Michigan's Bed Reduction Policy And Bed Loss Determination

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INTRODUCTION

Over the years technological advances in the health industry have increased health care costs to the extent that many people are unable to afford needed care. During this same time hospitals continued to expand, develop, and offer new services and programs to the public. Hospitals began to compete with each other in an effort to gain a larger proportion of the population in their service area. This uncontrolled growth led to increased costs of services and health insurance. In an effort to control the over expansion of health care delivery the federal government created the national Certificate of Need program.[1]

The federal Certificate of Need program was created as a mechanism to control health care spending and expansion. Like many other federal programs the control and management of the program was given to the individual states. Each state has its own set of requirements and needs, in regard to health care delivery and management. Because of these differences, the requirements for a Certificate of Need vary from state to state reflecting what each state perceived to be important health care delivery issues.

An issue of common concern in many states is the excess of needed hospital beds. In an effort to reduce these numbers states began to write amendments to their Certificate of Need laws and established committees, or panels to develop a plan to eliminate unused hospital beds. Michigan amended its state Certificate of Need legislation to require that the local health planning agencies reduce the number of excess hospital beds in their area, and also formed a special coalition made up of concerned parties

from the public and the private sector. This was an attempt on the part of the state to maintain an adequate bed to population ratio, and to reduce the high cost of health care within the state.

This paper will explore how Michigan's amended Certificate of Need legislation and the development of the state wide bed reduction policy affected hospital bed levels within the state. It will also show how the decisions that were made in 1978 by the state to develop and implement a bed reduction policy continue to affect current hospital bed levels and the overall Certificate of Need application process.

CHAPTER 1

FEDERAL HISTORY

THE HILL-BURTON ACT

Over the past four decades the federal government has become increasingly involved in the funding, planning, and regulating of health care. What began as the federal government's attempt to improve and expand hospitals in needed areas, has developed into the formation of state and local health care planning agencies which regulate hospital expansion and regulate how hospitals and other health care providers deliver health services to the community.

Following the end of World War II the United States was in the same situation as many of its European allies in regard to health care. Many of the European countries concentrated their efforts on trying to improve health care delivery. As an example, England developed a national health care program. The United States looked at its problem from a different perspective. The United States was more concerned about the limited number of hospital beds and the existence of substandard, outdated, and obsolete facilities. Congressional reports of that time reported the existence of substandard facilities and an overall shortage of hospital beds, and also a large maldistribution of beds among states and between rural and urban areas.[2] It was thought that this maldistribution of hospitals and other facilities was directly related to the lack of quality health care in certain areas of the country.

In 1946, President Harry Truman approved and signed into law the Hospital Survey and Construction Act, (P.L. 79-725). This act

was proposed and written by Senators Hill and Burton and was commonly referred to as the Hill-Burton Act of 1946. Hill-Burton authorized federal categorical grant monies for:

> Surveying state needs and developing state plans for the construction of public and voluntary non profit hospitals and public health centers; and assisting in the construction and equipping such facilities.[3]

Hill-Burton was set up as a Federal-State partnership program. The original program authorized $75 million a year for five years for grants to states and non-profit groups for hospital construction. An additional $3 million was also made available for state survey needs.[4] The federal government developed and used a set formula for determining how much money a state should receive. This formula was based on state population and the number, type, and condition of hospitals that were already in existence at the time. Priority was supposed to be given to those states that had a large rural population and/or limited number of hospitals per population. Each state was given initial grant money to survey their hospitals needs and to develop a construction program based on the survey. The survey was subject to federal approval and if approved the hospital or agency was granted the allotted funds. The state, local agency, or hospital was responsible for paying any remaining portion of the total construction costs.

Since it's original implementation, Hill-Burton has been amended many times in an effort to expand and improve the program. In 1949, Congress extended the program through 1954 and doubled the appropriations from $75 million to $150 million, (P.L. 81-380).[5] In 1954 President Eisenhower made recommendations to expand

and improve the HIll-Burton Act. The Medical Facilities Survey and Construction Act of 1954, (P.L. 83-483)[6], not only extended the existing program and monies, but also for the first time provided $60 million in additional grant monies to the states to assist specifically in the construction of diagnostic and treatment centers, out care facilities, and rehabilitation centers. Between 1959 and 1964, the Hill-Burton Act was extended with no increase in programs but there was an increase of $100 million in appropriations over that five year period.[7]

Under President Johnson's "Great Society" programs, Hill-Burton was again amended. The Hospital and Medical Facilities Amendment of 1964, (P.L. 88-443),[8] once again extended the Hill-Burton Act for an additional five years. Other provisions in the act included increasing authorizations for existing construction categories, added a new category of long term care facilities, and also provided new grant money for the modernization or the replacement of extinct facilities.

During the Nixon administration an effort was made to do away with categorical grants and go to more general block grant programs. Though originally vetoed by President Nixon, Congress enacted the Medical Facilities Construction and Modernization Amendment of 1970, (P.L. 91-296)[9]. This Hill-Burton amendment authorized new grant appropriations for the construction and modernization of health care facilities. The new amendment was also supplemented by a program of low interest loans and loan guarantees. The new amendment also made several important changes in the operation and administration of the program. Priority was now given to areas with minimal financial resources, rural

communities, and to those agencies who wished to establish out-patient facilities. New money was also earmarked for those facilities that provided training of health care or allied care professionals. In 1973 the Health Programs Extension Act, (P.L. 93-45),[10] provided a one year extension to the program without any substantive changes in programs or increase of the $197.2 million a year in appropriations.

Between July 1, 1947 and June 30, 1974 more than 4 billion dollars, ($4,481.2), in appropriation grants was distributed to states for the construction and modernization of hospitals and other health care facilities.[11] This money was distributed among 11,493 approved projects nation wide. The total costs of all of the projects by the states was more than $14.5 billion dollars of which $10.4 billion was supplied by state and local agencies or the hospitals themselves.

In 1948, 78 percent of the Hill-Burton funds went for the construction of new health care facilities, particularly general hospitals. In its final year of existence, 1974, less than 3 percent of the money was spent for this purpose. The remaining 97 percent went for replacement, additions, and the modernization of existing facilities.[12] Toward the end of the program, the state's priorities shifted from building new hospitals and the addition of beds, to an increase in the construction of out patient facilities, the modernization of existing facilities, and the installation of new technological improvements.

Effective January 1, 1972, the portion of the 1970 Medical Facilities Construction and Modernization Act that allowed for low interest loans and loan guarantees to the states went into

effect. At the completion of the program in 1974, this act provided $1,039.1 billion dollars in direct loans and loan guarantees to hospitals and other health care providers.[13] Of the 255 approved projects, 244 involved either the modernization of existing facilities and/or the addition of additional services such as out patient clinics and long term care beds. The remaining 11 projects went towards the construction of new hospitals.

In it's 27 years of existence, Hill-Burton provided billions of dollars to hospitals and other health care providers to improve the quality of health care. Although the act was amended many times during those 27 years, the original idea of providing quality health care facilities with adequate bed capacity was never lost.

THE NATIONAL CERTIFICATE OF NEED PROGRAM

At the close of the Hill-Burton Act on June 30, 1974, State plans nationwide showed that there was a surplus of over 20,000 beds throughout the country. At the same time, it was projected that by 1975 there would be a surplus of 67,000 beds nationwide.[14] Despite the surplus of hospital beds, some areas of the country still reported shortages but this was primarily due to population shifts and/or growth. But the Hill-Burton Act did not remedy all of the nation's hospital problems. Studies showed that there was still a need for the modernization of 167,000 hospital beds and 2,800 health centers, and that over one third of the country's general hospitals and long term care facilities had reached a point of needing to be remodeled or replaced.[15]

The Hill-Burton Act had accomplished what it was originally

designed to do: increase the number of hospital beds in the U.S.. But it had increased to a point where some areas actually had an over supply of hospital beds and facilities while other areas still had a shortage. In an effort to stabilize the growth of health care, something the Hill-Burton Act was unable to do, a new bill was written to regulate and control health care growth. On January 4, 1975 the Federal government signed into law the National Health Planning and Resource Development Act, (P.L. 93-641).[16] This law was Title XVI to the Public Health Service Act and contained a new text to the Hill-Burton program. The new act authorized funds for the development of state and local health care planning agencies and for the development of state run Certificate of Need Programs. States without a Certificate of Need program would be denied federal funds for planning agencies, and reduced Medicare and/or Medicaid payments.

A Certificate of Need, (C.O.N.), is a state regulatory mechanism for the review and the approval of capital expenditures and service expansion by hospitals and other health care facilities.[17] The main purpose of all C.O.N. programs is to control health care costs by restricting the growth of institutional health services. The states also used the C.O.N. programs to help accomplish other policy goals. Some of these goals included a means of regulatory control for weak market restraints on expansion and new technology introduction, to justify that their is a "need" for a particular service in a given community, to bring about an even geographical distribution of services, and to be used as adjuncts to other state regulatory and reimbursement programs.

If a state has a C.O.N. program, a hospital or other health care facility is forbidden from proceeding with such projects unless it gets prior approval from the state and local health care planning agency. Approval or denial of the project is based upon the review of the project against set criteria to determine if a real need exists for the service in the community. The criteria that is used varies from state to state although there are certain federal guidelines that must be followed. The federal regulation allows each state to set it's own standards for the application, review, and approval process.

The first C.O.N. program was adopted in the state of New York in 1964. This was a program that was set up by the state in an effort to curb the rapid growth of hospitals and to prevent the duplication of services within the same geographical area. By 1974, twenty five other states developed similar laws based on the New York program. These early laws provided for prior approval by the state agencies for capital expenditures that exceeded $100,000-$150,000 dollars, addition of new beds, the expansion of services, or the development of new services.[18] With the passage of Federal law P.L. 93-641, 46 states and the District of Columbia had developed C.O.N. programs by the end of 1975.

By 1982 every state except Louisiana had some sort of C.O.N. program in effect that resembled the federal model.[19] These updated federally approved programs were intended to control expansion and the introduction of new technology into the health sector, preserve the quality of health care, prevent the maldistribution of health services, and to help the state regulate reimbursement

programs.

CHANGES IN STATE AND FEDERAL C.O.N. PROGRAMS

At the peak of the NHPRDA (National Health Planning Resource Development Act of 1975) program it had provided for $150 million dollars annually for the state and local planning programs throughout the nation.[20] Funding was also provided by the state and from local funding sources. In 1980 under President Reagan's administration it was suggested that the C.O.N. programs had been ineffective in controlling the rate of hospital and health care inflation. This information was based on several econometric studies. It was for this reason and President Reagan's ideology of "getting the federal government off the back of the people" that federal funding for the C.O.N. programs fell sharply. Because of the cuts in federal funding for the state and local planning agencies the federal government dropped or rewrote many of the NHPRDA requirements. One of the requirements that it did drop was that states no longer had to adopt and/or maintain a complying Certificate of Need program. With the deletion of the federal C.O.N. requirement it was thought that there would be widespread repeal of state C.O.N. laws.

Between 1982, when the C.O.N. requirement was dropped, and 1985, seven states (Idaho, New Mexico, Minnesota, Utah, Arizona, Kansas, and Texas) repealed their Certificate of Need laws.[21] By mid 1986 Louisiana joined the ranks of states without a working C.O.N. program. Since that time these states, with the exception of Arizona, Utah, Kansas, and Texas, have either reinstated their C.O.N. program or replaced it with a moratoria on new hospital construction and expansion projects.[22] These moratorias not only

limited the number of new projects but many also put ceilings or caps on the dollar amount of the projects approved in a given year. Other state moratorias limit the number of new beds or the relocation of existing beds.

Many of the other states have attempted to streamline their requirements or review process in an effort to maintain the use of their Certificate of Need programs. As an example the State of Washington exempts capital expenditures that will not directly affect patient charges. These include parking facilities, heating and air conditioning systems, purchase of land, repairs to the physical plant, and others. Kentucky does not require a C.O.N. if the hospital is replacing or repairing equipment that is more than five years old or if the hospital is making improvements or alterations to the physical plant. Other states have removed the requirement for a C.O.N. if the hospital is refinancing a debt.

Raising the maximum expenditure thresholds is another way that states have streamlined their programs. A large number of states have raised their thresholds past the federal level of $100,000.[23] This has been a common practice among western states. Colorado has a $2 million capital expenditure threshold. Alaska and California have a $1 million threshold on certain projects. Washington and Oregon have a similar $1 million threshold. Other states that have raised their thresholds include Tennessee, West Virginia, and Mississippi. As of 1986 only seven states have kept their expenditures at the old NHPRDA levels.

In an effort to evade the Certificate of Need application process many health care providers continue to place expensive high tech medical equipment in non institutional setting such as

clinics and physician offices. This was a common practice used in the purchase of CT scanners. In an effort to stop this tactic, states began to amend their C.O.N. laws. Virginia's C.O.N. law now covers the purchase of equipment by physican's offices that is generally associated with that of a inpatient setting. Iowa, Colorado, Connecticut, Hawaii, Wisconsin, Montana, New Hampshire, Rhode Island, and the District of Columbia all have made similar amendments to their C.O.N. laws.

As the states' Certificate of Need programs expanded, some of them were experiencing unavoidable side effects. Questions of preferential treatment to existing facilities and the reduction of competition among new and existing facilities were sometimes challenged through litigation. Some state laws have been amended to lessen the possibility of monopoly, though most state laws support the policy of promoting competition.

Although the initial function and purpose of the federal Certificate of Need program has not changed dramatically since its introduction in 1975, individual states have written their C.O.N. laws to be more than just a means or controlling costs. Some states are using C.O.N. programs to limit the number of beds, control the purchase and distribution of high tech medical equipment, and to promote competition. The purpose of streamlining is also used as a means to remove the planning agencies from the minor projects or routine business transactions that do not risk excess investments.

CHAPTER 2

MICHIGAN HISTORY

MICHIGAN'S CERTIFICATE OF NEED LAW

The National Health Planning and Resource Development Act of 1975 gave the states guidelines to follow in developing a Certificate of Need program. States had to comply with this law if they wished to receive federal grant monies for health planning agencies and to receive full Medicare and Medicaid payments. As Michigan relies heavily on federal reimbursement programs it chose to develop a C.O.N. program.

Although the state of Michigan has had a Certificate of Need program since September 30, 1978, (P.A. No.368 of 1978), it was not ratified by the state legislation until June 24, 1986. Since 1978 the act has only been amended once, (1980).[24]

Like other federal and state laws, a significant portion of the document defines the terminology used throughout the document, (sections 22101 through 22108). Within these sections terms such as Health Facility, Change in Service, Health System Agency, Physical Plant, New Construction, and Change In Bed Capacity are defined. These terms are used extensively within the document and are referenced throughout the other sections of the act.

Section 22111 of the law states that a Certificate of Need program shall be established and defines the provisions and the duties of the law.[25] The three provisions within the law are as follows:

A) Provide for review and determination of need before a new institutional health service, facilities, or organizations are offered or developed or substantial expenditures are undertaken in preparation for the offering or development.

B) Provide that only needed services, facilities, and organizations shall be offered or developed in this state.

C) Meet the policies and procedures governing the issuance of certificates of need required for projects under federal grant-in-aid programs and federal loan guarantee programs.

Simply stated, all policies and procedures will be followed and that only those facilities that can prove their need and have gone through the application and review process shall be granted a Certificate of Need.

Sections 22113 through section 22115 give an explanation of who must apply for a Certificate Of Need. They give the basic provisions when a C.O.N. is required either by a hospital, health care facility, or local HMO.

Who shall review a C.O.N. application and their duties and responsibilities is spelled out in section 22121. The C.O.N. review board consists of five members who are appointed by the governor. Two members of the board must be practicing physicians. The remaining members are consumer representatives of the general public. Each member of the board serves for a four year staggered term. Section 22123 through section 22152 explains the C.O.N. requirements, the application process, the different types of reviews, procedural requirements, timelines, and the waiver provisions that may be used.

The question of identifying appropriate hospital bed capacity is addressed in section 22154. This section addresses the guidelines that are used in the determination of excess beds, the long term impact of costs and charges, and how it will affect the physicians and surgeons who utilize that facility. This section also addresses the criteria that a hospital must use in

formulating and submitting a bed reduction plan.

Section 22156 of the law pertains to the hospital bed reduction plan. This 1980 amendment states that a hospital that is located in an subarea of a health service area with a population greater than two million will not be granted a C.O.N. if that subarea has been determined to have an excess number of hospital beds. A C.O.N. will only be issued if a plan for the elimination of the excess hospital beds is drawn up by the local health planning agency and approved by the state.

The last remaining sections, 22158 through 22181, explain what is required by the board in the way of reports and hearings. There is also a section on the injunction power that the board retains to use against hospitals or others who proceed in a project without getting the necessary Certificate of Need.

In November 1987 the Michigan House Committee on Public Health introduced a new bill to modify the existing Certificate of Need laws.[26] HB 5145 contains draft legislation that would make significant changes in Michigan's Certificate of Need law. These changes include raising the capital expenditure threshold to $750,000., adopt new review criteria, create statutory authority for the use of comparative reviews, and revise the substantial elimination of the process for appealing C.O.N. denials. At the present time this bill is still under debate. If passed by both of the state houses it will allow many hospitals to proceed with new projects and be exempt from the C.O.N. application and review process.

Michigan's Certificate of Need program attempts to insure that there will be an even distribution of services among the

different subareas of the state. And that this distribution will in some way help insure that patients will receive timely and proper treatment and that the rising cost of health care will be kept in check and to a minimum.

APPLICATION AND REVIEW PROCESS

When a hospital or other health care facility wants to apply for a Certificate of Need within the state of Michigan, they must go through a step by step process. The application and review process that is used by the state is determined by the project and cost of the project. Different timelines and application fees will vary by what is it that the hospital or institution wants to do.

The first step in the process is to have the applicant write a letter of intent. This letter is actually a four page form that is sent to the applicant from the Bureau Of Health Facilities, Division Of Construction. (Appendix) Only application letters that have a preassigned application number will be accepted by the Michigan Department of Public Health, (MDPH). The letter requires that some basic information about the facility's current status be given. Facility name, address, contact agent, facility type, and current bed status are some of the information that is required. The second portion of the letter is to describe what it is that the facility proposes to do. This includes a detailed description of the project, bed status change if any, the total project cost, what sources of funding are to be used, estimated time requirements for completion of the project, staff changes related to the project, and if the project will correct any code and/or licensure deficiencies.

Upon completion of the letter of intent, the applicant sends the letter to the local Health System Agency that covers their area of the state. The local agency will then review the application and send it to the MDPH along with recommendations for either approval or denial. The local agencies are supposed to have the greatest knowledge of what services are available to the public in that area and therefore can assist the state to determine if the service is really needed.

The state is divided up into eight regional Health System Agencies,[27] with each region representing a number of counties. The eight regions are then divided into seventy one different sub areas. Each subarea is centered around a populated area such as a city or town. The individual agencies are then responsible for covering all health care activities within their own geographical area of the state. The agencies are:

Area 1 Comprehensive Health Planning Council of Southeastern Michigan

Area 2 Michigan Mid-South Heath Systems Agency

Area 3 Southwest Michigan Health Coordinating Council

Area 4 Alliance For Health

Area 5 GLS-Health Systems, Inc.

Area 6 East Central Michigan Health Systems Agency

Area 7 Northern Michigan Health Systems Agency, Inc.

Area 8 Upper Peninsula Health System Agency,Inc.

Because of the cuts in federal funding to states for running

to close. Out of the eight agencies in Michigan only four, areas 3, 4, 7, and 8, remain open. And of those four only areas 3 and 4

are still reviewing the C.O.N. applications. These agencies are still in operation because they receive funding from the counties or other local sources. If an applicant is in an area where the local agency is no longer in operation, the application is sent directly to the Lansing office with no local recommendations.

Fifteen days after the letter of intent is received by the state, the MDPH must reply back to the applicant and notify them if a Certificate of Need is required. If a C.O.N. is required the MDPH will supply the applicant with all of the appropriate forms. The applicant will complete the forms and return it to the MDPH at the appropriate time depending on the type of review that will be required.

Michigan currently has four different review processes.[28] The type of review that is used depends on what the hospital is asking for permission to do. The four different processes are nonsubstantive, substantive, comparative, and an emergency review. Each type of review has different timelines and a different application process.

A nonsubstantive review is for a project that will not exceed a capital expenditure greater than $600,000. These projects include ones that are classified as renovation of existing facilities, the correction of licensure deficiencies, the replacement of old or inoperable equipment, or a project that is not directly related to patient care. A project of this type must not increase the number of patient beds, increase the number or types of services offered or change the availability of existing services that are offered to the public, and it cannot increase the institution's operating costs by more than $150,000

the first year of operation.

A substantive or regular review is for projects that exceed a total cost of $600,000. This is the most common review process because most projects fall above the $600,000 minimum. Like the nonsubstantive review, these projects include the renovation of existing facilities, the correction of licensure deficiencies, the replacement of old or inoperable equipment, and projects not directly related to patient care which are ineligible for the nonsubstantive review process.

The third type of review process is a comparative or competitive review. This review is used for projects which exceed $600,000 in total costs and/or are involved with the addition of new beds, the addition of new services, or the expansion of all ready existing facilities. When an application is made and it is compared to other applications that have applied for the same or similar projects. The MDPH will look at other existing facilities in the area to determine if there is a need for additional services of that type. If the MDPH feels that the need exists it will compare all of the applications with each other and rank them using 15 different criteria and 3 levels of importance. The application with the greatest weight will be given approval for their project. If the need is great enough the MDPH may grant approval for more than one project. All of the other projects will be denied a C.O.N..

The final review process is that of an emergency review. This review is used by the state if the proposal meets the four requirements: (1) immediate relief is needed due to a natural disaster, a fire, or other unforeseen safety considerations and

the life and safety of patients and staff would be threatened; (2) any delay in approval would cause serious adverse effect on the applicant and the community; (3) a lack of substantial change in the facilities and/or services that existed prior to the emergency; and (4) the temporary construction or services will not preclude the regular application for a C.O.N.. An emergency Certificate of Need is subject to limitations and restrictions set by the state. These restrictions include the possible extension or renewal of the C.O.N..

The time that it takes for a hospital or other health care facility to receive an approved Certificate of Need can take from 30 to 180 days. Although the actual length of time has been longer, these are the standard timelines under the permanent rules. The length of time is determined by the type of review process. Although all four review processes have the same basic application requirements, some of the reviews have additional or more detailed steps within the review process.

After receiving the completed application the MDPH has fifteen days to ask the applicant for any additional information about the proposed project. After that time the applicant then has fifteen days to respond back to the state with any of the requested information. If the applicant does not respond within the time period allowed, the original application will be considered complete. This is true for all types of review.

In a nonsubstantive review once the application is complete, the local agency has thirty days to provide MDPH with any recommendations. Starting on the same application completion date, MDPH has forty five days to make a decision of whether or

not a C.O.N. should be granted to the applicant. In a substantive or regular review the application review cycle will begin on the first MDPH working day of the month, consequently the application must be completed on or before that date. For this type of review the local agency has ninety days to provide MDPH with any recommendations and MDPH has 120 days to make a final decision for granting a C.O.N.. The comparative review is very similar to the substantive review except that the application can be filed with the MDPH only three times a year on the first working day in February, June, or September. If the applicant misses the date they have to wait four months until the next deadline. The other difference is that the MDPH has thirty days to group similar applications together for review. It is at the end of this thirty days that the application cycle begins. The remaining timelines are the same as those of a substantive review.

The application and review process is determined by what it is that the applicant is proposing to do. The entire process is designed to be fair to all of those who apply and to insure that the public will have available to them facilities and services that will be both beneficial and cost effective to the public, the facility, and the insurance companies.

BED LOSS DETERMINATION

The Michigan Bed Reduction Plan of 1979 was a way for the state and local health care agencies to control the rapid growth and expansion of hospitals. Guidelines were set up by the state for identifying not only appropriate hospital bed capacity but also for determining excess hospital beds in each of the eight health agencies. These guidelines were developed with the help of

the health systems agencies and other concerned individuals or organizations. The state also used existing Michigan Department of Public Health Guidelines and National Guidelines for Health Planning.

The first step the state took was to do an inventory of hospitals by subarea. The total number came to 216 hospitals that were licensed by the state. In addition their were 13 hospitals that were exempt from involvment with the bed reduction plans.[29]

Hospitals exempt from the Michigan
Bed Reduction Policy

Rehabilitation Institute, Detroit
Kent Community Hospital, Grand Rapids
Mary Free Bed Hospital, Grand Rapids
Southwestern Michigan Rehabilitation Center, Battle Creek
Saginaw Community Hospital, Saginaw
Brighton Hospital, Brighton
Olin Health Center, Michigan State University
Student Health Center, University Of Michigan
Bronson Hospital, Kalamazoo
VA Hospital, Iron Mountain
VA Hospital, Saginaw
VA Hospital, Ann Arbor
VA Hospital, Allen Park

These hospitals were classified as freestanding rehabilitation centers, research facilities, student health centers, Veterans Administartion hospitals, or centers limited to the treatment of substance abuse.

Once the total list of hospitals had been made the next step was to determine the total number of licensed beds of each of the hospital. Included in the total bed count were Pediatric, (PD), Obstetric, (OB), and Medical/Surgical, (MS) beds. Beds that were licensed to hospitals as long term skilled nursing or intermediate care were excluded from the total count as well as

those beds in hospitals that held a valid certificate of need as of April 9, 1979.[30] The total numbers were grouped by health system agency and then broken down into the seventy one subareas.

Total 1979 Hospital Bed Capacity
By Health System Agency

	PD	OB	MS	TOTAL
HSA 1	1361	1867	17976	21204
HSA 2	215	262	1955	2432
HSA 3	275	382	2451	3108
HSA 4	338	364	3080	3782
HSA 5	188	268	2139	2595
HSA 6	260	326	2493	3079
HSA 7	116	129	1233	1478
HSA 8	142	136	1207	1485
Totals	2895	3734	32534	39163

Once the final lists were made and the numbers tallied, the state came up with the appropriate number of hospital beds for each of the eight Health Agencies. These numbers were determined in accordance with a methodology utilized by the Michigan Department of Public Health.

Excess hospital beds were determined by calculating the difference between current hospital capacity, based upon the number of licensed beds as of April 9, 1979, and the appropriate hospital capacity as projected by the application of these guidelines. Using these two guidelines the state came up with the following minimum regional and state totals for bed reduction. The totals did not reflect any beds that a hospital may choose to voluntarily reduce or the addition of new beds that had been approved prior to the implementation of the policy.[31]

Total number of hospital beds to be reduced within each health system agency

HSA 1	2529
HSA 2	140
HSA 3	270
HSA 4	86
HSA 5	447
HSA 6	223
HSA 7	0
HSA 8	105
State Total	3800

Each health system agency had to identify any deviations from the adopted guidelines in the identification of overbedded subareas. These deviations had to be listed within the agency's bed reduction plan and had to be accompanied by any supporting documentation and justification. The state did not accept any deviations which would result in the identification of fewer beds than the perscribed number.

CHAPTER 3

LITERATURE REVIEW

Since the development of the Michigan C.O.N. legislation in 1978, a great deal of literature has been devoted to the topics of bed reduction and the downsizing of hospitals. These articles deal not only with the bed reduction plans within the state of Michigan but also look at how other states have dealt with the issues of bed reduction and utilization. Some authors spent time critiquing and questioning the federal government studies on the supposed maldistribution and over abundance of hospital beds that the U.S. is experiencing. Other authors concentrated their efforts at looking at the bed reduction issue in one particular state.

In 1978 Merian Kirchner looked at H.E.W.'s plan to eliminate 100,000 beds nationwide. At that time the United States had twice the number of beds than it had in 1946 with over 135,000 of those beds added in the 1970's. The ratio of beds to population also had risen from 3.3 per 1,000 to 4.5 per 1,000. Federally sponsored studies done by InterStudy and the National Institute of Medicine both argued that a 10 percent reduction in bed capacity would cause no hardship to the patients and raise the average occupancy rate to 80 percent or more. Kirchner concludes that the adoption of state certificate of need programs have not been effective in cutting back on the number of beds or in the controlling of the total hospital expenditures.[32]

A question that is often addressed in articles is just what is an excess bed? In 1977 H.E.W. set the standard of 4.0 to 1000 bed to population ratio.[33] Most planners agree with this figure but

many find that the manner in which the state or agency is counting beds will greatly affect the outcome. In 1979 only four states, Connecticut, Rhode Island, Delaware, and Maryland, were in compliance with the H.E.W. standard.[34] John Lind pointed out that in Massachusetts the excess bed capacity can range from 0 to 5000 beds depending if they used the federal, state, or local guidelines. He also points out that there is confusion between bed capacity determined by counting beds and bed capacity as determined by measuring the amount of square footage that is required to support those beds.[35]

Many factors can contribute to excess hospitals beds. The main one is that of poor or under utilization. Bed utilization is ultimately determined by the medical staff who use the facility. It is the medical staff that determine the amount of inpatient care as opposed to outpatient care. Timely patient discharges and the ability to put patients of one type in the bed type of another can also affect utilization. The hospitals themselves can also affect utilization by the amount and type of services that they offer. A hospital which has a greater number of available services are going to attract a larger amount of physicians into the area. This will ultimately result in higher utilization.[36]

Regardless of the type of method that is used to determine excess bed levels within a region, once that number has been determined the next question is which hospital will be the one to lose beds? The most common method used is to eliminate the beds from the area with the highest bed to population ratio. In 1978 the American Hospital Association showed that the rural areas had the highest bed to population ratio. At that time North Dakota

had a 6.8 to 1,000 ratio. But this finding is common in rural areas of the country because hospitals in rural communities have a much larger service area. A high ratio does not necessarily mean higher costs. In the North Dakota area the daily cost for care was only 75 percent of that of the national average.[37]

Christianson and McClure point out that the closing of these smaller less utilized hospitals would not have a great impact on the overall saving. They point out that 50 percent of the hospitals in the United States account for only 10 percent of the total expenditures while 12 percent account for over 50 percent of all expenditures. The closing of smaller hospitals would be easier and more politically feasible but the overall benefits and saving would be small.

When a hospital has been affected by a bed reduction policy the effect of those closed beds is felt throughout the entire area. The closing of beds will always mean a reduction of staff at the hospital not only in the nursing units but in other ancillary services as well. The reduction in the number of available beds makes it more difficult for area physicians to admit patients. This in turn reduces income for the hospital and eliminates the possibility of implementing new programs at the hospital. This alone will encourage physicians to use other area hospitals. A study done in 1986 by White and Arstein-Kerslake on California hospitals shows that the downsizing of hospitals affects all level of employees within the affected hospital.[38] This is based on the number of people who are on waiting lists to work at the particular facility. They do point out that the downsizing trend seems to be diminishing. The number of hospitals that have

reported closed beds have been reduced by 8 percent over the two previous years. At the same time 15 hospitals reported an increase of 196 beds. They both conclude that the increase in new services offered to the public by the hospitals are the main reason for any gains in FTE's.

When a hospital closes a wing or the hospital shuts its doors completely the an alternative use for that wing or hospital is sought. Richard Johnson looked at some of the alternative uses for a closed hospital. Nursing homes, residential home, physician offices, and extended care facilities are among the alternatives some hospital corporations and communities have considered. Johnson argues that there are no alternative uses and a hospital can rarely be used for anything other then the purpose for which it was built.[39] Other than the overall cost of the conversion the lack of privacy, adequate office space, small room size, and the overall out dated building will have adverse affects for potential customers. Johnson also points out that although being more cost effective local agencies are reluctant to close entire hospitals. The reason is simple: closing beds is more politically feasible than closing hospitals.[40]

With the all of the attention in recent years over the idea on reducing the total number of beds, how is it that some areas of the country are having new facilities constructed? Glen Richards notes two areas in which new hospitals were to be built in an area which was already over bedded.[41] Both areas were able to obtain a C.O.N. by agreeing to close an older hospital in the same area. In a Virginia case there were two hospitals that proposed to close and build new replacement facilities. The first

was in an area of the community that had lost a great deal of its population. The new hospital was to be built in the suburban area where the population had shifted. The second hospital was to located in the same service area as the old, but was being moved to have better transportation access. Both of the original projects were to have an increase in the total number of beds. When this was turned down a scaled down version with a bed to bed match of the old facility was presented and approved by the local agency. In a second example Richards describes a similar situation in suburb of Miami, Florida. A small 27 bed hospital had an approval to expand to a 127 facility. This new construction had been approved before the state C.O.N. regulation went into effect. Since the approval the small hospital had gone into bankruptcy. A local health corporation tried to obtain the approval from the bankrupted hospital and build the new hospital in an area other than where it was first proposed. The court denied the exchange and stated that the area was already over bedded and did not need a new hospital.

In Pontiac, Michigan a local group sought to build a new 153 bed facility in one of the Pontiac suburbs.[42] Their C.O.N. was turned down because the area was determined to be overbedded. At the same time Pontiac General was being cited as being unsafe and required extensive renovation. Their C.O.N. was also turned down because of a court injunction prohibiting the approval of any new C.O.N.. The hospital argued that any delay in the C.O.N. approval would not only increase construction costs of $230,000 a month, but would also cause irreparable harm to the hospital from the delay. If the improvements were not completed in time the

hospital could lose its state license. The original plan called for a bed to bed exchange between the old and the new hospital. In an effort to improve their chances of obtaining a C.O.N. the hospital reduced the number of beds from 383 to 350 therefore reducing the number of beds in the area by 33. The C.O.N. was approved and the new hospital was built. In the meantime the local group that wanted to build the new hospital in the area filed suit against the hospital and the planning agency for restraint of trade. The suit was later dismissed.[43]

Many articles about bed reduction cite Michigan as a state to watch. Because Michigan was the first state to adopt a mandatory bed reduction policy, all others areas of the country waited and watched to see what effect this policy would have on health care within the state.

In 1983 Lawrence Brown published a report on the Certificate of Need legislation in different states.[44] He compared how the states differ in their basic policies. In regard to the issue of overbedding he cites an example from Maine in which a hospital was approved for the increase of 11 beds even though the hospital was in an area that was already determined to be overbedded with a ratio of 6.3 to 1000, far above the federal standards. The agency chose not to look at the total services in the community and the adjacent service areas. Brown also cites the Michigan experience. He explains how the state's first method of determining excess beds came up with a figure of roughly 7,400. This figure was strongly protested by the state hospital association as being inaccurate. By the time the discussions were over, the numbers had been reduced to approximatly 3800. Brown explains how

the state and private parties got together in an effort to curb the rising costs of health care within the state of Michigan.

The most detailed article covering the Michigan bed reduction policy was completed by Eugenia S. Carpenter and Pamela Paul-Shaheen in 1984.[45] The paper traces the implementation of the program through the first 30 months following the implementation. They explain what they call the three phases of implementation, standard setting, the developing of bed reduction plans, and the plan approvals. They cover all of the different agencies that were involved at each phase and the amount of their involvement. It explains the bed reduction plans within the Detroit and Flint areas and the problems and questions that arose during implementation including questions of racial and class conflicts. Later the authors add a fourth phase to look at the legislative oversight. This phase looked at the challenges and the moratorium that were issued from both sides. The appointment of new committees, the reanalyzing of old data, and the appeals are noted. In conclusion they cite good and bad points of the program. The issue of bed reduction cannot be accomplished through a simple solution. Political compromises and everything else was up for negotiation. On the positive side 62 percent of the total excess beds had been reduced to that point, and the policy did pressure the hospital to work more closely with the local planning agencies. However, the policy increased the costs involved in mergers, closures, and consolidations. The program also brought about shifts in the power among the interest groups.

These articles dealt with just a few of the issues that have risen because of the wide spread concern of under utilization of

hospital beds and the introduction of bed reduction policies. It is clear from the articles that the problems that led to the introduction of the bed reduction policies in Michigan are occuring in other areas of the country. These occurences may lead to the development of similar bed reduction policies in other states.

CHAPTER 4

RESEARCH TOPIC: THE DEBEDDING ISSUE

As stated earlier it was projected that by the end of 1975 there would be a surplus of 67,000 beds nationwide. Although some of these unused beds were due to population shifts, a large portion was due to the build up of the number of hospital beds in an effort to gain a larger portion of the market share in a given area. Earlier federal legislation allowed, if not encouraged, the hospitals to increase their bed capacity. It was those hospitals that had over-built their needs and had a low bed utilization that was the concern of groups involved in the bed reduction plans in Michigan and other states.

In 1975 the National Health Policy Planning Guidelines set a standard of 4.0 hospital beds per 1000 persons as the maximum. This figure was accompanied by a 80% occupancy rate.[46] When these guidelines were adopted the country was experiencing a 4.5 hospital bed to 1000 person ratio with only a 75% occupancy rate. Some studies determined that these unused beds were costing 50% of the occupied cost. Other studies suggest a lower range of only 8-10%. Taking both factors into account, in 1976 it was estimated that 20% of the nation's hospital capacity could be reduced with no threat to the public's health and a cost saving of over $6 billion annually.[47]

Michigan's bed reduction policy was divided up into three phases of implementation. Phase 1 involved setting of guidelines and criteria. This was done by the state with help and influence from interest groups and the newly formed Adhoc Committee on Bed Reduction, (AHCBD). These guidelines had to be approved by the

Office of Health and Medical Affairs, (OHMA), the Statewide Health Coordinating Council, (SHCC), and the Joint Committee on Administrative Rules, (JCAR). Phase 2 of the policy was devoted to the development of bed reduction plans. These plans were to be developed by the local health care agencies that would be affected by the bed reduction. These plans not only determined how many beds were to be reduced in a given area but also who was to lose those beds. The state had given this power to the eight individual Health System Agencies. Phase 3 involved the approval of the individual health care agency bed reduction plans. This portion of the three step process was handled by the AHCBD.

In 1979 during the initial phase 1 of the Michigan bed reduction plan it was determined that the state of Michigan had a surplus of 4,900 beds. Of that total, 4,626 of those beds were in areas of the state where there were 25 or more excess beds. An initial plan was drawn up to reduce this number of beds over a five year period. Areas that had more than 25 excess beds would be required to develop a bed reduction plan. Those areas that had under 25 excess beds would not be required to develop a plan, but were encouraged to voluntarily reduce any excess beds.

This initial plan was rejected by the groups involved as being too costly. The groups revised their criteria for determining what is an excess bed and developed a new strategy.[48] The new alternative plan was to reduce the number of beds state wide by 3,800 over a five year period. This new plan was also going to mean more total state reduction and not so much local or regionally oriented.

The issue of which hospitals were to lose beds was a

difficult decision since the beginning. Some studies suggested that some favoritism was given to the larger more prestigious or suburban hospitals and that the inner city hospitals were to absorb the majority of the reductions. The question of ethics and prejudice also rose when some areas focused their plans for bed reduction and closures to those hospitals that were predominantly staffed and used by the black community.

Because each health care agency came up with their own plan for reducing beds, each area's plan was different not only in who was to have beds removed but also the manner in which they were to be removed. In some agency's area the closure of underutilized hospitals could solve that area's bed reduction problem. Other areas absorbed the bed reductions among all hospitals evenly. Still others would remove beds from hospitals based on their overall utilization.

The state's plan led to some dramatic changes for the affected hospitals. Many hospitals had to reduce their total bed capacity. Others reclassified beds in an effort to avoid bed closure. Still others chose to remove beds from a smaller affiliated hospital in an effort to maintain the current bed status at the main hospital. The plan even led to the closure of some smaller hospitals within the Flint and Detroit areas.[49]

Although the state's plan to remove excess beds has been over for a few years, the ripple effect that the plan has had on the state Certificate of Need application process continues. Because of the plan, the states C.O.N. law was amended so that no hospital would be issued a C.O.N. unless that hospital was in an area that was determined not to have an excess number of beds and

that the individual hospital that was applying for the C.O.N had carried out any bed reductions that they were required to meet. These targeted hospitals were limited in their growth because the state and local agency had control over their development and expansion.

The hypotheses of this paper are: (1) There has been a decrease in the total number of hospital beds state wide but that the total numbers of beds reduced never reached the minimums within the time period that was set by the state. (2) Some beds that were closed due to the bed reduction policy were allowed to reopen at the end of the five year period and that the majority of those beds were relicensed to other hospitals within the same geographical area of the state. (3) Hospitals that historically experienced low bed utilization would be required to remove the greatest number of beds within each subarea. (4) The majority of the beds to be cut would be from areas that had the highest bed to population ratio. (5) Some of the larger more high utilization hospitals would gain beds during the five year bed reduction peroid. (6) Hospitals would find legal ways to avoid removing beds through mergers and the reclassification of beds. (7) No new hospitals would be opened and no new hospital construction projects would be approved during the time that the bed reduction policy was in effect.

CHAPTER 5

RESEARCH DESIGN AND PROCESS

The amended Certificate of Need legislation in Michigan required the elimination of excess hospital beds throughout the state. An approved plan was to be agreed upon by both the state and a special committee made up of interested parties. The final version of the policy called for the reduction of 3446 hospital beds throughout the state over a five year period.

The number of beds that were to be reduced were divided between the eight local Health Care Agencies. These numbers were not evenly distributed among the different agencies, but were based upon criteria set by the state. The policy also required that each agency write a formal plan for the reduction of the beds within their own area. Pending formal approval from the state, each agency was allowed to decide the manner in which the bed reductions were to take place. The local health care agencies decided how many beds each hospital had to lose. The criteria that the agencies used for determining who was to lose beds was individual to each agency.

The policy that was written in 1978 was based upon the bed utilization statistics at that time. Since 1978 health care delivery within the state of Michigan has gone through many changes. These changes have directly influenced not only the growth and expansion of the hospitals within the state, but also the utilization of the beds within those hospitals. Changes and shifts in the population have also affected health care delivery and utilization.

This paper builds a data base of each hospital in the eight

different health system areas. The main issue examined is whether any hospitals have had any increases in the number of licensed beds since the completion of the original bed reduction plan. If so, were these hospitals gaining new beds or reopening beds that had been previously closed because of the bed reduction policy. Also examined are how many licensed beds each hospital had at the implementation of the bed reduction policy, how many of the total 3446 beds were reduced from each hospital, looking at the reasons why some hospitals were exempt from the bed reduction policy and if any hospitals gained licensed beds during the five year time period.

The method of study was retrospective. Because each local health agency' bed reduction policy had to be approved, the state has records of the bed levels of the hospitals at both the start and at the finish of the five year period. By looking at the current bed levels, it was determined if any hospitals did increase their bed capacity since the completion of the bed reduction policy.

CHAPTER 6

FINDINGS

TOTAL BEDS LOST STATEWIDE

The final version of Michigan's bed reduction policy called for the removal of 3800 hospital beds state wide. These 3800 beds represented a 10.04 % reduction in the total number of hospital beds.[50] The individual hospitals had a five year period to remove the beds that the state and the local health system agency determined to be overbedded. The health system agencies as well as the individual hospitals had to have an approved bed reduction plan in place. Failure to remove beds on the part of the hospital meant a possible denial of any future C.O.N. applications.

At the close of the five year bed reduction plan, only 1557 or 40.9% of the required 3800 beds were actually reduced. Seven of the eight local health system agencies did not meet their bed reduction levels during the five year period. The one remaining agency was not required to reduce beds but did gain beds during this same time period.[51]

Total number of beds reduced from 1980 through 1984

Health System Agency	Beds Required To Reduce	80-84 Bed Variance	Percent Reduced
Area 1	2529	-701	27.7
Area 2	140	-48	34.3
Area 3	270	-118	43.7
Area 4	86	-92	106.9
Area 5	447	-331	74.0
Area 6	223	-205	91.9
Area 7	0	+21	0
Area 8	105	-93	88.5
Totals	3800	-1557	40.9 %

Many hospitals continued to remove beds during the years

following the end of the program. This was because some of the hospitals were unable to, or chose not to, meet their reduction quotas during the five year period. Five years after the closing of the bed reduction policy, the Michigan hospitals were still unable to meet the bed reduction levels that were set by the state 10 years earlier. As of Decenber 1988 state wide bed reduction was limited to 3606 or 94.89% of the total number of beds that the hospitals were required to remove.[52]

Total number of beds reduced from 1980 through 1984 and 1980 through 1988 with total percent reduction

Health System Agency	Beds Required To Reduce	80-84 Bed Variance	80-88 Bed Variance	Percent Reduced
Area 1	2529	-701	-1982	78.37
Area 2	140	-48	-57	40.71
Area 3	270	-118	-309	261.86
Area 4	86	-92	-296	344.18
Area 5	447	-331	-421	94.18
Area 6	223	-205	-296	132.73
Area 7	0	+21	-25	
Area 8	105	-93	-220	209.52
Totals	3800	-1557	-3606	94.89 %

By the end of December, 1988 only five of the eight health system agencies met or exceeded the total number of beds that they were required to remove. The remaining three agencies had reduced only 2460 or 78.9% of the total 3116 beds that were targeted for reduction.[53]

THE EFFECT ON INDIVIDUAL HOSPITALS

The bed reduction policy was designed to remove beds from hospitals that historically had shown low bed utilization. Other factors taken into consideration by the state were population to bed ratios for the area, the total numbers of hospitals in the same geographical area, and the types of beds that the hospitals

were licensed to have open.

The overall effect of the program varied from one hospital to another and from one area of the state to another. During the implementation of the policy many hospitals lost beds while a few hospitals gained beds. Some hospitals went through a process of reclassifing existing beds. And some hospitals were not required to reduce any beds. The following chart shows, by health system agency, the bed status change if any during the five year period of the program.[54]

Hospital Bed Status Change At The End
Of The Bed Reduction Policy Year 1984

Health System Agency	Lost Beds	Gained Beds	No Change	Re-Licensed
Area 1	32	6	25	3
Area 2	2	1	9	3
Area 3	6	1	12	2
Area 4	11	3	14	1
Area 5	6	1	1	0
Area 6	5	2	11	4
Area 7	2	4	10	0
Area 8	7	1	10	1
Total	71	19	92	14

The total number of beds that each hospital lost varied. St John's Hospital in Detroit lost only one bed while Saginaw General Hospital lost a total of 81 beds during the same time period.[55] Just like the total number of beds lost varied so did the type of beds. The beds that Saginaw General reduced were divided between obstetric, pediatric, and med/surg.[56] Other hospitals like Emma A. Bixby Hospital in Adrian, Michigan lost all of their beds from the med/surg catagory.[57] The number as well as the type of beds that each hospital were required to remove was determined by the state and the local health system agency using the criteria

described earlier.

The status of the hospitals current bed capacity as well as if bed reduction requirements were met, are reviewed by the state at the time the individual hospital applies for a C.O.N.. As of January 1988, eight hospitals had not met their bed reduction requirements. Those eight hospitals are: Detroit General, Park Community Hospital in Detroit, Doctors Hospital in Detroit, Harrison Community Hospital in Mt Clemens, Northwest General Osteopathic Hospital in Detroit, Redford Community Hospital, Straith Memorial Hospital in Southfield, and Wheelock Memorial Hospital in Goodrich.[58] Any reduction quotas that these hospitals were required to meet will have to be met prior to the approval of any C.O.N. applications.

As a way of reducing the number of beds from a particular category without losing the total number of beds, 14 hospitals went through the process of shifting or reclassifing beds.[59] As examples Marlette Community Hospital in Marlette, Michigan removed one med/surg bed and reclassified it as a pediatric bed. Crystal Falls Community Hospital in Iron County gained additional med/surg beds through the reclassifing of four pediatric beds. And Doctors Hospital in Jackson, Michigan removed all five of their obstetrical beds and reclassified them as med/surg beds.[60] Of these 14 hospitals 9 of them have maintained their 1984 bed levels and classification. One hospital maintained bed levels but went through reclassification again and 1 hospital gained new beds. During this same time period, 3 of those hospitals ended up reducing beds and 1 of the hospitals was closed.[61]

At the end of the five year period 92 hospitals had neither

reduced their total number of beds or went through some sort of reclassified process. This is not to say that these hospitals were exempt from removing beds. 27 of the 92 hospitals that did not change their bed capacity at the end of the five year period ended up reducing beds the following years. Three hospitals went on to reclassify beds without any loss of beds while another 11 of those hospitals closed their doors for good. In the end only 51 hospitals state wide were exempt from having to remove beds.[62]

GAINS DURING A TIME OF LOSS

In an effort to reduce the number of underutilized hospitals, the state promoted the consolidation of services and the merging of area hospitals. This policy was also seen as a benifit to the hospitals by reducing competition and bringing together services to one central location. Although hospital affiliation meant the closing of some smaller or low utilization hospitals, it brought gains to many of the larger hospitals.

Many hospitals were already affiliated with each other at the time the policy was implemented. St Joseph Hospital-East and St Joseph Hospital-West, both in Detroit, were two such hospitals. Although independently run, these two sister hospitals merged into one unit. St Joseph West was the larger of the two but had only med/surg beds. The smaller St Joseph East had obstetrics, pediatric, as well as med/surg beds. By the end of 1984 St Joseph West reduced their total bed capacity by only 4. St Joseph East also removed beds but the reduction dropped their bed capacity from 168 to 142, a loss of 26 beds. The two hospitals merged into one following the end of the bed reduction policy. The merging of the two hospitals resulted in the transfering of beds from St

Joseph East to St Joseph West. This lead to the closing of St Joseph East. Although this merger did not reduce the total number of beds in the area, it did reduce the number of hospitals and consolidated services into one location.[63]

Mercy Hospital and Mercy Memorial Hospital both located in the St Joseph, Michigan area is another example of two hospitals merging into one. Prior to the end of the bed reduction policy the smaller Mercy Hospital merged with Mercy Memorial. All of the licensed beds were transfered to Mercy Memorial Hospital and Mercy Hospital was closed. The transfer of beds increased the total number of beds from 168 to 337 more than doubling their bed capacity. By December of 1984 Mercy Memorial did not remove the licenses of any beds. By the end of 1988, Mercy Memorial Hospital did remove 35 beds dropping their bed capacity down to 302. Although Mercy Memorial was forced to remove beds as part of the bed reduction policy, the merger of the two hospitals allowed for the removal of acquired beds. This satisfied the bed reduction policy as well as benefiting the hospital by increasing their bed capacity by 134 which represents an bed increase of 44.37%.[64]

By the end of the bed reduction program 19 hospitals had gained a total of 414 beds.[65] Of these 19 hospitals 6 of them continued to maintain their new beds levels, 1 hospital ended up reclassifing beds but maintained total bed levels, and 11 of them reduced beds in later years. In the years that followed, 12 other hospitals had gained a total of 465 beds since the completion of the program.[66] Many of these gains were due to the merging of hospitals or the reallocation of beds from the hospitals that had closed in that area of the state.

THE CLOSING OF HOSPITALS

Since the start of the bed reduction policy in 1979 a total of 34 hospitals have been closed within Michigan. This represents a 15.96% reduction in the total number of established hospitals in the state. Of the 34 hospitals that were closed, 18, or more than 50%, of them came from area 1 which represents the Detroit metropolitian area.[67]

Total number of hospitals closed by area during and after policy implementation.

Health System Agency	Total Hospitals	Dec 1979- Dec 1984	Dec 1984- Dec 1988
Area 1	76	10	8
Area 2	16	1	0
Area 3	22	1	3
Area 4	30	1	3
Area 5	9	1	0
Area 6	23	1	1
Area 7	17	1	1
Area 8	20	1	1
Total	213	17	17

The reason for the hospital closings varied. Some hospitals such as St Joseph East and Mercy Hospital mentioned earlier were closed do to consolidation. Other hospitals closed because of low utilization. The closing of a low utilization hospital meant that all of the beds within that hospital could be used in the total number of beds reduced in that particular health service area. Doing this reduced the number of beds that the higher utilization hospitals would have to delicense. An example of this would be the closing of Flint General Hospital located in area five.

Area 5 was to eliminate 447 beds between 9 hospitals. If beds were reduced equally, each hospital would have to eliminate 49 beds. The closing of Flint General, which was considered to be

a low utilization hospital, eliminated 116 hospitals beds. That accounted for a 26.95% reduction in the total number of beds for that area. This left 331 beds to be reduced between the remaining 8 hospitals. The closing of the one hospital reduced the number of beds that the remaining hospitals would have to eliminate.[68]

The closing of some low utilization hospitals may have been good for the overall implementation of the policy, but in some cases the closing of a hospital put a burden on the people who did utilize that facility. La Croix Hospital located in the Upper Peninsula was closed. Although having only 18 beds it serviced the people of that community. The closing meant that those people now had to travel greater distances to receive medical care.

NEW HOSPITALS

During a time when the state is implementing a bed reduction program, it would seem unlikley that any new hospitals would be allowed to be built and opened, but there were. As stated earlier any C.O.N.'s for the addition of new beds that had state approval prior to the implementation of the bed reduction policy were exempt in the total numbers to be reduced. This also held true for the building of any new hospitals.

During the five year implementation of the bed reduction policy a total of 4 new hospitals were opened in the state. All four of the new hospitals were in area 1 with 3 of them located within the Detroit city limits. The opening of these four hospitals represented an increase of 1137 beds to the area.[69] In the years that followed, 5 additional new hospitals were opened. 2 of these new hospitals are located in area 1, 1 is located in area 2, and 2 are located in area 3. These 5 new hospitals

represented a total addition of 867 beds.[70]

New hospital construction
by health system agency

Health System Agency	80-84	84-88
Area 1	4	2
Area 2	0	1
Area 3	0	2
Area 4	0	0
Area 5	0	0
Area 6	0	0
Area 7	0	0
Area 8	0	0
Total	4	5

Of the four hospitals that were opened during the time of the bed reduction policy, two of them ended up reducing total bed capacity during the next five years. The remaining two hospitals gained beds during the same five year period.[71]

Some of these new hospitals such as Detroit Receiving, were built to replace outdated facilities. Westland Medical Center and others were built to accomodate shifts in the population from the inner city to the suburbs. Regardless of the reason all nine of these hospitals had received or had applied for a C.O.N prior to the start of the bed reduction policy.

DISCUSSION OF HYPOTHESIS

Earlier in the paper seven hypoyhesis were stated. The research design, the collection of data, and the interpretation of the data proved all but one hypothesis to be true.

The first hypothesis was that there was a decrease in the total number of beds statewide but the total number of beds reduced would not reach the minimum numbers in the alloted amount of time set by the state. The table on page 41 shows this to be

true. Although the numbers and percentages varied from agency to agency, hospitals state wide were only able to reduce 40.9% of the total bed reduction levels.

The second hypothesis that some of the closed beds were allowed to reopen in other hospitals in the same geographical area was true. 19 hospitals gained a total of 414 beds during the five year bed reduction policy. Many of the increases were due to the merging of hospitals. Other hospitals gained beds because of high utilization and/or shifts in the population.

The third hypothesis that hospitals with low bed utilization would be required to remove the greatest number of beds was also true. The local health care agencies used historical data to determine which hospitals had low utilization. It was these hospitals that reduced the greatest number of beds. In fact these low utilization hospitals were often the hospitals designated to be closed. Flint General Hospital is an example and is described on pages 47 and 48.

The fourth hypothesis that the majority of beds to be cut would be from areas that had a high bed to population ratio was true. Using the federal government standard of a 4.0 bed to 1000 persons ratio, pg 35, the state was able to determine which areas had a high bed to population ratio. The table on page 42 shows that area 1, the Detroit metropolitian area, and area 5, the Flint and surrounding area, had to reduce over 75% of the total beds statewide. This was partically due to uncontrolled hospital growth and shifts from the inner city to the suburbs. Both of these reasons attributed to a high bed to population ratios.

The fifth hypothesis that the larger more utilized hospitals

would gain beds during the reduction period was true. The tables within the appendix show that hospitals such as Providence in Detroit, Macomb Hospital Center, Bronson Hospital in Kalamazoo, and others had an increase in their total number of licensed beds. All of these hospitals were shown to have high utilization.

The sixth hypothesis that hospitals would find legal ways to avoid reducing beds was true. The table on page 43 as well as the tables in the appendix show that many hospitals went through a bed reclassification process. This allowed them to reduce the number of beds within a particular classification without reducing the total number of beds hospital wide.

The seventh and last hypothesis was the only one that was proven false. The hypothesis stated that no new hospitals would open or no new hospital construction projects would be approved during the five year bed reduction policy period. Although no new hospital construction projects were approved, four new hospitals did open during the five year period. The tabel on page 49 shows that all four of the hospitals were opened in the Detroit area. But as stated all of these hospitals had received approval prior to the implementation of the policy.

CONCLUSION

The writing of legislation to force hospitals to reduce bed capacity as a way of controlling the expansion of the health care industry was thought by many to be an unobtainable goal. The idea of the state government telling private as well as public hospitals to remove beds was never done before. And the impact that private and special interest groups played on influencing not only the development of the legislation but also the setting of standards was unique at the time. Many states sat back and waited to see what effect, if any, the forced bed reduction would have on the delivery of health care within the state of Michigan.

The state saw the bed reduction policy as not only a means of removing beds from hospitals that had low utilization but also as a means of redistributing beds to hospitals that historically showed high utilization and to areas of the state that have had a growth in population. This redistribution of beds was also looked upon as a way to consolidate services and consequently reduce costs.

Hospitals located in the inner cities had a greater bed loss than those hospitals located in the suburbs. Higher utilization, more up to date facilities, and a greater bed to population ratio were some of the reasons the health agencies used to justify their plans. Hospitals located in the rural areas of the state did not lose as many beds. High utilization and the overall limited number of facilities within a geographical area were used as primary justification. Although some rural areas did reduce the total number of hospital beds it was primarialy due to shifts in the population.

The closing of 34 hospitals over the ten year period had both positive and negitive effects on the delivery of health care. The closing of outdated or smaller hospitals allowed for the consolidation of like services. This consolidation was thought to provide better care for the patients by being able to provide a modern setting, better equipment, and a specialized staff. This also allowed for the administration to have a better control of the operating costs.

Although the majority of the beds from a closed hospital were absorbed by other hospitals, the loss of the hospital itself put a direct hardship on the surrounding community. The additional time needed to travel for health care and the loss of jobs were just a few of the negative sides of a hospital closing.

The objective of controling the growth of hospitals within the state was eventually obtained. Although taking twice as long as planned, the bed reduction policy succeeded at removing 94.89% of the total beds that were targeted for reduction. The policy also succeeded at consolidating hospitals and services. This consolidation allowed for the removal of duplicate services and insuring that the remaining facilities were utilized to a greater capacity.

The legislation was not sucessful at writing a policy without any loopholes. Because hospitals only had to meet the bed reduction standards in order to receive an approved C.O.N., many hospitals went years without reducing beds. It was only when that hospital needed a C.O.N. did they attempt to reduce beds or develop a plan for bed reduction. The policy also allowed hospitals to reclassify beds in an effort to remove beds from one

category without reducing their total bed capacity. Both of these strategies allowed hospitals to continue to maintain their old status and at the same time attempt to utilize those targeted beds.

Because many special interest groups, primarily those of the auto industry and insurance companies, had a role in setting standards the question of over influence comes up. Would the standards have been more lax without their input? It's difficult to say. Political influence must also be looked at. Were legislators from certain districts able to convince the health agency to maintain status quo at a certain hospital? And what about hospital influence? Were university affiliated hospitals or the more prestigous area hospitals able to influence bed loss determination. All of these questions are difficult if not impossible to answer but must be taken into consideration.

The idea of the state allowing the agency to determine bed loss was not incorrect. However the state could have provided the agencies with a better set of standards in determining bed reduction. More direct and precise guidelines would have allowed for a more uniform bed lose determination perhaps less vulnerable to special intrest groups and political influence.

Michigans bed reduction policy proved that the reduction of hospital beds did not reduce the quality of health care delivery within the state. In fact it may have improved it.

APPENDIX

State wide bed capacity listed by hospital within each health system agency. Time periods represent bed levels at the start of the policy, the end of the policy, and current bed levels. The table represents Obstetric (OB), Pediatric (PD), and Medical/Surgical (MS) beds.

Area 1 Comprehensive Health Planning Council of Southeastern Michigan

Hospital Name	Dec 1979			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
McPherson Comm Health Center	14	12	110	14	12	110	13	12	111
BiCounty Community Hospital	24	25	199	24	25	199	24	8	215
St John Hospital-Macomb	-	6	93	-	6	90	-	6	90
Community Hospital Foundation	-	2	46	-	2	46	-	-	-
Mt Clemens General Osteo	20	46	190	20	26	242	20	26	242
Macomb Hospital Center	32	28	305	37	13	318	37	4	322
St Joseph Hospital-East	30	31	107	24	23	95	-	-	-
St Joseph Hospital-West	-	-	300	-	-	296	24	20	409
McNamara-Warren Comm Hosp.	-	-	54	-	-	-	-	-	-
Kern Hospital	-	-	54	-	-	54	-	-	20
Mercy Memorial Hospital	24	15	183	24	15	178	24	15	178
William Beaumont Hospital	79	81	727	73	89	718	73	89	707
William Beaumont-Troy	-	17	183	-	10	183	-	10	179
Botsford General Osteo	29	17	262	29	17	254	29	17	265
Madison Community Hospital	-	-	37	-	-	37	-	-	36
Crittenton Hospital	50	13	227	50	13	227	50	13	227
Oakland General Hospital	11	39	211	-	14	225	-	14	221
Pontiac General Hospital	38	80	264	35	65	250	35	65	250
Pontiac Osteopathic Hosp.	15	29	264	15	29	260	15	29	264
Providence Hospital	60	12	358	60	17	358	60	22	352
St Joseph Mercy Hospital	42	41	365	42	41	365	42	41	365
Straith Memorial Hospital	-	-	41	-	4	41	-	2	32
Mercy Hospital	-	9	110	-	7	112	-	-	119
Port Huron Hospital	25	30	166	25	30	165	27	27	147
River District Hospital	8	5	55	8	5	55	8	5	55
Yale Community Hospital	6	5	29	6	5	28	-	5	30
Beyer Memorial Hospital	34	31	104	34	31	104	18	12	118
St Joseph Mercy Hospital	48	46	464	48	46	464	48	15	491
Saline Community Hospital	-	-	82	-	-	82	-	-	82
U of M Medical Center	32	236	586	32	232	585	32	188	582
Chelsea Community Hospital	-	4	93	-	4	93	-	4	89
Annapolis Hospital	36	22	238	19	20	237	19	20	237
Bon Secours Hospital	15	19	286	15	19	286	15	12	284
Cottage Hospital	18	4	133	-	-	140	-	-	139
Dearborn Medical Center	-	-	65	-	-	65	-	-	-
Detroit Osteopathic Hosp.	-	14	291	-	-	275	-	-	249
Garden City Osteopathic	22	26	312	14	26	309	14	23	312
Oakwood Down River (Lynn)	-	2	74	-	-	72	-	-	68
Oakwood Hospital	52	40	476	62	50	476	62	50	476
Outer Drive Hospital	37	25	233	16	-	237	16	-	202

Redford Community Hospital	-	-	72	-	-	72	-	-	68
Riverside Osteopathic Hosp.	23	23	153	22	23	153	20	-	145
Seaway Hospital	16	29	191	-	10	204	-	10	196
Sidney A Sumby Memorial Hosp.	-	4	89	-	-	88	-	-	-
St Mary Hospital-Detroit	36	19	249	24	-	249	24	-	249
Wyandotte General Hospital	30	44	231	30	44	231	28	26	227
Metropolitan Hospital	-	4	40	-	-	-	-	-	-
Heritage Hospital	-	22	189	-	22	189	-	22	179
Wayne County General Hosp.	32	51	305	-	-	-	-	-	-
Osteopathic Hosp Detroit-East	9	6	136	-	-	-	-	-	-
Osteopathic Hosp Detroit-West	17	12	126	-	-	-	-	-	-
Alexander Blain Memorial	-	4	113	-	-	117	-	-	-
Brent General Hospital	13	-	103	13	-	103	-	-	-
Childrens Hospital of Mich.	-	320	-	-	290	-	-	290	-
Detroit General Hospital	-	-	395	-	-	-	-	-	-
Detroit Memorial Hospital	36	12	187	36	12	187	-	-	-
Doctors Hospital	-	6	93	-	-	101	-	-	101
Deaconess Unit of Samaritian	-	-	181	-	-	-	-	-	-
Henry Ford Hospital	34	90	866	34	66	778	34	66	803
Grace Hospital	44	4	359	44	-	360	44	-	358
Harper Hospital	-	-	939	-	-	921	-	-	858
Holy Cross Hospital	13	15	369	13	15	337	-	15	262
Hutzel Hospital	91	-	328	91	-	328	91	-	303
Kirwood General Hospital	-	-	100	-	-	-	-	-	-
Lakeshore Hospital	-	3	125	-	-	109	-	-	-
Metropolitan Hospital	3	-	148	-	2	164	-	4	40
Mt Carmal Mercy Hospital	-	48	509	-	79	478	-	79	472
North Detroit Gereral Hosp.	-	-	329	-	-	311	-	-	225
Northwest General Osteo	-	6	89	-	6	89	-	6	89
Detroit Central (New Center)	-	-	145	-	-	145	-	-	104
Plymouth General Hospital	-	4	142	-	-	-	-	-	-
St John's Hospital	82	73	392	82	73	391	52	88	432
St Joseph Unit of Samar.	18	19	241	-	-	-	-	-	-
Saratoga General Hospital	-	-	203	-	-	203	-	-	200
Siani Hospital of Detroit	45	-	525	51	15	519	51	20	512
Southwest Detroit Hospital	-	18	226	-	18	226	-	18	142
Detroit Receiving Hospital	-	-	-	-	-	325	-	-	305
Michigan Osteopathic Memor	-	-	-	22	-	218	22	8	250
Detroit Riverview Hospital	-	-	-	-	-	-	24	2	234
Samaritan Health Center	-	-	-	20	20	208	20	20	236
Westland Medical Center	-	-	-	14	44	189	-	-	256
Huron Vally Hospital	-	-	-	-	-	-	13	11	129
Totals:	1311	1797	16990	1227	1628	16542	1128	1439	15549

Area 2 Michigan Mid-South Health Systems Agency

Hospital Name	Dec 1979			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Clinton Memorial Hospital	9	-	67	9	4	63	9	4	63
Eaton Rapids Comm Hospital	6	3	32	6	3	32	6	3	32
Hayes green Beach Hospital	7	3	36	7	3	36	7	3	36
HIllsdale Community Health	9	8	69	9	8	69	9	9	68
Ingham Medical Center	-	29	202	-	29	218	-	29	214
Lansing General Hospital	26	29	188	20	21	202	20	21	202
St Lawerance Hospital	23	23	154	23	23	154	23	6	169
Sparrow Hospital	53	67	376	59	67	376	59	67	376
Mason General Hospital	-	4	38	-	-	-	-	-	-
Foote Memorial Hospital	43	43	378	36	32	380	36	32	380
Doctors Hospital-Jackson	5	7	63	-	7	68	-	7	68
Duane L Waters Hospital	-	-	-	-	-	-	-	-	40
Addison Community Hospital	-	3	21	-	3	21	-	3	21
Emma L Bixby Hospital	21	25	174	21	25	166	21	25	126
Herrick Memorial Hospital	7	8	61	7	8	61	7	8	61
Morenci Area Hospital	3	4	28	3	4	24	3	4	24
Thorn Hospital	3	2	20	3	2	20	-	-	22
Totals:	215	258	1907	203	239	1890	200	221	1902

Area 3 Southwest Michigan Health Coordinating Council

Hospital Name	Dec 1978			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Pennock Hospital	9	12	71	9	12	71	9	12	71
Vistors Hospital	-	3	39	-	3	39	-	3	39
Community Hospital	-	10	60	-	10	60	-	10	60
Mercy Memorial Hospital	22	15	131	46	40	251	28	35	239
Mercy Hospital	24	25	120	-	-	-	-	-	-
Pawating Hospital	17	15	142	17	15	142	17	15	142
Berrier General Hospital	10	4	41	10	4	41	10	4	41
Community Health Center	14	16	108	14	16	108	14	12	84
Battle Creek Health Center	-	-	-	-	-	-	-	31	353
Womens Hospital	-	-	-	-	-	-	30	-	-
Oaklawn Hospital	9	15	53	9	15	53	9	15	53
Albion Community Hospital	8	11	70	8	11	70	8	11	70
Leila Post Hospital	-	29	199	-	10	199	-	-	-
Lakeview General Hospital	11	13	124	11	32	124	-	-	-
Community Hospital	30	21	159	30	21	159	-	-	-
Battle Creek Adventist	-	-	75	-	-	75	-	-	75
Lee Memorial Hospital	6	17	51	6	9	59	6	9	59
Borgess Medical Center	28	26	365	22	21	365	22	21	365
Bronson Methodist Hospital	45	115	318	45	90	343	45	90	321
Bronson-Vicksburg Hospital	-	5	45	-	2	44	-	2	39
Sturgis Hospital	12	8	74	12	8	74	12	8	74
Three Rivers Community Hosp.	7	5	60	7	5	59	7	6	47
South Haven Community Hosp.	8	5	69	8	5	69	8	5	69
Lakeview Community Hospital	6	8	45	6	8	42	6	8	25
Totals:	266	378	2419	260	338	2347	231	297	2226

Area 4 Alliance For Health

Hospital Name	Dec 1978			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Community Hospital	-	-	31	-	-	31	-	-	-
Allegan General Hospital	11	10	59	8	8	55	8	5	58
Pipp Community Hospital	9	4	32	7	4	32	7	4	32
Orchard Hills Hospital	5	8	43	5	8	43	5	8	43
Ionia County Hospital	11	12	54	11	12	54	11	12	54
Blodgett Memorial Hospital	44	37	329	44	37	329	44	37	329
Butterworth Hospital	67	89	398	67	78	374	67	88	374
Ferguson Hospital	-	2	103	-	2	103	-	2	103
Metropolitan Hospital	21	30	214	19	29	200	19	29	200
St Mary's Hospital	23	24	313	34	34	302	34	34	262
Memorial Medical Center	9	9	81	9	9	77	9	9	77
Mecosta Memorial Hospital	-	-	36	-	-	36	-	-	-
Mecosta County Hospital	9	4	61	9	4	61	9	4	61
Carson City Osteopathic	11	13	90	11	13	90	11	6	70
Sheridan Community Hospital	3	3	36	3	3	36	3	3	36
Tri Country Community Hosp.	5	4	31	5	4	21	-	4	21
Kelsey Memorial Hospital	7	5	40	7	5	40	7	5	40
United Memorial Hospital	10	7	49	10	7	49	10	7	48
Hackley Hospital	35	28	264	30	22	258	30	22	238
Mercy Hospital	-	13	225	-	12	216	-	12	216
Muskegon General Hospital	12	18	107	12	15	110	18	15	94
Heritage Hospital	-	-	46	-	-	46	-	-	-
Gerber Memorial Hospital	8	10	69	8	10	64	8	6	68
Grant Community Hospital	-	2	30	-	-	-	-	-	-
Oceana Community Hospital	-	4	32	-	4	32	-	2	34
Lakeside Community Hospital	7	3	26	7	3	25	7	3	25
Reed City Hospital	6	6	36	6	6	44	6	6	44
North Ottawa Community Hosp.	16	18	89	16	8	80	16	8	80
Holland Community Hospital	23	28	151	23	23	167	23	23	159
Zeeland Community Hospital	11	4	46	11	4	46	11	4	46
Totals:	363	385	3081	352	364	3021	363	358	2958

Area 5 GLS-Health Systems, Inc.

Hospital Name	Dec 1978			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Flint General Hospital	-	12	104	-	-	-	-	-	-
Flint Osteopathic Hospital	30	40	331	30	28	301	30	28	301
Genesee Memorial Hospital	-	9	167	-	2	93	-	2	93
Hurley Medical Center	36	100	449	36	75	424	45	99	300
McLaren General Hospital	50	30	359	33	18	351	33	18	351
St Joseph Hospital	26	28	369	26	28	369	26	28	369
Wheelock Memorial Hospital	-	3	50	-	3	31	-	-	31
Lapeer General Hospital	23	22	121	25	22	158	25	10	150
Shiawassee Memorial Hosp.	23	24	189	21	24	169	17	14	154
Totals:	188	268	2139	171	197	1896	176	199	1799

Area 6 East Central Michigan Health Systems Agency

Hospital Name	Dec 1978			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Standish Community Hospital	4	3	30	4	3	30	-	-	30
Bay City Samaritian Hosp.	-	4	66	-	-	-	-	-	-
Bay Osteopathic Hospital	11	14	76	7	-	79	7	-	79
Bay Medical Center	35	35	281	33	35	311	25	35	311
Clare Community Hospital	6	6	54	6	4	54	6	4	54
Gladwin Hospital	-	4	38	-	-	42	-	-	42
Gratiot Community Hospital	16	15	105	16	14	106	16	5	118
Huron Memorial Hospital	6	4	83	6	4	83	6	4	83
Scheurer Hospital	5	4	19	5	4	19	5	-	23
Harbor Beach Community Hosp.	6	2	19	6	2	19	6	2	19
St Joseph Hospital-Tawas	6	2	54	6	2	57	6	2	57
Central Michigan Comm Hosp.	12	11	122	12	11	113	12	11	95
Midland Hospital Center	27	17	195	27	17	195	27	17	195
Tolfree Memorial Hospital	7	4	81	7	4	81	7	4	81
Saginaw General Hospital	64	60	290	54	30	249	54	30	225
Saginaw Osteopathic Hospital	14	30	159	14	30	159	-	-	-
St Lukes Hospital	-	54	272	-	28	254	14	30	384
St Mary Medical Center	-	22	233	-	17	221	-	17	244
Deckerville Community Hosp.	4	4	17	4	4	17	4	4	17
McKenzie Memorial Hospital	6	3	40	6	3	40	6	3	34
Marlette Community Hospital	-	3	45	-	4	44	-	4	44
Caro Community Hospital	4	6	40	4	6	40	4	6	40
Hills & Dale General Hosp.	8	4	53	8	8	49	8	8	49
Totals:	241	309	2372	225	230	2262	213	186	2227

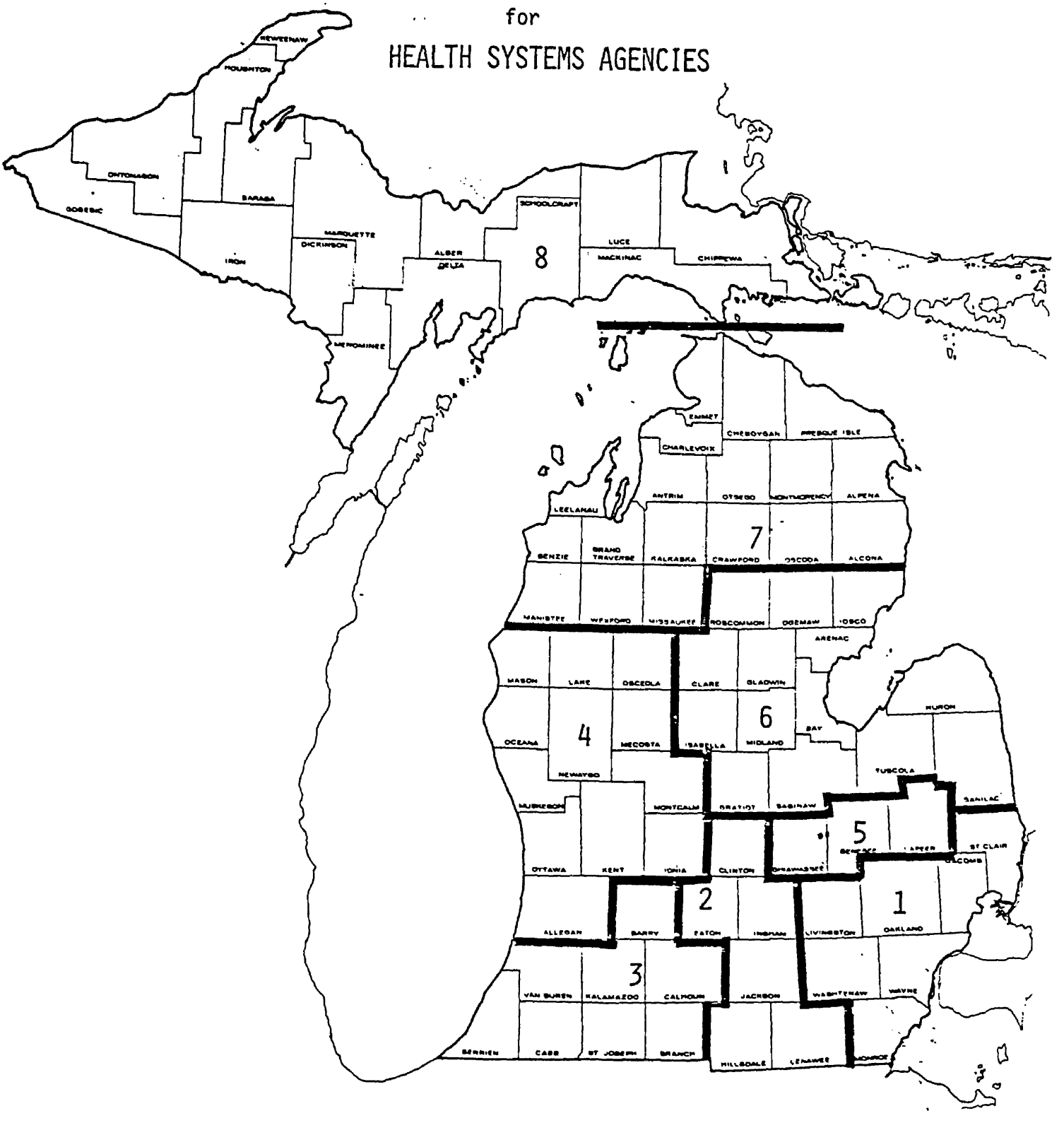
Area 7 Northern Michigan Health System Agency, Inc.

Hospital Name	Dec 1978			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Alpena General Hospital	12	17	112	12	17	112	15	6	117
Paul Oliver Memorial Hosp.	5	4	31	5	2	41	5	2	23
Beaver Island Medical Cent.	1	1	1	1	1	1	-	-	-
Charlevoix Area Hospital	4	5	35	4	5	35	4	5	35
Community Memorial Hospital	6	6	67	6	6	67	6	6	67
Mercy Hospital	6	6	76	6	6	76	8	6	76
Northern Michigan Hospital	14	20	220	20	26	239	20	14	251
Munson Medical center	19	33	243	19	33	249	19	33	249
Traverse City Osteopathic	5	4	72	5	4	72	5	4	72
Kalkaska Memorial Health	-	-	21	-	-	13	-	-	13
Leelanau Memorial Hospital	4	3	26	4	3	26	4	3	26
Memorial Hospital of Manistee	-	-	24	-	-	-	-	-	-
West Shore Community Hosp.	11	5	79	11	5	79	11	5	79
Otsego County Hospital	5	2	35	7	2	44	7	2	44
Russell Memorial Hospital	2	-	15	2	-	15	2	-	15
Rogers City Hospital	7	5	34	7	3	31	4	3	33
Mercy Hospital	15	18	142	15	18	142	15	18	121
Totals:	116	129	1233	126	131	1242	125	107	1221

Area 8 Upper Peninsula Health System Agency, Inc.

Hospital Name	Dec 1978			Dec 1984			Dec 1988		
	OB	PD	MS	OB	PD	MS	OB	PD	MS
Munising Memorial Hospital	3	4	33	3	4	33	3	4	33
Baraga County Memorial	6	8	39	6	8	25	6	-	33
Chippewa County Memorial	20	15	98	10	-	113	10	-	77
St Francis Hospital	21	14	92	21	14	88	14	-	98
Anderson Memorial Hospital	5	-	14	5	-	14	5	-	14
Dickinson County Memorial	12	13	89	12	13	89	12	11	84
Grand View Hospital	5	3	64	5	3	64	5	3	64
Calumet Public Hospital	9	2	59	9	2	59	9	2	59
Portage View Hospital	9	6	93	9	6	95	9	6	78
Crystal Falls Community Hosp.	3	4	28	3	-	32	3	-	32
Iron County General Hospital	3	-	35	3	2	31	3	2	31
Helen Newberry Joy Hospital	4	6	33	4	6	33	4	6	28
Mackinac Straits Health Cnt.	4	2	15	4	2	14	-	2	13
Francis A Bell Memorial	12	8	95	12	8	95	12	8	79
Marquette General Hospital	14	28	260	14	26	202	14	22	222
Bay Area Medical Center	-	14	68	-	14	64	-	4	74
La Croix Hospital	-	1	17	-	1	17	-	-	-
Ontonagon Memorial Hosp.	3	4	34	3	4	34	3	4	34
Schoolcraft Memorial Hosp.	8	6	41	8	6	41	8	2	37
Mackinac Island Medical Cnt.	1	-	-	-	-	-	-	-	-
Totals:	142	136	1207	131	117	1143	100	76	1088

HEALTH SERVICE AREA DESIGNATIONS
STATE OF MICHIGAN
for
HEALTH SYSTEMS AGENCIES



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MICHIGAN DEPARTMENT OF PUBLIC HEALTH
Bureau of Health Facilities, Division of Construction

L E T T E R O F I N T E N T

To apply for to apply for a Certificate of Need under P.A. 368 of 1978, as amended.

ITEM 1:

Facility Name
Facility Address
County
City, State, and Zip Code
Federal Identification # or S.S. #

FOR MICH. DEPT. OF PUBLIC HEALTH USE
MDPH Application Number
Date Received
Date Accepted as Complete
Health Systems Agency Acceptance
Facility Number Subarea

ITEM 2:

Legal Name of Applicant Organization
Mailing Address
County
City, State, and Zip Code

ITEM 3:

Principal Contact Agent for Project
Area code and telephone number
Mailing Address
City, State, and Zip Code

ITEM 4: FACILITY TYPE _____

EXAMPLES:

Hospital, general
Hospital, psychiatric
Nursing Home
Home for the Aged
Health Maintenance Organization
Clinical Laboratory
Freestanding Outpatient Surgical Facility
Tertiary Health Care Facility
Ambulatory Health Care Facility
Outpatient Physical Therapy Clinic
Outpatient Psychiatric Clinic
Substance Abuse Program
Freestanding End Stage Renal Disease Facility

ITEM 5: PROJECT TITLE/SUMMARY

_____
_____
_____

ITEM 6: SERVICE.CHANGE

List the services affected by this project and indicate how changed.

	Type of Service Change			
	Add	Expand	Reduce	Delete

ITEM 7: BED CHANGE

Bed Type	Number of Beds		
	Current	Proposed	Change
Medical/surgical (M/S)			
Special care (ICU, etc.)			
Pediatric			
Obstetric			
Rehabilitation (M/S)			
Nursing home			
Home for the aged			
Psychiatric			
Inpatient substance abuse (M/S)			
Residential substance abuse			
Other_____			
Total			

ITEM 8: PROJECT COSTS

Building Purchase	
Arch./Eng. Fee	
Construction Costs	
Fixed Equipment	
Movable Equipment	
Financing Costs	
Land Purchase	
Lease Cost	
Other	
TOTAL	

ITEM 9: SOURCE OF FUNDS

Facility Funds	
Mortgage	
Bond Issue	
Grants	
Appropriations	
Contributions	
Operations (lease only)	
Donation	
Other	
TOTAL	

ITEM 10: PROJECT TIME REQUIREMENT

What is the estimated total time required to complete the project including design, financing, construction, etc.? _____ Years, _____ Months

ITEM 11: CHANGE IN STAFF RELATED TO PROJECT

Staff	Current FTEs	Projected FTEs	Change + or -
Professional			
Support			
Other_____			
Totals			

ITEM 12: NARRATIVE DESCRIPTION OF THE PROJECT

Include location(s) and where applicable, a breakdown by floors, departments, or programs. Specify the number of square feet of new construction, renovation, and how size of affected departments will change. Specify number of square feet to be leased or purchased. Attach additional sheets as necessary.

ITEM 13: CODE DEFICIENCIES

Does this project correct code or licensure deficiencies including those cited by the State Fire Marshal?

YES [ ] NO [ ] NONE CITED [ ]

Briefly describe how the project will correct code deficiencies.

ITEM 14: PROJECT TYPE - Check all applicable categories.

_____ New construction/replacement	_____ Replacement equipment
_____ Renovation/modernization	_____ Change in ownership
_____ Conversion	_____ Lease
_____ Additional equipment	_____ Other_____ (Specify)

ITEM 15: REQUEST FOR NONSUBSTANTIVE REVIEW

A. Is a nonsubstantive review being requested? Yes [ ] No [ ]
If yes, complete B. below.

B. Nonsubstantive projects must relate solely to one or more of the numbered categories described in the Michigan Department of Public Health Procedure for Nonsubstantive Reviews (T-148) effective February 1, 1987 and expanded effective October 1, 1987. Please indicate the specific project category number, category type, and project description as set forth in the Procedure for Nonsubstantive Reviews.

Category Number	Category Type	Description

THE INFORMATION ON THIS FORM WAS REVIEWED AND APPROVED FOR THE FACILITY BY:

Name _____ Title _____

Signature _____ Date _____

FOOT NOTES

1. U.S. Congressional Record, Vol 120, 1974, pg 7995.
2. Ibid., pg 7859.
3. Ibid.
4. Ibid.
5. Ibid.
6. Ibid.
7. Ibid.
8. Ibid., pg 7860.
9. Ibid.
10. Ibid.
11. Ibid.
12. Ibid.
13. Ibid., pg 7863.
14. U.S. Congressional Record, vol 120, 1974, pgs 7994-7995.
15. Ibid.
16. Ibid.
17. J.B. Simpson, State Certificate Of Need Program: The Current Status, pg 1225.
18. Ibid.
19. Ibid.
20. Ibid., Congressional Record.
21. Ibid., Simpson.
22. Ibid.
23. Ibid.
24. General Provisions For Certificate Of Need, Michigan Department Of Public Health, pg 5.
25. Ibid.
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27. Ibid., General Provisions.

28. Ibid.; pgs 5-9.

29. Statewide Coordinating Council, Guidelines For Identifying The Appropriate Hospital Bed Capacity And Excess Beds In Each Subarea, pg 1.

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32. Merian Kirchner, What They Don't Say About Those "Surplus Beds", pg 89.

33. Federal Register, Proposed National Guidelines for Health Planning, September 1977.

34. Richard L. Johnson, Hospitals Buildings Have Few Alternative Uses, pg 44.

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