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The Fiscal Health of Michigan Hospitals

by Peter Pratt

In the last twenty-four months, 150 of the nation's 6,300 hospitals have closed their doors—11 in Michigan. Almost half the nation's hospital executives say their institutions could close within five years—the same holds true of Michigan's executives. Half of Michigan's 102 hospitals with fewer than 150 beds lost money in 1986. The average operating margin—operating income minus operating expenses—of smaller hospitals has stayed below zero since 1984. On any given day, over one-third of the state's 35,500 hospital beds do not need linens changed; no patient has lain there.

If the economic yardstick of manufacturing (percentage of plant capacity in production) were applied to hospitals, trade papers would scream "depression."

The patient is not terminally ill and, in truth, has performed well. Few "industries" have been buffeted by more radical declines in sales volumes, drastic changes in the products they deliver, tighter regulation, deteriorating prices, and stronger competition all while providing a public service to which most people believe they have a right. Looking back at the revolution in American health care delivery and reimbursement, a revolution of barely ten years, our surprise is less that hospitals are at risk than that 98 percent of hospitals have survived.

The fate of hospitals lies not only in the hands of hospital boards and administrators, many of whom accept the new "business of health care": diversification, repositioning, and cost consciousness. As the biggest purchasers of health care, federal and state governments, through regulation and price-setting, control much of hospitals' destiny. Business, through volume discounts, selective purchasing, and governmental lobbying, holds a loaded gun to their head. Insurers and health maintenance organizations can broker contracts between consumers and hospitals that restrict hospital services and cut payments. Health care entrepreneurs (most particularly physicians) concentrate on the profitable lines of medical care and compete head-to-head with hospitals for myriad traditional hospital-delivered services.

Purchasers of health care have endured years of inflation in medical prices that exceeds inflation in total consumer prices (see Exhibit 1). They argue that the sizeable gap is a sign of excessive health care costs. Hospitals respond that the high costs of the goods and services they must buy to provide health care account for the lion's share of the annual difference in inflation. Many purchasers of health care find this explanation unconvincing. In cutting their health care costs, they contend that they are paying fairly for all the health care that people need and that containing costs need not sacrifice quality or access. They cite growing bodies of research that (a) attack the premise that more medical care (and, therefore, more money) means better health and (b) show that many surgeries require fewer days of hospitalization than was previously thought. Hospitals retort that they have cut away the fat from their operations and adjusted to the prevailing wisdom that less costly outpatient care and shorter hospital stays will often not com-

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EXHIBIT 1
Annual Percentage Increase in Index of Medical Care Prices and of Consumer Price Index, 1970-87

Year	IMCP	CPI	Year	IMCP	CPI
1970	7.1	5.9	1979	9.7	11.3
1971	7.3	4.3	1980	11.3	13.5
1972	3.7	3.3	1981	10.7	10.4
1973	4.4	6.2	1982	11.9	6.1
1974	10.3	11.0	1983	8.7	3.2
1975	12.6	9.1	1984	6.0	4.3
1976	10.1	5.8	1985	6.0	3.6
1977	9.9	6.5	1986	7.7	1.9
1978	8.6	7.7	1987	5.8	4.4

promise patient care. Inadequate payments for inpatient care, however, do threaten their ability to provide quality health care that patients need.

One thing is certain: Purchasers' drive to reduce health care expenditures and cost-saving technological and medical advances that free patients from extensive hospital care will continue to change the role of the hospital from a **facility** where health care is provided to a **facilitator** of health care. As inpatient care becomes less the focus of medicine, hospitals will fill the breach with more outpatient treatment and surgery, primary care in satellite clinics, chronic and long-term care for our aging population, home health care, wellness programs, rehabilitation, and other programs. Much of this care will be coordinated by the hospital but provided outside its walls.

This move in hospital care away from the hospital itself will be accompanied by a consolidation of our health care system. Small hospitals unable to diversify and survive continued pressure from purchasers will close their doors or merge with large health care systems. The flagship hospitals of these systems will maintain the latest technology and provide high-cost acute and critical care. The medium-sized and small hospitals in the system will provide limited acute care, concentrating on primary and outpatient care and the management of nontraditional hospital services cited above that are now performed largely by autonomous nursing home, home health care, and physician concerns. Big and diversified systems will control more of health care delivery and provide less of it in the hospital. While this consolidation may reduce health care expenditures, it is no guarantee that access or quality of care will be maintained. This paper will examine the forces behind the fundamental changes in the role of the hospital and the possible implications for access to and quality of care.

FROM PUBLIC SERVICE TO BUSINESS

There was a golden age for hospitals. The post-World War II economic boom and shortage of hospital beds fueled federal government funding of hospital construction and modernization in communities throughout the nation. More than $4 billion was given to nearly 7,000 hospitals. Between 1946 and 1971, hospitals grew in number from 6,125 to 7,678. The spread of employer-based private health insurance,

with increasingly comprehensive benefits packages, guaranteed hospitals a steady source of revenues. In the mid-sixties, Medicare and Medicaid—health care for the aged, disabled, and poor—brought government full-force into payment for health care. Government helped build and then pay hospitals. Few if any questions were asked by public and private payers, who paid most of hospital and physician charges. Nearly everyone—payers, providers, and consumers—believed we were well on our way to the ideal health care system, rich in technology and expertise, capable of providing anything from routine check-ups to sophisticated heart surgery at any time. With steady improvements in access to care, it was easy to call health care a right. Like public education, health care was a public service.

In the late 1970s and 1980s, everything changed. The story of this change is familiar because it has been told, with only slight variations in plot, about Michigan's automobile industry. With agriculture and tourism, automobile manufacturing and health care are the state's biggest industries. In the seventies, a storm of international competition threatened automobile manufacturing in America. The automakers were forced to produce higher quality cars at lower costs if they wanted to survive. To do this, they affiliated with other manufacturers and suppliers around the world ("outsourcing"); rid themselves of superannuated manufacturing plants and consolidated manufacturing in new plants, many overseas where labor and production costs are lower; reduced the white- and blue-collar work force; forged into high technology with computers and robotics, aiming to reduce human error. The American automobile industry—a cause and beneficiary of the same post-WWII prosperity that fueled health care expansion—painfully reorganized in the seventies and eighties as outside forces buffeted it.

Like the automobile industry, the hospital industry is struggling with change, but not as a result of international competition. Hospitals began to compete with each other for fewer and fewer patients, as the government and other third-party payers decided they cannot afford unlimited health care. Like the automobile industry, hospitals have steadfastly sought new markets to recover decreasing inpatient revenues, including outpatient services in and outside the hospital. Like the automobile industry, hospitals are "retooling," upgrading their physical plants and clinical equipment and eliminating unnecessary facilities and services with an eye toward greater efficiency. Like the automobile industry, hospitals have been and will be forced to consolidate. Mergers and closings are increasing in the industry each year. Many jobs—with the equivalent of 127,689 full-time workers, hospitals are the fourth largest employer in Michigan—and a resource that many feel is essential to the community are in jeopardy.

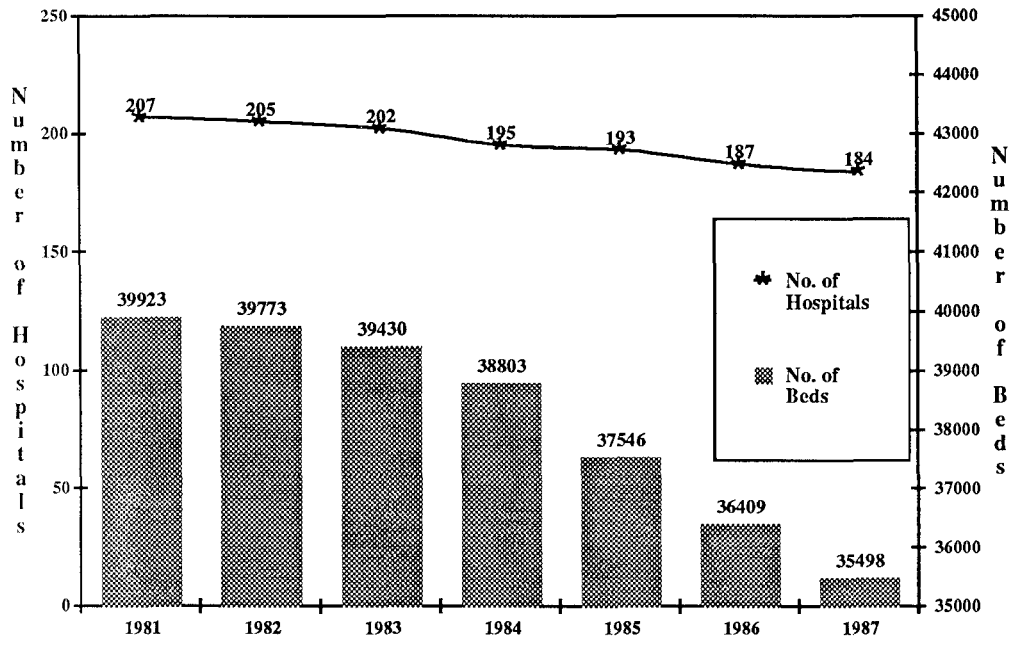
Hospitals, nevertheless, are not only businesses. They continue to provide a public service. Most people still believe that all Americans have a right to health care; few believe we have a right to a new mid-size sedan every two years. Because it provides a public service, a hospital ideally runs enough like a business to make sufficient profit on some services so that it can offer other unprofitable services that are necessary to its public mission. In the current health care financing climate, even the most efficient hospitals are having great difficulty accomplishing this.

EMPTY BEDS AND LOW MARGINS

The numbers testify to the struggling hospital industry, in Michigan and across the nation. In the past two years, 150 of the nation's 6,300 nonfederal, short-term hospitals [called "community hospitals" by the American Hospital Association (AHA)] have closed their doors. Michigan had 207 community hospitals in 1981; in 1987, it had 184, with 4,500 fewer beds. (See Exhibit 2.) Almost half of the 1,419 hospital executives who responded to a nationwide survey by Touche-Ross in July 1988 said that their hospi-

EXHIBIT 2

Michigan Hospitals and Beds, 1981-87



tals were "vulnerable" and could be forced to close in the next five years. More than half of the Michigan hospital executives surveyed felt the same way.

Hospital closings are the starkest evidence of the struggling industry, but other measures better indicate where the typical hospital is going. As a rule, hospitals are barely making ends meet by treating patients. Net patient margins—the percentage by which revenues from patient care exceed the expenses of providing that care—averaged 0.1 percent for the nation's hospitals in 1987. Total net margins for hospitals have declined since 1984 to 5.0 percent in 1987, the longest period of decline since such statistics were first compiled in 1963. Because hospitals' expenses continue to grow faster than their revenues, these margins are likely to shrink even more in coming years.

Small hospitals, including those in Michigan, have been hardest hit. Half of Michigan's 102 hospitals with fewer than 150 beds lost money in 1986. The average operating margin of these hospitals has remained below zero since 1984. A 1988 Michigan Hospital Association (MHA) survey of small hospital executives found that nearly three of four saw their hospitals as "financially troubled." In many rural areas, the small community hospital has replaced the physician's house call as a symbol of the responsiveness of our health care system. Financial pressures threaten this responsiveness.

There are many reasons for hospitals' shrinking bottom lines, and reasons behind those reasons that signal large-scale transformations in the delivery and financing of health care. Declining inpatient admissions, average lengths of stay, and occupancy rates offer the clearest evidence that the role of the hospital is changing radically. Patients are entering the hospital much less frequently and leaving sooner than

just six years ago. In 1981 in Michigan, there were 156 hospital admissions for every 1,000 population; by 1986, it was down to 125 per 1,000. Between 1983 and 1987, the average length of stay in a hospital dropped from 8 days to 7.3 days. These declines cut deeply into hospital occupancy rates. On any given day, more than one-third of Michigan's 35,498 hospital beds are empty. Six years ago, only one-quarter of the beds were empty. Michigan's small hospitals have lower average occupancy rates (47 percent) than hospitals in general (65 percent) and shorter average lengths of stay (6.6 to 7.3 days). (See Exhibit 3.)

EXHIBIT 3

Admissions per 1,000 Population, Average Length of Stay, Occupancy Rates of Michigan Hospitals, 1981–87

Year	Admissions per 1,000 Population	Average Length of Stay (days)	Occupancy Rate
1981	156	7.8	78.3%
1982	154	8.0	77.2
1983	153	8.0	76.7
1984	147	7.6	71.5
1985	138	7.3	66.8
1986	130	7.2	64.4
1987	125	7.3	64.8

CHANGES IN HOSPITAL PAYMENT

Medicare Prospective Payment

As the declines in admissions, lengths of stay, and occupancy rates illustrate, government, employer, and insurer attempts to cut runaway health care costs have centered on inpatient care. The resulting reductions in net patient margins have occurred largely because inpatient care still accounts for over three-quarters of hospitals' gross patient revenues.

Cost-based reimbursement, in which purchasers pay hospitals' costs—including operating and capital costs and in some cases costs for medical education, bad debt, and capital formation—for providing services, was the primary method of payment until the early eighties. Under this method, hospitals were assured of not losing money and encouraged to expand services because they would be paid for. This promoted access to care and technological advancement. On the other hand, hospitals that performed services better and/or more efficiently than other hospitals were not rewarded.

Some purchasers became dissatisfied with cost-based reimbursement because it did nothing to encourage efficiency or discourage unnecessary hospital use (overutilization). Facing a deepening deficit, the federal government became convinced that it could fashion a cost-limiting reimbursement system—for Medicare hospital payments, at least—that would reward efficiency without compromising quality or access.

This system was the Prospective Payment System (PPS). Under the PPS, which began operating in October 1983, the federal government pays a hospital a single rate for a diagnosis (diagnosis-related group, or DRG) rather than for a procedure or series of procedures and services to treat the diagnosis. This rate is based on the average hospital costs of providing care for a particular diagnosis, with adjustments for hospital location, wages, and case mix (i.e., sicker or healthier patients). The PPS, then, introduces competition into reimbursement: Because a hospital is paid largely according to industry average costs, rather than its own costs, it profits only if it delivers services at below industry average costs. In theory, PPS reimbursement rates will force hospitals to become efficient by cutting waste and by adopting cost-saving services and technology and by eliminating specialized services that other hospitals can provide at lower cost.

To complement the PPS, the federal government's Health Care Financing Administration (HCFA) has sought to quantify quality in the Medicare program. However, the annual publication of hospitals' mortality data, adjusted for the collective severity of illness of all patients in a given hospital, is at best a crude measure of quality. Assessing quality is obviously much more difficult than cutting costs, and, at this point, the PPS equates efficiency with cost-cutting; quality is not in the equation. Cost-based reimbursement may not have rewarded quality, but neither did it introduce another variable, cost cutting, which may discourage quality care.

The PPS has been controversial since its inception. Because hospitals responded to PPS incentives by cutting costs while payments were fixed, the PPS provided hospitals with substantial profits—14 percent in the first two years of the PPS, 9.9 percent in 1986, and 6.3 percent in 1987—despite significant declines in occupancy. At the same time, the PPS has helped limit Medicare expenditures. These facts, proponents of the PPS argue, suggest that hospitals were inefficient before prospective payment and still can afford to cut costs more.

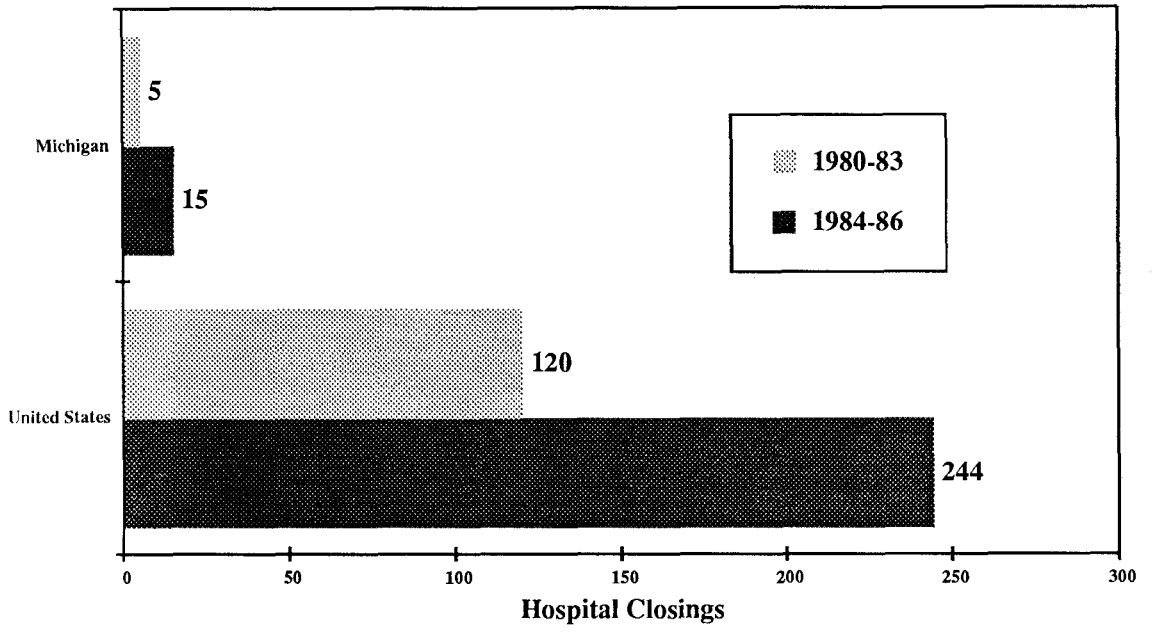
Hospitals answer that average profits disguise the plight of many hospitals that are not meeting costs under Medicare. Designed to eliminate inefficient hospitals, the system has played a substantial role in closing many needed rural and inner-city hospitals. Between 1980 and 1983, 120 hospitals closed in the country, 73 urban and 47 rural. After prospective payment, from 1984 to 1986, 244 hospitals closed, 128 urban and 116 rural. In Michigan, five hospitals closed between 1980 and 1983, and 15 closed between 1984 and 1986. (See Exhibit 4.) The Prospective Payment Assessment Commission (ProPAC), the rate-setting body for Medicare, estimates that the average Medicare margin for a hospital in 1988 will be near zero. In 1986, 34 percent of hospitals lost money on Medicare.

Moreover, Medicare payment for rural hospitals is lower than that for urban hospitals, even lower than rural hospital's lower costs of doing business warrant. This hits rural hospitals especially hard because, on average, they depend more than urban hospitals do on Medicare for their revenues. While small urban hospitals do not face the DRG inequity that rural hospitals face, they, too, depend more on Medicare than does the typical hospital. In Michigan in 1986, 41 percent of small hospitals' gross patient revenues came from Medicare while 37 percent of the average hospital's patient revenues did.

If prospective payment was designed around industry average costs, how is it that more and more hospitals are losing money on Medicare? The answer lies in the failure of the federal government to update DRG prices as originally mandated in law. DRG prices were supposed to be increased by the rate of inflation in the costs of goods and services hospitals purchase in order to care for their patients. In addition

EXHIBIT 4

Hospital Closings in Michigan and the United States Before and After Medicare Prospective Payment



to this "market-basket" inflation rate, DRG prices were supposed to increase by one percent each year in 1984 and 1985 for the cost of new technology. However, increases in DRG prices have never matched the increase in hospitals' market baskets. According to the federal government, the price for hospital-purchased goods and services rose 28.3 percent between 1984 and 1987, while DRG rates rose only 12.2 percent.

Medicare would not have such a profound effect if it were not the source of 40 percent of hospitals' revenues and more than 40 percent of small hospitals' revenues. With an aging population and the recently enacted expansion of catastrophic illness coverage, it will assume an even greater role in hospital payments in the future.

Medicaid

Medicare's prospective payment casts a long shadow over hospital reimbursement. It has (1) become a model for other payers, namely Medicaid in Michigan, who wish to cut costs, and (2) saved private insurers money by changing the way hospitals deliver care. (Medicaid is the state and federally funded program designed to provide health care for the poor, blind, and disabled.) In 1985 the Michigan Medicaid program implemented DRGs for inpatient care. In 1987, DRG prices were adjusted, with an estimated annual savings of over $30 million. These cost-containment measures cut already low Medicaid reimbursement rates. Medicaid reimburses hospitals at approximately 85 percent of costs for inpatient care and 45 percent for outpatient care. Moreover, the governor and the legislature have regularly pursued further cuts in the Medicaid budget. In his proposed budget for FY 1988-89, Governor Blanchard called for a

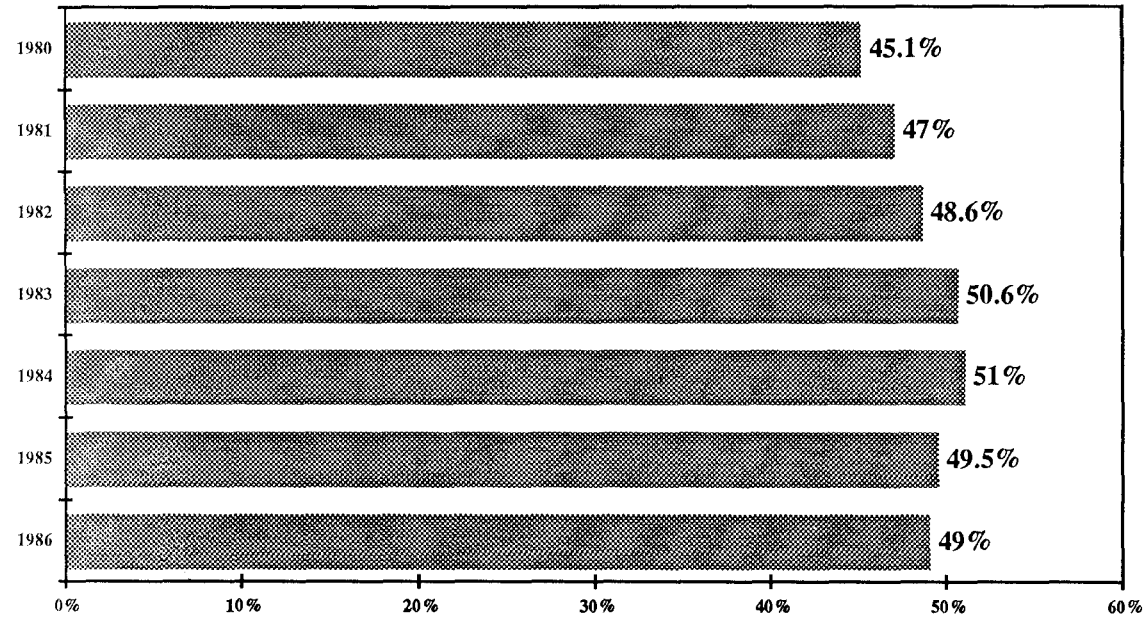
$7.5 million reduction in DRG payments to hospitals whose rates exceeded the 85th percentile for all hospitals. The legislature did not support this reduction but did cut Medicaid by standardizing hospital prices for certain routine inpatient DRGs and outpatient procedures and reducing the subsidies to hospitals treating high proportions of indigent patients (including Medicaid and the uninsured).

These low rates are especially troublesome for hospitals with high Medicaid shares. Forty-three hospitals provide three-quarters of Medicaid hospital care in Michigan. These hospitals also tend to provide more uncompensated care than those with lower Medicaid shares. High-Medicaid-share hospitals thus have fewer private payers to offset losses from Medicaid and the uninsured. Paradoxically, the hospitals that care for the most poor patients are, because of that fact alone, least able to do so and survive. Hospitals will close before they refuse to care for the poor, but closing has the same effect as refusal. Medicaid cost-containment raises a crucial value-laden question: If a hospital's survival or ability to provide high-quality health care to privately insured patients is jeopardized by serving a large poor population, should a hospital serve the poor?

The importance of cuts in Medicaid and Medicare payment cannot be exaggerated. Michigan hospitals' dependence on public payers—mainly Medicare and Medicaid—is increasing. Between 1980 and 1986, hospitals' revenues from government programs has risen from 45 percent to 49 percent of all revenues. (See Exhibit 5.)

EXHIBIT 5

Michigan Hospital Revenues from Public Sources (Medicare and Medicaid) 1980-86



Blue Cross and Blue Shield, Employers, and HMOs

Prospective payment has affected private payers for health care as well. In Michigan, Blue Cross and Blue Shield of Michigan (BCBSM) reimburses hospitals through a cost-based, prospective system, the Prospective Reimbursement System (PRS). Hospitals are paid ahead of time for their expected costs for services. If they exceed a "budget screen," which limits inflation on costs to a certain percentage annually, they are not paid the amount by which they exceeded the screen. If their costs are less than the screen, they and BCBSM each keep half of the difference. The PRS thus limits hospital losses and encourages efficiency at the same time.

Though major differences separate BCBSM's and Medicare's prospective payment systems, the PPS has indirectly helped reduce Blue Cross payments. A study released in August 1988 by the University of California-Berkeley and funded by the federal government found that the PPS, by changing the way that hospitals treat all patients and not just Medicare patients, has saved private insurers money. The author of the study estimates that Medicare reforms lowered total Blue Cross payments to hospitals by 3 percent ($507 million), due in large part to declines in hospital admissions. Although BCBSM reimburses hospitals at cost, then, it is paying that cost for fewer services.

In attempts to cut health care costs even more, BCBSM has stepped up its utilization review (refusing or limiting payment to hospitals for admissions it determines are inappropriate and stays that are too long). Bigger cost-containment efforts have appeared on the horizon. BCBSM has indicated that it may soon look into establishing a DRG system.

Employers see cutting health care costs as essential to their well-being. They seek to pay for less health care and pay less for the health care they must buy. This is not surprising: Employer health care costs consumed 8 percent of total payroll costs in 1986, up from 6 percent in 1981. Working with BCBSM and commercial insurers, employers have instituted managed care programs, trimmed generous employee benefits packages, required second opinions for surgery, begun utilization reviews, and increased employee cost sharing (copays and deductibles). For example, General Motors has set its sights on moving into managed care all of the two million people to whom it provides health benefits. All of these strategies are aimed at discouraging unnecessary health care. With hospitals, large corporations and BCBSM have used their considerable leverage to negotiate volume discounts. These efforts prevent hospitals from offsetting losses in revenues from Medicare and Medicaid by shifting costs to private insurers and employers. Businesses are moving from subsidizing care for the poor, medical research, malpractice premiums, and medical education toward paying only for their own employees, and at reduced rates if possible. This trend will be accelerated when the Financial Accounting Standards Bureau requires businesses to include future retiree health benefits as liabilities on their balance sheets.

Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) also depend on volume discounts. At the same time, HMOs survive only by keeping down hospital use. Hospitals participate in and even begin their own HMOs and PPOs in hopes of securing more patients in exchange for lower payments on fewer services. In other words, they sell their services for less and hope to make a profit on the volume. More than a few hospitals, however, join HMOs because that may be the only way to keep many of the patients that they already have. These hospitals must choose between (1) losing some money by accepting lower rates and utilization or (2) losing much more money by not joining the HMO and losing patients to other hospitals who join the HMO.

LOWER REIMBURSEMENT: EFFICIENCY *AND* QUALITY CARE?

Payers' health care cost containment helps produce shrinking margins that impede hospitals' access to capital for renovation and new construction. Many hospitals, especially small and rural hospitals, cannot afford to update services and convert or eliminate acute care beds, changes that would make them more efficient. Payers also stifle the development of innovative, efficient services by not reimbursing for the services for years after they are in place. Without accumulated capital, hospitals cannot operate a new service or technology at a loss until payers decide it merits reimbursement.

Small hospitals have fewer ways than large hospitals have of managing the problems brought on by low reimbursement and occupancy rates. On the one hand, reducing labor costs by laying off employees is often difficult because small hospitals operate nearer minimum staffing requirements than do larger hospitals. On the other hand, they often cannot recruit physicians and nurses to care for the patients they do see. As more small hospitals than large hospitals have negative operating margins, they also have fewer resources to make necessary improvements and changes in services and the physical plant.

What does all this mean to patients? Obviously, if a hospital in an isolated rural area were forced to close, routine health care would be less accessible. The sick would travel longer distances to reach a hospital. Lives could be lost because emergency care is too far away. Lower reimbursement rates from any major payer may force surviving hospitals to eliminate valuable services. The verdict has yet to come down from health care policy observers on whether they believe that quicker discharges from hospitals sometimes jeopardize patients' health. No one questions, however, that there is a threshold above which cost cutting hurts patient care. Payers say that we have not reached that threshold, hospitals fear that we have.

Lower quality care can assume subtle forms. It rarely means that a patient dies from out-and-out neglect. It can mean, however, that a hospital cannot maintain state-of-the-art services and technology, update services to remain at the standard of care, or alter services to meet changing community needs. Because the PPS does not allow for new labor costs, it becomes difficult for hospitals to remedy nursing shortages by offering substantial raises. These subtle threats to the standard of care force hospitals into a quandary: As a group, they argue that low reimbursement can hamper quality, but no hospital dares say that it ever offers substandard care.

OTHER PRESSURES ON HOSPITALS

Hospitals face other pressures. Michigan's certificate of need (CON) program, which requires government approval of hospital construction, acquisition of technology, and changes of services, encumbers many hospitals. Costly in time and money, the present CON review process slows—sometimes for years if decisions are appealed—renovations that can make hospitals more efficient and responsive to changing health care needs. While the CON program should and can discourage unnecessary services and technology, it can also obstruct the efficiency and cost cutting it was established to promote. New CON laws, which take effect January 1, 1989, will streamline the review process; it remains to be seen whether they will promote greater efficiency.

In Michigan, malpractice premiums for hospitals average more than $1 million annually, or $190 for each hospital admission. These hospital premiums are the highest in the nation, and some small hospitals

pay more than do large hospitals in New York and California. These premiums cut deeply into hospital margins.

As nonprofit hospitals have begun to focus on efficient management, they have been accused of abandoning their charitable duties to the community. Three nonprofit hospitals in Pittsburgh have agreed to pay more than $11 million in the next ten years to forestall the city's plans to revoke their property tax exemption. The Texas attorney general will look at the financial records of four nonprofit hospitals to determine whether they provide enough charity care to deserve their tax exemption. Proposed reforms in the unrelated business income tax have also led the Internal Revenue Service to scrutinize the criteria used to justify hospitals' and other nonprofit organizations' exemption from taxes. On the one hand, then, government and private payers' cost containment erodes hospital margins and their ability to provide charity care while the uninsured population and the volume of charity care continue to grow; on the other hand, local, state, and federal government criticize hospitals for failing to provide sufficient free care to the uninsured.

In addition to the current pressure on hospitals brought on by recent changes in the delivery and financing of health care, there are other broad economic and political factors that will improve or worsen hospitals' health in the near future. Despite the push in some areas to measure hospitals' commitment to the community solely by the charity care they provide, there is growing recognition at all levels of government that too many people—37 million nationally, and more than one million in Michigan—have neither public nor private insurance. The advent of universal health insurance in Massachusetts and bills in Congress for employer-based coverage suggest that businesses, and not hospitals (directly at least), will bear the brunt of expanded health insurance coverage.

With state and local government and private payers tightening their belts, communities may build support for their own hospitals. Philanthropy may increase as citizens and businesses come to recognize that their community hospital may not flourish or even survive without their help. Recognizing that the hospital is no less vital to the community than schools or fire and police departments, local governments may choose to devote a greater portion of their revenues to health care. Limited partnerships between local physicians and hospitals could give physicians greater control over administrative functions in exchange for guaranteeing hospitals more patients.

The belief that hospitals are impervious to economic pressures, however, still pervades most communities. One fundamental problem that many embattled community hospitals face is that board members make decisions about community health care needs without acknowledging the hospital's financial imperatives. Hospitals are not run by entrepreneurs or beholden to stockholders; board members have no financial stake in the hospital's success. While admirably ensuring that the needs of the community will be foremost in board members' minds, this system often fosters some vague sense of mission that blinds them to the specific financial decisions that "serving the community" entails. Administrators who decide to eliminate floundering or unnecessary services often run up against board members who do not recognize that preserving these services may endanger the hospital's survival or prevent the hospital from offering other needed services.

Hospitals face other obstacles down the road. Treating AIDS patients will continue to strap affected hospitals as long as government assumes—and underfunds—the great proportion of its costs. The nursing shortage, or rather the inability of health care providers to attract persons with nursing degrees, promises to restrict severely the care that some hospitals can offer. The likelihood of a recession means

that many workers—within a few months of losing their jobs—will join the ranks of the uninsured. As Michigan is hit harder during recessions than the nation as a whole, healthy young adults are more likely to leave the state in search of work. This leaves Michigan with a high proportion of uninsured and Medicaid patients, whose payments do not meet hospital costs. Population shifts from central cities to the suburbs, especially from Detroit to Oakland County, hurt inner-city hospitals unable to build or acquire facilities outside the city. As a result, these hospitals also must rely more and more on inadequate Medicaid reimbursement.

In sum, these trends will likely exacerbate rather than relieve hospital woes. Expanded private insurance may only provoke more determined cost cutting by employers. As a rule, local governments lack the resources to hold up otherwise faltering hospitals.

HOSPITAL RESPONSE TO CHANGES IN HEALTH CARE

Hospitals have not sat idly by as the health care delivery system has assumed a new shape. Improved management is the cornerstone of most hospitals' responses. Hospitals simply cannot survive now without administrators who understand inventory control, materials management, and utilization review. Overhead costs—payroll, records, purchasing, laundry, food services—must be reduced without hampering patient care. Every hospital service from laundry to open-heart surgery must have its efficiency, quality, and productivity reviewed.

Striving to balance public service and business-like efficiency, hospitals have metamorphosed. Hospitals have moved quickly into outpatient services as a way to combat payers' cuts in reimbursement for inpatient care. In Michigan, hospital outpatient visits have risen from 710 for every 100 inpatient admissions in 1981 to 991 per 100 inpatient admissions in 1986. Even more dramatically, outpatient surgeries have increased from 29.4 for every 100 inpatient surgeries in 1981 to 101.6 for every 100 in 1986. (See Exhibit 6.) Many procedures that once required several days' hospital stay can now be performed as outpatient surgery. Arthroscopy, cardiac catheterization, cataract removal, and other procedures—abetted by advances in anesthesia—can be performed so patients sleep at home that night. Sophisticated diag-

EXHIBIT 6

Michigan Hospitals Outpatient Utilization and Revenues, 1981-86

Year	Outpatient Revenue as Percentage of Total Patient Revenue	Outpatient Visits per 100 Inpatient Admissions	Outpatient Surgeries per 100 Inpatient Surgeries
1981	15.0	710	29.4
1982	15.3	944	37.2
1983	15.6	792	47.4
1984	17.1	803	61.0
1985	23.5	831	82.3
1986	21.8	991	101.6

nostic tools—CT scanners and magnetic resonance imaging machines—eliminate the need for much exploratory surgery. The hospital has diminished its role as an institution for recovery.

Despite these medical advances and the lower cost of outpatient care compared to inpatient care, the large increases in outpatient utilization have aroused the suspicion of payers. As a rule, they have paid much less attention to outpatient care in their cost-cutting efforts until very recently; the PPS, for example, includes only inpatient care. This is changing now. Medicare pays a flat fee, and not hospital costs, for many commonly performed outpatient procedures such as cataract removal. Beginning February 1, 1989, the Michigan Medicaid program will also begin paying set rates to hospitals for certain outpatient surgeries. More and more, payers will look to facilities not owned by hospitals for their customers' outpatient surgery, thereby avoiding the "facility fee" tacked onto all outpatient surgery bills performed in hospitals and hospital-owned freestanding facilities. And even if purchasers were not looking to cut their outpatient costs, hospitals—hampered by limited access to capital and CON regulation—receive less than one-quarter of their patient revenues from outpatient care.

In addition to increasing outpatient services, hospitals are converting acute care beds into beds or space for substance abuse treatment, women's health, long-term care, wellness programs, rehabilitation, and chronic disease care. Nationwide, nearly 40 percent of hospitals had eliminated acute care beds or converted them into other services. In Michigan in the last year alone, nearly 60 percent of small hospitals have added nonacute services. Hospitals have also moved off-site, establishing satellite clinics, offering home health care and respite care, and purchasing physicians' practices.

Importing patients offers a possible way for larger hospitals to increase their revenues. Intense competition among hospitals for fewer Michigan patients has become a zero-sum game: Any patient gained by one hospital is a patient lost by another. If hospitals can develop into "centers of excellence," recognized nationally for the health care they provide—like Sloan-Kettering, the Cleveland Clinic, and the Mayo Clinic—Michigan can draw patients with reimbursement from other states. While Michigan's size and limited land borders discourage interstate travel for health care, there are still opportunities for enterprising hospitals to attract new patients. The export potential of Michigan medicine cries out for state government and industry action.

Forced to vie against each other for fewer patients, hospitals have also pushed into areas of health care previously reserved for nursing homes, home health care agencies, and physicians, but this does not guarantee success. Hospitals, handicapped in payers' eyes by facility fees, must compete with physician-owned surgicenters and ambulatory clinics. Nationwide, hospitals performed 83 percent of all outpatient surgeries in 1987, down from 98 percent in 1980. At the same time that many small and medium-sized hospitals diversify, they are squeezed between big hospitals with state-of-the-art acute and critical care and technology and physician-owned ambulatory centers.

The common plight of hospitals has bred cooperation as well as competition. Small hospitals are working with larger hospitals to refer patients. In exchange, the large hospitals return patients to the small hospitals after an episode of critical care. Hospitals are also sharing services, recruiting practitioners, and purchasing supplies, achieving economies of scale that benefit all.

Mergers are the next step, as hospitals unable to survive on their own affiliate with larger hospitals. In a 1988 Michigan Hospital Association survey of small hospital administrators, 29 percent of the respon-

dents had affiliated or merged with another institution in the last five years. Nearly two-thirds of those whose hospitals had not merged felt a merger would benefit them. These cries for help point up the difficulty many small hospitals face: Diversification is necessary to their survival, but—without accumulated capital and with the promise of intense competition from other health care providers—it will not ensure their survival.

CONCLUSION

Hospital mergers signal the inevitable consolidation of our health care delivery system. As inpatient care focuses on critical care for only the sickest patients, small hospitals will not have the resources to provide it. As drug therapy replaces more and more surgery, as advances in technology enable the chronically ill to live at home, as outpatient services replace much noncritical care, many hospitals will not generate the revenues to survive. Large health care corporations will have the capital to acquire some smaller hospitals to feed their hospitals. Much better equipped than small hospitals to diversify and compete with other health care providers, these corporations will establish themselves in all areas of health care: long-term care, hospices, home health care, satellite clinics, and other services. Their flagship hospitals will marshal the latest technology in the service of the critically ill. The small and medium-sized hospitals will provide limited acute care while focusing on emergency, primary, and outpatient care. But these hospitals will also orchestrate the wide variety of care offered outside the hospital.

In the sixties and seventies, as the belief that health care is a right for all gained ascendancy, access overshadowed cost containment and quality. In the eighties, cost cutting has come to overshadow access and quality. In the nineties, efficiency must mean more than cost cutting; efficiency must mean balancing cost containment, quality, and access. If health care remains a right, any imbalance must favor quality and access.

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