D.C. GENERAL HOSPITAL SHOULD BE RENEWED,

NOT CLOSED OR CONVERTED

Alan Sager, Ph.D.

Professor of Health Services
Boston University School of Public Health
715 Albany Street
Boston, Massachusetts 02118

phone (617) 638-4664
fax (617) 638-5374
asager@bu.edu

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

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I. INTRODUCTION AND QUALIFICATIONS

Good afternoon. My name is Alan Sager. I am a professor of health services at the Boston University School of Public Health, where I have taught since 1983. I serve on the Massachusetts Attorney-General's Advisory Group on Health Care Reform, and on the state Secretary of Health and Human Services' Working Group on Health Care Finance. I hold a B.A. in economics from Brandeis and a Ph.D. in city and regional planning (specializing in health care) from MIT.

I have been asked by the Committee of Interns and Residents to travel to Washington today to testify before you. The Committee is the union to which interns and residents at District of Columbia General Hospital belong. While I am compensated for my work on this issue, I have written this testimony myself and it represents only my own independent professional views. It has not been edited or approved by anyone else.

I am not a physician or a hospital administrator. This testimony rests in part on my 27 years of investigations into hospital closings, hospital survival techniques, and reshaping hospital care in 52 U.S. cities (including Washington, D.C.) from 1936 to-date.

Today, D.C. General Hospital presents many financial, medical, staffing, physical plant, political, and other problems.

For tomorrow, you face three alternatives for D.C. General Hospital:

- an outright closing, but that would result in denial of needed care to many patients vulnerable to under-service, and it could de-stabilize other hospitals;
- a conversion to a "community access hospital," but that would be complicated, difficult to design and coordinate, medically risky, and costly; or
- renewing and reforming the hospital with the right services and number of inpatient beds, but that would require complex, highly-charged, sustained, and costly efforts.

This is not an easy choice. If it were easy, the future of the hospital would have been successfully resolved years ago. But please don't agree with those who have despaired or would bail out. Instead, go the distance. The hospital's crises create opportunities, as more people are willing to be part of a comprehensive compromise reform solution.

Closing the hospital is unacceptable because too many patients will be hurt. And converting it to a CAH cannot work because it is simply too complex—administratively, medically, and financially. When these impossible options are eliminated, what is left is what must be done, however difficult it may seem today.

On balance, therefore, I strongly urge you to adopt the third alternative. For all its complexity and difficulty, I believe it is the safest for the people of the District who are vulnerable to deprivation of needed care. It is substantially better than a "community access hospital" (CAH). I do not believe that renewing and reforming the hospital will be more expensive than the CAH, especially in light of the medical benefits that renewal and reform would offer. And for all its problems, it is much less of a gamble than the CAH would be. Renewing D.C. General requires reform so it works as efficiently as possible, as all hospitals should. This is not a leap into the unknown—but it is a tough job that will require hard and long work from smart, experienced, and dedicated people.

This approach is realistic. It is not merely a fantasy or a glossy brochure that lacks substance. It has been done before. Hospitals have been turned around. Cambio's studies have identified many problems and eleven groups of specific recommendations to address those problems. The problem analysis and recommendations are grounded in months of experience in the hospital, and are supported by detailed evidence about the hospital.[1] Most of these recommendations seem reasonable to me.

The CAH, by contrast, would be a leap into the unknown. Right now, its two main attractions seem to be that it avoids the immediate political problems that closing D.C. General Hospital would bring, and it seems to present a magical last-minute solution that avoids the tough work of actually fixing D.C. General Hospital. But avoiding political problems or tough work is no solution. There is no free lunch in health care.

Worse, while making the transition to a CAH is not as complicated as, say, the Normandy invasion of June 1944, it comes close—as medical reconfigurations go. It could be so difficult to make the transition to a CAH that D.C. General Hospital could well be irretrievably destroyed in the process—with no assurance that substitute care is available. The CAH proposal should not become a roller-coaster ride to a closing.

The CAH proposal approved by the PBC constitutes the single most unrealistic and risky proposal I can recall seeing in the health care field.

Renewing and reforming D.C. General Hospital is the most conservative approach of the three. It is appropriate to be conservative when lives are at stake. This approach thereby cleaves to the old medical admonition to "First, do no harm."

This approach respects at least three important realities.

First, it respects the great amounts of care D.C. General Hospital provides—such as:

- over 51,000 ER visits in 1999 (second-highest in the District and one-seventh the District-wide total), and
- over 10,000 admissions in 1999 (up 5.7 percent since 1995).[2]

Second, it respects the people of the District, and their need for health care that is located reasonably near where they live. It respects D.C. General Hospital's location in an area that has already lost many hospitals, and where few hospitals remain.

Third, it respects the likely growing need for hospital and emergency room care in the years ahead—when other financially distressed hospitals might close, and when greater numbers of older patients will need more hospital beds, not fewer.

Choosing to renew and reform D.C. General Hospital is a little like relying on democracy itself. Churchill called democracy "the worst form of government, except all those other forms that have been tried from time to time." [3]

Renewing and reforming D.C. General Hospital, for all its difficulty, is probably the least risky and even the least expensive—in money and lives—of the three alternatives.

The rest of this testimony spells out the evidence and the reasons why I urge you to go the distance and support the strategies that have been and are being developed to renew and reform D.C. General Hospital.

II. ARGUMENTS FOR CLOSING OR RADICALLY DOWNSIZING D.C. GENERAL HOSPITAL

For years, you have heard many arguments for closing or for radically downsizing D.C. General Hospital, or for downgrading its mission so it will no longer be a genuine acute care hospital:

- D.C. General Hospital is too far gone. It can't be brought back. Anything has to be better.

- The hospital is too expensive. A combination of inefficiency, poor management, or over-staffing has established an unaffordable cost structure. Or public hospitals are inefficient. Or unionized hospitals are inefficient.

- Revenues are too low. The hospital serves too many patients without insurance.

- It would cost too much to renew the hospital. The cost of a new building would be too great. And it would be too hard to work with doctors, nurses, and other employees to shape an affordable pattern of care.

- The current quality of the hospital's clinical services may be good in some respects, but it is not good enough in other respects.

- The hospital is not needed. Empty beds are available elsewhere. And moving D.C. General Hospital's patients to other hospitals will help to stabilize and retain other hospitals vital to the residents of the District.

- Money that would have to be spent to stabilize the hospital would be better spent by providing health insurance coverage to people who are vulnerable to deprivation of needed care—or by preventing more problems through better ambulatory care.

III. SUMMARY OF THE COMMUNITY ACCESS HOSPITAL PROPOSAL

After considering these problems, and other matters, the Public Benefit Corporation (PBC) has voted to convert the D.C. General Hospital into a new "community access hospital" (CAH).[4] That CAH would offer selected services:

- minor ER services, but not Level I trauma—which would be re-directed to other hospitals

- short-term observation and stabilization (for up to 36 hours), but not acute inpatient care, which would be provided under contract at other hospitals

- basic laboratory, limited radiology, and a pharmacy

- a DC Qualified Health Center (DCQHC), with primary care, with disease management and prevention for diabetes and cardiovascular problems, with preventive dentistry, and possibly with certain specialty clinics; but other "chronic and specialty care will be provided through contracts with other providers and facilities."

The PBC proposal would also direct resources to "community-based primary care" health facilities. It notes the previous commitment of $14.5 million in capital for clinics. It asserts that "*The dollars must follow the patients.*"[5]

The PBC's proposal "anticipates being able to provide the equivalent of health insurance for the current uninsured populations served by D.C. General." This would be done by giving cards to people lacking insurance—cards that would entitle them to services at the proposed CAH and at contracting providers.

The PBC's proposal also mentions the District's hope of expanding Medicaid.

The PBC asserts that its proposal is "manageable within the current PBC subsidy." But it does expect that unquantified transition funding will be required.

The PBC expects that aligning the current D.C. General Hospital into the CAH and the DCQHC, preparing referral and contracting arrangements, preparing eligibility-determination systems, designing and testing needed payment systems, and obtaining needed regulatory approvals can all be accomplished by 1 January 2001.

IV. SPECIFIC CONCERNS AND QUESTIONS ABOUT THE CAH PROPOSAL

The CAH proposal may appear feasible and desirable. It may appear to be a medically, financially, and politically palatable alternative to closing D.C. General Hospital. It would seem to avoid the hard, slogging work of renewing and reforming D.C. General Hospital.

But the evidence supporting the feasibility of the CAH is insubstantial. And the proposed timetable for implementing the CAH is so short that it constitutes a recipe for financial, administrative, and possibly medical disasters—disasters that would discredit all those responsible for them. Further, it appears that the staff time and expertise needed to design and test the CAH—and get it up and running on schedule—is simply not available.

The PBC Board apparently voted to support the CAH proposal without first securing evidence on its medical safety, its financial feasibility, or its capacity to meet the medical needs of the uninsured and patients currently served at D.C. General Hospital. If this is so, the PBC's vote is premature at best and reckless at worst.

The PBC's Board seems to have ratified a top-down planning process, one that appears to have sought little participation from other stakeholders—such as patients, employees, and the communities served by D.C. General Hospital.

It will not be easy to implement the CAH proposal responsibly. Doing so would require at least the following eleven elements of detailed design, testing, and preparation of clinical, administrative, medical records, legal, and financial systems:

1. estimating the volumes of patients to be served in the CAH's emergency room, its observation beds, or its ambulatory care programs;

2. estimating with reasonable confidence the volumes of emergency room patients, hospital inpatients, ambulatory patients requiring specialized services, and other patients to be served under contract at other hospitals and facilities in the District;

3. estimating with reasonable confidence the costs of patients served at the CAH and at contracting caregivers;

4. estimating with reasonable confidence revenues generated by serving patients at the CAH and at contracting caregivers;

5. developing a practical and comprehensive work plan for designing and managing the conversion of D.C. General Hospital into the CAH;

6. developing a practical and comprehensive work plan for addressing the reductions in force, retraining, and associated issues involving D.C. General Hospital's employees;

7. designing, negotiating, and signing a set of contracts to ensure that other hospitals deliver specified services to former patients of D.C. General Hospital;

8. putting in place fall-back or contingency plans to deliver care to uninsured, Medicaid-sponsored, and other vulnerable patients formerly served by D.C. General Hospital

in the event that contracting hospitals themselves suffer financial distress or are forced to close;

9. designing and implementing procedures to coordinate care (including referral methods, and methods coordinating medical records) by D.C. General Hospital or health center physicians with care by specialists at hospitals that do accept referrals;

10. designing methods to assess and certify patient eligibility for services at D.C. General Hospital and at contracting hospitals and other caregivers; and

11. designing methods of paying contracting hospitals and other caregivers for services performed.[6]

Performing these eleven steps quickly, competently, and safely is enormously difficult. I am surprised that anyone could expect them to be accomplished in anything like the time contemplated with the human, financial, software, information systems and other resources likely to be available.

Consider the statements by Dr. Ivan Walks, D.C. Commissioner of Health, mentioned during the City Council's hearing on 18 September 2000 that he and his staff "worked all-nighters and on Labor Day" to get the CAH proposal ready, and that "we have a complete lack of resources" to prepare the CAH.[7]

The evidence base for the proposal is very weak. For example, the proposal claims that

> Careful research was conducted to determine the feasibility of offering a freestanding emergency room with primary care and resources services together on one campus. The research revealed that there are freestanding emergency facilities currently operating in urban metropolitan areas and in dense suburban areas including Philadelphia, Fairfax, and a statewide system in Illinois.[8]

This language is confusing at best and positively misleading at worst. The research is called "careful" in the first sentence. And it is true that the Fairfax, Philadelphia, and Illinois examples involve freestanding emergency rooms, as stated in the second sentence. But no research was able to demonstrate the feasibility of a freestanding emergency room like the CAH proposal envisages. That is because the ***Philadelphia, Fairfax, and Illinois cases bear virtually no important resemblance to what is proposed for the CAH.[9]***

Therefore, while each of the two sentences may be true, individually, they are simply not connected, either logically or substantively. Joining them in the same paragraph leaves the false impression that research into the Philadelphia, Fairfax, and Illinois cases support the feasibility of a freestanding ER.

Any investigations in these three jurisdictions should have revealed striking differences from what is proposed for D.C. General Hospital. These differences are so striking that the Fairfax, Philadelphia, and Illinois examples should not be considered to offer relevant evidence regarding the medical safety, financial feasibility, or managerial feasibility of the CAH plan for D.C. General Hospital.

Perhaps most important, the Philadelphia, Fairfax, and Illinois emergency rooms, while physically freestanding, are actually ***owned by and fully integrated with large hospital systems***. They are not organizationally freestanding, as the CAH would be. Further, three of the four facilities are located in relatively affluent suburban areas, while the fourth serves a wide cross-section of an urban community.

- INOVA, the umbrella for hospitals in Fairfax County, Virginia, operates its two physically freestanding ER/urgent care facilities in close coordination with its major hospital and its three smaller hospitals.[10] The four INOVA hospitals operate a total of some 800 beds.[11] Patients are transported by ambulance from the freestanding ER to other sites of care when appropriate, and clinical services and information are integrated throughout the system. Because services, information, and transportation are integrated, this system does not depend on contracts and referrals among entities that are legally and financially independent. INOVA has strong financial resources, and is located in a fairly affluent set of communities. Estimated per capita income in Fairfax County in 1997 was 53.0 percent above the statewide Virginia average.[12]

- Germantown Hospital, formerly an acute hospital in Philadelphia, was converted into a freestanding ER. But it is owned by and part of the Albert Einstein Medical Center, a 700-bed major tertiary teaching hospital. Again, the ER is physically freestanding but it is integrated with physician, inpatient, and other services. Albert Einstein Medical Center serves a wide cross-section of the community.[13]

- The Adventist hospital system in Hinsdale, Illinois, owns a freestanding ER in nearby Bolling Brook. That facility is completely integrated into the Adventist system. The system supports the ER, which is located in an affluent community. The ER was to have been a full-service acute care, but the state denied a certificate of need for that facility. The Adventist system fought successfully to overcome state Department of Health opposition to licensing a freestanding ER, eventually persuading the legislature to over-ride the Department's position.[14]

- Similarly, the Trinity hospital system in Moline/Rock Island, Illinois runs a Recovery Center, which includes a freestanding ER along with a wide range of specialty services. The facility, which is completely integrated into the Trinity system, is also located in an area whose residents' incomes are above the regional average. Trinity is now trying to convert and designate the Recovery Center as a hospital because the present reimbursement rate is not adequate to pay for care.[15]

All four of these examples are incorrectly cited as precedents for the CAH proposal because all four are fully integrated into large and relatively strong hospital systems. The challenges that the CAH will face—in arranging referrals, in coordinating among physician, ER, and inpatient care, in billing, in payments, in coordinating medical records, and the like—are much smaller in a fully integrated system.

Three of the four freestanding ERs serve affluent suburban areas, and one is a large teaching hospital that serves a broad cross-section of city residents and suburbanites.

The CAH proposal, therefore, is without precedent. It is not right to ask that vital services for people vulnerable to denial of needed care by the objects of risky

experiments. A hospital for under-served low-income urban citizens should not be one of the nation's institutional guinea pigs.

One of the many benefits of operating a freestanding ER as part of a strong, well-financed, reasonably well-functioning, and integrated system of care serving a wide cross-section of the community is that many of the fixed costs of operating a freestanding ER— particularly all of the administrative functions of billing, central administration, payroll, ordering supplies, and the rest—can be spread among the entire system. Expertise is at-hand in all areas.

Further, when a freestanding ER does operate under the license of a strong hospital, legal and reimbursement issues—those that must be settled before a freestanding ER can be paid for services—might be easier to resolve. Despite this advantage, those who would try to imitate any aspect of the Germantown – Albert Einstein experience should note that Germantown apparently suffers ongoing licensure problems with the Pennsylvania Department of Health. And the Bolling Brook facility required a legislative over-ride of Illinois Department of Health opposition to a freestanding ER.

The CAH proposal for D.C. General, would not make for an integrated system under one ownership and management. Instead, the CAH proposal calls for complicated referrals of patients among different hospitals and other facilities. The CAH would serve many low-income patients, many of whom are vulnerable to deprivation of needed care and some of whom suffer from more than one medical problem. All of the costs of the CAH would have to be borne by the CAH. There would be little opportunity to spread fixed costs.

How will clinical care be coordinated when a patient receives some services at the CAH, other services at another hospital's ER and inpatient facilities, and still other services from specialist physicians—possibly located elsewhere? Coordination of care and continuity of care are likely to suffer. Patients and their problems could fall through the cracks in the system, or be caught in webs of incomplete or inaccurate eligibility, medical records, or other information. Billing, eligibility determination, and medical records will be difficult to coordinate. And many other hospitals in the District suffer substantial financial problems, as discussed elsewhere in this report.

The Fairfax County, Philadelphia, and Illinois arrangements are so different from the CAH that is proposed for D.C. General Hospital that it is very surprising that they are presented as support for the CAH proposal.

The CAH proposal approved by the PBC is very ambitious, untested, complicated, hasty, and rushed. I can recall nothing like it. I find it inconceivable that the necessary elements and systems could be designed, tested, and implemented in the few months remaining before 1 January 2001.

The proposal's haste is demonstrated even in the words of the Medimetrix consulting group that prepared a presentation on two models, including an "emergency stabilization and access center" that closely resembles the CAH. According to Medimetrix, "***10 days ago, these two models were just terms***." [16]

If the CAH idea was only a term in the middle of August of this year, what is it today? Even on the 25th of August, according to Medimetrix, the CAH idea is "only at a level of refinement that allows for a choice of direction to pursue. . . further research and evaluation."[17]

There has been little time to flesh out the idea. There has been little time to address, in detail, the eleven sets of tasks just listed. The Commissioner of Health has said, as noted earlier, that he and his staff have been working under serious stresses of time and resources. And there has been almost no time to test them to see how they work in practice. Even if the CAH idea is the right one for this hospital—and it does not seem to be—it is being pursued too quickly to do it right.

The CAH proposal therefore violates the long-respected injunction on doctors to "First, do no harm." This injunction makes enormous sense even when applied to a doctor who is treating one patient at a time. It makes even more sense to apply it to governmental agencies that are treating a hospital that serves 50,000 ER patients, 10,000 inpatients, and even more ambulatory clinic and health center patients annually.

Even to contemplate moving to a CAH in a few months is surprising. To vote for it is shocking.

What might explain such a vote? These are two of the possible elements:

1. A belief that D.C. General Hospital is too broken to be fixed, that "anything's got to be better than keeping this hospital open."

   But those who say "anything's got to be better" can easily find ways to make things worse, because they are so convinced that anything must be better that they fail to scrutinize carefully the different alternatives.

2. A belief that D.C. General Hospital is not needed, because

   - prevention of illnesses will make hospital care less necessary,
   - use of the hospital has declined dramatically, so it is bordering on being irrelevant, or
   - other hospitals will provide needed services to replace those of D.C. General Hospital.

   But while prevention is valuable, it does not mean immortality. It means that one problem is prevented, but others take their place a few years—or months—later. Hospitals are needed today, and they will be needed even more tomorrow as the population ages, as discussed elsewhere.

   Use of D.C. General Hospital has not declined dramatically, as shown shortly in this report.

   And it is far from clear that other hospitals will be available (if some close their doors), close enough, able (if they have enough capacity), or willing (unless sufficiently and securely paid) to replace D.C. General Hospital's services.

V. SPECIFIC REASONS FOR RETAINING AND RENEWING D.C. GENERAL HOSPITAL

The hospital certainly has had its problems. Many of these persist today. But we should look forward, not backward, and focus on the need for the hospital today and in the future, not on the problems of the past. We should examine the evidence, and not be governed by frustration or other emotions.

If the hospital is needed to protect the health of the people, it must be retained and renewed. The weight of the evidence indicates that D.C. General Hospital is needed to protect the health of the people of the District.

Examining this evidence requires considering both space and time.

Let's first examine space—where the hospital is located today, the communities it serves, the services it provides, and the locations and survival prospects of other hospitals. It is important to retain needed hospitals and emergency rooms near where people live today, and also where they will be needed tomorrow.

A look at a map helps to show D.C. General Hospital's current importance in the city.

Doing so requires considering the past six decades' legacy of closing or relocating hospitals from African-American neighborhoods of the District.

Please turn to the attached series of maps. These are included at the end of this report, following the notes.

A. The Loss of Hospitals in the Eastern Half of Washington, D.C.

The first map identifies hospitals locations. D.C. General Hospital is number 7, as shown in the "***Key to Washington, D.C. Hospitals***" following the first map. This map shows that D.C. General Hospital is the only surviving institution in the eastern half of Washington, with the exceptions of the Greater Southeast-Hadley hospitals, now run for-profit by Doctors Community Healthcare Corporation, and of Providence Hospital.

This map displays the loss of hospitals from the eastern half of the district.[18]

- Central Dispensary/Emergency on New York Avenue closed in the 1950s, removing 310 beds.

- Providence relocated from near Capitol Hill in the 1950s, moving 297 beds.

- Sibley relocated from North Capitol Street in the 1960s, moving 248 beds.

Several other smaller hospitals closed or converted to other uses.

As a result, some 1100 beds in five hospitals were removed from the heart of the eastern half of the district.

This map shows the importance of D.C. General Hospital as a surviving caregiver for a large expanse of the District and its citizens. The map shows that Greater Southeast and Howard University hospitals are both about three miles from D.C. General Hospital.

D.C. General Hospital would be even more important if, for example, Greater Southeast were to close.

And if D.C. General Hospital were converted into a CAH, the most time-sensitive services—those of a Level I trauma center—would be the farthest away from the citizens of the eastern half of the District. Without D.C. General Hospital, only four Level I trauma centers would remain to serve residents of the District—those of Washington Hospital Center, George Washington, Georgetown, and Howard.[19]

As a public hospital, D.C. General has been able to remain open in the face of trends that have removed most of the other hospitals in the eastern half of the District.

The second map shows hospital closings against the background of the race of the residents who were living nearby when the 1990 census was conducted.[20] The racial data indicated are the African-American share of each census tract's population in 1990. (The third map combines ethnicity with race; it indicates the African-American plus Hispanic shares of each census tract's population in 1990.)

Visual inspection of the second map shows the close association between community race in 1990 and closing or relocation of hospitals in earlier decades. This association is not restricted to Washington, D.C.

One long-standing reality, which I have found in 52 U.S. cities—decade after decade since the first data were available in 1936—is that ***hospitals located in African-American neighborhoods, are significantly more likely to close, even after controlling for other factors—such as efficiency, teaching status, and the like.***

Exhibit 1

Acute Hospitals in 52 U.S. Cities:
Shares of Hospital Surviving to 1997
Grouped by 1990 Area Percent Minority

	% of the 701 hospitals open in 1936 that survived		% of the 1,170 hospitals ever open between 1936 and 1997 that survived		% of the 706 hospitals open in 1980 that survived	
Area % minority, 1990	% survived	total	% survived	total	% survived	total
0 - 19.9 percent	48.5%	171	53.8%	320	79.1%	196
20 - 39.9	50.5%	107	56.1%	180	74.8%	123
40 - 59.9	53.9%	102	57.4%	188	74.4%	133
60 - 79.9	39.7%	121	45.4%	194	69.3%	114
80 - 100	30.5%	200	32.6%	288	63.6%	140
All areas	42.9%	701	48.1%	1,170	72.8%	706

- As shown in Exhibit 1, on the preceding page, residents of neighborhoods with high minority (African-American plus Hispanic) population shares in 1990 were much more likely to have lost hospitals located in those neighborhoods. We found a fairly regular and consistent relation between the 1990 minority share of the people residing around a 1936 hospital's location and its chances of survival. For example, as the following table displays, while almost half of the 171 hospitals open in 1936 in neighborhoods under 20 percent African-American or Latino in 1990 remained open in 1997, only about 30 percent of hospitals located in neighborhoods 80 percent or more minority remained open in 1997. We found the same general pattern for hospitals ever open at any time between 1936 and 1997. And we found the same for hospitals open in 1980.

B. Hospital Use Data Show the Value of D.C. General Hospital

The evidence on the high level of use of the hospital suggest that it is needed.

- ***D. C. General Hospital is the second most important trauma center in the District. In calendar year 1999, 51,596 ER visits were made to D.C. General Hospital.*** This was the second-highest figure in the city, just 3,500 visits behind Washington Hospital Center.[21]

- In 1999, this meant that D.C. General Hospital provided 14 percent of the District's ER visits.

- ***Use of the hospital's inpatient beds rose substantially between 1995 and 1999. So the hospital seems to be becoming more useful, not less useful.*** Admissions rose by 5.7 percent, to just over 10,000 admissions. This was the largest rise among all of the District's hospitals.

- This increase contrasts with drops at some other nearby hospitals. Greater Southeast lost 12.3 percent of its admissions; Hadley Memorial lost 5.7 percent, and Howard University lost 2.5 percent.

These use data show the importance of the hospital. It is helpful to appreciate that hospitals are not inter-changeable parts in some health care machine. Patients make the best choices they can in today's world. Patients go to D.C. General Hospital today for good reasons of their own. Many of the District's estimated 88,000 uninsured patients have particularly strong reasons.

And the number of uninsured citizens of the District has been rising substantially, even during very good economic times. From 1996 to 1998 alone, the estimated number of uninsured people rose from 79,700 to 88,600, a rise of 11.3 percent. The share of the District's people lacking insurance rose from one in seven to one in six.[22] While it is decent and proper to talk about expanding Medicaid eligibility and designing new insurance options, doing so can be difficult.

If one hospital is closed, and its patients are obliged to go elsewhere, they can suffer harm. Shepard has found, for example, that almost one-third of a hospital's patients cease to seek inpatient care for some time after their hospital is closed.[23]

More than inpatient care is involved. ***Nationally, in 1996, African-American citizens depended twice as heavily on hospitals to organize and deliver ambulatory care (32 percent of their ambulatory care visits were in hospital ERs or OPDs) as did white citizens (15 percent)***.[24] Washington, D.C. may or may not have too many hospital beds (much depends on whether we count licensed beds or beds actually set up and staffed, as discussed elsewhere), but African-Americans' heavy reliance on hospitals for ambulatory care obliges caution before disrupting existing arrangements. Heavy reliance on hospital clinics and ERs for routine primary care services is seldom optimal, but it is much better than no care at all. More satisfactory alternative arrangements should be put in place and tested and stabilized before existing patterns of care are dismantled or forced to undergo hasty reorganization.

And would nearby hospitals have the physical capacity and the practical willingness to serve the patients who would be displaced if D.C. General Hospital were to be closed or reshaped into a CAH? Would nearby hospitals be willing and able to provide the emergency room capacity, the inpatient care, the ambulatory care, and the specialized services (such as dental, orthopedics, burn, or trauma care) required by displaced patients?

Would nearby hospitals have the financial capacity to serve patients displaced from D.C. General Hospital?

Many—though certainly not all—District hospitals lost money in fiscal year 1998, the latest for which data are available to me now, as shown in Exhibit 2.[25]

Exhibit 2

Operating Margins, Fiscal Year 1998, Selected District Hospitals

Hospital	Operating Margin, 1998
George Washington University	-2.5%
Georgetown University	-14.2%
Greater Southeast Community	-51.9%
Howard University	1.1%
Providence	3.3%
Washington Hospital Center	3.0%

The finances of some hospitals in the District may have improved since 1998, particularly those of Greater Southeast Community Hospital, while others' may have deteriorated.

Additionally, George Washington University and Greater Southeast Community/Hadley hospitals have been bought by for-profit hospital corporations. If those corporations are

unable to earn substantial rates of return on their invested equity, they should be expected to sell, convert, or even close hospitals they own.

Looking beyond the hospital-to-hospital variation, it is important to note that the District's acute care hospitals, taken as a group, were not in good financial condition even in 1998.

According to the District of Columbia Hospital Association, private non-profit hospitals in the District suffered an overall operating margin of – 3.77 percent in fiscal year 1998.[26]

When we consider all the acute care hospitals of the District, and compare their finances with those of hospitals in Maryland and Virginia, a similarly bleak picture emerges, as shown in Exhibit 3. Here, total margins are reported. These include non-operating revenues. The District's acute care hospitals' financial margins were only 29 percent of Maryland's, and only 14 percent of Virginia's.

Exhibit 3

Total Hospital Financial Margins, Fiscal Year 1998, D.C., Maryland, and Virginia

Jurisdiction	Total Net Revenue	Total Expenses	Total Margin
D.C.	$1,828,063,922	$1,804,493,901	1.3%
Maryland	$5,441,766,935	$5,198,032,054	4.5%
Virginia	$6,874,805,160	$6,233,864,195	9.3%

Some have said that a great deal of money could be saved by closing D.C. General Hospital, or by re-shaping it into a CAH. They have suggested that the savings could be devoted to insuring people who are currently uninsured, so they could use other hospitals. But this raises several questions.

- First, how much money would be saved by closing D.C. General Hospital or by re-shaping it into a CAH?

- Second, would the savings be adequate to insure all the patients now served by D.C. General Hospital, or to finance their care at a CAH—and also to pay for needed contracted emergency room and specialist physician and inpatient care services at other hospitals and facilities?

- Third, the draft proposal approved by the PBC "anticipates being able to provide the equivalent of health insurance for the current uninsured population served by D.C. General."[27] This language appears to exclude both currently uninsured people who are not served (or who are not acknowledged to be served) by D.C. General Hospital, and people who lose their insurance in the years ahead.

- Fourth, where would uninsured patients obtain needed inpatient and outpatient care once D.C. General Hospital was closed or re-shaped into a CAH? What are the assurances that care at those hospitals would continue to be paid for—or even that those other hospitals would remain open?

- Fifth, even if citizens were given insurance cards, would the rates of payment be adequate to persuade doctors and hospitals to provide care? It is one thing to put in place contractual provisions; it is another thing to enforce them.

- Sixth, if the new insurance were cancelled—or if eligibility or payment rates were cut back—during the next recession and resulting District fiscal crisis, where would patients get care? Providing insurance for all is a decent and worthy goal. ***But the rhetoric of offering insurance tomorrow (like the rhetoric of prevention) should not be used, even unintentionally, as a smokescreen behind which needed care is withdrawn today. It should not be used, even unintentionally, to grease the skids for closing D.C. General Hospital***. Uninsured patients need guarantees and carefully designed reforms, not promises or hastily sketched proposals.

C. Looking Forward: The Growing Need for Hospital Care

In recent decades, some experts have argued that the U.S. had built too many hospital beds, and that closing beds was a sensible way to save money. Indeed, some hospitals had built too many beds. But my evidence indicates that urban hospitals that closed were, on average, somewhat less expensive and more efficient than the survivors. Survivors tended to be larger teaching hospitals, hospitals with more money in the bank, and hospitals located in non-minority communities. Someone called this "survival of the fattest," not survival of the fittest.

Closing hospitals has been over-sold as a method of saving money in health care.

Some might assert that the District has too many hospital beds today. But this may depend largely on whether licensed beds or beds actually set up and staffed are counted.

In calendar year 1999, an 2,117 patients occupied beds at the District's 11 acute care hospitals on an average day.[28] Few hospitals today set up and staff beds that are likely to be empty. If hospitals set up and staff beds to achieve an average occupancy rate of 85 percent—a reasonable safety margin—they actually set up and staffed some 2,490 beds on an average day in 1999.[29] Dividing that figure by an estimated District population of 519,000 in 1999[30] yields an average of 4.8 set up and staffed beds per 1,000 District residents. When we allow for the substantial number of patients who live outside the District but obtain inpatient care within the District, this is not an unreasonable number.

Looking forward, the need for hospital beds is likely to rise again, we predict, as the number of older citizens rises. The baby boomers will start turning age 55 next year, and 65 in eleven years. People over age 55 need and use hospital beds much more

frequently than do younger citizens. It is important to retain enough hospitals and beds to serve them.[31]

The first signs of hospital crowding are becoming very visible in many cities. Hospitals from coast-to-coast have complained of ER gridlock during the past few flu seasons. And this year, some hospitals are voicing similar complaints even in warm weather.

Closing too many hospitals and beds today will require costly building projects tomorrow. If the nation liked bailing out the S&Ls for $500 billion, it will love replacing a thousand or so closed hospitals at a cost of $1 million per bed.

As mentioned earlier, D.C. General Hospital's importance would be even greater if one or more of the remaining nearby hospitals were forced to close, or to restrict services, in coming years. Some would argue that closing or substantially down-sizing D.C. General Hospital would tend to financially buttress other nearby hospitals. Right now, that is only an interesting theory about the future. The reality would depend on the numbers and types of patients who actually went to surviving hospitals, the costs of treating them, and the public and private revenues they provided. A competing interesting theory about the future is that closing D.C. General Hospital would tend to financially stress other nearby hospitals, resulting in a domino effect.

Health care for the citizens of the District is too important to rest on theoretical arguments. Citizens and patients need assurances, guarantees, and commitments, not theory and promises.

Guaranteeing health care to District patients who are vulnerable to denial of needed services means stabilizing, renewing, and reforming a hospital like D.C. General Hospital, that is located where it is needed, that will be even more needed in the future—when the population ages and if other hospitals in the District close.

VI. ELEMENTS OF AN AGENDA FOR RENEWAL AND REFORM

In light of these considerations, I would like to suggest that at least these six items be included on an agenda for renewing and reforming D.C. General Hospital:

1. Recruit the best available public hospital administrator (CEO) in the nation. Pay enough to attract and retain that person. Many non-profit urban hospitals' CEOs are paid from one-half million dollars to over one million dollars yearly. And their jobs are typically not as hard as the job of running a public hospital. Recruit the best available chief operating officer and chief financial officer in the nation. Pay them enough as well.

2. Bill to collect all the revenue the hospital deserves.

3. Cut costs in appropriate and realistic ways.

4. Design and implement a staffing plan that is commensurate with patient need for high-quality care. This will require cooperation among all parties, and willingness to work for the good of the patients the hospital serves today—and those who will need it tomorrow. Pay all physicians, nurses, and other hospital employees enough money to attract and retain highly-qualified and dedicated professionals.

   Perhaps surprisingly, the cost of replacing residents appears to be substantially greater than the cost of retaining them. I have calculated that the gross financial cost could be as great as $17.6 million annually. This does not reflect offsetting savings from greater productivity of attending physicians, or from improved staffing. The results of this calculation are summarized in an appendix.[32]

5. Avoid speculative, unproven, or imaginary solutions, such as a Community Access Hospital, which have not been demonstrated to work effectively or efficiently in cities. The high fixed costs that must be incurred to provide emergency care—laboratories, radiology, critical care unit, and the like—can make a CAH very costly. Unit costs are reduced when they can be spread over a variety of needed services, such as acute inpatient care, and ambulatory care.

6. Undertake indispensable capital investments when needed, but consider big investments in physical reconfiguration or reconstruction only after the hospital is stabilized financially, medically, and politically. A rebuilt D.C. General Hospital might seem vital to some, but the best should not be allowed to become the enemy of the good. Rebuilding should come later, not earlier—when its cost could defeat or undermine reform and renewal of patient care itself. This means trimming costs through improved management, through staffing that is appropriate to meet patient needs, and through other reforms. It means harvesting all the revenue to which the hospital is entitled. Other countries have shown that superb medical care can be provided in old and even run-down physical facilities.

More generally, I urge a return to the path originally taken in the first and second Cambio reports to the PBC. Those reports, which rested on careful analysis of the problems of the D.C. General Hospital, described eight sets of recommendations for renewing and reforming the hospital. While I am not in a position to validate or invalidate any specific recommendation offered by Cambio, they do appear reasonable to me, taken together.

Appendix

Estimated Costs of Replacing Resident Physicians at D.C. General Hospital[33]

total annual cost of replacing residents with ancillaries	$6,653,982	
total annual cost of replacing residents with attendings	$12,462,813	
grand total replacement cost	$19,116,794	
less current cost of residents	$4,200,000	
net cost of replacing residents	$14,916,794	
forgone medical education revenue	$2,691,296	
total financial penalty (net cost + forgone income)		**$17,608,090**

Note: As mentioned in the text, these estimates do not reflect possible offsetting savings from greater productivity of attending physicians, from streamlined patient care, or from improved staffing. These savings are likely to be substantial, but probably not sufficient to offset the costs of replacing residents at this time.

NOTES

[1] See, for example, Cambio Health Solutions, *Recommendations [to Public Benefit Corporation] for Phase II,* Executive Summary, May 2000, pp. 3-18 (draft).

[2] District of Columbia Hospital Association, *Utilization Indicators, Calendar Year 1999,* Washington: The Association, 2000, http://www.dcha.org/99Utilization.PDF.

[3] Winston S. Churchill, 11 November 1947, speech, House of Commons.

[4] Public Benefit Corporation, District of Columbia, "Community Access Hospital," Draft, 11 September 2000.

[5] Emphasis in original.

[6] Other items could be added, such as developing for detecting problems in contractors' compliance with their agreements to serve patients displaced from D.C. General Hospital, and methods of enforcing compliance speedily.

[7] Ivan Walks, D.C. Commissioner of Health, statements in response to questions, D.C. City Council, Subcommittee on Health and Human Services hearing on D.C. General Hospital, 18 September 2000.

[8] Public Benefit Corporation, District of Columbia, "Community Access Hospital," Draft, 11 September 2000, p. 2.

[9] I was not able to contact anyone in Illinois to verify claims regarding freestanding emergency rooms in that state.

[10] See INOVA's web sites, particularly "INOVA Emergency Care Center," www.inova.com/beyond/iecc.htm.

[11] American Hospital Association, *AHA Guide to the Health Care Field, 2000-2001 Edition,* Chicago: The Association, 2000.

[12] Data compiled by the Virginia Hospital and Healthcare Association. I am grateful for help from Mr. William L. Murray, Vice President, Virginia Hospital and Healthcare Association.

[13] For background on Germantown Hospital and Albert Einstein Medical Center, I relied in part on a information provided by Andrew Wigglesworth, President, Delaware Valley Healthcare Council, Philadelphia, telephone conversation, 15 September 2000.

[14] Information on the two Illinois facilities was provided by Mr. Ron Damasauskas, Illinois Hospital Association, telephone conversation, 20 September 2000.

[15] Please note that the information on the two Illinois facilities was not available in time to prepare the written testimony submitted on Monday 18 September 2000. It is added here to round out the record.

[16] Rod Wiggins, Medimetrix Consulting, *Review of Models 1 & 2,* presentation prepared for the Public Benefit Corporation: District of Columbia Hospitals, 25 August 2000.

[17] Rod Wiggins, Medimetrix Consulting, *Review of Models 1 & 2,* presentation prepared for the Public Benefit Corporation: District of Columbia Hospitals, 25 August 2000.

[18] Alan Sager, Hospital Closings and Other Reconfigurations in 52 U.S. Cities, ongoing study. See, for example, Alan Sager, "Why Urban Voluntary Hospitals Close*," Health Services Research*, Vol. 18, No. 3 (fall 1983), pp. 451-475; Alan Sager and Deborah Socolar, "Urban Hospital Closings, Relocations, and other Reconfigurations," American Public Health Association, New York, 18 November 1996; and Alan Sager, Deborah Socolar, and Jasprit Deol, "Causes of Hospital Closings in 52 Cities," American Public Health Association, Indianapolis, 10 November 1997.

[19] Telephone conversations with emergency room personnel at Washington Hospital Center, George Washington University Hospital, and Providence Hospital, 17 September 2000.

[20] Data from the 2000 census are not yet available.

[21] District of Columbia Hospital Association, *Utilization Indicators, Calendar Year 1999,* Washington: The Association, 2000, http://www.dcha.org/99Utilization.PDF.

[22] Author's calculations from U.S. Census Bureau, "State Population Estimates: Annual Time Series, July 1 1990 to July 1, 1999, Census Publication ST-99-3, http://www.census.gov.population/estimates/state/st-99.3.txt; and U.S. Census Bureau, "Health Insurance Coverage, 1998," Series P60-208, Issued October 1999, Table 2.

[23] Donald S. Shepard, "Estimating the Effect of Hospital Closure on Areawide Inpatient Hospital Costs: A Preliminary Model and Application," *Health Services Research*, Vol. 18, No. 4 (Winter 1983), pp. 513-549.

[24] Calculated from David A. Woodwell, "National Ambulatory Medical Care Survey: 1996 Summary," Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention/National Center for Health Statistics, Number 295, December 17, 1997, Table 2; Linda F. McCaig and Barbara J. Stussman, "National Hospital Ambulatory Medical Care Survey: 1996, Emergency Department Summary," Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention/National Center for Health Statistics, Number 293, December 17, 1997, Table 1; and Linda F. McCaig, "National Hospital Ambulatory Care Survey: 1996 Outpatient Department Summary," Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention/National Center for Health Statistics, Number 294, December 17, 1997, Table 1.

[25] District of Columbia Hospital Association, *Financial Indicators, Fiscal Year 1998,* Washington: The Association, Fall 1999, p. 2.

[26] District of Columbia Hospital Association, *Financial Indicators, Fiscal Year 1998,* Washington: The Association, Fall 1999, p. 1.

[27] Public Benefit Corporation, District of Columbia, "Community Access Hospital," Draft, 11 September 2000, p. 6.

[28] Calculated from data in District of Columbia Hospital Association, *Utilization Indicators, Calendar Year 1999,* Washington: The Association, 2000, http://www.dcha.org/99Utilization.PDF, page 4 on average length-of-stay and page 5 on inpatient admissions. (Average length-of-stay of 5.93 days * 134,000 admissions = annual patient-days / 365 = average daily census.)

[29] This is only 81.1 percent of the 3,072 beds that are called "operating beds" in District of Columbia Hospital Association, *Utilization Indicators, Calendar Year 1999,* Washington: The Association, 2000, http://www.dcha.org/99Utilization.PDF, p. 2.

[30] U.S. Census Bureau, "State Population Estimates: Annual Time Series, July 1 1990 to July 1, 1999, Census Publication ST-99-3, http://www.census.gov.population/estimates/state/st-99.3.txt.

[31] For calculations that demonstrate this problem, see Alan Sager and Deborah Socolar, *Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People,* Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999.

[32] On request, the author will provide the documentation for each element of the table.

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