Politics and policy: Hospitals in New Jersey

BY SANFORD M. JAFFE and LINDA STAMATO

Making decisions about hospitals and health care in New Jersey is hardly a task for the faint-hearted. Resistance to reform is virtually guaranteed. But with costs escalating and pervasive problems of access to and the delivery of health care in the state's system of public and private hospitals, decisions cannot be avoided. How to make those decisions is the rub.

What we have now, in New Jersey, amounts to triage. Twenty hospitals have closed since 1985; nearly half lost money last year and the rest eked out a profit of less than one percent. We have a medical arms race with too many hospitals (81 acute care and three psychiatric, rehabilitation and specialized-care facilities) spending too much money and chasing a limited number of cases at the same time, so that there are unmet needs and potential opportunities.

Given the considerable interests at stake — nearly all of New Jersey's hospitals are operated by private, nonprofit organizations — and the fact that New Jersey does not have the legal authority to order any of them out of business for economic reasons (indeed, in 1992, a state panel recommended that six hospitals be closed; three of these institutions continue to operate), and that roughly $10 billion in the state budget goes to support health-care providers, including hospitals, not to mention the role of insurance coverage, reimbursement and charity care that are inescapably part of this picture as well, it is clear that the state has an appropriate role and that a creative approach is needed.

A number of people, including the governor, talked about the federal effort to close military bases as a potential strategy. And, indeed, New York State's Commission on Health Care Facilities in the 21st Century followed this model. Just last week, it recommended closing nine hospitals and significant downsizings, mergers and specific allocation of services in order to guide the hospital industry to a smaller, healthier condition. That commission's recommendations have received positive reviews from the current and incoming governors, several legislators and editorial boards.

What is the genesis of this strategy and why does it make sense? For more than a decade, every effort that the Pentagon made to shut down obsolete military bases was thwarted by lawmakers whose states or districts benefited from the installations — a situation not unlike community resistance to closing local hospitals (indeed, those who propose such moves are often seen as committing acts of political suicide). Accordingly, only a strategy that is itself political is likely to succeed in breaking this kind of political stalemate. With military bases, such a strategy was provided in the form of legislation that established a nonpartisan commission to develop criteria, hold hearings and make recommendations on base realignments and closings and that outlined a timetable and provided resources to ameliorate impact (several hundred million dollars over a period of years). The key was the provision for members of Congress to either support or reject the commission's entire proposal, with no modifications or exceptions allowed.

Several commissions have made recommendations since 1988. When neither Congress nor the president attempted to alter the package, which was most of the time, the process worked exceptionally well. Closings and realignments have taken place; significant savings have been achieved. The strategy worked.

The base-closing experience suggests that shifting responsibility for analysis and action to a nonpartisan commission diminishes the potential political fallout, significantly reducing the odds for political punishment and political intimidation, and, particularly noteworthy, the base commissions used consensus-building techniques to develop objectives and methods for the base closings, a process that was both convincing and credible, producing final plans and recommendations that proved to be acceptable.

What is critical, though, is genuine consensus on the objective and confidence in the process for meeting it. To this end, Gov. Corzine has created a Commission on Rationalizing New Jersey's Health Care Resources, which will assess financial and operating conditions at acute care hospitals, compare performance, identify factors contributing to fiscal distress, develop criteria for maintaining access to health care, make recommendations concerning assistance, recommend ways to improve policy to facilitate closures, and develop a "health care resource allocation plan" (www.state.nj.us/infobank/circular/eojsc39.htm).

As substantial as it is, it doesn't go far enough. What is needed, in our view, is a more ambitious, comprehensive undertaking geared to action, and soon. Implementation is critical. Why? The commission needs to have the responsibility to recommend specific actions to take place, and by a specific timetable, unless the governor or legislature rejects the entire plan.

Given the political terrain of health care in New Jersey, this will take some doing (not to mention, admittedly, finding additional resources to provide needed incentives). While it is not the noblest expression of democracy, it is one that can work. As it is now, market forces can place certain hospitals at considerable risk, and, absent cooperation, conventional politics produces paralysis. For all those involved in health care in New Jersey, and for the citizens of the state (and their treasury), an independent commission — with teeth — may be the only way to get a necessary job done. It is not too late to follow that path.

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