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For the last 20 years, our nation's policymakers have been struggling mightily to control the rising cost of health care which now accounts for 11 percent of the country's Gross National Product. It is a battle that is not being won without casualties.

The advent of both public- and private-sector cost-containment efforts, such as health maintenance organizations and the federal government's DRG (diagnosis related group) based prospective payment system, have squeezed hospital profitability. Constraints have been placed on the way physicians are allowed to practice. Hospital bed usage is at an all time low, but the intensity of treatment has never been higher. The business of medicine, which once was one of the most rewarding of professions, has fallen into a financial abyss from which escape is uncertain.

One of the primary questions being asked by those who have devoted their lives to curing the sick and healing the infirm is whether quality health care for all citizens will remain one of our society's top priorities. There is heightened fear that the bottom line mentality practiced by legions of green-eyeshaded bookkeepers will forever doom the health care industry to the gods of profit-loss statements, with little regard for the people who may be trampled in the process.

American health care has undergone a rapid and radical transformation. Competition and deregulation have combined to change the health care industry more in the last five years than it had in the previous fifty. The same kinds of strains faced by other deregulated industries (airlines and trucking, to name two) are now being faced by hospitals, doctors, chemical dependency treatment centers, outpatient clinics and other health related endeavors. Many smaller, less competitive hospitals have fallen by the wayside; some gobbled up by larger health care corporations whose size provides savings through such advantages as group purchasing and better reimbursement contracts with insurers.

The Minnesota Experience

We in Minnesota have been fortunate. Our hospitals and physicians are renown for their expertise. Rochester's Mayo Clinic is in an international class of its own, attracting patients from around the world. Both Abbott Northwestern and the University of Minnesota have pioneered techniques in transplantation surgery. Our top-notch medical school attracts the best and brightest students, and our North Country quality of life keeps them after graduation. For some time now, when Americans have wanted the best in health care, they have turned to Minnesota as a medical mecca.

For decades, when policy leaders have been challenged with health care issues, they have looked to see how Minnesota is responding. So when health care costs began spiraling upward, Washington looked toward the North Star state.

Locally, what was also not anticipated was the fierce and protracted fight for market share among insurers, during which premiums were held artificially low in attempts to pick up new subscribers and build networks in other states.

What the policymakers saw developing was a system of privately funded health maintenance organizations (HMOs), based on the elementary precept that it's better to spend a dime on prevention than a dollar on cure—and the realization that traditional fee-for-service coverage, in which patients had to pay a 20 percent deductible on all medical treatment, discouraged preventative medicine. HMOs gained consumer popularity by offering total medical coverage at a predictable fixed rate. Group Health became the nation's first HMO when it opened in the late 1950s, and by the late 1970s the idea had germinated. Between 1975 and 1985, the proportion of the Twin Cities population enrolled in HMOs soared from 5.5 percent to 46.1 percent, far eclipsing any other region in the nation in penetration by prepaid plans.

Minneapolis-St. Paul became a microcosm for managed health care, with three types of HMO systems being practiced: staff model (in which doctors are hired by and work for the HMO on a salary basis), individual practice associations (in which independent doctors contract with HMOs to treat the plan's patients) and networks (in which groups of physicians or clinics contract with HMOs). Local examples would include Group Health using the staff model, Physicians Health Plan using the individual practice model, and Park-Nicollet MedCenters using the network model.

Adding to the alphabet soup confusion are PPOs, or preferred provider organizations (Blue Cross Blue Shield's "Aware Gold" being the largest), which offer HMO-like benefits when subscribers use designated doctors, and fee-for-service coverage when subscribers use other providers.

Congressional policymakers looked at what was happening with HMOs in Minnesota, with prospective payment in New Jersey and with soaring medical costs nationwide, and decided that the time had come for radical action. They wanted to be able to budget more accurately for health care

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expenditures. They wanted to better control costs by negating the financial incentives for physicians to perform additional procedures and hospitals to keep patients more days. They wanted to preserve and hopefully enhance quality health care. Their creation in 1983, for better or for worse, was the prospective-payment system and its 475 diagnosis-related groupings.

What wasn't quite as apparent when the HMO revolution and the prospective-payment system began were the methods being used to provide care at such affordable prices: slashing the length of hospital stays, cutting back on hospital reimbursement rates, and limiting physician discretion in the caregiving process.

Locally, what was also not anticipated was the fierce and protracted fight for market share among insurers, during which premiums were held artificially low in attempts to pick up new subscribers and build networks in other states. The cost of that expansion was laid at the doorstep of local hospitals and physicians, who saw their reimbursement rates slashed and their profitability wiped out. Only within the last year or so have payors stopped deliberately undervaluing health care insurance and begun assessing charges that are more in line with costs.

The struggle has left hospitals fighting to keep their heads above water, floating in a sea of red ink. More importantly, health care professionals are alarmed that the traditional way of practicing medicine may have disappeared. They are fearful that the tail may be wagging the dog, with treatment decisions based more on financial consideration than on physician judgment—and that the quest for quality may be compromised in the attempt to implement "sound business management decisions."

Health care professionals readily acknowledge that the financial spigot was wide-open in the 1960s, and that not enough attention was being paid to holding down costs. The fear today is that the pendulum has swung too far in the other direction, and that fewer dollars may be driving down quality. The challenge ahead is to strike an acceptable balance between cost and quality.

Health Care is Different

Those who work in traditional commercial-industrial sectors like manufacturing, banking and retail sales have a hard time understanding the health care dilemma. That's because they don't face the same obstacles to profitability. For one thing, they have a much easier time pricing their product. Widget makers calculate their costs for raw materials, manpower, overhead, shipping and marketing, then add a reasonable profit margin which will reward investors to determine a selling price. If they build good widgets and offer them at a competitive price, they'll occupy a niche in the market and will survive. If not, they'll go broke and someone else will take their place.

Not so in health care; particularly in the Twin Cities, where state and federal governments and a handful of large purchasers (HMOs and commercial insurers) determine the price they are willing to pay to use hospital services. Hospital administrators have little choice—they either acquiesce to the fee schedule (no matter how inadequate) or they turn their backs on hundreds of thousands of potential patients that the prepaid plans represent. In no other industry do customers control the fee-setting structure to the extent that they do in health care. With approximately 85 percent of hospital revenue based on such unilateral fiat, it's easy to understand why 69 of Minnesota's 160 hospitals (and 20 of 28 in the Twin Cities) ran operating deficits last year.

The Medicare Shortfall

The situation surrounding the Medicare program provides a good example of the problem facing the U.S. hospital industry. Medicare absorbed 36 percent of all domestic spending cuts in Congress's 1988 appropriations bill, even though the Medicare program accounted for only 9 percent of the budget. Over the last five years, Congress has limited Medicare reimbursement increases to 11.2 percent—at a time when inflation has been running at 19 percent, and the cost of goods and services purchased by hospitals has risen by 21.7 percent.

Since Medicare accounts for 45 percent of all hospital patient-days, congressional underfunding has put a serious crimp in hospitals' ability to provide care to all patients. More than 40 percent of all U.S. hospitals are now losing money on Medicare patients, and that number is expected to exceed 50 percent within two years.

Medicare was established 22 years ago as a way to insure proper health care for the elderly and disabled. Today, there are 32 million recipients, and that number is growing. As a our nation's population grows increasingly older, demands on Medicare are going to grow as well. Unless a recommitment is made to that most basic program, millions of Americans are going to face the final years of their lives without the quality of health care that they paid to have provided for their parents.

So far, much of the Medicare shortfall has been absorbed by private payors as a "cost shift" that in effect has employer-sponsored policies paying proportionately higher premiums than they otherwise would be paying. It is estimated that $8.8 billion in costs were shifted from public to private payors in 1984, and that the public sector subsidization is substantially higher today.

The Nursing Shortage

One of the most critical problems facing hospitals as they move toward the 1990s is a shortage of highly trained professional nurses, particularly nurses who are able to handle high stress areas such as the emergency room and the intensive care unit. Although the nursing shortage is most evident on the east and west coasts, the problem is spreading to the heartland and is expected to worsen if not addressed.

Not too long ago, nursing was one of the few professional fields open to women (teaching being another). The advent of equal employment opportunities has opened dozens of career avenues previously not available to females, in areas that pay more money, offer better hours, and provide far less emotional anxiety. Nursing has always attracted—and always will continue to attract—committed caregivers, those who want to devote their lives to helping the sick and injured. But for those women simply looking for careers, nursing no longer carries great appeal.

For many nurses, status and dignity within the health care industry are just as important as financial considerations. In just about every case it is the nurse who has the most interaction with the patient. When someone leaves a hospital, their perception of the treatment they received (positively or negatively) will be based almost entirely on their relations with nurses. Nursing staffs can make or break a hospital's reputation. Yet too often within the medical community, nurses are perceived and treated as second-class citizens, not receiving the attention or credit that they deserve. The result

is that nurses are finding new jobs that pay higher salaries and offer more personal satisfaction.

As a result, in some parts of the country, entire hospital wings have been shut down because of lack of staffing. This hasn't happened in the Twin Cities, and probably won't happen. In early 1987, the St. Paul-based Healthcare Education and Research Foundation initiated discussion between hospital administrators, the Minnesota Nurses Association, the Minnesota Organization of Nurse Executives and other healthcare providers. Outlined were several areas of common concern, including staffing ratios, degree requirements, pay rates and others—all centered around enhancing the recruitment and retention of nurses. It is still too early to tell whether the local initiative will bear fruit. But for the first time in a long time, nursing representatives are playing a key role in developing health care's future.

Indigent Care

Another casualty in the hospital funding crisis could be the poor and the uninsured, the indigents who up until now have received free care from hospital administrators who knew that they would never be reimbursed for their services. The caregiving mission of non-profit hospitals has been to provide protection for the less fortunate. All Twin Cities hospitals dedicate a portion of their revenues to offer as charity care, with the three taxpayer-supported public hospitals naturally providing more than the rest. Declining revenue margins and attempts by some levels of government to take non profit tax status away from hospitals may force some health care providers to rethink their commitment to indigent care.

Every dollar of free care that is provided by community non-profit hospitals is one less dollar of care that must be provided by government. It would seem to make sense to protect the network of care currently serving the underclass. Instead, multi-directional attacks are serving to undercut it. In 1987, state lawmakers considered taking away hospitals' property tax exemption. That single step would have cost Minnesota hospitals $73 million a year. It was also proposed to extend the state's six percent sales tax to purchases made by non profit hospitals. That would have cost an additional $16 million. Given hospitals' razor thin operating margins ($36 million on revenues of $2.1 billion in 1987), overall profitability would have been wiped out.

The Response from Hospitals

What are hospitals doing to try and escape from the sea of red ink? Merging, consolidating and closing facilities have been some of the answers. Thirty years ago, most Twin Cities neighborhoods and many rural towns had a hospital they could call their own. It was the place where children were born, where 10 years later those youngsters' tonsils were removed and broken arms repaired, and where, 10 years after that, another generation of children were born. The only time patients would venture away from the friendly confines of their local hospital was if specialized treatment was needed. Often the local hospitals were religion-based facilities, built adjacent to churches, managed by clergy and staffed by nuns or other orders. All were non profit, so all they required was enough reimbursement to meet their costs and maintain their facilities and equipment.

When the financial squeeze hit hospitals, many of those small neighborhood facilities were unable to survive. Declining patient utilization and increasingly inadequate reimbursement rates left them uncompetitive. Just as the inefficiency of neighborhood ma-and-pa grocers gave way to the size and selection of supermarkets, neighborhood hospitals have done likewise. Many small independently-owned hospitals found it impossible to compete and were folded into regional multi-hospital management corporations. Some have been converted to specialized treatment, such as chemical dependency treatment, psychiatric care or geriatric medicine. Others have been sold and are now used for colleges or nursing homes. And some have simply been torn down.

Which of the hospital groups will succeed and which will fail is unknown; many of the questions cannot be answered until public and private payors decide what type of healthcare system they are willing to finance.

Today, in the Twin Cities, four large "multis" (Health One, HealthEast, Fairview and LifeSpan) represent about 70 percent of the market, and three public teaching hospitals (Hennepin, Ramsey and Universiy) share another 20 percent. North Memorial Medical Center in Robbinsdale is the last of the large independents, and there remains a scattering of smaller independents.

After three years of near frantic specialization and consolidation, a period of relative calm has descended upon the Twin Cities hospital market, as the remaining corporations position themselves for short term leverage and long term survival. Which of the hospital groups will succeed and which will fail is unknown; many of the questions cannot be answered until public and private payors decide what type of health care system they are willing to finance.

Conclusion

What will Minnesota and U.S. health care look like in the year 2000? If current trends continue, it could be far different from what we have today. Here are some of the predictions often cited:

- Two different types of care may be offered: continued high quality care for those who can afford to pay for the best, and a substantially more moderate grade of care for those who must rely on inadequate government programs. "Rationing" could become commonplace, with the latest in technologies and drugs available only to those who can pay. (A current example is the federal government's refusal to cover the drug TPA for Medicare patients with heart problems.)

- Employers and/or consumers may be required to pay increasingly more, picking up the "cost shift" tab for both their own workers and others, similar to the plan Gov. Michael Dukakis pushed through in Massachusetts. First dollar coverage and total preventative-maintenance HMO coverage may still be available, but at a substantially higher price.

- Indigents, who until now have been able to rely on the caregiving mission of non profit hospitals, may have more difficulty finding hospitals that are financially able to meet their needs. That would mean that the least fortunate in our society could be without any kind of health care safety net.

- Half the 5,800 U.S. hospitals may close their doors or be converted to other uses, which will mean longer drives for treatment and more danger in emergencies, particularly in

rural areas, where transportation delays are already a problem.

This doomsday scenario need not occur, of course, if public policymakers make a renewed commitment to provide quality health care to all citizens, regardless of ability to pay. It would cost money (lots of money), primarily because technological miracles don't come cheap. The demands our aging population place on elected officials and bureaucrats will determine, to a large degree, the kind of medicine and hospitalization Americans can expect to receive in the future.

Fairness and equity are the keys. Policymakers need to set decent and humane priorities, then live up to their promises. When they enact a new program such as prospective payment and promise to provide annual cost adjustments, they must do so. When they come out with a new wonder drug such as TPA, they cannot refuse to make it available.

If our leaders make quality affordable healthcare a top public priority . . . if they maintain and strengthen the public-private partnership that exists with non-profit hospitals . . . if they resist the temptation to balance skewed budget priorities on the backs of the less fortunate . . . then we can look forward to continuing America's reputation as the provider of the best health care in the world.

Human Immunodeficiency Virus in Minnesota: Summary of 1988 Statewide HIV Risk Reduction and Disease Prevention Plan

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The AIDS epidemic continues to grow in Minnesota. As of December 10, 1988, 447 cases of AIDS had been reported to the Minnesota Department of Health (MDH), and 252 Minnesotans had died from AIDS. An effectively implemented risk reduction and disease prevention plan that has broad support and involvement of all segments of the statewide community is essential to reduce the tragic morbidity and mortality caused by this disease in Minnesota. The Commissioner's Task Force on AIDS approved a statewide human immunodeficiency virus (HIV) risk reduction plan in the spring of 1986 (1). The original plan has been updated to incorporate the following objectives for 1988.

Objectives

The ten objectives of the statewide HIV risk reduction plan form a comprehensive and unified approach to preventing the spread of AIDS in Minnesota. The plan objectives are:

1. To study the prevalence and incidence of HIV infection in Minnesota.
2. To study and evaluate knowledge, attitudes, and behavior of persons at risk of acquiring HIV infection.
3. To conduct outreach programs.
4. To conduct programs leading to risk elimination/reduction through behavioral change.
5. To provide adult public education.
6. To provide youth education.
7. To provide professional education to health care providers.
8. To develop a plan for addressing the disproportionate risk of acquiring HIV infection among Minnesota's communities of color.
9. To assist local public health agencies in developing community-based plans for dealing with HIV infection and providing education to their local communities.
10. To evaluate the efficacy of all risk reduction programs.

Study HIV Infection in Minnesota

The MDH will continue to conduct surveillance for AIDS cases and patients with positive test results for HIV infection (repeatedly reactive EIA with a positive Western blot, positive HIV antigen test, or positive culture for HIV), regardless of symptoms. Ongoing tabulation of seroprevalence rates from the blood banks and the state-sponsored counseling and testing sites can also provide such information. During 1988, the MDH has begun to obtain HIV seroprevalence data from

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