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EDITORIAL

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What Is a Hospital?

Hospitals in the United States are changing dramatically. Motivated by the high cost of hospital care, payers have worked hard both to keep patients out of the hospital and to discharge them early. Because only the severely ill are now welcome as inpatients, the market has responded with a wide array of creative approaches to provide care outside the hospital: chest pain observation units, outpatient surgery centers, expanded rehabilitation and postacute care settings, and home health care. The future of the U.S. hospital appears certain: fewer beds, sicker patients—essentially an expanded intensive care unit.

The article by Halpert and colleagues[1] in this issue of **ecp** should be understood in this context. Given the current high cost of acute inpatient care, any intervention that identifies patients who can safely receive care in a less costly setting should be welcomed by both patients (who must often share some of the cost of hospital care) and payers. Direct admission to an extended-care facility exemplifies this effort to limit hospital utilization. At the same time, Halpert and colleagues' study provides an opportunity to step back and ask whether the widely accepted vision of the hospital as intensive care unit is a vision we wish to pursue. Does the new hospital really reduce costs? Is it really best for patients?

Does the New Hospital Really Reduce Costs?

Although it stands to reason that money must be saved by reducing the number of days people spend in hospitals, the actual impact depends on whether true or apparent costs are being considered and to what extent system-wide effects are considered. Apparent costs (charges) may not reflect true costs (actual resources consumed). For example, when hospitals charge flat per diem rates, as in many managed care contracts, the high costs of the hospital are spread equally across each hospital day. It will appear cheaper for the payer, therefore, to move the patient to a subacute setting, even though the actual cost of the final days of hospital care may be lower than the cost in the subacute facility.[2] The payment method can further muddle information about cost. Medicare, for example, reimburses a hospital a fixed amount according to the patient's diagnosis (regardless of the length of stay), while allowing postacute care and home care providers to charge for their services on a cost-plus basis. The assumption seems to be that it is the hospital itself that is expensive, rather than the activities that take place within it. Sick patients are expensive; recuperating patients may not be.

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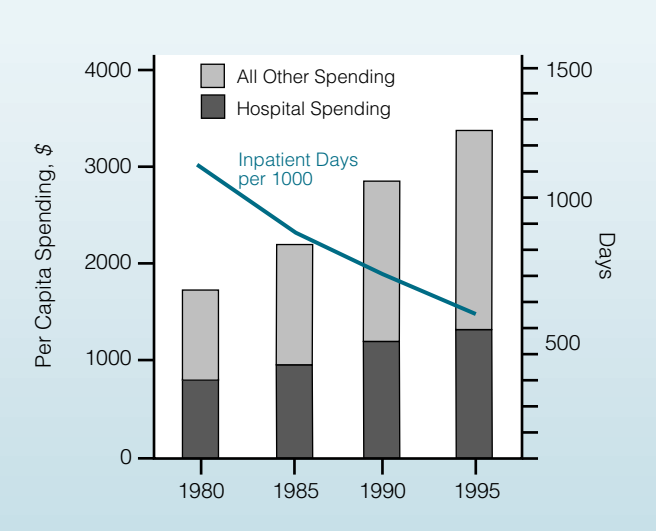

FIGURE 1. U.S. hospital utilization (days per 1000 patients, *blue line*) and per capita health care expenditures (in 1995 U.S. dollars) from 1980 to 1995.[3] Hospital use decreased while hospital and total spending increased.

What are the system-wide effects of the new hospital? **Figure 1** compares the trend in hospital utilization with the trend in health care spending over the past two decades. Although hospital use declined by more than 52%, real per capita spending on inpatient hospital services alone increased by over 50%.[2, 3] The paradox is apparent: Although fewer patients are in the hospital for shorter stays, they are receiving more care. And total health care spending has increased dramatically.

Thus, despite the best of intentions, the new hospital could increase costs. The development of new programs and institutions to care for patients outside the hospital can achieve savings only if hospital costs decline commensurately. An outpatient surgery program may allow many operations to be performed on an outpatient basis, but if the inpatient surgical suites and staff remain intact and busy, total costs will increase. A new chest pain observation unit may allow better (and perhaps less expensive) care for patients with chest pain, but if the intensive care unit is now available and is used for more patients who are close to death, total costs will increase.[4] It is at least possible, therefore, that the effort to shift patients out of the hospital actually exacerbated the rapid cost increases of the 1980s.[2]

Is the New Hospital Best for Patients?

The clinical concerns raised by the new hospital are easily articulated. First, shifting less severely ill patients from the hospital to short-stay postacute facilities may not be best for patients because doing so fails to account for the trajectory from illness to recovery and disrupts important relationships. When patients are transferred to a rehabilitation hospital only a few days after major surgery, they lose daily contact not only with their surgeon but also with their family practitioner and the nurses on whom they have come to depend.

Second, the new hospital fails to account for the critical role of uncertainty. Some patients are obviously severely ill and must immediately receive the interventions that are now required to justify hospitalization. For many others, however, the need for intervention is less obvious at the outset but their physicians may legitimately fear acute deterioration. How many patients are currently given intravenous fluids simply to justify observation in the inpatient setting?

Finally, the hospital as intensive care unit also fails miserably to accommodate the needs of the populations for whom the hospital was originally intended[5]—the poor or otherwise disadvantaged populations for whom home care is either unrealistic or extraordinarily expensive because of the absence of effective caregivers in the home.

Conclusion

The future of the U.S. hospital may already be here in some communities. The United States as a whole has 3.3 beds per 1000, and many communities have more than 4.0 beds per 1000. But some communities, largely in the West, have already reduced hospital capacity to fewer than 1.7 beds per 1000.[6] Physicians in these communities acknowledge that the hospital is now devoted largely to intensive care and major surgery. Moderately ill and recuperating patients are cared for in nursing homes or other nonhospital settings.[7] This could be a wise path to follow because it may reduce the risk for infections and other adverse events associated with hospitalization.

At the same time, we must remember that both clinical outcomes and costs depend primarily on what we do to patients, not where we do it. The aggregate capacity of the health care system has a powerful influence on both treatment and cost.[6, 8] The path to successful cost containment, therefore, is more likely to be found in reducing administrative overhead[9] and eliminating duplication of technology[10, 11] and redundant postacute care systems than in simply reducing hospital days. Before the rest of us sign on to the new hospital, we should carefully consider its true system-wide costs and clinical consequences.

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Endnotes

On the next four pages of **ecp**, you will find "A Shared Statement of Ethical Principles for Those Who Shape and Give Health Care: A Working Draft." The statement is an effort by a multidisciplinary group to find a common ground among separate, discipline-based codes of ethics. Truth be told, I'm not a big fan of "ethical principles" (and have even been known to wince upon hearing the term "ethicist"). On the other hand, we all know that our health care system is increasingly dominated by money (a reality that applies to providers and payers alike) and is increasingly distracted from caring. So if the statement by the Tavistock Group can help us rebalance, I'm all for it. (Hence my decision to publish the document).

I particularly like the fact that the statement on ethical principles is a working draft. The document has already been published in several medical journals, and the goal of this widespread publication is to elicit feedback to improve the document. Your mission, should you choose to accept it, is to look it over and voice your honest opinion of its contents.

To get you in the spirit, I'll share the two areas I take issue with. The first is really a quibble. Although the prevention of illness takes center stage in Principle 3, none of the five principles say anything about caring for the sick. The second is more fundamental: the characterization of health care as a human "right." Is it any more of a "right" than food, clothing, shelter, or education? Does the word help foster a recognition of competing social needs or is it more of "trump card" to be played by those of us with obvious self-interest? Sure, health care warrants special status, but wouldn't "public good" or "social obligation" do the trick? Can't we find a phrase that moves health care beyond the commercial realm, but not beyond reproach?

What do you think? If you have comments, send them to: Ms. Penny Janeway, Initiatives for Children, American Academy of Arts and Sciences, Norton Woods, 136 Irving Street, Cambridge, MA 02138-1996; e-mail: penny@amacad.org.

H. Gilbert Welch, MD, MPH
Editor