BEST PRACTICES
MINNESOTA’S HIGHEST VALUE HOSPITALS

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Minnesota 2020 Graduate Research Fellow
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Table of Contents

Executive Summary 1

Introduction 4

Minnesota’s Top Ten Hospitals 6

Data & Statistical Correlations 7

Recommendations 13

Appendix 15

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Executive Summary

Minnesotans don’t have to sacrifice health care quality in order to control costs; however, for the state’s hospitals and medical centers to continue delivering high-quality health care at an efficient value – relative to the rest of the country – state policymakers and health administrators must find ways to increase the number of well-trained, dedicated and caring primary care medical professionals. This is becoming increasingly difficult, as general practice physicians are becoming a scarce commodity in Minnesota and across the nation, especially in rural counties.

This report outlines the positive outcomes and cost savings for hospitals, medical providers and insurers when medicine is coordinated through a primary care physician using a holistic approach that encourages healthy habits, manages chronic conditions, and provides routine check-ups and immunizations.

To that end, the report examines quality of care (measured by diagnosis outcomes, mortality rates and patient satisfaction) and value (measured by average Medicare reimbursement for Diagnosis Related Groups adjusted for cost of living, percentage of uncompensated care and educational costs) and ranked the ten best medical centers in terms of value in Minnesota with Fairview Northland Regional Hospital coming in on top. Overall, for the quality ranking, the margins between positions were sometimes very small, indicating Minnesota hospitals, in general, deliver high-quality health care.

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Typically, smaller medical facilities that had a higher proportion of primary care physicians to specialists came out better in both value and quality of care. The report finds that while specialists play an important role in treating and caring for those with advanced and acute illnesses, the United States’ system of medicine and the insurance payment structure has resulted in an increasing overreliance on specialty doctors as a first line of defense. This has led to many of the skyrocketing costs associated with medical care.

To battle these high costs and expenses, Medicare has increased its reimbursements to hospitals that treat high proportions of low-income patients (via disproportionate-share hospital funds). While this certainly helps targeted hospitals, there is question as to whether or not the help is negligible and that the distribution formula might not target correctly the hospitals that cater to the majority of uninsured patients. The hospitals that ranked well in the report not only earned high quality marks, but they did so with less Medicare funding per-patient than competitors given the cost-of-living, educational and uncompensated care expenses each hospital covered. If anything, these hospitals deserve more Medicare reimbursements to help compensate for their number of uninsured patients.

Minnesota typically ranks toward the top of lists when it comes to national medical and health studies, coming
in as the 4th healthiest state, according to United Health Foundation’s America’s Health 2008 rankings. The main reason Minnesotans are generally healthier is our low uninsured rate; on average more than 92 percent of Minnesotans have some type of health coverage compared to the nations’ 85 percent. That means more people are seeing primary care doctors who are prescribing preventative treatments and better managing illnesses like diabetes and heart disease, limiting the need for extensive and more expensive specialists’ procedures.

In order to continue on this trend toward high quality, efficient health care outcomes, Minnesota needs to better incentivize primary care positions for young medical professionals. Recently, The Journal of the American Medical Association released a report concluding that only two percent of medical school students planned to pursue a career in general internal medicine. The lures of prestige, high six figure salaries, and lack of laborious administrative work have many young doctors continuing on toward a specialization. By 2020, the U.S. will be short 40,000 primary care doctors, according to the president of the American Academy of Family Physicians. In rural Minnesota, the lack general practitioners is even starker, with fewer primary care doctors per capita than micropolitan and metropolitan counties.

While our nation is looking for ways to ensure more people receive access to medical services, cutting cost without reducing services or coverage is crucial. This report examines how that is possible both here in Minnesota and across the country.

**Key Findings**

- While this report concludes that higher spending does not necessarily correlate with better quality, it shows that increasing the primary care labor corresponds to higher value and quality of care

- By taking a holistic approach to medicine, where primary care doctors encourage healthy habits, manage chronic conditions, and provide routine check-ups and immunizations, costs can be better controlled.

- The American Academy of Family Physicians estimates that adding one primary care doctor for every 20,000 people decreases the number of unexpected premature deaths by 9 percent.

- 98 percent of medical school students plan to seek careers in fields other than primary care because of the extra administrative duties, lower salary and exorbitant administrative duties.

- The U.S. health care system will be short 40,000 primary care doctors by 2020.

- In general, hospitals that have low proportions of Medicare reimbursements to amounts of uncompensated care, education costs and cost-of-living expenses, perform more favorably in the value ranking, while hospitals that have higher proportions of primary care/family physicians compared to specialists fair better in the quality ranking.
**Recommendations**

- Medicare and insurance companies should structure payments to encourage more preventative medicine, wellness programs and better treatment coordination to help control costs while increasing salary and other incentives for primary care physicians.

- Encourage medical students to enter primary care practices, especially in rural areas by extending incentive programs.
  
  o The Minnesota Rural and Urban Physician Loan Forgiveness Program and the Minnesota State Loan Repayment Program provide up to $17,000 and $20,000, respectively, for students who practice in federally designated Health Professional Shortage Areas.

  o The National Health Service Corps, which covers U.S. medical students, offers up to $50,000 loan forgiveness to primary-care providers—including nurse practitioners and generalists—who will work in rural counties.

- Nurse practitioners need to play a larger role in health care reform as they have many of the same privileges as physicians such as diagnosing patients and prescribing medicine, but cost much less. Medicare even reimburses up to 80 percent to nurse practitioners of what physicians receive.

- More Medicare reimbursements need to be made to hospitals with higher percentages of uncompensated care.
The number of Minnesotans over the age of 65 is expected to increase 58 percent by 2020. This means Minnesota’s dependency on Medicare benefits will continue to rise, and with Baby Boomers nearing retirement and requiring more medical attention, Medicare reimbursements will need to carry more weight when it comes to paying medical bills. Additionally, public insurance has become more prevalent in Minnesota over the past decade – reliance in 2006 increased by 4.7 percent from 1999 and of all the forms of public coverage, Medicare comprises the largest proportion (42.1 percent).

Throughout Minnesota, Medicare reimbursements have varying weights when it comes to paying medical bills for treating conditions such as heart failure, pneumonia, chronic lung disease and hip replacements. Interestingly, a larger Medicare reimbursement for these treatments does not necessarily mean better quality of care. Baicker et al. (2004) demonstrate that quality and Medicare spending actually have a negative relationship, and that a $1000 increase in Medicare reimbursements per beneficiary results in a drop of nearly ten positions in overall quality ranking (p < .001). On the other hand, Richard Cooper (2009) has found a positive correlation of health care quality and “total spending” at the state level.

This MN2020 report, however, does not find a significant correlation between hospital quality and Medicare spending. After compiling hospital quality, mortality rates, patient satisfaction and Medicare reimbursement data from the Hospital Compare website created by the Center for Medicare and Medicaid Services (CMS), this report finds many of the most effective (or lower Medicare reliance with high quality) hospitals are located outside suburban regions.

Based on two rankings – quality (measured by diagnosis outcomes, mortality rates and patient satisfaction) and value (measured by average Medicare reimbursement for Diagnosis Related Groups adjusted for cost of living, percentage of uncompensated care and educational costs) – and data from the Dartmouth Atlas finds:

- Fairview Northland Regional Hospital in Princeton, MN came in first place as Minnesota’s most efficient and self-reliant hospital. This is no surprise in that this hospital was the smallest of all surveyed in terms of licensed hospital beds and tenth in the least number of discharges. Cambridge Medical Center in Cambridge, MN and Buffalo Hospital in Buffalo, MN came in second and third, respectively.

- In general, hospitals that have low proportions of Medicare reimbursements to amounts of uncompensated care, education costs and cost-of-living expenses, perform more favorably in the value ranking, while hospitals that have higher proportions of primary care/family physicians compared to specialists fair better in the quality ranking.

- As hospitals get larger, both in the number of staffed beds and patient discharges, their ability to stay

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4 The p-value is the probability that there is no correlation between the dependent and explanatory variables. This merits statistical significance when a threshold is met. In this case, the threshold is the 10% significance level (or .10).

self-reliant – deliver high proportions of uncompensated medical care – and maintain quality diminishes.

- For every medical specialist addition, the quality rank decreases by 1.3 positions.

- Every extra physician seen reduces the overall quality rank by two positions.

- Every addition of a primary care physician per 1,000 decedents, increases the value rank by 2.7 positions.

- As a hospital grows by 100 beds, the value rank decreases by 2.2 positions and 2.5 positions overall.

- The composition of physician staff (in terms of specialists and generalists) has a statistically significant relationship with overall hospital ranking. More specifically, as the composition of specialists to generalists increases (more specialists per generalists) by 10 percent, the overall rank decreases by 1.3 positions.

Hospitals that fall in the middle of the overall ranking may have performed excellent in one category (value or quality) but poorly in another. For example, after adjusting Medicare reimbursements for cost-of-living differences, educational cost proportions and disproportionate shares of low-income patient expenses for each hospital, Hennepin County Medical Center in Minneapolis ranked first for having the lowest amount of per-beneficiary Medicare reimbursements, but came in lower for quality of care. Moreover, Lakeview Memorial Hospital in Stillwater came in first in the quality ranking, but lower in the value ranking.
The top ten hospitals out of 42 surveyed in Minnesota is summarized in the table below. All data was collected from the CMS Hospital Compare website, published on June 29, 2009 and represents the last quarter in 2007 (October) through the third quarter in 2008 (September), unless otherwise specified. The quality ranking takes into consideration three aspects: clinical conditions, mortality rates and patient satisfaction. The value ranking considers average Medicare reimbursement payments to hospitals for several treatments. Due to the limited observations for certain hospitals, not every quality measure supplied by Hospital Compare was used, and the number of Minnesota hospitals was consequently narrowed down to 42.

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** - Micropolitan Counties: Between 10,000 and 50,000 people in the core urban area.  
*** - Metropolitan Counties: A core urban area of 50,000 or more

The average overall ranking of metropolitan hospitals in Minnesota is 21.8, 18.7 for micropolitan hospitals and 27.7 for rural hospitals. While the sheer size of metropolitan hospitals undoubtedly contributes to these averages, the percentage of primary care doctors within a region also has a statistically and economically significant relationship with respect to overall hospital ranking. This is important because the primary health care workforce is disproportionately located in urban areas.

The Minnesota Department of Health estimates that 70 percent of physicians in the state's 46 most rural counties practice primary care medicine, compared to 64 percent in micropolitan counties and 48 percent in Minnesota's metropolitan counties. Moreover, only 8 percent of Minnesota's physicians work in rural areas, but comprise 17 percent of all family doctors. Even though rural counties have a higher percentage of primary care doctors, micropolitan and metropolitan counties still have higher quantities of primary care physicians per capita than rural counties, and these gaps are widening.
Data & Statistical Correlations

Quality Ranking

Of the three quality criteria (clinical conditions, mortality rates and patient satisfaction), clinical conditions took into account fourteen factors ranging from the percentage of heart failure patients given an evaluation of Left Ventricular Systolic (LVS) Function to percentage of pneumonia patients given oxygenation assessment to the percentage of surgery patients who were given the right kind of antibiotic to help prevent infection. For the complete measure specifications see the Specifications Manual for National Hospital Quality.⁶

Mortality rates considered the 30-day mortality and readmission rate for heart failure and pneumonia patients, which was gathered from July 2005 through June 2008. And patient satisfaction was based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The questions therein varied from rating the hospital on a ten-point scale to how clean the hospital room was during the hospital stay. All of these quality measures can be seen in the Appendix.

Value Ranking

The amount of Medicare reimbursements collected by hospitals, which is updated on the Hospital Compare website quarterly, is a proxy indicator designed to measure how much the state is spending on health care. Every year, hospitals that wish to receive Medicare reimbursements for patients who are over 65 years old, have some type of disability or have end-stage renal disease, need to comply with federal regulations to qualify for full reimbursement.⁷

There were four Medicare payment groups, or Diagnosis Related Group (DRG), that are specified for each hospital. Medicare pays each hospital an average reimbursement for each DRG. The DRGs used in this report were Chronic Lung Disease, Heart failure, Pneumonia and Pleurisy in Adults With Complications or Preexisting Conditions and Replacement of Hip, Knee or Ankle or Reattachment of Thigh, Foot or Ankle.

Hospitals are eligible to receive a higher reimbursement for a DRG for any reason outlined by the U.S. Department of Health and Human Services; i.e., it is classified as a teaching hospital, it treats a high percentage of low-income patients (disproportionate share), it may treat unusually expensive cases, and/or it pays its employees more compared to the national average because the hospital is in a high-cost area (wage index). Therefore, to generate appropriate comparisons among statewide hospitals, the DRG payments were adjusted for cost of living differences (based on county estimates), the percentage of low-income patients and educational costs for each hospital.

Statistical Correlations

Given that the margins for quality ranking positions were small in many cases, final rankings can be deceiving. More meaningful comparisons and policy implications can be ascertained from the correlation statistics below.⁸

⁶ This can be seen at www.qualitynet.org.

⁷ If hospitals do not comply with federal regulations on disclosing quality, satisfaction and other measures they will lose 2 percent of Medicare reimbursements.

⁸ All equations hereinafter are significant at the 8% significance level or better.
The Dartmouth Atlas publishes data on the proportion of specialists and primary care doctors for every 1,000 decedents during the last two years of life by hospital from 2001 to 2006. Exhibit 1 below shows a negative correlation between the quality rank and number of medical specialty doctors (p < .08), implying that more primary care doctor visits and less specialist visits correlated with a higher overall hospital quality ranking. Specifically, for every additional medical specialist the quality ranking decreases by 1.3 positions. Plausible explanations for this result are better patient outcomes as a result of the primary care philosophy – promoting healthy habits, managing chronic conditions, giving routine checkups and immunizations, and coordinating the care delivered by specialists, nurses and the remaining aspects of the health care corporations – in contrast to the role of specialists who treat already present ailments.

Medicare and other insurance providers do not reward primary care doctors for this holistic approach, but rather give preference to specialists who typically earn four to five times more per year than general practitioners.

The American Academy of Family Physicians estimates that adding one primary care doctor for every 20,000 people decreases the number of unexpected premature deaths by 9 percent, which also reduces the amount of hospitalization and medical bills required for medical care. While the demand for primary care physicians is increasing, supply is diminishing, as many physicians, nurses and other medical providers near retirement.

Sources: Quality data gathered from the CMS Hospital Compare website. Specialist data collected from the Dartmouth Atlas.
Note: For quality ranking, smaller positions equal higher quality.
On the other hand, older patients typically need more specialized care resulting from complex combinations of chronic conditions. Rural residents have fewer visits to health care providers and receive less preventative services, which can be attributed to longer traveling distances and fewer practicing physicians per capita. As a result, rural areas often have a higher incidence of poor health while experiencing medical complications because patients do not seek treatment until the symptoms worsen.

**Relationship Between Quality Ranking and Total Number of Physicians Seen**

A surprising result of this study is that the more physicians a patient is visits, the lower quality ranking. Exhibit 2 demonstrates this relationship ($p < .067$).

**Relationship Between Quality and Number of Different Physicians Seen per Decedent, As Expressed by Overall Quality Ranking, Oct. 2007-Sept. 2008**

Every extra physician a patient visits reduces the overall quality rank by two positions. The Mayo’s St. Mary’s Hospital, for example, where physicians are paid a salary to promote cooperation and enhance patient care came in 7th in the quality ranking. St. Mary’s Hospital avoids unnecessary patient-physician interactions and tests because the “aim is to raise quality and to help doctors and other staff members work as a team,” said Atul Gawande in a recent New Yorker article.12

SOURCES: Quality data gathered from the CMS Hospital Compare website. Physician data collected from the Dartmouth Atlas. Note: For quality ranking, smaller positions equal higher quality.


Another finding was that as the number of primary doctors increases, thereby reducing the number of specialists, medical costs decline. This relationship can be seen in Exhibit 3 below (p < .024).

**Relationship Between Value and Number of Primary Care Doctors, As Expressed by Overall Value Ranking, Oct. 2007-Sept. 2008**

For every extra primary care physician added per 1,000 decedents, the value rank increases by 2.7 positions. As value rankings increase, the hospitals become less reliant on Medicare spending. The obvious exception is HCMC (point (5.5, 1) in Exhibit 3) which is ranked first in value and Medicare spending, which sounds counterintuitive. On an aggregate level, HCMC is the most reliant on Medicare reimbursements, but at the patient level the opposite is true. Lake Region Healthcare Corporation (LRHC), for example, in 2007 incurred eleven times less uncompensated care expenses per discharge\(^{13}\) (the proxy for number of low income patients treated) than HCMC. In fact, HCMC accounted for the highest amount of uncompensated care per discharge, 4.5 times the average, but only received 1.2 times the average Medicare reimbursement per beneficiary. LRHC, on the other hand, was less efficient than HCMC in the cost ranking, but scored eighth in overall quality.

**Relationship Between Value Rank and Number of Staffed Beds**

As the size of the hospital increases, reliance on Medicare reimbursements also increases (see Exhibit 4).

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\(^{13}\) The uncompensated care values taken from the Minnesota Department of Health and the amount of discharges per hospital gathered from the American Hospital Directory.
For every addition of 100 beds, the value rank decreases by 2.2 positions ($p < .016$). Exacerbating larger hospitals’ ability to contain costs is the magnitude of uncompensated care required. Larger hospitals tend to cover a higher proportion of uncompensated care than smaller hospitals. This situation is unavoidable in areas of high population density and helps explain why Medicare reimbursements are greater in these localities.

### Correlation Between Overall Hospital Rank and Number of Staffed Beds

Exhibit 5 demonstrates that as the number of staffed beds increases, the hospital ranking decreases ($p < .006$).

### Relationship Between Overall Hospital Rank and Number of Staffed Beds, Oct. 2007-Sept. 2008

**Sources:** Hospital ranking data gathered from the CMS Hospital Compare website. Number of staffed beds data collected from the American Hospital Directory website.

**Note:** For value ranking, smaller positions equal better value.
Every extra 100 beds corresponds to a decrease in 2.5 overall rank positions. Even after adjusting for various discrepancies, as a hospital becomes larger the proportions of uncompensated care per patient become larger. Unfortunately for larger hospitals, these higher proportions are not met with equally proportioned Medicare reimbursements. The hospitals that made the top ten list have a distinct ability to rely less on Medicare while maintaining high quality levels.

**Correlation Between Overall Hospital Rank and Specialist/Generalist Visits**

Exhibit 6 shows that as the number of specialists increases relative to the number of primary care doctors, the overall hospital ranking decreases ($p < .028$).

**Relationship Between Overall Hospital Rank and Ratio of Specialist/Primary Physician Visits, Oct. 2007-Sept. 2008**

![Graph showing correlation between Minnesota Hospital Ranking and Ratio of Specialist to Primary Care Physician Visits to Terminally Ill Patients in Their Last 2 Years of Life.](image)

**Sources:** Hospital ranking data gathered from the CMS Hospital Compare website. Ratio of specialist to primary care physician visit data collected from the American Hospital Directory website.

The smaller the ratio – more generalists per specialists – the higher the overall hospital ranking. This implies that, not only is the delivery of care higher when there are more primary care doctors than specialists, but also the value is higher. This might be attributed to less unnecessary tests and treatments, adding to costs, and more preventative measures.
Recommendations

While this report outlines ten of Minnesota’s outstanding hospitals, it should be noted that the margins between the quality rankings were, in many instances, small. Minnesota has a phenomenal health care system and the 42 hospitals surveyed are all excellent health care providers. If Minnesota wants to maintain its ranking as the 4th healthiest state, several guidelines need to be considered.

First and foremost, Minnesota must address the growing shortage of primary care physicians, particularly in rural areas. Currently, general practitioners are among the lowest compensated physicians. Also, there has been a long-associated stigma attached to generalists among medical students as being less prestigious because of lower compensation compared to specialists. Financial barriers resulting from medical school debt is not the only obstacle deterring medical students from entering primary practices. Location and prestige are also major characteristics medical students consider in choosing a specialty.

A recent paper surveyed medical students and found that 98 percent plan to seek specialties instead of focusing on primary care.

Mindful of this trend, the Minnesota Rural and Urban Physician Loan Forgiveness Program and the Minnesota State Loan Repayment Program, both of which require recipients to work in areas where primary care is needed, should be extended. These programs provide up to $17,000 and $20,000, respectively, for students who practice in federally designated Health Professional Shortage Areas. The National Health Service Corps, which covers U.S. medical students, offers up to $50,000 loan forgiveness to primary-care providers — including nurse practitioners and generalists — who will work in rural counties. Nurse practitioners will also need to play a large role in health care reform as they have many of the same privileges as physicians such as diagnosing patients and prescribing medicine, but cost much less. Medicare even reimburses up to 80 percent of what physicians receive to nurse practitioners.

Second, primary care doctors aren’t reimbursed enough by insurance companies, Medicaid and Medicare for the work they provide. Insurance companies pay large amounts of money for gastric bypass surgery for obese patients but significantly less to provide dietary, counseling and exercise advice. Internist Elliot Fisher of Dartmouth Medical School found “that patients in high-cost areas were actually less likely to receive low-cost preventive services, such as flu and pneumonia vaccines, faced longer waits at doctor and emergency-room visits, and were less likely to have a primary-care physician. They got more of the stuff that cost more, but not more of what they needed.” Doctors need to be rewarded for performance, not quantity.

Third, Medicare needs to reassess the disproportionate share hospital (DSH) funding formulas to ensure facilities that bear the majority of uninsured patients are adequately reimbursed. Unless universal health care

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15Karen E. Hauer, M.D., Steven J. Durning, MD; Walter N. Kernan, MD; Mark J. Fagan, MD; Matthew Mintz, MD; Patricia S. O’Sullivan, EdD; Michael Battistone, MD; Thomas DeFe, MD; Michael Elnicki, MD; Heather Harrell, MD; Shalini Reddy, MD; Christy K. Boscardin, PhD; Mark D. Schwartz, MD. “Factors Associated With Medical Students’ Career Choices Regarding Internal Medicine.” Journal of the American Medical Association, 2008;300(10):1154-1164.


is enacted on a national scale, the problem of uncompensated care will always persist, especially for safety-net hospitals like HCMC.

Fourth, while this report concludes that higher spending does not necessarily correlate with better quality, it shows that increasing the primary care labor corresponds to higher quality. That said, more Medicare reimbursements need to be made to hospitals with higher percentages of uncompensated care so as to increase the number of primary care doctors. In Gawande’s recent article, he states:

“Providing health care is like building a house. The task requires experts, expensive equipment and materials, and a huge amount of coordination. Imagine that, instead of paying a contractor to pull a team together and keep them on track, you paid an electrician for every outlet he recommends, a plumber for every faucet, and a carpenter for every cabinet. Would you be surprised if you got a house with a thousand outlets, faucets, and cabinets, at three times the cost you expected, and the whole thing fell apart a couple of years later? Getting the country’s best electrician on the job (he trained at Harvard, somebody tells you) isn’t going to solve this problem. Nor will changing the person who writes him the check.”

An efficient health care system requires coordinators to pull together resources in a holistic manner. Increasing primary care doctors should not be at the expense of losing specialists. As the AAMC (Association of American Medical Colleges) recently reported, medical schools are increasing their enrollment to meet higher physician demand. But even these adjustments won’t be enough. The medical system will be short over 40,000 primary care physicians by 2020. It is unfortunate that in a state with such a high quality of medical care, Minnesotans may find it easier to obtain costly and invasive emergency care instead of the basic diagnostic care that could have prevented it. This is why, there needs to be continued promotion of physicians practicing family medicine, pediatrics, internal medicine, obstetrics/gynecology and psychiatry. The best we can do for our state, both fiscally and preventatively is the continued promotion of physicians practicing family medicine, pediatrics, internal medicine, obstetrics/gynecology and psychiatry. Otherwise universal coverage is unlikely as the cost of care will not decrease to levels comparable to the top ten hospitals listed above.

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19 Kavilanz, Parija B. “Family doctors: An endangered breed. As more medical students shun primary care for higher-paid specialties, experts warn of a severe imbalance that could cripple the nation’s health care system.” CNNMoney, July, 2009.