Health Planning, Regulation and Gain Sharing:

A Strategy for New Direction

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My name is Alan P. Brownstein. I have been professionally employed in the areas of health planning and policy for the past 10 years, including two years as Deputy Director of the Office of State Health Planning in the Commonwealth of Massachusetts. Currently, I am a member of a District Board (G, Queens) and three citywide task forces of the N.Y.C. Health Systems Agency, including the Regionalization Task Force which is developing the Acute Care Studies. Today, I wish to comment on the role of health planning in New York City, and offer several suggestions that are pertinent to the Acute Care Studies which are now nearly completed by the HSA.

Health planning in New York City and State (as well as elsewhere) is being done in a regulatory context. The emphasis has been cost control and system shrinkage designed to correct inappropriate utilization and health industry excesses of the previous two decades. Too frequently health plans are developed to justify cost containment activity, with only lip-service paid to increasing needed health services. And regulation is too often conducted on a case-by-case basis, without a planning framework. In the case of New York City, it appears that the Health Systems Agency made a genuine effort to develop an overall plan for acute care services - but this is only one component of the system. While the Acute Care Studies of the HSA recommends strategies to reduce excess beds, there is no similar strategy for expanding services that are sorely needed. Planning should no longer be used to justify regulation. Instead, it is important that future <u>regulation should be developed out of planning context</u>, that shapes the system.

In shaping the health system, the concern should be reallocation of health resources based on needs documented in a plan. Multi-faceted

regulatory strategies should be employed in a concerted effort toward implementing the plan. Today, we look at a community in New York City, presumably with excess acute care beds, and we attempt to shrink the over-bedding. In the future, we should first assess needs, then take inventory of the resources, examine the fit between resources and needs, and then make appropriate adjustments. Let us assume that this New York City community, based on a needs assessment, does indeed have excess acute hospital beds, but also has an undersupply of primary and preventive care resources. Regulatory mechanisms should then be coordinated to reduce bed supply, but also to expand needed primary care resources.

While the example given is an oversimplification of how planning and regulation should operate, two shifts in orientation are suggested:

- a shift from health system shrinkage to redistribution of health system resources; and

- a shift from health regulation-based planning to health planning-based regulation.

This is also important for political reasons. The most basic and most complex aspect of closing hospitals or reducing beds is that the hospital's patients, trustees, operators and employees all view the hospital as "their own." These groups frequently represent a solid wall of resistance to reducing the number of beds--not without some good reasons. It is unreasonable to expect health consumers, many of whom receive inadequate health services, to support the closing of beds, even if need for those beds is undocumented or marginal, without getting something in return. Similarly, it is unreasonable to expect a health provider, whose hospital requires major modernization, to support closing of a hospital wing, without getting something in return.

Balancing political realities, and the need for health systems change, I would like to propose a strategy of "gain sharing" - an approach that involves trading-off excess beds for better services.

Gain sharing, in this instance, denotes the redistribution of excess hospital resources to other areas. As previously mentioned, current efforts to "shrink" the health care system are aimed solely at the reduction of costs, without incentives to improve health care. However, derived savings should not be removed entirely from the health care system, but rather, any reduction in inpatient services should be accompanied by prior commitments to specific plans to divert a proportion of the savings into the development of other kinds of needed health services, including modernization and other purposes (see below). It is important to emphasize the need to establish--not only in principle but in terms of specific plan development--gain sharing prior to bed reductions. Too often the promise is made (or strongly implied) by public officials that closing hospital beds will permit the reallocation of wasteful hospital dollars to provide other needed health services, but it rarely happens, for a variety of reasons.

A Gain Sharing Strategy: The State's Role

Only the state has the regulatory ability to directly and indirectly effect the redistribution of health dollars through its certification of need, licensure and rate-setting authority. To date, this approach has been piecemeal, without adequate planning and coordination. Further, even if regulatory functions were to be coordinated to achieve specific health system goals, it is questionable whether the state has sufficient reimbursement leverage to create the financial incentives to bring about desired changes. The state's proportion of direct savings derived from bed closings is primarily from its contribution to Medicaid, or less than 20% of total savings.

In other words, for gain sharing to work, the state must commit itself to the principle of gain sharing and coordinate all of its regulatory functions, including insurance regulation (so that insurance rates and reimbursement can be applied to gain sharing). In addition, to increase the gains and strengthen the incentives, it is essential that federal and city governments be plugged into a gain-sharing strategy. Because the basic tenet of reimbursement programs is to provide funds for costs incurred, funding based on reduced reimbursement due to declining hospital costs (resulting from bed reduction) would require special Medicare and Medicaid waivers. Only with federal, state and local participation, can a substantial portion of derived savings be used for these purposes. In sum, it is essential that the health care dollar be aggregated inorder to move the system in desired directions.

For gain sharing to succeed it must be done in a political context considering the legitimate concerns of all parties who would be affected by bed reductions and gain sharing--consumers, hospitals, employees and their unions. The following hypothetical Gain Sharing Distribution Formula (GSDF) is a conceptual outline for discussion purposes that incorporates political considerations, health status and system needs, based on the assumption of $100 million of savings (from all sources) derived from closing 1500 (the HSA Acute Care Studies project closing 1000-4000 beds between 1981-1984) beds at an estimate of $65,000 (a round figure for these purposes) savings per year per bed.*

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*There is considerable debate as to the magnitude of savings that can be realized from reducing beds in the long-and short-term. However, for the purpose of illustrating the concept of gain sharing this 1977 estimate is used.

Hypothetical Gain Sharing Distribution Formula

Resource Development Fund	$25 million
Modernization Fund	$20 million
Hospital Closure Incentive Program	$35 million
Re-Entry Training Fund	$15 million
Debt Service Fulfillment	$ 5 million
State and City Savings (see explanation below)	0
Total	$100 million

SOURCE: Alan P. Brownstein, "Reducing Beds: A Gain-Sharing Option," Health Perspectives, Vol. VI, No. 2 (1979)

RESOURCE DEVELOPMENT FUND (RDF). This fund would provide monies for resources that are needed, based on analysis of the health system and health status of the region. For example, these funds may be used to convert existing beds to other purposes (e.g., hospice, Health Related Facility, Skilled Nursing Facility). Expanding long-term care beds may further reduce the demand for acute care beds, as the state Office of Health Systems Management has documented (1978) 3400 patients are backlogged in acute care beds awaiting placement in Long-Term Care facilities. The RDF may also be used to expand free-standing primary and preventive care services in tandem with the New York State Primary Ambulatory Care Program. Here too,such a strategy would reduce the demand for hospital care, as experts have documented that the increase in supply of ambulatory care services reduces the demand for in-hospital care. However, these are just examples of how these funds might be used. It is suggested that the RDF gain sharing funds be aggregated by boroughs (county) for borough use and

administered and distributed by the state. Priorities for use of RDF funds should be based on needs identified by the HSA as recommended by the Boroughwide Coordinating Council of the HSA.

MODERNIZATION FUND. Hospitals in New York City alone need hundreds of millions of dollars of modernization. GSDF should support needed upgrading using the same method suggested for distribution of RDF funds. Although only 20 million dollars are provided in the hypothetical GSDF, one must remember that these costs are amortized over a number of years.

HOSPITAL CLOSURE INCENTIVE PROGRAM (HCIP). HCIP is an innovative New York State program that subsidizes the placement of hospital employees for a limited time period in other hospitals when beds and staffing are eliminated. This is a declining subsidy based on projected attrition at the new hospital. First attempts at implementing this program at Unity Hospital in Brooklyn were disappointing. More recently, however, HCIP was quite successful in securing employment for 400 health workers displaced from Flower Fifth Avenue Hospital in Manhattan. HCIP has the basic ingredients of a humane approach to hospital employee displacement. With earmarked GSDF funding, it may prove suitable for replication in other parts of the country. The hypothetical GSDF assumes that 1500 beds will result in 4,000 displacements (a high estimate) with 2500 employees participating in HCIP, 1,000 employees being retrained for other health jobs and the majority of the remainder seeking employment elsewhere.

RE-ENTRY TRAINING FUND. These funds would be used to retrain laid off hospital employees for health careers in services that are created by the RDF (see above). It is important to note that retraining would be quite difficult for many employees who have been displaced, especially when one considers the dissimilar nature and requirements of the new jobs.

DEBT SERVICE FULFILLMENT FUND. These funds would be used to, in effect, allow hospitals to mothball excess beds without penalty, by absorbing a portion of the cost of the debt service. Costs of the debt service include those associated with long-term loans (interest and principal) for purchase of hospital equipment, construction and renovation.

STATE & CITY SAVINGS. The state and city would not realize any savings during the first year. However, substantial savings would be realized for each succeeding year as the state's obligation for HCIP and the re-entry training fund is reduced each year.

The GSDF is offered for discussion purposes only. Clearly, one of the most serious flaws is that we are not really talking about "savings," but "reduced deficit expenditures" in this period of fiscal constraint. In assessing the merits of the above approach, we must consider the short-term costs and potential long-term human and fiscal benefits in reshaping the health system.

The goal is to eliminate needless expense of carrying extra resources in the most costly part of the health system--inpatient facilities--and to divert them to areas where we have visible gaps in service. More importantly, this kind of policy encourages efficient use of already built facilities, while upgrading the total system.

In sum, my view of the major directions for health planning and regulation in New York City and State is as follows:

1. Health planning is currently preoccupied with system shrinkage and cost containment concerned with correcting costly errors from the past. Health planning should be future oriented and concerned with shaping the system through redistribution of health resources

in a cost-effective fashion--in other words, the gain-sharing principle should be used to reduce shortages and fill gaps in need through reducing excess capacity.

2. Health regulation and financing should conform to health planning goals and objectives, rather than the other way around.
3. Inorder to effect systems change, health financing must be aggregated from public and private third parties and used to encourage desired ends.

The recent $14 million federal/state pilot project to bail-out Brooklyn Jewish (and other hospitals) and provide health care to Bedford Stuyvesant and Crown Heights is an example of the principle of gain sharing and the power of the aggregated health dollar. Although the details are not known at this time, the plan is to replace expensive inpatient hospital services with needed neighborhood primary care centers. In addition the project seeks to convert several hundred hospital beds into less expensive, long-term nursing beds.

A similar "gain-sharing type" development was reported in the November 20 New York Times. Dr. James Prevost, State Commissioner of Mental Health, said he would ask the Legislature to close two state psychiatric hospitals so that $30 million in state funds could be shifted from institutional to community programs for the mentally ill.

Returning to the Brooklyn Jewish Plan, we see a crisis oriented response. It is important that gain-sharing type remedies be developed in a more thoughtful, systemmatic way, not in a last-ditch, bail-out fashion. The HSA Preliminary Report shows that New York City hospitals are in bad fiscal shape. No less than 50 hospitals are operating in the red, of which, 15 are in

severe danger. This suggests that the Brooklyn Jewish situation is but the tip of the iceberg. Therefore, it is not too early to start thinking seriously about remedies to serve the needs of institutions and communities.

Perhaps gain sharing, or some variation of that which is proposed, offers a systemmatic method for addressing the needs of the 2.5 million New York City residents living in federally designated medically underserved areas and the 15 hospitals that are in serious fiscal trouble at this time.