Written Testimony of
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CON Ad Hoc House Committee
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I am a health care economist and have completed over 150 CON application reviewed by DHEC over a 30 year career. I have done CON applications for rural hospitals, nursing homes, home health agencies, hospices, and for 29 ambulatory surgery facilities in South Carolina. I have also participated in seven contested CON application appeals. My personal library has at least 18 State Health Plans. I have observed three major CON reform efforts. So here are my observations and recommendation for the Ad Hoc Committee Members consideration:

In South Carolina health care is a $30B industry. It is BIG Business in SC. It is 22% of our state domestic product. It employs over 250,000 people in over 1,000 occupations. These are jobs that are out sourced outside South Carolina. We spend as many public state dollars on health care as we do on public education. Half of all the health care in South Carolina is paid for with public dollars and half with private dollars. The State pays for or manages directly the care of 1.8M people through the State Employee Health Plan and Medicaid program. The General Assembly has the authority to dramatically shape or reshape South Carolina's health care environment if in no other way than what it chooses to pay or not pay for.

I believe there is a role for the public in the allocation of health care resources and CON is an element of this public role. CON was initially conceived to direct where capital was spent. We argued over hospital bed size and location. When I began my career the rule of thumb was 4 hospital beds per 1000 people. Forty years later we're below 1 hospital bed per 1,000 people. Population grew, the number of hospital beds didn't. The big dollars costs in health care today are for health information systems and these expenditures aren't reviewed under CON.

Patient care shifted from inpatient to outpatient. Who has access to what health care services and facilities is now a factor of insurance coverage, benefit design, and composition of provider networks and not the size or number of health facilities in your county.

CON is not a good tool for allowing payer, patients, policy makers, and providers to design a health care "system" for our future needs. How we've structured CON and its state health planning process around facilities and how we license facilities and professionals has reinforced our system of health silos or boxes. Care is fragmented and uncoordinated. Patients too often fall through giant cracks not because we lack hospital beds but because they lack transportation or money for gas or a local drug store or the ability to afford their prescription drugs. All of this outside the CON process.

CON and facility and professional licensing regulations often stand in the way of communities creating a flexible care system. To be paid a provider must be a doctor, a hospital, a nursing home, home health

agency or outpatient surgery center. You can't be a health center which does physician clinical care, outpatient surgery, and emergency care. Part of this is a Federal problem the way Medicare/Medicaid pay for care. CON isn't helping though.

I'd like to see a public CON program restructured with an emphasis on robust health services planning and CONs granted to the creation of pragmatic service programs and away from facilities and not some arbitrary dollar threshold. I want to see the purpose of CON be on access and quality. Health care dollars are too precious today for facilities to waste them. No one builds big expensive facilities today unless they NEED them and can afford them. What we need in South Carolina today is a robust telemedicine network that reaches all corners of South Caroline. We've done this with our ETV system, certainly we can do this in health care. This isn't covered by CON either.

We need to stop wasting time and resources with battling consultants and lawyers over what entity can and can't construct some facility in a county. CON works to sustain the status quo and encourages monopolies. It stifles innovation. It assures the unequal distribution of scarce health care resources to suburban and urban areas and it starves rural area of resources. It discourages real public participation.

CON if reformed properly can forcefully encourage health care institution to work with each other for the public's good. Focus on services and not on facilities. Payers need to be intimately involved and pressured to pay for different types of care delivery. Health planning needs to be accountable for outcome and improvement in health status across counties and regions. We need a robust data network to do this.

The exception to this is long term care. SC has 20,000 nursing home beds in facilities that are on average 30+ or 40 years old. We need a robust CON facility program designed to facilitate the replace of these sadly out of date, energy hogging, and human spirit stifling warehouses of the old and dying. This is a multi0billion effort and requires public leadership and involvement if SC wants to have adequate facilities. We have about 5 years to do this. Let's use CON to lead and not to inhibit this process.

Thank you.

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