

***THREATS TO URBAN PUBLIC HOSPITALS
AND HOW TO RESPOND TO THEM***

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Doctors Day Address

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As always, I write and speak only for myself, not for the Boston University School of Public Health, or for organizations that provide financial support.

Thank you for inviting me to speak with you this afternoon.

I. INTRODUCTION

Since the 1930s, decade after decade, urban hospitals that serve lower-income patients and minority patients (African-Americans or Hispanic-Americans) have been substantially more likely to close, even after controlling for number of beds, whether the hospital is a teaching hospital, efficiency of the hospital, and other factors.

I've examined all hospitals (some 1,200) open at any time since 1936 in 52 U.S. cities—all of the large cities and most of the mid-sized ones. Fully 54 percent of hospitals have remained open in census tracts with 1990 minority population shares under 20 percent, but only 33 percent of hospitals have remained open in hospitals with minority shares over 80 percent.

If we map hospitals and their closings in several cities, we can see how this works out for people. These maps of St. Louis, Washington, Detroit, and Brooklyn succinctly summarize hospital survival over time in relation to demography.

When we look at public hospitals alone, in these 52 cities, we find that there were 73 public hospitals with 48,000 beds in 1936 and 53 public hospitals with only 24,000 beds in 1996. Public hospital beds dropped from almost one-third of the total beds in those cities in 1936 to about one-seventh of the beds in 1996. (Please refer to chart at end of document.)

II. CAUSES OF URBAN PUBLIC HOSPITAL CLOSINGS/DOWNSIZINGS

A. General and broad policy-level causes—macro causes

Four large-scale environmental changes, phenomena, or perceptions have contributed to public hospital closings and downsizings.

- Rising numbers of people with private health insurance and Medicaid meant falling numbers of people lacking health insurance—at least until the mid-1970s. Since 1976, the number of Americans lacking health insurance has risen from roughly 23 million to roughly 45 million.
- Skyrocketing cost of hospital care versus slow growth of local public tax revenue. For example, U.S. acute hospital costs rose 13.6-fold between 1970 and 1995, while U.S. local governments' property tax revenues—their financial mainstays—rose only 4.9-fold.
- Delegitimation of publicly-provided services generally and endorsement of private services; labeling public hospitals as irredeemable sinners (they are not saints, either, merely essential under many circumstances)
- Belief that cities are over-bedded, and that “a closed hospital is a good hospital.” The nation’s acute hospital beds per 1,000 residents peaked at 4.3 in the early 1980s and has since fallen steadily to 3.0 in 1999—a drop of almost one-third. Further, the number of beds reported by hospitals probably exceeds the number of actually available for patients.

B. Specific local or circumstantial causes—micro causes

Five hospital-specific factors have contributed in various ways at various times to most public hospital closings and downsizings:

- Financial
- Economic
- Medical
- Physical
- Political

1. Financial—hospital deficits

- The number of uninsured patients remains high.

- Hospital costs have been rising much faster than local government tax dollars.
- Hospital revenues are sometimes inadequate because of under-billing. That can be a result of antiquated systems or managerial problems, or sometimes a result of an old public hospital culture of “we take care of people and the city provides the dollars; we don’t need to send out bills.”
- “Atmosphere of financial crisis in local government can result in panic, often manipulated,” as I said in a talk at Boston City Hospital on Valentine’s Day of 1985.
- City governments can be impelled to try to balance their budgets by closing the city’s hospital.

2. Economic—high costs

For the past two decades, health care cost control efforts have often focused on hospitals—with their perceived high costs. Hospitals consume over one-third of the health dollar and they simply look expensive. Perceptions of inappropriate over-use of the hospital (“a bed built is a bed filled”) and of low occupancy rates have fuelled efforts to close hospitals and beds in hope of saving money. Sometimes, this is possible without eliminating needed care. On other occasions, efforts to save money by closing entire hospitals and beds can actually increase total spending. Hospitals that have closed are often more efficient than survivors. Further, closings can exacerbate access problems in cities whose hospitals actually experienced very high actual occupancy rates even before the closings. (In some cities, actual occupancy rates are substantially higher than those reported.)

- Public hospitals can be—or they can appear—particularly vulnerable on grounds of efficiency and cost.
- Some cities are thought to be over-bedded, even though this is no longer a problem in many cities, if it ever was one. Hospital closings and downsizings, population growth, and population aging have reduced over-bedding considerably. Many cities face looming (or current) shortages of acute hospital beds.
- Public hospitals often look inefficient and sometimes they are inefficient.
 - Consider these data on case mix-adjusted cost per adjusted discharge in 1990 hospitals in the 52 cities, arrayed by teaching hospital status and ownership status. The important comparison concerns the major teaching

getting sick from problems that can't be prevented. And the costs are right back. Like managed care, prevention offers what is at best a one-time savings—or a delay in incurring costs—and even this is wide open to dispute. Still, prevention is the right thing even when it does not save money. Its advocates are naïve if they over-sell prevention as a money-saver because they and their mission will likely be discredited.

- politicization of a public enterprise, and associated risks of patronage, no-shows, and feather-bedding
- unionization
- civil service

How real are these perceptions?

- Some public hospitals have histories of weak management—CEOs are sometimes low-paid (usually low-paid), inexperienced, unassertive, or political appointees.
 - Managing public hospitals is harder than managing other hospitals. I suggest that their CEOs probably deserve higher salaries, not lower ones. But how do you pay the hospital administrator more than the mayor or governor get? We should find a way to pay more, given how many non-profit and for-profit hospital CEOs make much more than the president.
- Closings of urban public hospitals are usually preceded by attempts to cut costs and to make other reforms
 - often too little, too late
 - sometimes only half-hearted
 - enough to publicize the cost problem but not enough to turn the hospital around or to satisfy critics
 - and sometimes badly-planned cuts that erode quality of care and drive patients away, and further undermine the hospital
 - Critics of the hospital may mistrust any promised reforms, saying they have heard these before. They come to believe that only a closing will make a difference.

- Many groups have the power to dig in their heels and veto reform, thinking and saying: “We’ve heard all of this before, and they didn’t close the hospital. They won’t do it now.” They come to believe that no closing will happen.
- People who think like this only have to be wrong once, and then closed is usually forever. In this respect, a hospital resembles a small and endangered country surrounded by enemies. It cannot afford to lose one battle.

History, we all know, is about both continuity and change—things continue as they were, and continue, and then they often change, sometimes radically. And sometimes for the worse.

3. *Medical*

- Public hospitals provide vast amounts of high-quality care to patients who need that care vitally. It’s sounds almost trite to say that, but it has to be said because it is so easy to forget.
- At the same time, quality problems arise at all hospitals, including public hospitals. Are public hospitals’ quality problems more serious? Does anyone know?
- Still, public hospitals’ quality problems can be pounced on selectively
 - sometimes by enemies of the hospital
 - and sometimes by friends of the hospital who want more money to improve care
- Some quality problems can be associated with legacy of years or even decades of under-funding or inefficiency or failure to invest in new equipment or buildings.
- Other quality problems can be associated with more recent budget cuts.
- These can lead to low morale, especially if combined with under-staffing of some services.

- If a public hospital's quality problems are publicized or selectively publicized, use of the hospital may decline.
- This can be offered as evidence that the hospital is not needed.

4. Physical

Many public hospitals were last rebuilt on a large scale many decades ago.

Particularly when they suffer inadequate maintenance, they reach a time when many mechanical, electrical, and other systems simply fail, requiring substantial spending each year just to bandage the facility.

The need to rebuild forces a decision about spending a great deal of money. This can help to crystallize sentiment against the hospital.

But after a point, refusing to rebuild means slow suffocation.

Unattractiveness deters some patients—especially those with a choice—from coming to the hospital.

Publicized horror stories of falling plaster and burst steam pipes add to the problem.

The hospital is further delegitimized in the eyes of much of the public.

Yet, ironically, rebuilding is a two-edged sword.

In Detroit and Boston, decisions were taken to rebuild public hospitals. But after the new buildings were opened, local governments decided, for various reasons, that they could not afford to pay for both the costs of caring for uninsured people and the costs of paying off the bonds. So they leased the public hospitals to nearby non-profit hospitals.

5. Political

- Urban public hospitals have been vulnerable when conservative local politicians dominate city or county governments.

- Especially at times of local fiscal crises.
- And especially when non-profit urban hospitals seek to capture some of the patients who have been served at the public hospitals.
- Conservative local governments are inevitable from time to time.
- It is equally inevitable that they will coincide with local fiscal crises.
- If conservative local governments and local fiscal crises also coincide with a perceived need to invest a great deal of money to rebuild the hospital physically, the threat to the hospital is magnified. This happened in both Philadelphia and St. Louis in the middle- and late-1970s.
- Each time such a conjunction occurs, an urban public hospital's survival is at risk.
 - Financial, economic, medical, or physical plant problems may weaken the political legitimacy of the city remaining in the hospital business.
 - Political supporters of the hospital may be weak or disorganized. They may have seen so many threats to the hospital that they don't take any one threat seriously enough.
- The political supporters of closing a hospital often think along three lines.
 - First, "The people who voted for me don't use this hospital."
 - Second, they engage in magical thinking—eliminate the hospital and the cost can go away. Eliminate the hospital, and you don't have to take care of the people who the hospital served. Someone else will do that.
 - Third, "Anything has to be better than this hospital." Blind ideology. People who think this way invariably find ways to make things worse.
- Politically, it is much easier to see the disadvantages and imperfections in an existing hospital, than to anticipate the problems in closing it, and in replacing its services elsewhere. Those problems often become apparent only after the hospital closes.
- Sometimes, skewed reporting exacerbates political problems. Some local reporters may judge that a hospital has no future, or should be closed, and

write accordingly. They believe they are working in the long-term interests of the community, but they seldom do in fact.

- Once a public hospital is closed, it is very difficult—some think it impossible—to change your mind.
 - Patients drift away, out of sight though often unserved. Workers depart. The organization is dismantled. Supporters demobilize.
 - Re-opening a hospital was tried in St. Louis, where a new mayor was elected a couple of decades ago on the promise to re-open the recently-closed Homer G. Phillips municipal hospital. But re-opening would have been very costly because it required compliance with all of the most current building and life-safety codes, which had been grandparented for the old building. A bond issue to finance the new hospital failed, and the closing stood.
- If a decision is taken to close the hospital, it is often done undemocratically. In Philadelphia, for example, the voters approved a million dollars to plan the reconstruction of Philadelphia General Hospital on the same night that they voted in Frank Rizzo as mayor. Mayor Rizzo announced that he would close the hospital and did so.
- Further, there have been few analyses or assessments of the possible or actual effects of public hospital closings, either before, during, or after the closing. As a result, proponents of closings could insist that they were safe—since all those other beds were somehow available out there. It is surprising how little evidence and public debate is required before a hospital can be closed. Contrast this with the evidence that must be compiled before trees can be cut down, a road or runway built, or a new drug marketed. Our nation has an environmental protection act that requires environmental impact statements, but we lack a health protection act that requires health impact statements.

III. SURVIVAL STRATEGIES

A. Nation-wide considerations

Although survival strategies must be tailored to the specific causes or threats that endanger a particular urban public hospital, several general and nation-wide factors are also important.

For example, the context of the discussion has changed radically over the past 25 years. In many cities, it is simply no longer true that an overall surplus of hospitals or of beds persists. The aging of the baby boomers could well lead to serious bed shortages in many cities and entire metropolitan areas in the years ahead.

Looking from the overall to the specific, the steady and disproportionate removal of hospitals from African-American and Hispanic-American communities has increased the need for care by surviving public hospitals.

At the same time, the growing financial distress of many surviving non-profit hospitals—both teaching and community hospitals—has weakened their abilities—and undermined their willingness—to pick up the burdens of caring for patients who had formerly been served by closed public hospitals.

These new and growing realities threaten old prejudices against urban public hospitals.

Unfortunately, some opponents of public hospitals cling to the notion that “Anything has to be better than this hospital.”

B. Local considerations

As difficult as the debate over the future of DC General has been, in several ways, it has been different from—and, in some ways—more serious than the discussions in cities where public hospitals were closed.

- One reason is that the need to sustain care for vulnerable citizens is more important today, and the demand to close hospitals recklessly is weaker today.
- A second reason is that local politics in the District in 2001 are simply different from those in Philadelphia in 1974, St. Louis and San Antonio in 1980, New York in the early 1980s, and others.
- A third reason is that the Financial Control Board has been involved in ways that are both negative and positive.

- On the negative side, the Board seems to have adopted the mayor's view that DC General should be closed, and has done so without considering the effects of the closing or ways to provide substitute services.
 - On the positive side, having made this mistake, the Board may be seeking more detailed commitments and assurances from Doctors Community than the mayor might have sought. The Board may be demanding evidence and guarantees, not rhetoric and promises. The interesting question will arise when the Board must decide whether Doctors Community is offering to do an adequate job, at an affordable price—and whether it can be trusted to do what it offers. The Board's actions may be exposing a clearer view of the full, real costs of closing DC General and of delivering satisfactory services elsewhere.
- The push to close DC General has been strong, mainly for reasons having little to do with health care and having much to do with spending less money.
- But an outright, stark, simple, and harsh closing has not proven to be politically realistic. Why not?
 - One of the reasons given to close the hospital was to make money available for primary care and other services.
 - And local political figures have scrutinized the plans.
 - So alternative services had to be offered.
 - Last fall, the Community Access Hospital proposal took shape, but it has been largely discredited. (Unfortunately, the District and Control Board did not understand the full reasons why the Community Access Hospital proposal was discredited. Those reasons include the difficulty of coordinating inpatient care, emergency services, and specialty and primary physician services at multiple sites operating under multiple ownership—under conditions of relatively weak managerial capacity.)
 - It seems clear that any alternative to DC General must deliver and finance appropriate types and amounts of care.
 - ❖ Primary
 - ❖ Specialty
 - ❖ Emergency
 - ❖ Inpatient

- The cost of doing this, the quality of the services, and the durability of the caregiving arrangements must all be scrutinized.
- In other words, the effort to close DC General to save money has gradually evolved into a discussion of how best to finance and deliver health care to vulnerable citizens of the District. If the health care finance and delivery discussion grows stronger and if the focus on closing DC General to save money weakens, the people of the District will benefit.

Looking backward, on the down side, the trouble is that two decisions—closing DG General and delivering alternative services—were made largely in isolation and at different times.

- Some of this stems from the mayor’s decision to close DC General without carefully analyzing the consequences. The decision is redolent of the assumption that “anything’s got to be better (or cheaper) than this.”
- The Financial Control Board seems generally to have taken an anti-DC General position and does not seem to have demanded analysis of the consequences of losing the hospital. This has strengthened the mayor’s hand on the closing.
- The other decision, which has been evolving over time, has been to deliver and finance alternative services to replace many of those that had been offered at DC General, and perhaps to supplement those services.
- The trouble has been that the two options were never compared side-by-side—sustaining and reforming DC General versus contracting out its services.
- The cost, quality, coverage, and acceptability of the two choices were never compared. Instead, a hospital with real strengths and weaknesses was compared with imaginary solutions, leading to a closing.
- Subsequently, the promises by Doctors Community are being analyzed separately.
- From a simple strategic viewpoint, this has been a massive blunder. The city’s bargaining position with Doctors Community was much stronger before the mayor decided to close DC General.

On the positive side, the growing scrutiny of the DC General closing, and of the alternatives offered over the past six months, have raised the level of the discussion.

The results:

- possibly, a greater focus on the need for care by uninsured citizens of the District, on the services required, and on how to finance and deliver those services; and
- a closer examination of the Doctors Community proposal and sub-contracts.

Still, while we still don't have information on the full Doctors Community proposal or on the detailed contract that is being negotiated among the parties, there is reason to fear that the services to be provided will be

inadequate,
incomplete,
geographically inaccessible,
under-financed,
inadequately managed and coordinated,
expensive to deliver,
costly to administer, or
most or all of these things.

Worse, we can expect that the contract will be difficult to enforce, and also that the District will have trouble enforcing it.

All responsible parties need time to read and evaluate the full contract that is being negotiated. To be successful, such a contract must specify

- the patients to be served,
- the full health care delivery plan for serving them—which caregivers, at which locations, with which volumes of various services, and with which medical, administrative, and financial coordination,
- the budget that shows the cost and volumes of services,
- the plan for coordinating services, referrals, and payments,
- the revenue stream (financing) for the services to be provided under the contract, and
- the plan for enforcing and monitoring the contract.

All parties need time to back away from the frenzied deadline atmosphere that has been created. This is not the way for a great city and nation to make health policy that will affect citizens for decades to come.

Unfortunately, like some efforts to save the public hospitals themselves in other cities, the current planning effort is a case of too little and too late.

It analyzes only one expedient plan, offered by a hospital that clearly has the upper hand, as it has become the only game in town.

There is a danger that, with the best intentions, the District and the Control Board, will not be able or willing to offer a tough evaluation of Doctors Community. If they do get tough, these are the choices that will probably remain—

- to accede to a Doctors Community plan that they know to be incomplete, under-funded, defective, or inadequate in the care provided—putting the District’s people and other hospitals at risk
- to provide more money to Doctors Community than has been made available to DC General—which would acknowledge that the District has been under-financing needed care
- to close DC General outright

A more realistic plan for the survival and improvement of health care for the vulnerable citizens of the District requires pulling back from the edge of the cliff on which we are now standing.

It requires guaranteeing that DC General be sustained—with ongoing reforms continuing and growing—for a minimum of one year.

During this time, a full and fair analysis of all reasonable alternative methods of giving care and paying for care in the District must be undertaken.

How to pay for this?

- First, mechanically, the possible steps are clear.

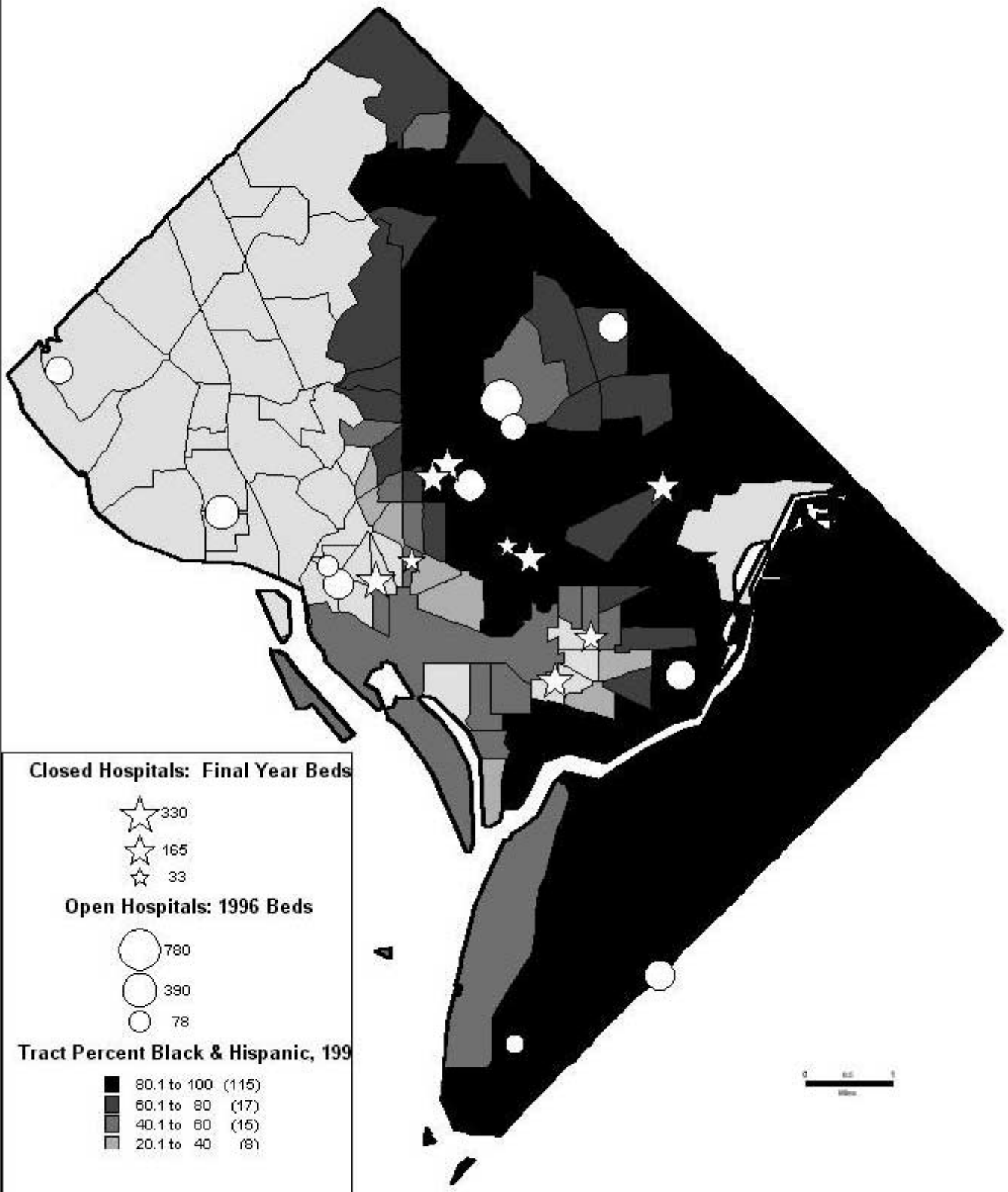
- Congress needs to find money to sustain the hospital for one year. This means finite financing for a real budget. The PBC should appeal for that money now. The mayor and Control Board should support that appeal.
 - The money might be provided through a Medicaid waiver, as was done for L.A. County Hospital.
 - It might require a direct emergency Congressional appropriation.
 - Or it might require Congressional authorization for the District to spend some of its available financial reserves to sustain the hospital.
- Second, politically, the path is rockier.
 - Appealing for money would require acknowledging that the rush to close DC General was rash, precipitous, and reckless.
 - It would require the mayor and the Control Board to re-evaluate what they have been doing for the past year or more.
 - But they can always say that as they obtained more information about the costs and feasibility of the Doctors Community alternative, they realized—week-by-week—just how complex this matter really is.

Thanks for the chance to talk with you today—I'd be happy to take questions in the time that remains.

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Washington, DC

- ☆ Hospitals Closing, 1936-1997
- Hospitals Open, 1997



Closed Hospitals: Final Year Beds

- ☆ 330
- ☆ 165
- ☆ 33

Open Hospitals: 1996 Beds

- 780
- 390
- 78

Tract Percent Black & Hispanic, 1990

- 80.1 to 100 (115)
- 60.1 to 80 (17)
- 40.1 to 60 (15)
- 20.1 to 40 (8)

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PUBLIC, NON-PROFIT, AND FOR-PROFIT SHARES OF HOSPITAL BEDS, 52 CITIES, 1936 AND 1996

