THE COSTS OF CHOICE:

County Reveals Study of Capitola Health Center

by Mary Bryant

It's hard to imagine that a simple little proposal by a group of local doctors, along with two out-of-town developers, to build a small hospital in Capitola could cause so much controversy and debate. After all, if they fail, it comes out of their pocket. Right?

Well, maybe not. At least this may not be the case according to a recent study. But to understand why not, it's necessary to understand a little bit about the report and the health care system. Fortunately, since comprehending health care systems is a little like learning about quantum physics, there is now a guide to some aspects the local industry.

A recently released report, authored by Lucy Johns, an independent consultant for Santa Cruz County's Health Services Agency, offers a significant start at understanding how health care systems are designed to perform. And its conclusions, while framed in a short study period and based on limited input and data, reveal insight into how this health care structure works—and doesn't work—for local residents, employers and industry insiders.

Granted, the primary focus of the study was to assess the impacts a proposed mini-hospital in Capitola would have on the existing hospitals. But the study also offers lots more, and it's the more that is perhaps most interesting.

But what does it have to say about the industry, and specifically, the Capitola Health Center proposal?

The Findings

The results of the 100-page investigation are based on an ambitious study, a report that not only considers data but finds it as well. The report submitted 46 findings and five conclusions. The find-

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Roger Hite and John Petersdorf or Dominican Santa Cruz Hospital and John Friel of Watsonville Community Hospital listen intently to Lucy Johns' report.

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ings are the facts the author believes most characterize the proposal and our local system, the conclusions are her own analysis.

Some are startling, some are not. Some we already understood, and some are new.

Some of what the narrative reaffirms, in its own words *[the italics are those of* The Post*]* about the market is:

1. The out-of-county market for inpatient care, which provides an average daily census of 69 beds filled by Santa Cruz County residents, is serving people who are probably seriously ill, who generate long stays and who otherwise appear unsuitable for treatment in acute care beds at a short-stay hospital. *[In other words: People aren't travelling away from home for care, unless they are seriously or suddenly ill. And generally when seriously ill, only when there are not special programs, like brain surgery or types of inpatient mental health services, to serve them locally. In short, a mini-hospital isn't going to keep many in town for care because they won't offer the kind of care missing in the market, or they won't be nearby when they might be needed.]*

2. Current trends in health care financing and quality assurance undermine patients' freedom of choices and the professional autonomy of physicians, two principles of health care organization in the United States which have enjoyed virtually sacred status. *[In other words: There is less and less money coming from the government and insurance companies for health services, a fact that makes life for hospitals, doctors and patients lots less pleasant in many ways.]*

3. The number of women residents hospitalized at AMI/-Community Hospital of Santa Cruz for tubal ligation following normal delivery was very small, while the lack of this service at Dominican Santa Cruz Hospital, a serious problem for some, is reportedly soon to be rectified. *[In other words: There are very few women affected by Dominican's policy of not offering tubal ligations for women requesting the procedure following delivery—like a little over two dozen in a year; and that the powers that be at Dominican are trying very hard to change the church's existing policy. This is a particularly important point, if you happen to be one of the people that still think abortions are services provided by hospitals. Abortions are no longer a part of hospital work, nor were they offered at AMI's Community Hospital when it was open.]*

4. Some physicians at both ends of Santa Cruz County are dissatisfied with their nearest hospital, those in the north especially so. *[In other words: Some of the doctors the author spoke with for the study are unhappy with local hospitals. While all concerned, including Wayne Boss, president of Santa Cruz Medical Clinic, whose doctors are credited in the study for their opinions, believe there may be too much made of this issue by the report.]*

Elinor, director of the County Health Services Agency.

5. Recalculation of Capitola Health Center's operating expenses [the author believes the expenses for the proposed facility were "unusually low"] to include a more typical labor expense results in: (a) operating expenses in year one of $10,837,000, increasing to $17,490,000 in year five; (b) deficits for the first four years of operation; (c) a 26 percent increase in cost per adjusted patient day in year one; and (d) an estimated charge per adjusted patient day of $1,123 in year one to maintain the developers' projected profit margin—a charge very close to those at Dominican Santa Cruz and Watsonville Community Hospitals. *[In other words: Capitola Health Center, as controversial as these facts may be, seems to be very unrealistic about how much it will cost to operate their facility. A point that will no doubt be of concern to both patients and investors, especially since prices to patients and expected returns to investors hinge on operating costs.]*

6. The potential of Capitola Health Center to enhance competition among hospitals and managed care plans is weakened by its high capital cost, implausibly low operating costs, inefficient physician group component, and the incentives of physician ownership, all of which may justify higher prices than anticipated. *[In other words: In order for the proposed Health Center to offer lower costs and therefore increase competition in the market, they would have to, in the author's opinion, have some realistic means in which to cut expenses—a claim by developers that the report can't substantiate even though it appears to make an effort to do so.]*

7. New entrants into the Santa Cruz County market for inpatient and managed care could enhance competition by assuming their share of the risks of doing business in health care: for all types of patients, for patients' full range of problems and for cost-effective care. *[In other words: It isn't going to be cheaper unless the competition is real. For costs of care on an industry-wide basis within the county to really drop, it will be necessary for new competi-*

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tion to not only agree to accept all types of paying and non-paying patients, but also offer all kinds of services. In fact, competing for only the profitable work with hospitals will only shift the costs of more complicated work and caring for the poor onto patients in a different way—someway, somehow, even people not using the facility are going to pay the bill for it. Conversely, if there really are efficiencies to be gained at local hospitals and money to be saved for patients, we are only going to know this if the hospitals have to compete on all levels.]

But what's new?

A New Form of Competition

The report brought forward a number of new issues to consider, although many of these are deeply buried in the lengthy and technical text. Of these, what may be most interesting is how the report looks at competition—especially when one remembers that competition is supposed to be the cornerstone of modern health care delivery, and that as traditionally defined, both Watsonville Community and Dominican hospitals have monopolies in the acute care market *(see interview with the report's author this issue)*.

Johns first examines the costs of competition to the consumer.

In most capitalistic economies, it is generally assumed that more competition in a market reduces costs for consumers. A simple, everyday way of looking at this might be retail sales: If only one store in town were to sell garden hoses, then it is likely that those garden hoses would cost more than if many stores sold similar products; if the supply of a product is limited, then it is anticipated that a for-profit business will capture the most profit available. But our hospitals are non-profit agencies, which isn't the only difficulty in looking at the issue of competition.

The problem with translating these supply and demand principles to health care is two-fold.

Hospitals that offer emergency and acute care services are required to accept any patient who needs care, and to provide that care even if there is no one to pay the bill. A reality that is easy enough to understand, but suffice it to say that most businesses wouldn't agree to letting the government decide when they would have to offer services for free.

The second point is less obvious. It is assumed that, regardless of however cost inefficient certain hospital departments may be, communities need to have certain medical services available at all times. In a sense, that certain efficiencies that are normally achieved in the business world can't be considered by a hospital.

If this still doesn't make sense consider the following: How would you like to be the poor soul that shows up to a hospital's emergency room suffering from sharp pains to the chest, only to find a closed sign on the door because there wasn't enough volume to justify the staffing costs?

But if the more is not better theory isn't working for health care why haven't we had to think about this before?

Here is where Johns points to changes in the market.

Changes in the Market

Tighter controls from government and insurance companies means that hospitals have to make dollars stretch farther than ever. And with lots less flex in the budget, most hospitals have had to consider what services they can and can't offer local residents, and then shift losses between departments.

This is also complicated by the fact that modern technology is allowing more and more procedures to move away from long to short hospital stays, which has been shrinking some of a hospital's historic markets.

And with all this change, some argue that hospitals, even those like Dominican and Watsonville that have gone through extensive down-sizing periods, aren't efficient in the delivery of some care.

Thoroughly confused yet? In simple terms, the hospitals are asking how they can be expected to offer so many things at prices that are less than their costs or not paid for at all. And at the same time not be allowed to charge more for procedures that they can get more for, from those who can pay—a practice known as cost shifting. Others are asking how we can know for sure hospitals are using our dollars wisely, unless we test the principles in real-world terms.

The Costs of Unequal Competition

Assuming that a mini-hospital is successful, and one should note that the Capitola Health Center developers are not the only ones talking about building such a thing locally (see Updates in *The Post* this issue), the study suggests

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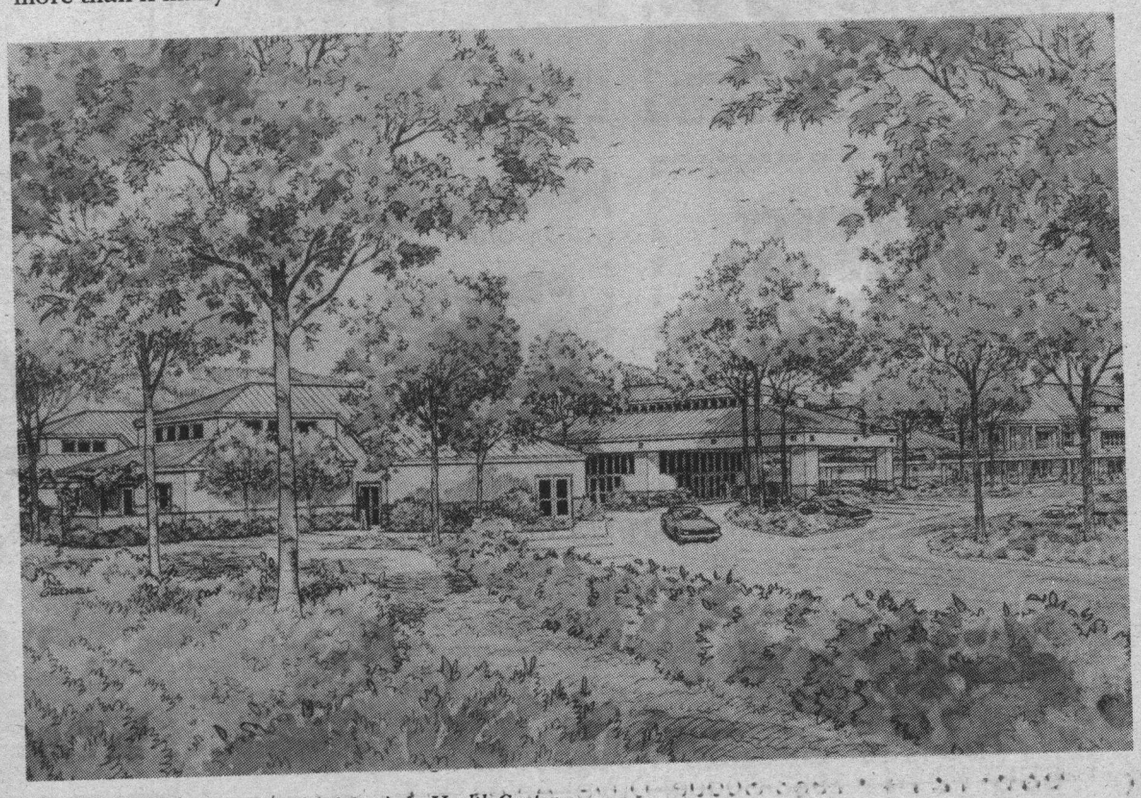

Artist's conception of the proposed Capitola Health Center.

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Dominican would lose about $3 million in business and Watsonville Community Hospital between $2-$5 million (the broader range being a function of how many of their doctors are involved in the project, and the number of patients they might lose in a competing facility). But this, at least on the surface, assumes that hospitals would not, even under the stress of more competition, reduce expenses.

To this point, Johns offers complex calculations to separate the fixed costs from the operational costs of the facilities. Don't worry, we're not going to even try and explain these calculations.

Instead, let's look at it in terms of the costs that hospitals can and can't control, which goes directly back to the point about the difficulties in managing certain kinds of care.

For this, Johns did what most do, and assumed that emergency rooms, acute care units and special infant health programs need to be kept open.

Johns goes onto say that, if a hospital has to compete for the easier kinds of surgery and care with a mini-hospital, then one of two things will happen.

Either the costs for the complex care services will increase dramatically (i.e. be shifted so their charges on the small stuff are competitive), or the hospitals will lose the business to the competitor, and the losses in revenue will be shifted to the more complex operations. In both cases, the patient that receives the specialized care will pay lots more, and in a sense, take up the slack that is now shifted away—at least as long as the hospital didn't have to compete for acute care business. But how much would this cost patients?

Should this prove to be the case, again through traditional economic theory, Johns calculates the number at about $5 million. That is, patients in the county will somehow have to come up with $5 million more each year, about $300 per in-patient admission, to support, either directly or indirectly, Capitola Health Center.

In a sense, the cost of choice to be absorbed by all.

But does this have to be true?

The evidence for proof is limited. Dominican is reporting that, by combining the operational costs of AMI's Community and Dominican hospitals, health care consumers have saved about $6 million this year. Or as John Petersdorf, chief financial officer for Dominican likes to say, "Put them together and you save money, pull them a part and it costs more." But who's benefiting?

According to county health officials, the area's budget for indigent care is going farther, and as a result, greater restrictions haven't had to be placed on those who can't afford care. Another, according to Dominican, is the paying patient isn't having to pay more. And granted, Dominican's rates are below those of Watsonville Community Hospital, and compare favorably when reviewed on a state wide basis, but it is still impossible to predict how long these savings will continue. Dominican says as long as they are there, while others, like Boss, of Santa Cruz Medical Clinic, believe only as long as everyone is watching closely.

The Sacred Cows

Anyone who suggests that the hospitals (Watsonville Community and Dominican) that helped fund the county's $21,000 study, along with the Santa Cruz Medical Clinic, got preferential treatment as a result, didn't read the report.

Johns was equally suspect of all, a point that Capitola Health Center's developers didn't express in a letter to the Board of Supervisors when they charged the report for being biased, even though they don't cite, in their letter, any specific criticisms with facts, figures or theories.

But who came out ahead?

The answer here is probably no one.

Johns certainly looked seriously at the Capitola's proposal, and it's likely the developers won't be happy with her findings.

Beyond estimating that the developers wouldn't return the profits to investors as easily as they claim, nor save patients money on the cost of procedures, Johns points out other flaws.

A calculated average hourly pay rate of $8.50 per hour for nurses and hospital staff, and construction costs of $21 million instead of the $12 million proposed by developers, are certainly two claims she questions.

And there are others. But most controversial may be the potential for conflicting interests with the physicians that would not only own the facility, but would also provide the work for the Center, an issue that, so far, has been missing in most of the reporting to date.

This is an issue that is receiving lots of attention and study these days across the nation, and is the impetus behind a new federal law limiting physician ownership in any health care institution, a law that may, according to Johns, dramatically effect the ownership requirement for the Capitola Center.

But in spite of strong criticism for the Health Center proposal, Johns was no less kind to anyone else.

Dominican, she implies, should have looked twice before opening a heart surgery center, and Watsonville Hospital may not be considering all the possibilities when planning a new facility—including the question about whether one is necessary at all.

She also points out a fact inherent in a small market with little competition. Doctors, along with patients, like to have choice. Choice is power and choice is sorely missed, even if choice is expensive.

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Dilemmas

Can a health care system that does not offer choice ever be completely trusted, or completely adequate to serve area physicians?

If there is not any mechanism to directly regulate hospitals, can we ever know for sure if the quality of care is up to industry standards?

And, in a sense, can health care institutions ever optimally perform in a market that is designed for competition, when there is none?

All tough questions that have left the hospitals scrambling for answers.

Dominican cites the current year's statistics for their heart surgery center (the report used their numbers for the first partial year of operations) to justify the need for the facility. Elinor Hall, the director of the county's Health Services Agency is not quite as sure yet, but does agree that for those who might have needed the facility the unit has been a blessing.

Dominican has also submitted to the county, in response to the report, facts and figures to show how they have contained costs and compared their rates favorably to other

Macy's passes us by for a department store, we look so attractive to health center developers, especially when the county's report also reveals that as a community, we are healthier than most and use hospitals less than others.

But maybe, even understanding the absence of choice as an incentive, isn't enough to grasp what is at hand.

The health care industry is changing at a rapid pace. There is little doubt that soon there will be some form of universal access plan for care, most likely to be sponsored by either the state or federal government. A plan that will conceivably maximize efficiencies by limiting choices even further. A possibility that suggests two more probabilities.

Will those who can afford "better" than the public health system of the future be willing to pay for private care? And who will offer that kind of service?

In a sense, maybe the best question to ask is, are small hospital developers planning for the health care system of today or tomorrow? What then will be the costs of choice?

Important questions, since ultimately we will be the ones to pay for them. ❑

Sutter health system to imagine more effective or more efficient ways of providing certain services within their system, seems to me a rational and predictable thing to do.

It's another matter when a proposal surfaces which selects some types of services to be provided in a certain manner, and pretty much ignores the rest of the players in the health care system.

If Sutter, for example wants to construct a 10 bed hospital somewhere, one would expect that this hospital would sort of be an outpost of a much larger facility, and would do only that which is appropriately done in such a small [setting].

MCP: But when Sutter builds a small hospital locally their primary system would be 150 miles away. Would this be close enough to connect the service?

LJ: I can not comment on the Sutter [proposal] whatever it is for Santa Cruz... When I was here in the county in late June, while I got wind of this idea, I knew no details of it, so I just can't be commenting on something that I haven't looked at first hand.

MCP: It been said by the developers proposing the Capitola Health Center that you held a bias against their project. Is this the case?

responsible for every word in that final document.

MCP: I'm sure the hospitals that helped fund the report won't appreciate all of your findings.

LJ: Hopefully not. I think if I pleased everybody, than that's a bad sign. And, if there is something in a report to displease everybody, that's a good sign.

Because nothing in health care works perfectly, and any provider, any financing mechanism, [or] any type of player in the system has room for improvement.

MCP: In the report it is noted that, in the traditional sense, Dominican and Watsonville Community Hospitals are monopolies in their areas. Are there instances or ways in which the hospitals work that illustrate how they are acting as monopolies?

LJ: I think we need to be very careful when using the term monopoly. We defined competition in the report, as potentially being present when two or more providers were providing a similar service in the same service area. [Ed: As defined by the State of California, the South and North areas of Santa Cruz county are each separate areas.]

So by definition, if you don't have two, but only one, you have what is technically