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Do expensive buildings improve health care?

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As an organization that follows health care issues closely, we would like to offer another perspective on Gov. John Lynch's request for a moratorium on hospital expansions.

One billion dollars has been spent on hospital expansion projects in New Hampshire since 2000. A significant amount of money for these expansions has been invested in the duplication of high-intensity and high-cost services like cardiac surgery, diagnostic, radiation and cancer centers. The Dartmouth Atlas Research Study, a 20-plus year study of variations in medical costs and practices across the United States has shown that the use of high-intensity services is not based on patients needs as much as one simple factor: their geographic availability.

All this means that hospital expansion projects in New Hampshire are contributing to a 'build it and they will come' mentality. We don't have an epidemic of heart disease, cancer or need for more MRIs. What we have is an epidemic of over-building that creates a demand for paying patients to keep them running. In no other industry does this model of increasing supply create demand except in healthcare.

As Concord Hospital CEO Michael Green pointed out, the common argument used to defend these multi-million dollar expansions is that they are needed to improve the quality of care ('Hospital construction ban is a bad idea,' Monitor Forum, Feb. 23). Yet unlike many other states, New Hampshire has no commission that produces data on hospital outcomes, so we have no way of telling if these expensive buildings improve the quality of care.

In fact, patients in New Hampshire are at a disadvantage because hospital quality data is kept secret by the New Hampshire Hospital Association and the Department of Health and Human Services.

The Agency for Health Care Research and Quality takes our hospital data and formats it into Patient Safety Indicators. These indicators have been shown to have complication rates that vary substantially across hospitals. Evidence suggests that high complication rates may be associated with deficiencies in the quality of care. They also drive up costs significantly. The PSIs include things like volume of surgery, complications like post-op bleeding, respiratory failure, sepsis, bloodstream infections, hip fractures, obstetrical trauma and several others.

Due to the economic strain that health care costs are putting on business, municipal, school and state budgets and their employees, several states have passed laws to make PSI data publicly available so that consumers can make informed decisions about the quality of care they are buying. This allows businesses and municipalities to gain leverage over escalating health-care costs by driving their employees to the facilities with better outcomes.

The data could also assist the state Certificate Of Need Board in making informed decisions when it is faced with a hospital expansion proposal.

Creative state initiatives like Maryland's Cost Review Commission have started reducing payments to hospitals whose quality data is below targeted levels. Officials estimate that $521 million could be saved in Maryland if quality is improved by a reduction in these common complications.

Lynch's proposed moratorium on hospital building shows that he's done his homework. This is not a political decision; it's a decision based on volumes of current evidence that shows we have a medical arms race across the United States that is also evident here in New Hampshire. This is driving up costs and, to quote the Dartmouth researchers, 'patients do not experience improved survival or better quality of life if they live in regions with more care. In fact, the care they receive appears to be worse.'

The reality is that consumers have to absorb the cost not only of these large building projects but the suffering quality of care that can result from them.

(Lori Nerbonne of Bow is a founder of New Hampshire Patient Voices.)