Is This Any Way to Do Health Planning?

By John Steen

When a state is spending $45 billion per year on its Medicaid budget, it needs to do something radical, and New York State is doing it now. In 2004, New York's generous Medicaid program paid $10,349 per enrollee, while California's paid $4,793. According to the federal Agency for Healthcare Research and Quality, New York's Medicaid program paid 21 percent of doctors' bills, hospital bills and other expenses in that state in 2003, compared to Medicaid's U.S. average of 9.2 percent of medical expenses. By comparison, Pennsylvania's Medicaid program paid 4.4 percent. The state relies so heavily on hospitals rather than private physicians to serve Medicaid clients that it paid $530 per capita for hospital expenses, while the U.S. average is $185 (2003). And long-term care, including nursing home services and home health and personal care, consumed $16 billion in 2004, or about 36 percent of the Medicaid budget, two-and-a-half times the U.S. average. In fact, according to the Centers for Medicare and Medicaid Services, about one-third of the Medicaid dollars spent on personal care in the United States in 2004 were spent in New York.

I first wrote on this topic in *Health Planning Today* one year ago. ("A Fiscal Crisis Revives Health Planning in New York State," *Health Planning Today*, Winter 2005) Not all of the questions I raised there have yet been answered, but the 18-member **Commission on Health Care Facilities in the 21st Century** issued its long-awaited report on November 28, 2006. On November 29th, the headline in *The New York Times* read, "Plan Could Close 20 or More Hospitals."

The Commission's report includes the following recommendations:

- Nine hospitals should totally close, including five in New York City;
- Several other hospitals should cease to exist through mergers or conversion to new uses;
- Throughout the state, 4200 beds should be eliminated, representing 7 percent of hospital capacity, and beds should be reassigned to different uses or to other institutions at scores of hospitals;
- About 3000 nursing home beds, representing 2.6 percent of capacity, should be eliminated, several nursing homes should be closed, and others downsized.

If adopted, the Commission's recommendations will have their greatest impact in shaping a new system out of the surviving resources, with 48 reconfigurations and restructurings. Among its most controversial is the merger of public institutions — two hospitals in Buffalo and Syracuse, and several upstate nursing homes — with private ones, a form of privatization that would remove them from government control. The report does not recommend reductions in New York City's municipal hospitals, nor closings of academic medical centers. This and adherence to their prime goal of protecting health care for the poor result in most of the hospitals recommended for closure being located in middle income neighborhoods. Geographically, the greatest impact from the plan's reductions would be felt in Buffalo/Niagara Falls, and in New York City.

A Failure of State Policy

Over the past eight years, New York State's more than 200 hospitals have been losing money and are more fragile financially than those in any other state. About two dozen have closed, and most of those that remain have lost money and gone deeply into debt.

This year, the state has made a commitment to fund the industry in transition with $1 billion, and the Bush Administration has confirmed its commitment of $1.5 billion over five years. This funding will be needed to pay off outstanding debts, pay severance to workers, and convert acute care buildings to outpatient clinics. In addition, the state's plans call for heavy investment in computer technology for the surviving hospitals. It will be far harder for officials to preserve and enhance access to primary care, given the state's extreme underpayment of physicians in Medicaid.

Gov. George Pataki and Governor-elect Eliot Spitzer have each endorsed the plan. For Pataki, the endorsement represents a reversal of policy on healthcare regulation. New York State once had the most robust regulation of hospitals in the nation, but he began to change all that when he took office in 1995, saying that "free market competition" would control healthcare spending. He eliminated his Department of Health's hospital rate setting function, and compromised its certificate of need regulatory program, laying off every one of the policy-level officials that had long been devoted to serving the public interest. And in 1996, he cut off state funding to the eight health systems agencies that carried out planning and review functions on the regional level. Without state funding, only two, in Rochester and Syracuse, have survived at a reduced size.

The Republican-led State Senate and the Democratic-led Assembly will hold hearings on the plan in December, and they have until December 31st to accept or reject it, unless they pass a new law extending their deadline, or negating the existing law. In its report, the Commission states that its "work should be considered a beginning, rather than an end, of a broader reform effort. We need to build on this effort to address an ongoing need for structured decision-making regarding health care resource allocations. The speed of change in health care, driven by changing technology, populations and finance, makes it essential that the work of reforming the system and the regulatory framework be continuous. New York State should implement an ongoing process to sustain the efforts initiated by this Commission."

The Moral

Can this scenario be viewed from a policy context as anything but the state and federal governments bailing out a massive policy failure, and performing emergency surgery with further operations to come, to make up for a decade of neglecting the public interest in healthcare? Intelligent regulation of healthcare is no oxymoron; but free market competition in healthcare surely is. The more the state freed its hospitals to compete, the more they ran up costs by acquiring every service and piece of equipment any other hospital had, and excess capacity developed like never before. Inner city hospitals were less successful in that "medical arms race," so they began closing, eroding the state's safety net. Perhaps the ultimate irony is hearing the governor explain his support for the Commission by saying, "we wanted to rationalize the downsizing."

To view the plan, go to: http://www.nyhealthcarecommission.org/final_report.htm.

New Jersey Studies Hospital Closings Too

On July 31st, Gov. Jon Corzine announced the formation of a panel to determine if New Jersey needs all of its hospitals, if they are properly located, and whether state funding is being distributed rationally. The New Jersey Hospital Association says that the state's hospitals posted a 1.6 percent average operating margin last year, and that almost 40 percent lost money. Gov. Corzine claims that state hospital officials have told him privately that the state has 25 hospitals more than it needs, but he is also concerned that the most financially distressed hospitals are those in urban centers with the greatest needs. The state has 81 acute care hospitals and 34 psychiatric, rehabilitation and specialized-care facilities.

In October, the governor signed an executive order creating an 11-member **Commission on Rationalizing Health Care Resources**, headed by Prof. Uwe E. Reinhardt, the world-renowned Princeton University political economist, that will study hospitals' finances and viability, map existing services and project future demands and develop oversight criteria for financially distressed hospitals. Its report will be due by June 1, 2007, and it is mandated to reassess the hospital system every three years.

The moral here? Well, New Jersey experienced a remarkably similar series of policy failures to and in parallel with New York's….

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* According to the American Hospital Association, the average operating margin for hospitals nationwide was 3.7% in 2005.