ICU beds at Lachine Hospital, when there is apparently a shortage of ICU beds in much or most of the region?
- Are geographic access and travel times considered?
- What is the appropriate balance of teaching and non-teaching hospitals in the Montreal region?
- This time, are appropriate standards being employed systematically? Are good evidence and analysis used? Or is the process fragmented and ad hoc, and possibly driven by particular interests that wear the cloak of the public interest? (That has been a U.S. pattern.)

Blaming the victim?

- Some hospitals are said to deserve to be closed because they can’t attract enough doctors to provide care
- But perhaps they can’t attract enough doctors because doctors fear that the hospital is to be closed.
- Which is the chicken and which is the egg?
- All needed hospitals should be assured revenue adequate to finance high-quality care, as long as they are operated efficiently.

Lessons from U.S. hospital closings

1. Hospitals are essential to providing safe and efficient health care.

2. Some people hope to save money by closing hospitals. But, in U.S. debates over the past 30 years, the savings from closing hospitals have been exaggerated repeatedly.

3. The weight of the evidence--across U.S. states, across wealthy nations, and over time--strongly suggests that higher ratios of hospital beds per 1,000 people are not associated with higher hospital or health costs. So how can closing hospitals or beds be expected to save money?

4. When many hospitals suffer financially, as happened in Detroit or New York State, advocates for some hospitals urge that other hospitals be closed, so that the survivors can garner increased revenues.

More U.S. lessons

5. Efforts to close hospitals have seldom been fair or reasonable. In my studies of 1,200 hospitals in 52 U.S. cities during the 70 years from 1936 to 2006, there has been no decade in which the more efficient hospitals were more likely to survive. Hospitals in black/African-American neighborhoods have been much likely to close. Larger teaching hospitals have been much likely to survive.

   Most of these closings were not prompted by government action.

6. When governments plan closings, very similar patterns result. Government decision-makers seldom close the large and powerful hospitals--usually teaching hospitals--where they and their families usually receive care.

7. Owing to hospital closings in U.S. cities, hospitals are more geographically concentrated, less accessible to minority and low-income patients, and more costly.

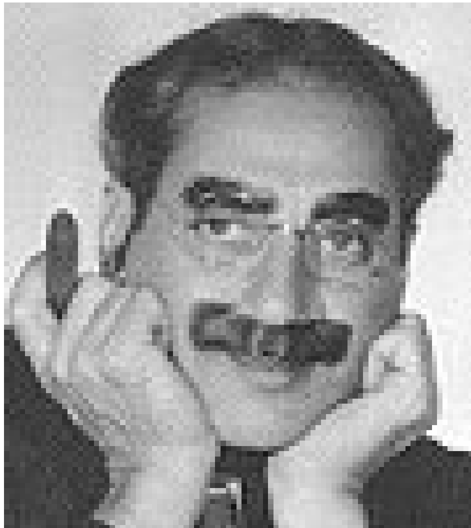
The romance: Why try to close hospitals if that doesn't save money?

- Logic: Hospitals are costly, so closings should save
- Feasibility: It is possible to close hospitals; this is a tool that can be used.
- Symbolism: Closing hospitals does something, even if it doesn't save money.
- Self-interest of hospitals that expect to survive—they may enjoy higher revenues or, at least, less risk of being forced to close.

More romance

- Insulation of decision-makers: Very few politicians favor the closing of the hospitals where they or their families receive care.
- Hope of linkage to improved ambulatory care.
- Closings would contain cost, so they are said to be in the public interest. Supporters of a hospital targeted for closing are castigated as selfish, parochial, opposed to the greater good.
- Lack of evidence. Assertions triumph over fact.
- Misdiagnosis of causes of high cost allows incorrect treatments.

An unhappy view of politics

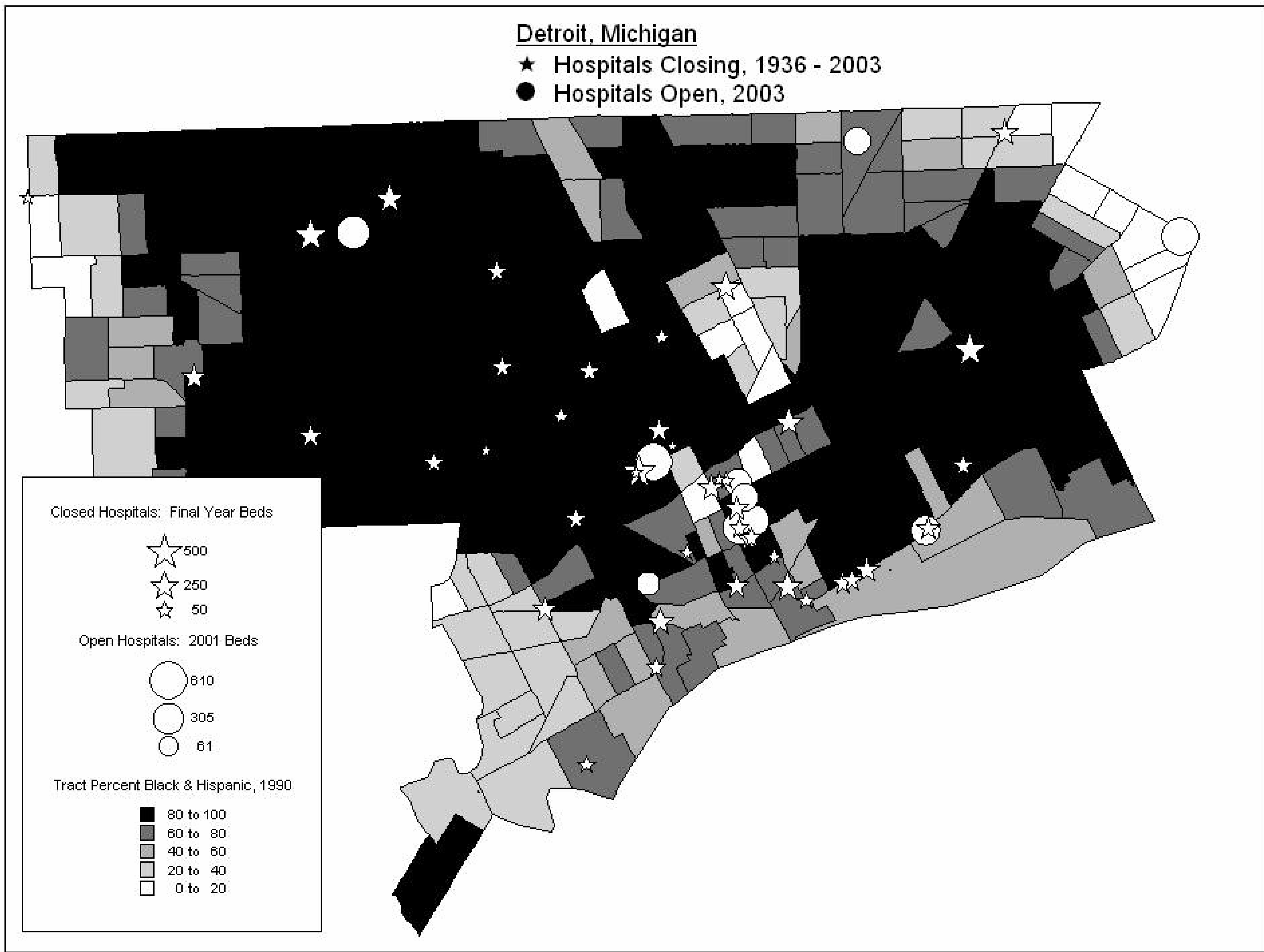


<<Politics is the art of looking for trouble, finding it everywhere, diagnosing it incorrectly, and applying the wrong remedies.>>

-- Groucho Marx

Hospital closings in Detroit

- Financial crisis in 1970s leads state government to squeeze hospitals financially
- Targeted closings urged as substitute for tight revenue across-the-board
- Flawed criteria were selected—perceived proxy measures of efficiency and quality, not actual measures
- Access to care for vulnerable patients was given less weight than hospital efficiency
- Community hospitals were scheduled for closing; teaching hospitals were protected.


Detroit, Michigan
Hospitals Closing, 1936 - 2003
Hospitals Open, 2003
Closed Hospitals: Final Year Beds
500
250
50
Open Hospitals: 2001 Beds
610
305
61
Tract Percent Black & Hispanic, 1990
80 to 100
60 to 80
40 to 60
20 to 40
0 to 20

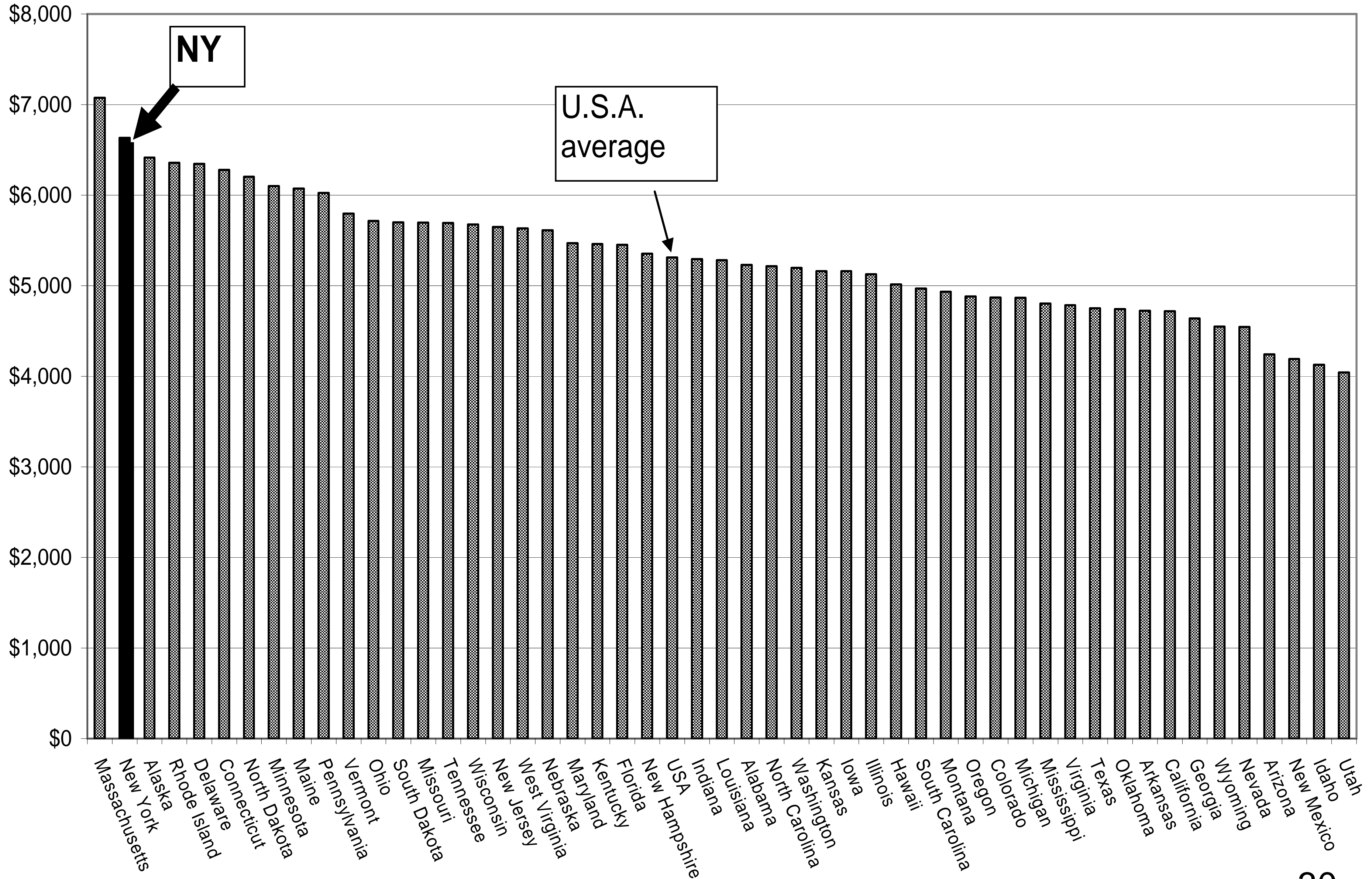
Hospital Closings in New York State

- New York's health care cost crisis is real
- Hospital closings and financial distress are real
- Berger Commission's mythology
- Excess beds don't cost more money
- Closing hospitals predictably won't save $
- Closing hospitals will harm access to care
- Who benefits from closings/mergers?

New York's health care cost crisis is real

- $175 B spent in 2006
  - Equal to 1/3 total U.S. defense spending
  - Over $9,000 per person
  - 2nd-costliest in world
  - Save $31 B if spend at U.S. per capita average
- Medicaid costs to state and county governments
  - Costliest Medicaid in nation
  - Counties pay 25% of total costs
  - State must pay a great share of Medicaid increases

Personal Health Spending per Person, by State, 2004



Hospital closings and financial distress are real

- Since 1993, 34/231 hospitals closed (1/7)
- Hospitals' operating margin 49th/50
- Total margin 47th/50

Berger Commission's mythology

- Empty beds/excessive capacity very costly
- ¼ of staffed beds are unoccupied
- Long average hospital stays very costly
- Low occupancy rates endanger safety net
- Planned closings vital since market could close many of the most-needed hospitals
- Process: public and local participation
- Closing hospitals helps finance primary care

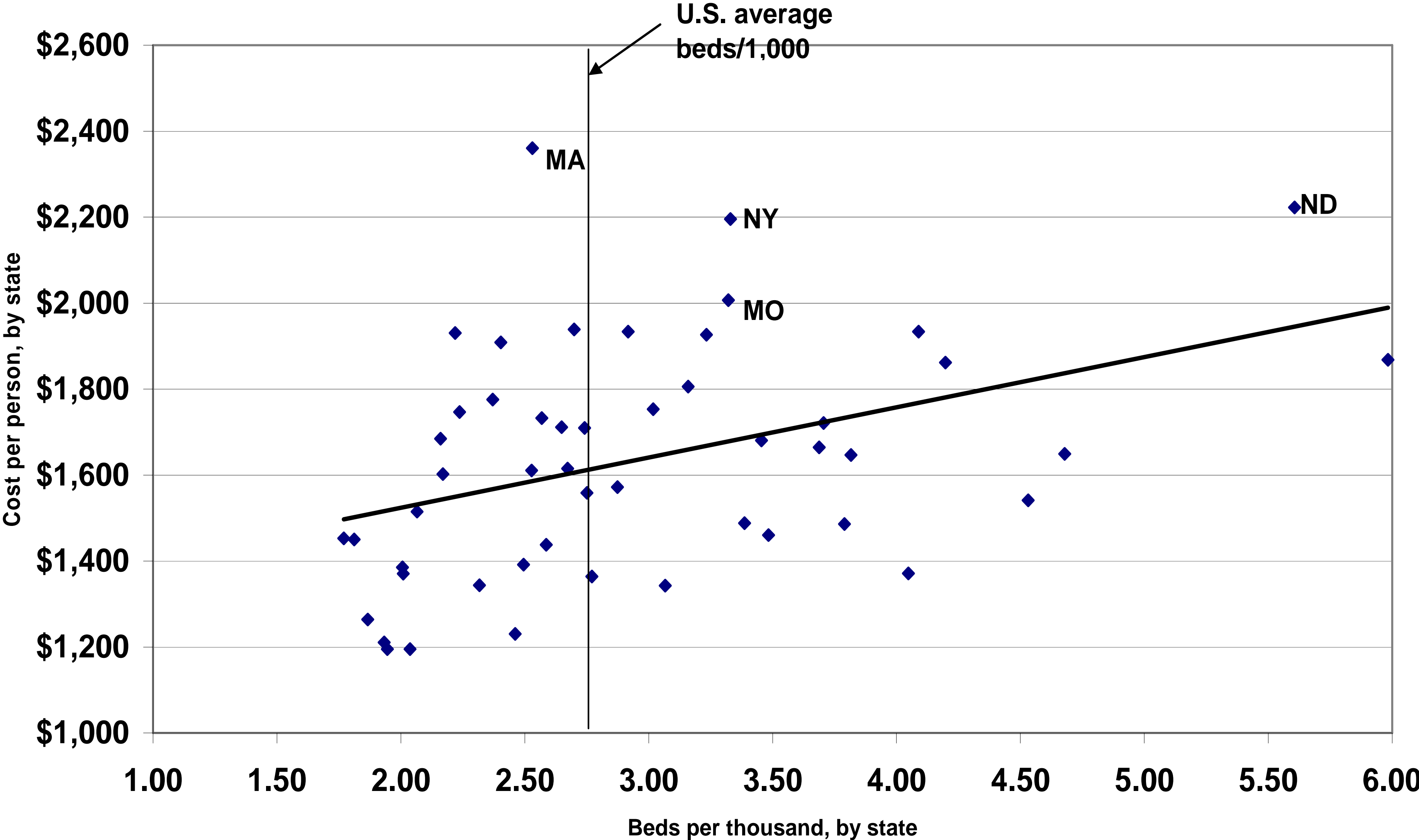
Excess beds don't cost more money

- Slight positive correlation between total beds/person and cost/person across states
- Slight negative correlation across nations
- Distinct negative correlation in U.S. over time
- Empty beds are not staffed
- Empty beds have only a fixed cost (does not go away, even after hospital closes)

N.Y. State hospital cost realities

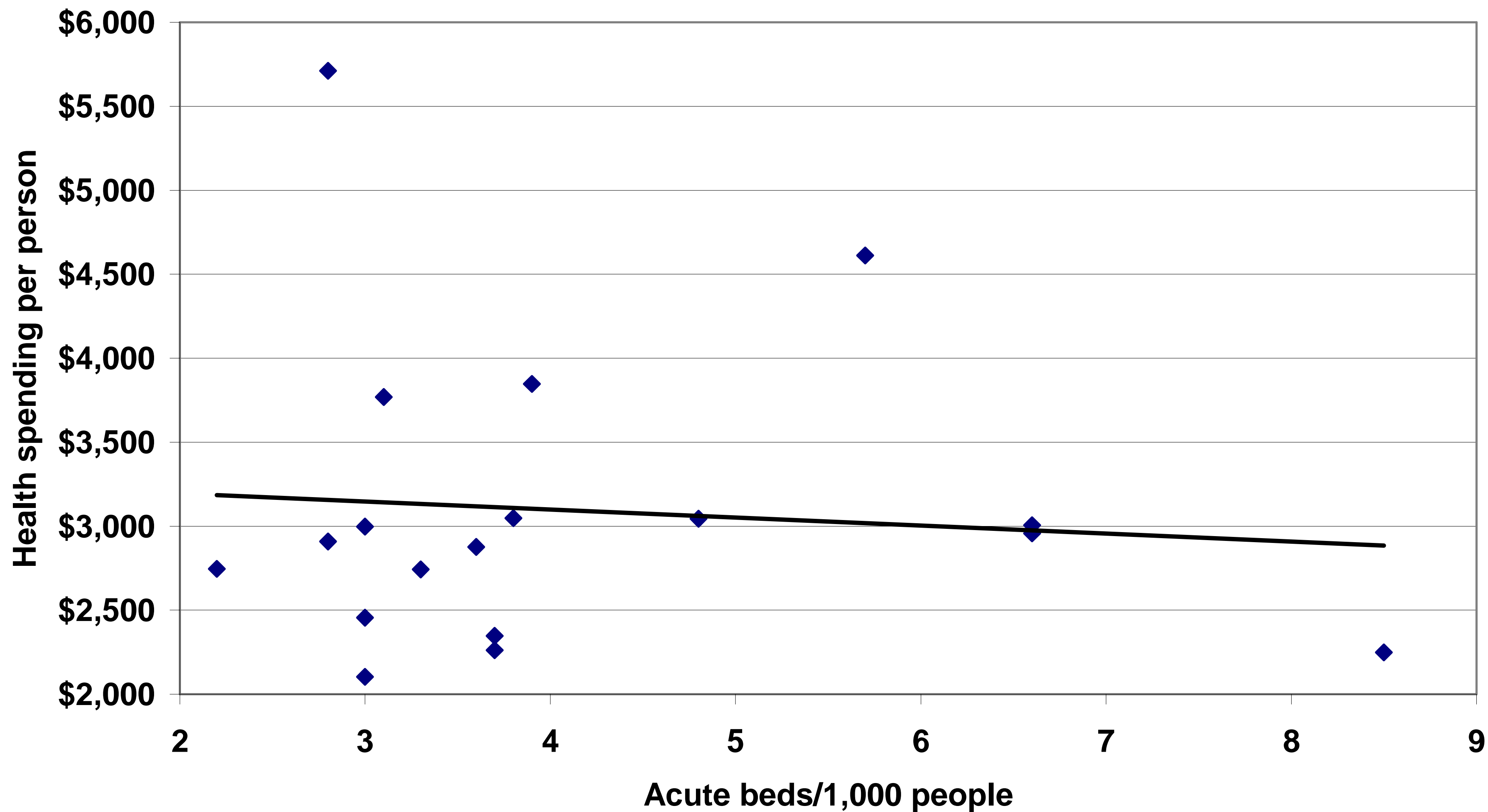
Characteristic	NYS % of USA	NYS rank
Cost/person	134%	3
Patient-days/1,000 people	142%	4
Admissions/1,000 people	110%	13
Average length-of-stay	130%	7
Beds/1,000 people	121%	15
ER visits/1,000 people	103%	23
Outpatient department visits/1,000	140%	13
Major medical center % admissions	213%	4
Resident FTEs/1,000 people	279%	1

Hospital Beds per Thousand Residents and Hospital Cost per Person, by State, 2004

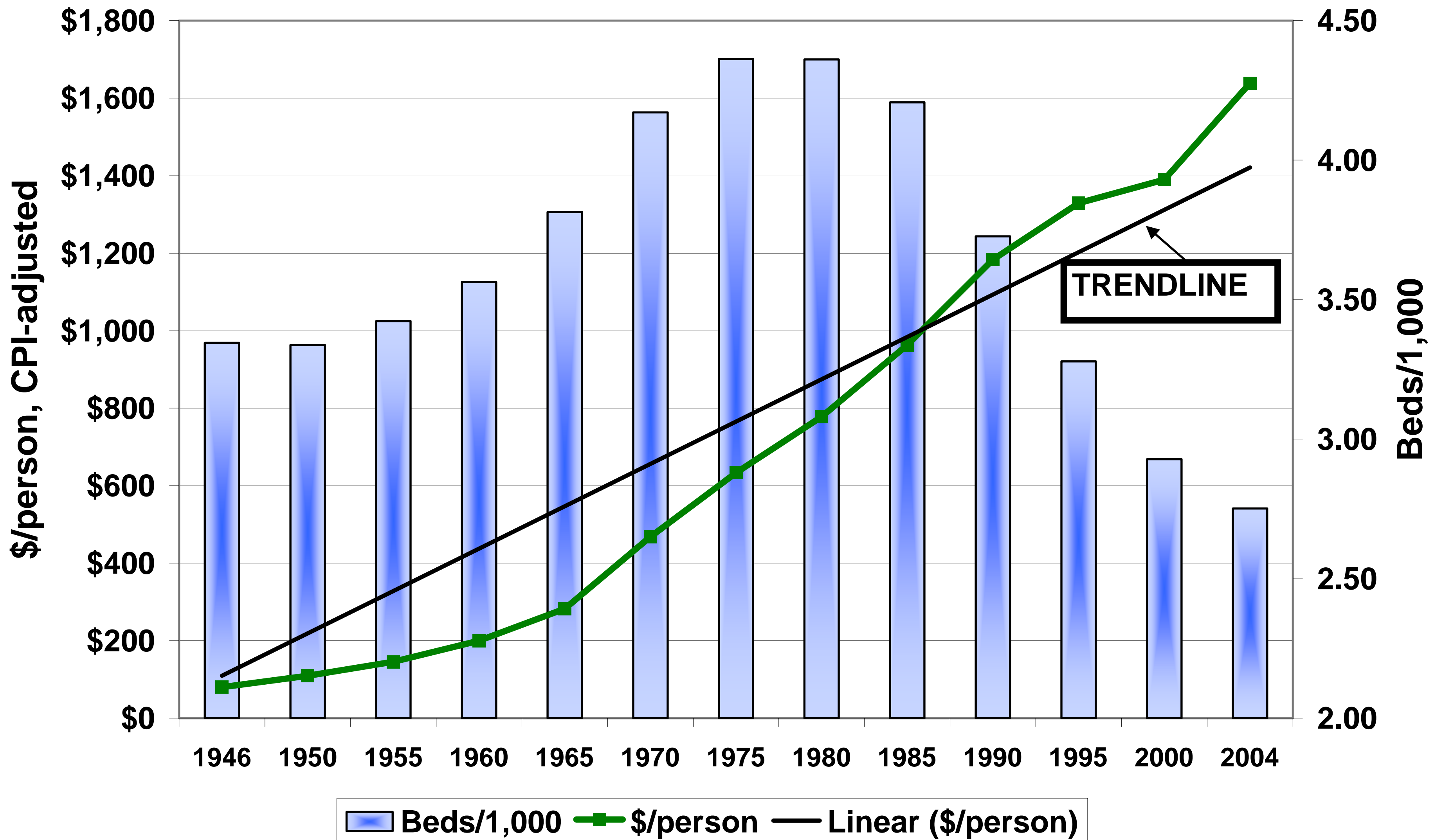


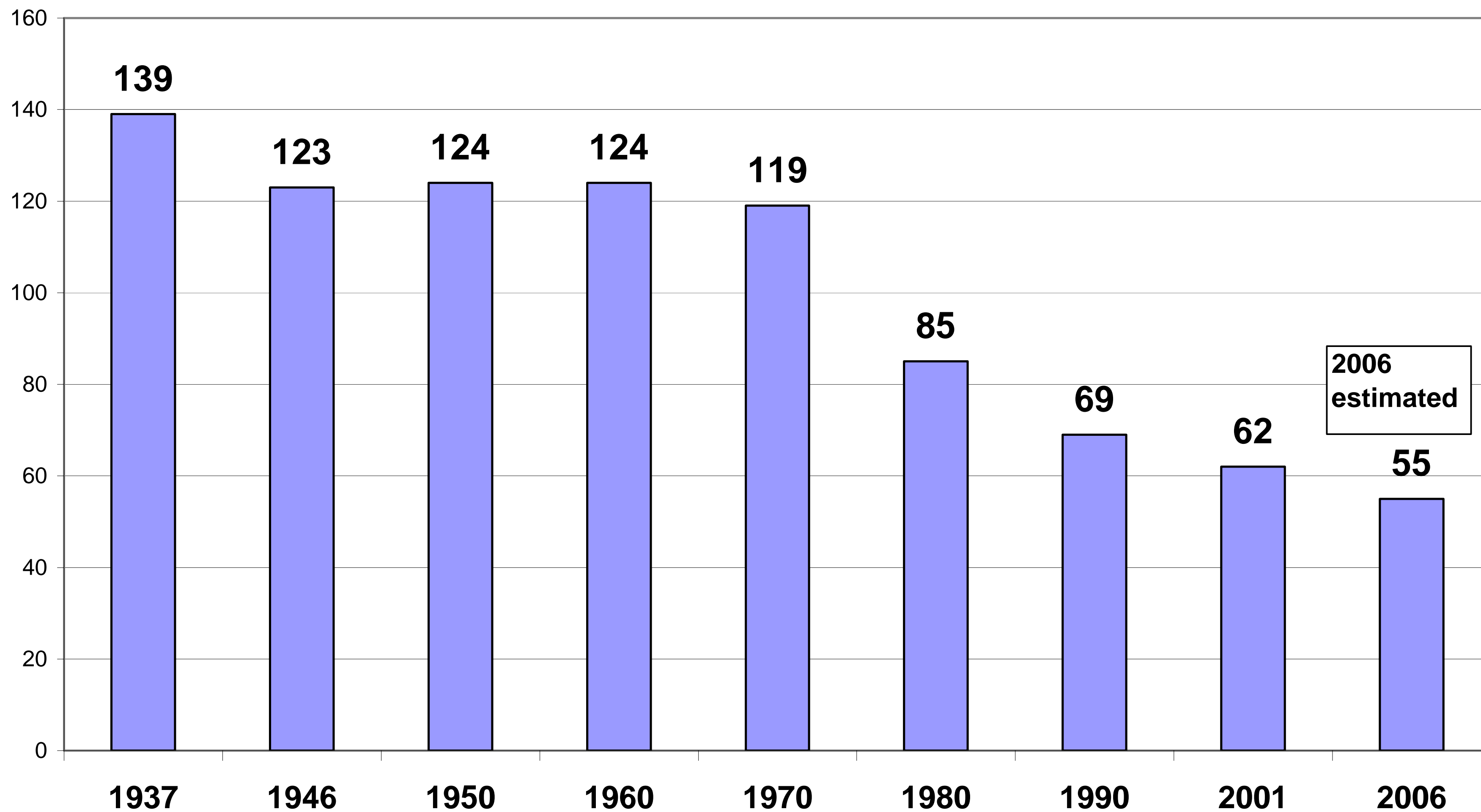
Predicting hospital cost/person across the 50 states, 2004

Factor	% of variance
COTH % admissions	12%
OPD visits/1,000	12%
Beds/1,000	11%
Office MDs/1,000	5%
Labor % expenses	4%

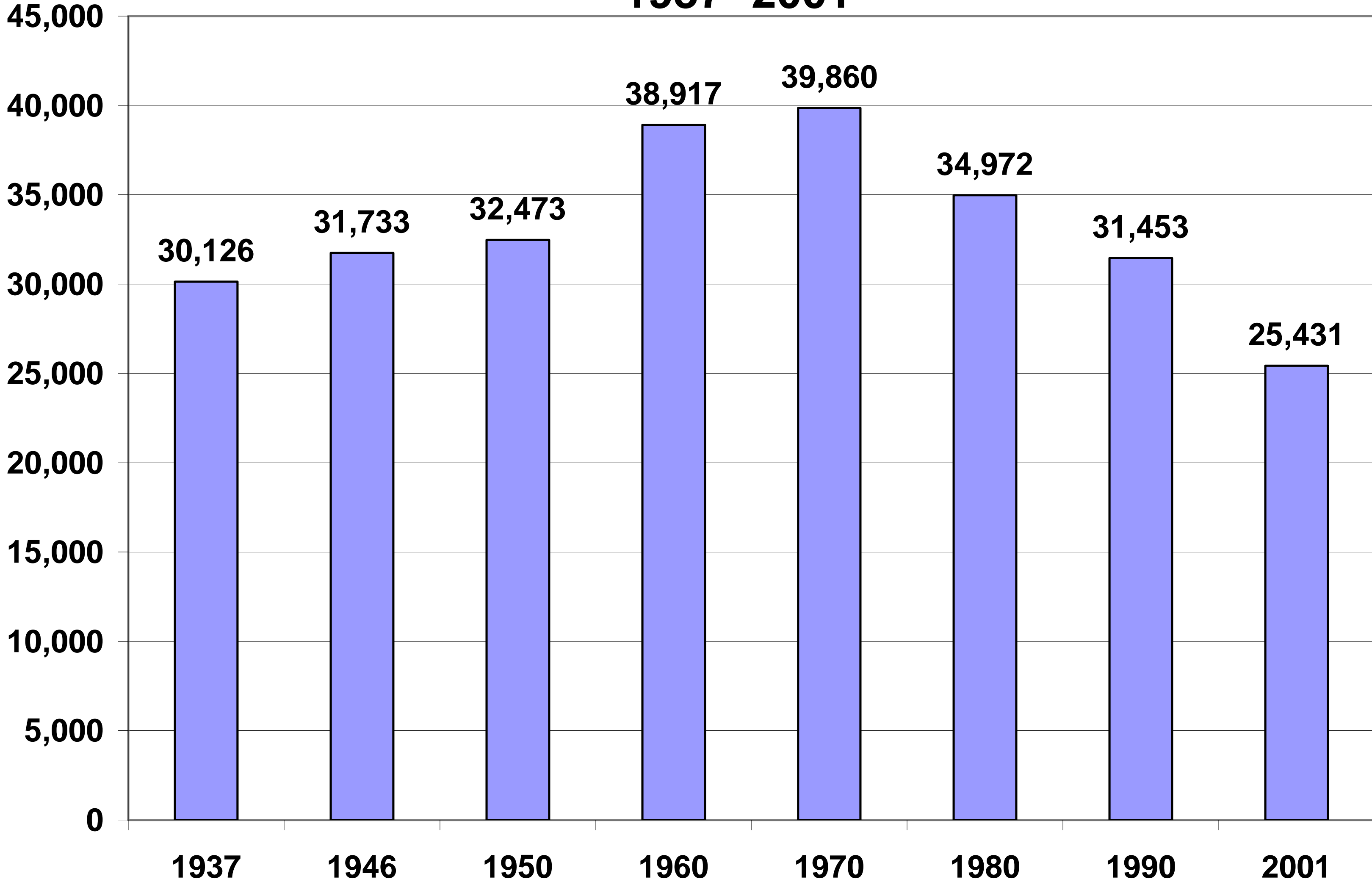

Health Spending per Person and Acute Beds/1,000 People, Wealthy OECD Nations, 2003
$6,000
$5,500
$5,000
$4,500
$4,000
$3,500
$3,000
$2,500
$2,000
Health spending per person
2
3
4
5
6
7
8
9
Acute beds/1,000 people

Hospital Cost/person (Consumer Price Index-adjusted) and Beds/1,000, U.S. 1946 - 2004

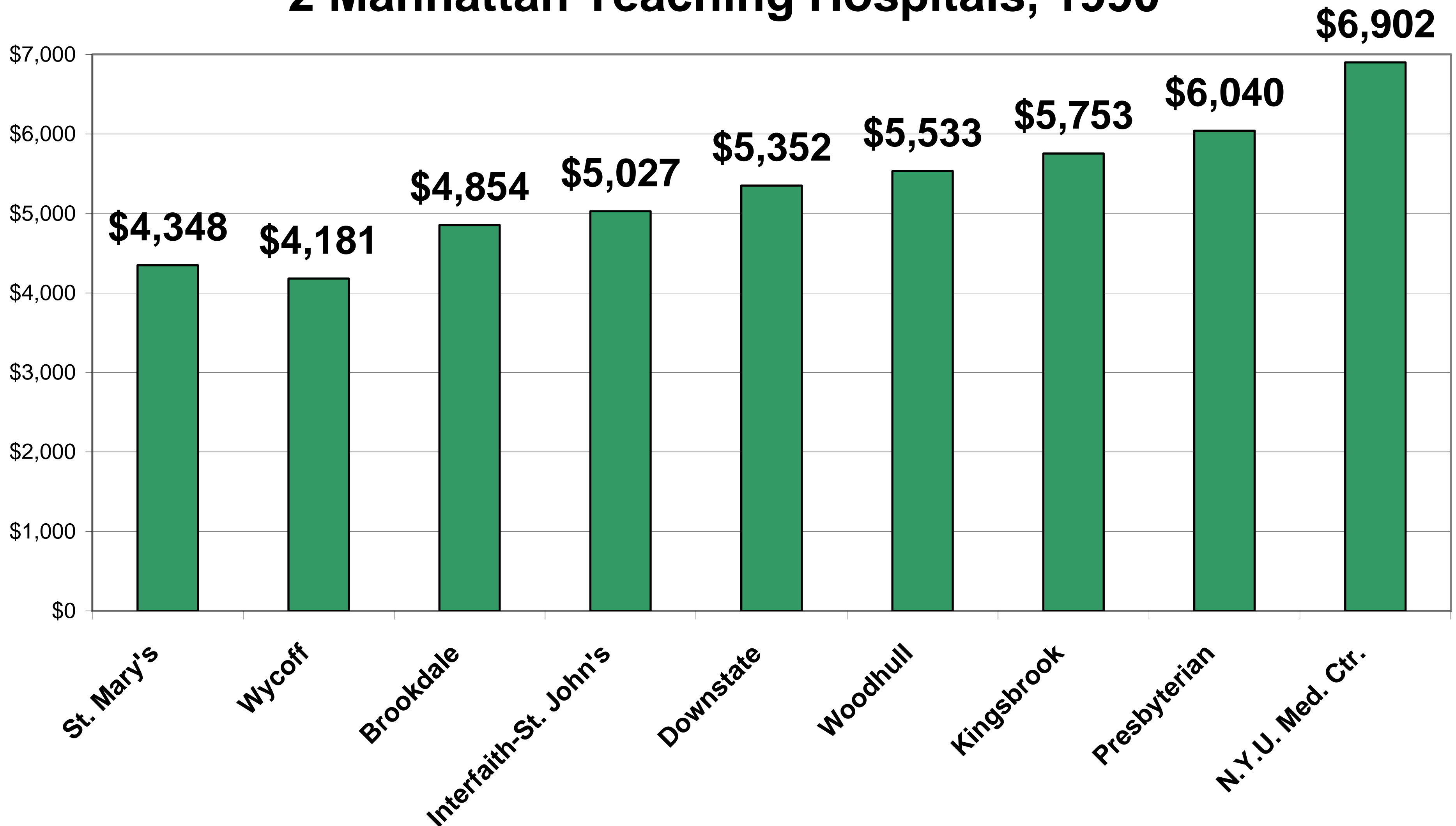




Number of Acute Care Hospitals, New York City,
1937-2006
160
140
120
100
80
60
40
20
0
139
123
124
124
119
85
69
62
55
2006
estimated
1937
1946
1950
1960
1970
1980
1990
2001
2006


Licensed Beds in New York City Acute Care Hospitals, 1937- 2001
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
30,126
31,733
32,473
38,917
39,860
34,972
31,453
25,431
1937
1946
1950
1960
1970
1980
1990
2001

Case Mix-Adjusted Cost per Adjusted Admission, 7 Brooklyn Hospitals and 2 Manhattan Teaching Hospitals, 1990



Closing hospitals predictably won't save money

- Smaller and less costly hospitals are easier to close politically.
- When they close, care, workers and costs migrate to costlier surviving hospitals
- Bigger hospitals and medical centers provide costlier care, but they are politically impossible to close
- <u>Efficiency has no value in predicting hospital survival</u>
- <u>Empty beds are not staffed so have only fixed costs</u>
- <u>Cutting average stay doesn't save, because days that can be cut cost little</u>

Lessons from study of closings among 1,200 hospitals in 52 U.S. cities, 1936-2006

Predictors of hospital closings, 52 U.S. cities, 1980 - 2003

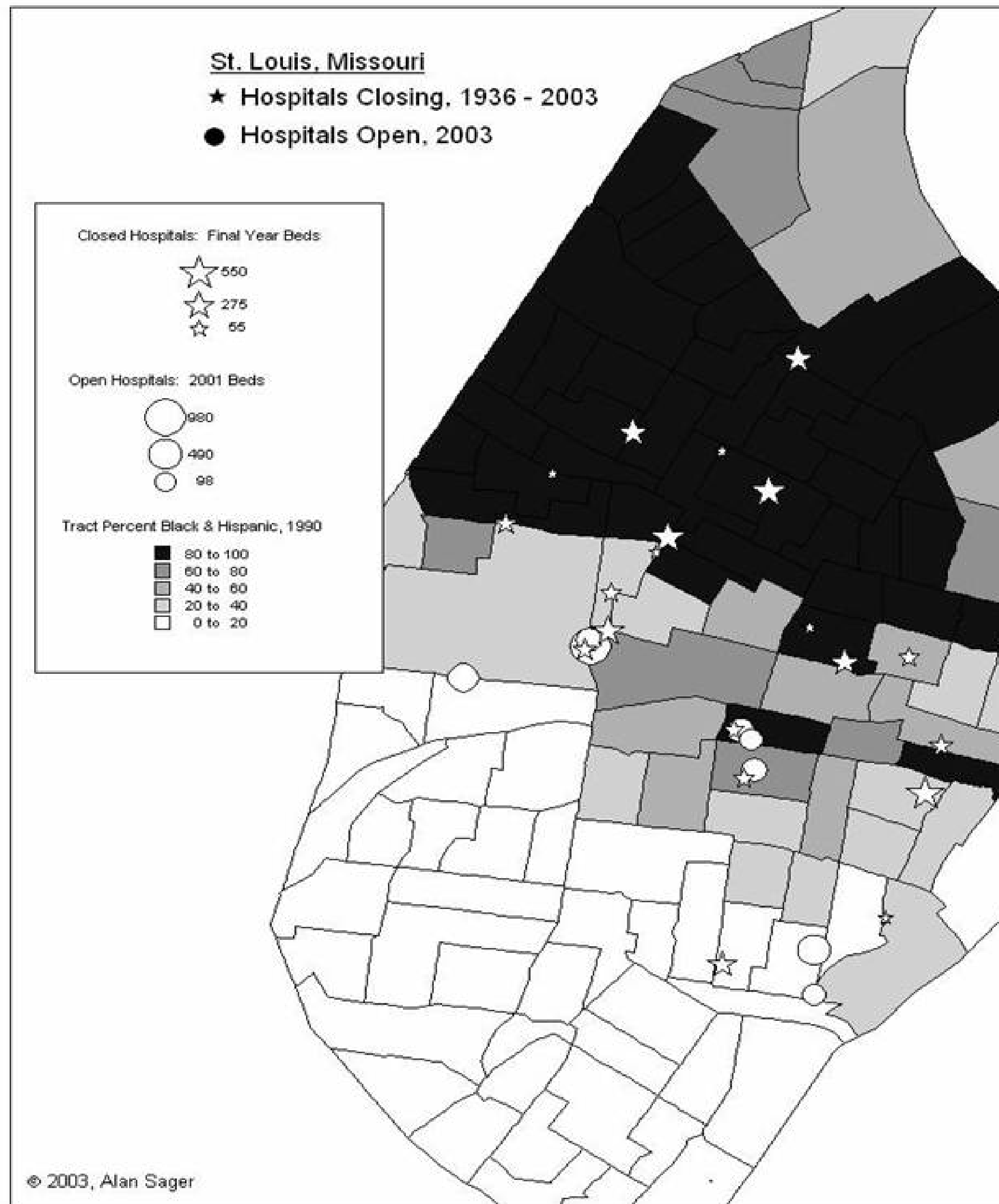
Initial year characteristic	significance
Medical school affiliation	0.0314
Beds	0.0000
Area percent black	0.0008
Hospitals within one mile	0.0190
Fund balance per patient	0.0002
Case mix index, Medicare patients	0.0047
Efficiency	0.1502
Adjusted R^2 from regression	26.1%
number of hospitals in 52 cities	692

Closing hospitals will harm access to care

- Link between race and closings
- Cumulative racial and geographic losses
- Hospitals vital providers of ambulatory care

The Chance of Closing 1980 – 2003 Is Greater for Smaller Hospitals and Those in Black Neighborhoods

Area % black,	Hospital beds in 1980				
1980	832	443	340	162	66
1	3%	16%	23%	40%	51%
30	4%	20%	29%	87%	59%
50	5%	23%	33%	53%	64%
90	7%	32%	43%	63%	73%


St. Louis, Missouri
★ Hospitals Closing, 1936 - 2003
● Hospitals Open, 2003
Closed Hospitals: Final Year Beds
550
275
55
Open Hospitals: 2001 Beds
980
490
98
Tract Percent Black & Hispanic, 1990
80 to 100
60 to 80
40 to 60
20 to 40
0 to 20
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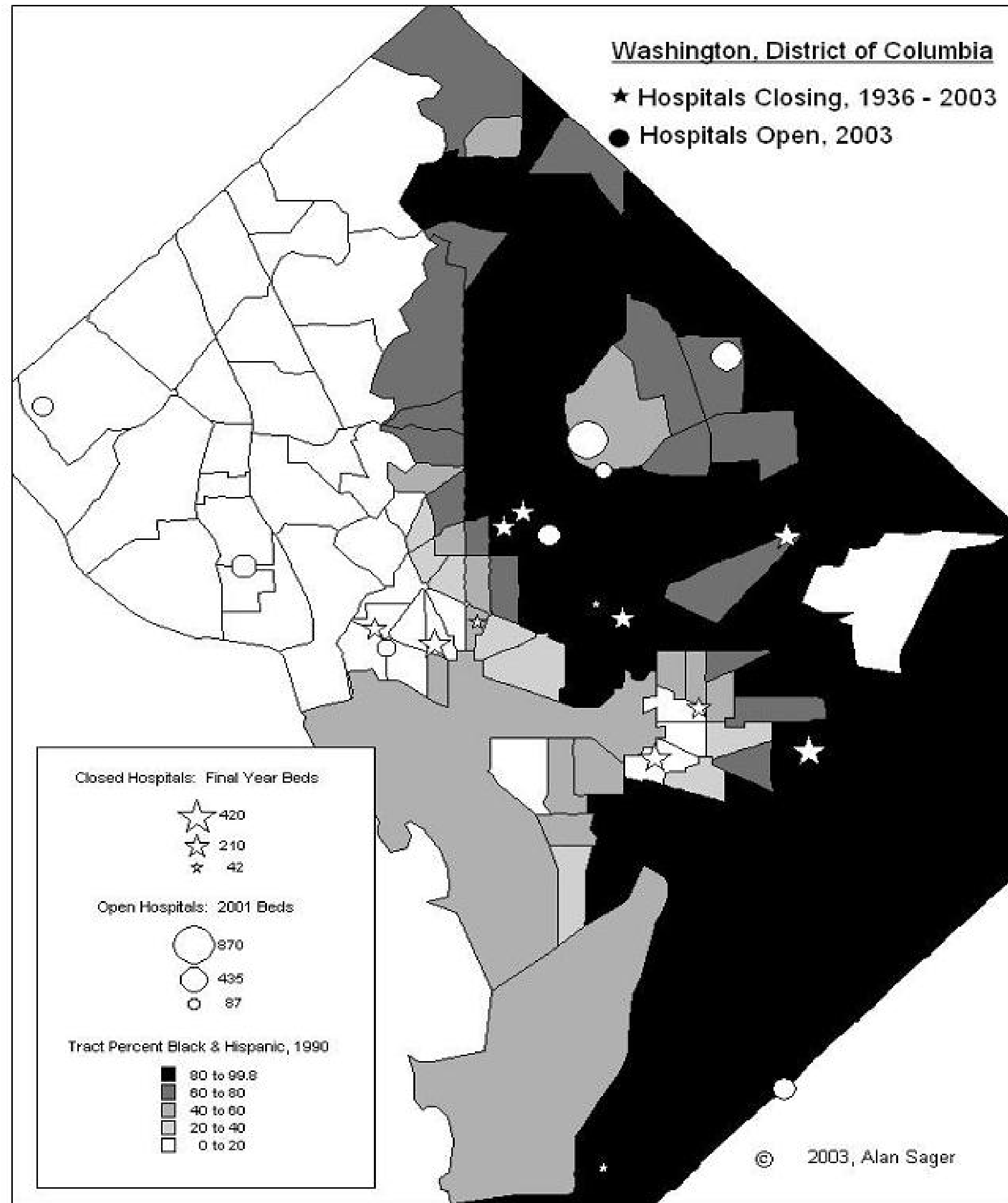
Washington, District of Columbia
★ Hospitals Closing, 1936 - 2003
● Hospitals Open, 2003
Closed Hospitals: Final Year Beds
420
210
42
Open Hospitals: 2001 Beds
870
435
87
Tract Percent Black & Hispanic, 1990
80 to 99.8
60 to 80
40 to 60
20 to 40
0 to 20
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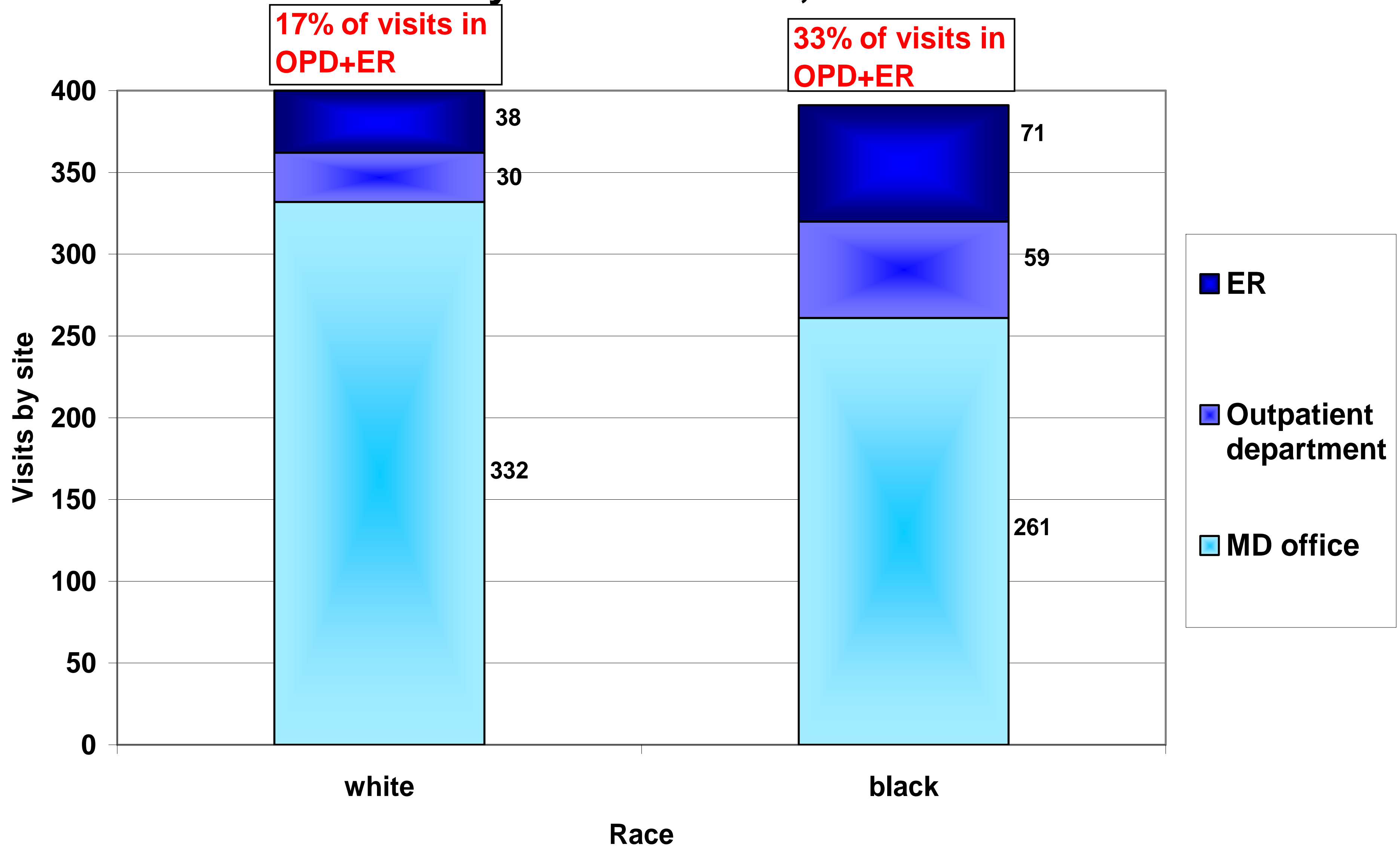
Visits to Physicians per 100 People
by Site and Race, 2003
17% of visits in OPD+ER
33% of visits in OPD+ER
400
350
300
250
200
150
100
50
0
Visits by site
38
30
332
71
59
261
white
black
Race
ER
Outpatient department
MD office

Who benefits from closings, mergers?

- Closings = distraction, not a cost control policy
- Since costs don't fall, it's survivors who benefit
- Most hospitals financially squeezed
- As in 1970s, powerful hospitals push less powerful from lifeboat
- Cutting beds gives survivors more market power
  - Raise prices
  - Borrow at lower interest rates
- That means higher revenues for hospitals, higher costs to payers
- Temporary peace, until the next crisis → close more hospitals?

The emperor’s new close

- Closings/consolidations sold as high-minded efficiency and step toward long-term reform in public interest
  - Military base-closings model
  - Insulated from politics to make hard choice
- (Opponents are insular, selfish traditionalists)
- Advocates of closings really hope to win short-term financial relief for some hospitals
- Focus on symptom, not on causes, so costs will rise as more care is shifted to major medical centers
- Distraction from heavy lifting, not durable reform