P U B L I C H E A R I N G

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

To examine the operation and effectiveness of the State and local health planning system in New Jersey

December 4, 1986
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Rodney P. Frelinghuysen

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and Human Resources Committee

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Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

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November 7, 1986

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE ANNOUNCES A PUBLIC HEARING TO EXAMINE THE HEALTH PLANNING SYSTEM IN NEW JERSEY.

Thursday, December 4, 1986
Beginning at 10:30 A.M.
Room 341 of the State House Annex
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Thursday, December 4, 1986, beginning at 10:30 A.M., in Room 341 of the State House Annex, Trenton, New Jersey, for the purpose of examining the operation and effectiveness of the State and local health planning system in New Jersey.

Address any questions or requests to testify to David Price, Committee Aide (609-292-1646), State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit nine copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available to each witness.

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ASSEMBLYMAN HAROLD L. COLBURN (Chairman): Good morning. I am Assemblyman Harold Colburn. I am the Chairman of the Assembly Health and Human Resources Committee. The other people here today are Assemblyman Frelinghuysen; John Kohler, in the back, one of our staff people; Donna Bahnck, of our staff; and David Matos, who is representing the Democrats. There is another meeting scheduled for right now, which some of our members may be attending. David Price is also here, who is our nonpartisan staff member.

We scheduled this hearing this morning in response to requests from people who are interested in having health planning continued in New Jersey, in spite of the Federal cutbacks. The Committee's purpose today is to hear testimony to try to get an idea as to how it has been working, how it might work better, and what, if anything, should be continued and to what extent. Of course, we do have bills in the Committee on the subject; however, we are discussing them specifically today. If we had called the hearing for that purpose, then I think there would be some sort of a time schedule we would have to meet, and we might not have been able to meet it. I think it would have interfered with progress if we had called this to discuss these bills.

Sometimes we break for lunch during these hearings. I think we have 15 people who wish to testify today, so we are not going to break for lunch. We are going to just go through. So, you can react accordingly. Has everyone seen the list of people to testify, so you will know in about what order you are to be called?

The first person will be Charlotte Kitler, Deputy Commissioner from the New Jersey Department of Health. Good morning, Ms. Kitler.

D E P U T Y C O M M. C H A R L O T T E K I T L E R (speaking from audience): Good morning.

ASSEMBLYMAN COLBURN: Do you have someone with you?

DEPUTY COMMISSIONER KITLER: Yes, I do, Dr. Colburn. I have John Scioli with me. He is Health Policy, Planning, and Certificate of Need Director in the Department of Health.

ASSEMBLYMAN COLBURN: Thank you.

DEPUTY COMMISSIONER KITLER: We did bring several copies of our written testimony, with an addendum.

ASSEMBLYMAN COLBURN: That microphone doesn't amplify, I don't think, so people cannot hear you. That mike is just for recording purposes.

DEPUTY COMMISSIONER KITLER: Oh, all right. I will try to speak loudly then.

ASSEMBLYMAN COLBURN: Okay, we're all set.

DEPUTY COMMISSIONER KITLER: I am Charlotte Kitler, Deputy Commissioner of Health. As I said, with me today is Mr. John Scioli.

I want to thank the Committee for the opportunity to participate in this hearing that has been called on the operation and effectiveness of State and local planning in New Jersey. Like many other programs which are designed to promote important social benefits, Health Planning and Certificate of Need may be subject to review to determine whether, and how well, their public purposes have been served. We welcome this occasion to comment, because the Health Planning Program in New Jersey was born out of the responsibility of government to promote equitable access to health care services of high quality at reasonable and affordable costs. In our view, the program has been, and continues to be, an essential means for implementing those goals.

Since government is, and will remain, the ultimate payer of health care for certain populations, and since providers have, and will continue to expect government to assume an even greater share of the payments for care of the uninsured, we believe we have a central responsibility for promoting a system which will offer the best prospect --

however imperfect that prospect may be -- of providing necessary care in a manner which will use our limited resources efficiently and be responsive to public need. No system is perfect, and I don't think it is particularly constructive to engage in a broad philosophical debate about the merits of regulation versus competition. The challenge, really, is not to choose between those elements, but to choose the best elements of each, which can combine to achieve a health care system that will be responsible, affordable, efficient, and responsive to public need.

In responding to your invitation for comment on the effectiveness of the current system for health planning in New Jersey, I would like to identify some of the most significant achievements that our approach has had, and also compare New Jersey's experience to that of other states, which have limited their planning programs and have "deregulated," in whole or in part.

In terms of dollars saved, we estimate that since 1979, the New Jersey system has saved approximately $400 million in unnecessary capital costs, and $100 million in annual operating costs, through the implementation of the planning and certificate of need processes. These savings are large, and they have been realized by our planning system through the discouragement of costly and unnecessary service investments. These savings have benefited all payers of health care, including the Medicaid Program.

Of course, the argument can be advanced that if we do away with regulation altogether, we will have lower health care costs through a more competitive system. This argument, however, as it applies to health care, is not really borne out by the evidence, as I will discuss further when we mention the experience in other states. Nor is the argument for free competition fully sensitive to the range of reasons why we regulate -- to promote quality, to protect access, and, yes, of course, to contain costs.

In my testimony, I refer to some recent studies which show that costs in a highly competitive environment are higher among hospitals than in an environment where there are fewer hospitals. That is the Luft and Robinson study, which is attached -- appended to the testimony.

We also have a recent announcement in the papers today, reporting on a study by Equicorp (phonetic spelling), which says that New Jersey's hospital costs are the lowest in the nation. That is not due entirely to certificate of need, but it is due, in part, to what the newspapers are calling "some occasionally unpopular cost-cutting programs in New Jersey, including certificate of need.

While I would challenge any opponent of our system to produce hard evidence to show that our rate of increase in either the hospital, long-term care, or home health sectors has been higher than in less regulated states, when we examine the effectiveness of our system, we also have to look at the other goals of the health planning process. Have we effectively improved access to care? Have we protected and improved quality and protected patients against unnecessary risks?

Quality is a difficult and elusive term to define, although I believe no one could seriously argue that quality is lessened or impaired in New Jersey's health care facilities as compared to elsewhere in the nation. But, if we consider quality as protecting patients from unnecessary and unwarranted risks, then New Jersey's system of regionalizing specialized services, such as open-heart surgery, offers a good example of protecting good quality.

Our system requires every provider of open-heart services to perform at least 200 procedures per operating room per year. Not only does this approach result in more efficient use of costly services, but since mortality is a function of the number of procedures a surgical team does to maintain the team's proficiency, this approach protects patients from

unnecessary risks associated with having open-heart surgery done at sites where there is not sufficient volume to ensure adequate surgical skills.

The data shows that in surgical centers doing fewer than 200 procedures annually, the mortality rate may be eight times higher than in sites where our minimum requirement, 200, or more procedures are done annually. While the application of this rule means that not every hospital that wants to do open-heart surgery has been approved to do it, nevertheless our system has enabled our cardiac surgery programs to avoid inappropriately high death rates.

In addition to containing the growth in the costs of institutional health care and promoting the quality of such care, New Jersey's system for health planning has also promoted needed access to health care. We can define access in two ways: geographic and economic. In terms of economics in this State, we have integrated our planning, certificate of need, and rate review functions, and because of that, we can be very proud that our system has virtually eliminated financial barriers to access to inpatient hospital care. Also, the planning and certificate of need processes in New Jersey help to ensure economic access to other kinds of care -- like nursing homes and home health -- by requiring new providers or existing providers who want to expand to serve a certain percentage of patients who are unable to pay or who are Medicaid eligible.

Access to long-term care services by Medicaid patients and by patients discharged from State and county psychiatric hospitals pending placement in a long-term care facility, is a serious problem in every state in this nation. There simply is no competition for these populations. However, we require that all applicants who receive certificate of need approval for new or expanded long-term care facilities set aside 35% of their beds for Medicaid eligible patients. Of this 35%, 7% must be

set aside for those patients discharged from State and county psychiatric hospitals pending their placement in a long-term care facility.

When this requirement was implemented in 1983, the Medicaid waiting list for long-term care placement was over 3000 patients, and it was rising; it was going up. Since the time we implemented this requirement, the waiting list is now 2000, and it shows a declining trend, a significant decrease in just three years. Additionally, the requirement concerning discharged psychiatric patients has not only enabled the closure of costly, inappropriate physical plants at State psychiatric hospitals, but has also provided care for those persons in a more appropriate, and perhaps more humane environment.

While the Nursing Home Association opposed us at first, we belive the industry has now come to accept that franchises in our State come at the cost of the assumption of these social responsibilities, and we continue to see a great deal of interest in long-term care investment by the sheer volume of certificate of need applications that come to us. Our planning approach has become a model for the nation, and we continue to receive inquiries from other states that are struggling with high Medicaid costs resulting from unnecessarily long hospital stays because they cannot place Medicaid patients in long-term care facilities.

To promote adequate geographic access, many of our planning rules are waived where an applicant can provide hard evidence that the denial of an application will result in serious access problems by a medically underserved population. In addition, and here is where local input into the process is particularly important, to be effective, a planning process has to examine the acceptability of a proposed health care service or a new facility by the consumers who are going to use it. Our process gains valuable insight into the acceptability of

these services through the hearings provided at local planning agency meetings. It is through these mechanisms that consumers -- many hundreds of them -- have helped to shape the development of health resources in their communities. At both State and local levels, the planning process is governed by volunteer boards, which participate in shaping the regulations which are used to guide our certificate of need process.

I would suggest that in a regulated environment such as ours, it is precisely because of our successes in constraining the growth of unnecessary new health care services that we receive criticism. I doubt that you would hear often enough from providers who have had a positive experience with the system, from the hospital, for example, whose financial base is protected from unwarranted invasion by new providers, who might come in and drive utilization down and unit costs up. Interestingly enough, in other environments, Utah, for example, the proliferation of new services beyond market demand is leading providers to call for more regulation.

Utah, at the beginning of 1985, sunset its certificate of need law, and at that time proposals were announced to build 39 new health care facilities, including the addition of 596 hospital beds, in a state that was already over-bedded. These projects are adding some $39 million in new and unnecessary capital costs -- costs that are borne by all payers, including Medicaid. Even in this short period of time since 1985, the long-term care industry in Utah, concerned about rising costs and the unavailability of staff, has petitioned the state legislature to reimpose certificate of need.

We have also described in our written testimony the experiences in other states which have deregulated: Texas, Tennessee, and Arizona. These states have experienced growth in the number of beds, provider agencies, and growth in the number of costs. There is a great deal of uncertainty about where those states will go.

We believe that the New Jersey planning system -- local and State -- will enable us to avoid the problems in other states, where elimination of planning and certificate of need have led to major cost increases, potentially serious quality concerns about maintaining quality, and little or no consideration of access and acceptability.

While our system has saved substantial sums and assured quality and access, we do not presume that the system can be static. We realize that change is necessary. Thus, we are working with the Statewide Health Coordinating Council and the Coalition for Local Health Planning to determine ways to restructure the local planning system in light of diminishing funding. We are also working with the New Jersey Hospital Association to determine if there are specific outpatient services which can appropriately be subject to lessened planning and certificate of need requirements, and will do so where there is no evidence of potential negative impact on considerations of cost, quality, or access.

I can state quite confidently that the planning system in New Jersey has been remarkably successful. And, importantly, it is a system that relies, to a large extent, on volunteers. It is a system that provides the general community with a voice in the shaping of their health care system. That we have attracted so many volunteers to the process is, in itself, another measure of its success. We look forward to the continued participation of members of the community in a health planning system -- a system that strives to assure that we can develop affordable health care services that will meet their needs.

I thank you very much for allowing me the opportunity to present this testimony. If there are questions, or further information we may be able to provide to the Committee, we would be pleased to do so.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman. Good morning, Commissioner. I know we have a busy agenda, but would you be so kind as to provide some statistics relative to your comments on page 2? You said: "In dollars saved, we estimate that since 1979 the New Jersey system has saved approximately $400 million--" I would like to know how you determined that amount. Could you please share that, as well as the $100 million relative to operating costs -- whether that just represents the sum of all the applications that have been turned down which New Jersey hospitals and other institutions have submitted over the years? Could you provide that information? Thank you.

In addition, if you could provide, relative to your comments on open-heart surgery -- on page 4 of your written testimony-- I would like to know how many New Jerseyans continue to go out-of-state to get cardiac assistance, if that information could be made available. Additionally, on page 6, you made some comments relative to the discharging of psychiatric patients, under what we commonly refer to as "deinstitutionalization." You made reference to the fact that we passed a law -- either that, or there was an edict -- requiring that a certain percentage of beds be set aside for those psychiatric patients in institutions, when they apply for new beds. Could you provide for the Committee any statistics as to the number of deinstitutionalized individuals who might need care -- long-term care -- but who do not receive it under this present system? I would assume that those figures would be quite substantial.

Lastly, if the system works so well -- and, quite honestly, I have been part of the system, having served in county government prior to being in the Legislature as part of a review group under the aegis, at that time, of Joe Slavin, who is on the list of individuals to testify-- How many

unfilled, or vacant beds does New Jersey have? If, in fact, it has a reduced number, is that a result of the abolition of private pay contracts in August, 1985, or, as you point out in your comments, for other reasons? Could you comment on that lastly, and perhaps for the other questions, provide the information at another time?

DEPUTY COMMISSIONER KITLER: Yes. Assemblyman, are you talking about vacant hospital beds?

ASSEMBLYMAN FRELINGHUYSEN: Nursing homes.

DEPUTY COMMISSIONER KITLER: Nursing home beds.

ASSEMBLYMAN FRELINGHUYSEN: If you don't have the information, maybe you could provide it at a later time.

DEPUTY COMMISSIONER KITLER: The number of vacant nursing home beds we have, and your question relates to the abolition of the private pay requirement in August, through the (indiscernible) statute that was passed relating to Medicaid. All right. Those are statistics that we probably can pull out for you. So far as the Medicaid requirement is concerned, you said you didn't know what the requirement was. There is a statute that has been passed by the Legislature that requires providers in the Medicaid Program to maintain a certain number of them, but we go beyond that, as well, in our process, to impose the additional requirement for discharged psychiatric patients.

ASSEMBLYMAN FRELINGHUYSEN: I know that; I realize that. What I am wondering about is, how much more of a population is there out there that isn't served?

DEPUTY COMMISSIONER KITLER: That is not being served, indeed.

ASSEMBLYMAN FRELINGHUYSEN: Quite honestly, a lot of our institutions would take care of psychiatric patients, even if they weren't required to do so under this assignment program. I think that is important to note. If it is permissible, Mr. Chairman, through the kindness of the

Commissioner, if she could provide the information I have requested, we could append it to her statement for the record.

ASSEMBLYMAN COLBURN: Absolutely.

DEPUTY COMMISSIONER KITLER: We would be glad to check our records and those of other agencies, such as Human Services, and enlist their help in gathering appropriate data which we can supply to you at a later time.

ASSEMBLYMAN COLBURN: One of the things that struck me in a couple of places, I think first of all on page 4-- Maybe I am not reading this quite right, but it sounds as though if you do 200 procedures you do a good job, and if you do less, you do a bad job. To me, there would be other factors beside the number of procedures you do that would make you either good or bad. I would think that ought to read: "Since mortality is a function in part of the number of procedures--" It is not just the number you do. It is the training of the people, how good the team is, and how you select the cases, too, because if you select tough ones, maybe you can only do 50, and if you take the toughest ones, your mortality is going to be much worse.

So, this whole business of relating certificate of need and those regulations directly to outcome, kind of forgets some of the other factors that might be involved.

Then, over in-- Let's see, which report was this? Dave Price came up with something that spoke about getting rid of certificate of need in other states, and I think in Arizona there were other factors that would bear on why people constructed -- or asked to construct -- things. Decisions would involve the age of the population and, I suppose, economic factors. It is not only the certificate of need being terminated that gave rise to this big mushrooming. Of course, keeping the certificate of need in place could certainly put a stall on it, I know. To me, it is a more complex situation than to just say, "Well, you have it or you don't." I know

your testimony can't bring in everything, but I just thought I would like to mention that.

Now, a question I have had in my own county for many, many years-- We felt we had a shortage of nursing home beds in Burlington County for 10 or 15 years. We couldn't get people out of the hospitals into the nursing homes. My understanding was -- and I would like to be corrected if I am wrong about this -- that the State used places like the Masonic Home and other private homes that were run by religious or fraternal organizations as part of our allotment, when about 90% of the patients in those places -- or at least in the Masonic Home -- came from out of the county. So, our people couldn't get into nursing homes there. I know this has been remedied now, but it just seemed to me that the State took a -- I thought it took a very inflexible view of the statistics in my own county.

Do you know how that was figured out by the State, by any chance?

DEPUTY COMMISSIONER KITLER: I wonder if I could call on Mr. Scioli, who may be more familiar with that than I.

J O H N S C I O L I: Actually, I can only speak to the current policy, which excludes from the bed need calculation those homes that treat exclusive populations, such as religious groups, and where their reference -- their market reference -- extends beyond -- extends statewide.

ASSEMBLYMAN COLBURN: So, as it now stands--

MR. SCIOLI: Those homes are not counted into the bed need count.

ASSEMBLYMAN COLBURN: Uh-huh.

MR. SCIOLI: To be very honest, I don't know what the historical problem was. I could only conjecture that this policy was put into place to correct the problem you are addressing.

ASSEMBLYMAN COLBURN: This went on and on and on for just years and years. But, you see, the thing that bothers me

about it is that it just shows how long the government takes to correct something, when it is so obviously-- To me, it seemed so stupid that I couldn't believe it. I just want to be sure that I am saying this correctly, because I don't want to be accusing you unjustly. But that was my real feeling at the time. If the government behaves that way, it is questionable in my mind how much power it ought to be given.

MR. SCIOLI: The criteria which are used in making these determinations are whether or not the facility, in filing for an exclusion -- whether their bylaws limit them to a specific population -- a special interest population -- and does at least 50% of their client population come from outside of the HSA, which I think extends beyond the county area.

DEPUTY COMMISSIONER KITLER: The question is whether they are serving a truly restricted and limited population, and perhaps what took us so long -- we don't know the history, but we assume it took a while -- was looking at the matter and getting sufficient data to make sure that the institutions were serving people who came from the restricted groups not open to the general public, and would not draw patients as other nursing homes in the area would do.

ASSEMBLYMAN COLBURN: I wonder, could I ask you to try to find out for me what the policy was on nursing home allocations between 10 and 15 years ago, and what it is now? Please focus in on Burlington County, because I happen to know that place better than the rest. But, I would be interested in that.

I think that is probably all the questions. Thanks very much for coming.

DEPUTY COMMISSIONER KITLER: Thank you very much. We will provide the additional date to you.

ASSEMBLYMAN COLBURN: Ralph Dean, Chairman, Statewide Health Coordinating Council? Please come on up front.

R A L P H D E A N: Good morning, Dr. Colburn. Thank you for having us here. With me is Mr. Jim Pascuiti, who is the Chairman -- the recently appointed Chairman -- of the SHCC Committee on Government Relations. It is a recognition of our interest in taking a greater part in the affairs you have here and becoming better known to you as we go through things.

We very much appreciate the fact that you have held this public hearing and are giving us a forum for presenting our views on local health planning. Before I begin to present those views, let me make sure you know what the SHCC is. I am not sure that everyone does know. It is one of the best-kept secrets in the State. SHCC is the Statewide Health Coordinating Council, and it consists of 34 volunteers, none of whom receive remuneration for their efforts. They give varying amounts of time to review certificates of need and to participate in other planning activities, as an assist to the Department of Health and, we believe, to the citizens of the State. It consists of those 34 folks, all of whom were appointed by the Governor. Twenty of them come from the HSAs as you know them today; four from each of the five. It also consists of the Commissioner of Health and the Commissioner of Human Services, as well as one legislative seat which, to the best of my knowledge, has not been filled since Mr. Saxton sat in that seat a few years ago.

The SHCC serves as a funnel for certificate of need applications which flow through the process through the HSAs and eventually wind up on the desk of the Commissioner of Health. We bring to the equation a statewide perspective. The HSAs bring a more local perspective; SHCC brings that statewide perspective. In addition, we participate very actively in the development of a statewide health plan, and in implementing that plan through certificate of need and recommendation of regulations, in particular the regionalization of services, etc.

All of the members who serve on SHCC are very dedicated people. They have been there for many years. They are educated in health care. Many of them have sat there for five and six years. They are not ignorant about the issues that you present or the statistics you are concerned about. They feel they are a part of the solution and, in fact, not the problem. They believe that they have contributed to what we believe to be an orderly, cost-effective health delivery system in New Jersey. You will hear many statistics which I think support that, some of which you will be getting at a later date.

We are very proud of what has been done, especially the regionalization of services. You have heard the cardiac side, and I think there is some significance there. I won't go into that again. The cost issues-- New Jersey's cost, per admission, is $600 less than the national average. I think that is significant. Please don't give all of the credit to the planning process or certificate of need. I think that has to be shared with the medical staffs and hospital administrations and DRGs, and so on. But, it is a recognition that, in fact, it is a complex system, and planning and certificate of need are just one part of what has produced, we believe, some significant results. There is no question in my mind that the idle capacity issue that we face in New Jersey is less significant than it is in the rest of the country.

The occupancy rates in our hospitals are higher than they are in the rest of the country. We will range 60%-70%. The rest of the country, in many areas, is looking at occupancy rates of 40%, 35%, 50%, and so on. Idle capacity is a curse that faces every industry. The steel industry in this country has faced the idle capacity issue and is reeling from it. In New Jersey, we simply faced the future better, in my estimation, than many other states have faced that situation. We saw the future better through planning. We saw the growth of HMOs; we saw the growth of many factors that are providing

treatment facilities for patients other than in a hospital setting -- ambulatory care settings, and so on.

We are especially proud of the access side of things, also. We believe very, very strongly that through our efforts -- through the planning processes' efforts -- and through certificate of need, that we have, in fact, improved accessibility to nursing home services and hospital services for people who may not have received that care, had we not been there. We believe very strongly that New Jersey stands for a one-class medical care system, and we want to support that as strongly as we possibly can. I am not saying that folks don't receive care; I am saying that we improve accessibility to care. We sensitize the communities to the need to make sure that we have a one-class system, and we are going to continue to do that. This is not to say -- and I don't want to confuse anyone -- that folks in hospital settings don't receive more care if they have more money, or less care if they have less money. There are private duty nurses; there are other things you can have, and that is not what I mean by a two-class medical care system.

We have done a lot in that particular area, and we look forward to continuing our efforts. Our success in New Jersey, and I think the statistics you will be seeing from Charlotte, plus other speakers who follow me, will bear out the fact that it is a successful effort, and it is the result of hospitals and nursing homes, home health agencies, the government, business and payers alike, all participating in a very complex system that has produced a good system for the residents of the State of New Jersey. But, give a lot of credit to the financing mechanisms also. Certainly they have kept the costs' side down.

Ten years ago, I seriously doubt that I would have sat before you as a volunteer and said the same words I am saying to you today. I think 10 years ago, the planning system was a

child. It was crawling and it was creeping and it was walking; now it is running. We went through a very difficult period in our early years and I, for one, have come up through the ranks, so to speak, and have sat through a huge number of meetings, in which we argued about whether periods should go in the bylaws in particular places, or commas, or semicolons. Those days are gone. They passed several years ago. We are now a mature adult system that is producing some significant results, and which has the respect, we believe, of provider communities and consumer communities alike.

In those early days, it cost $5 million or $6 million-- I don't know the exact number, but it cost an awful lot of money to provide a planning system in the State of New Jersey. Today, it costs about $2 million to provide that planning system. About $1.6 million of it goes to the local element, and about $400,000 goes to the State. So, over the years, we have seen a significant reduction in cost and, in my estimation, a significant improvement in the efficiency of the system. We have seen some good changes, and we are going to see better changes in the future. The planning system, I believe, is supported by most, if not all, of the significant groups that will appear before you today, and I think that is testament to the fact that through battle, and conflict, and change, folks can learn to respect each other and work within a system for the betterment of the citizenry of the State of New Jersey.

Charlotte mentioned that the system isn't perfect, and I can sure back her up on that. The system ain't perfect and, quite frankly, I don't think it is ever going to be a perfect kind of a system. It is a public process. It is not private at all. The SHCC meetings are open to the public. The membership consists of a broad range of people. So, it's public. It is a political process, which I think by definition precludes it from being perfect. We are part of the American

system, and I think that on occasion there are going to be decisions made and directions plotted, where we will shake our heads and say, "I just don't understand how the dickens that can happen." We may wish it wasn't like that, but, in fact, that is part of the way of life we have chosen. It is an imperfect process. I am pleased if I see 80% to 90% of the things I deal with in this process being understandable and logical. Sometimes we get confused when logic is brought in, but not all the time, and 80% to 90% of the time I think the results are quality results that do reflect the statistics and the direction people want us to go in.

As taxpayers, I believe we get good value from the $2 million we spend on this present system in New Jersey. That is not a lot of money -- two million bucks. That is a small amount of money to justify, even if in Ms. Kitler's comments the $400 million is only $100 million, or the operating costs are only $25 million, instead of $100 million. Two million is certainly not a lot to pay to justify that kind of savings, in my estimation. And the $1.5 million that is called for in A-3022, I think, is a reflection of even greater efficiencies that are going to have to result in the future. We know they are going to come. SHCC is playing a very active part in making some further changes to streamline the CN process and the planning process in New Jersey, to be as certain as we can that every dollar that is spent for this process is spent in a respectful way to make sure that the hurdles that are placed before providers who come before it are not high, or not unreasonable, but that the results we bring for the citizens of New Jersey are, in fact, quality results. We want the local component to stay. We don't believe that health planning should be just a State-planning effort. It should involve people from the local community, because they do have a vested interest in their health, and they have grown over the years to want to share in it. Many of the people who participate now

are much more educated than they were 10 years ago. They were making decisions about things on which they had no knowledge. Today, they make fewer of those. They still make a few, but they don't make as many as they used to make.

I think the two-year sunset provision of the bill you will be looking at in the future provides us the time to look at the national experiences related to what is going on with CN and planning in different states, and to come up with a model for New Jersey that, in fact, represents what is in our best interest. It is not an unreasonable time. The $1 million, or $1.5 million -- whatever the total winds up being -- is not an unreasonable amount of money, and I think it is certainly in all of our best interests to keep that system in place, with its faults, recognizing that SHCC will work with the Department of Health, the Legislature, and anyone else we can find to work with, to make sure that in two years, New Jersey will wind up with what it should wind up with. We believe there is a tremendous amount of opportunity to do innovative things in New Jersey in the planning area. You could find, in the City of Camden, in one building, five agencies spending money on health, none of whom have a coordinated effort. I am not sure but what there aren't ways to improve and become more efficient with the taxpayers' money we are talking about, providing more value for the dollars that we put into it. We have that as an interest and a goal.

I do thank you very much for the opportunity to share these words with you and, of course, stand ready to answer any questions you may have.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes. Good morning.

MR. DEAN: Good morning.

ASSEMBLYMAN FRELINGHUYSEN: With the demise of the Federal program, what, in real terms, does that mean to you? I know you made reference to some proposed legislation, but with the passage--

MR. DEAN: Do you mean--

ASSEMBLYMAN FRELINGHUYSEN: Yes, the first of October, and the end of the Federal program. Where does that really put us, in terms of finances and your operation?

MR. DEAN: As far as the planning system in New Jersey goes, the Department of Health has provided temporary funding, I believe to the tune of about $270,000, which will carry the local planning elements through the end of February. They continue to function with much reduced staffs, providing certificate of need review for the SHCC, but not doing many of the things they used to do before the demise of the Federal planning effort.

We look forward to the passage of A-3022, to provide us with a mechanism to put some money back into that local planning process, so it can continue for the next two years. As it relates to SHCC and the Department of Health, there really is no change. Our money-- SHCC actually doesn't cost a whole bunch, because we are basically volunteers who participate in it. There is one staff person related to it. Most of the cost is in the Department of Health, and I think that comes through the budget process somehow. I have not seen an effect of the loss of Federal funding. There very well may be one, but I have not seen it at this point in time.

What it does do for my personal time is, it provides other opportunities to spend time to find ways to keep things in place, and we accept that as a challenge. I have no vested interest in the loss of the SHCC or the planning process myself, except pride.

ASSEMBLYMAN COLBURN: Is there any need to look over the kinds of things that health planning requires a certificate of need for? Are all projects that have been subjected to that appropriately reviewed under certificate of need, do you think?

MR. DEAN: Given that it is a evolutionary process, I would suggest that there is probably room for a further look at

it. We looked at it last year. We had a group that changed the kind of things that we reviewed significantly. We increased the threshold, both at which a project came through, and below which it didn't come through. We provided more of what are called "administrative reviews," which permits an applicant to not go through the local planning process in the SHCC, but to go directly to the Department of Health; items such as significant computer systems and major telephone systems. Items like that that cost a great deal of money, but which are really quite necessary, and so on, do not go through the process at all.

We are now looking at other items that should not be included in that process. We want to make sure that we review projects that impact on access. We want to review projects that have major cost elements to them, such as construction, new technology, or those things that impact on regionalized services, for the quality reasons that Ms. Kitler talked about before.

To answer your question, though, very briefly, there are things that we need to look at. It is evolutionary in nature. As the world changes around us, we will respond to those, to some extent. We have done that over the years, and continue to do that.

ASSEMBLYMAN COLBURN: Do you have any thoughts about things like the private transportation systems for patients? I have had contact, over a number of years, with a fellow who runs one of these-- They look like -- they are ambulances, I guess, and they have to have a certain level of training of people and availability. I thought he told me that he spent quite a few thousand dollars getting this service through the certificate of need process, which went on, oh gosh, more than 10 years ago. I always wondered whether that kind of thing needed to go through the certificate of need.

MR. DEAN: Well, on the surface, I would agree with you. It probably shouldn't go through the CN process. It does not impact directly on the kinds of things we want to talk about. I haven't seen one of those go through the process in many years, so whether they are supposed to, and they now go around the process I am responsible for, I am not sure. I don't think they need a CN any more.

J A M E S P A S C U I T I: I think they go through an administrative review.

MR. DEAN: Oh, they go through an administrative review. We don't see them, so it should be a much quicker, easier process.

ASSEMBLYMAN COLBURN: But they used to go through the whole thing, didn't they?

MR. PASCUITI: I am not sure about the past, but now I believe they go through the administrative review process just to eliminate the problem you are addressing.

ASSEMBLYMAN COLBURN: Okay.

MR. PASCUITI: This is an example of some of the steps we have taken to eliminate some unnecessary review on the SHCC level.

ASSEMBLYMAN COLBURN: Should our health planning process have yielded fewer hospital beds over the last 15 years?

MR. DEAN: I guess, being a Monday morning quarterback--

ASSEMBLYMAN COLBURN: I mean, should we have come closer to what we now think we need, you know, with all this process, or shouldn't we? Or, what happened?

MR. DEAN: I wish we had but, quite frankly, I think we did a lot better than other states did. I think we have done as well as we could, given the environment we were in. We wish it had been better, but it is as good as we could do. I don't think any other system would have produced better results. In other words, if the local SHAs or the SHCC had not

been present, and it had been left to the marketplace, or left to the Department of Health, I don't think you would see fewer hospital beds in New Jersey than you presently have. So, I think we did the best we could, and the results show that we did better than most.

ASSEMBLYMAN COLBURN: Is there any way that that could be improved, that you could think of right offhand?

MR. DEAN: Yeah. I think our planning process needs to be much more pro-active, and actually do more planning for what is happening in advance, rather than being a reactive system. We have tended, over the years, to be a reactive system. When a lithotritter presented itself before us, we dealt with how many there should be and where they should be, rather than six months in advance of that knowing the lithotritter was coming, and being a little bit more prepared for it. I don't think we read the impact of HMOs and DRGs to the extent we should have, and that is a fault on our part. We needed to spend more time at that. I hope over the next few years we can become better at looking into the future and dealing with more Futurists on the impact of changes in financial regulations, changes in delivery models, and what kind of an effect it will have on our own delivery system.

We haven't done as good a job as we would like to do in that area, but we do have hopes to do better. We are talking more pro-actively about that than we have in the past.

ASSEMBLYMAN COLBURN: I think you referred to the level of expertise of the people in the planning system. I think you indicated that that has improved a lot. How has that improved, just by experience, or by more education, or what?

MR. DEAN: It is just the years it has taken to mature consumers and providers alike to the issues that come before them. Ten years ago, they were just new to it. They didn't know the words. It was like going to the Houston Space Center and listening to them talk about a space shot. It would

probably boggle my mind, as well as everyone else's in this room. Well, that same phenomenon, I think, happens when you come into the health arena as a consumer, because the providers' words are very specific, and they are very technical in nature. It takes a while to learn what impact a reimbursement system has on the funding of a capital project for a hospital or a nursing home, and how they are reimbursed. It takes several years. That learning process has occurred through trial and error, to some extent. We have improved their body of knowledge through educational sessions held periodically at the local level, or at the State level, on subjects that are of interest to keep them up to date. I think it is just through that on-the-job kind of situation that they have gotten better about it.

ASSEMBLYMAN COLBURN: Thanks very much.

MR. DEAN: Yes, sir.

ASSEMBLYMAN COLBURN: Mr. Joseph Slavin, Vice President for Planning, New Jersey Hospital Association? Good morning.

J O S E P H S L A V I N: Thank you for the opportunity. I would like to just keep my remarks very brief on a few key issues, and then submit some written material with data at a later time, if that is agreeable.

ASSEMBLYMAN COLBURN: That's fine.

MR. SLAVIN: I think we are here to discuss the effectiveness of health planning in New Jersey, and I would like to focus on that, and I guess allude to some of the proposed legislation. We could sit-- I think you will hear both sides today, with all the pluses about how much we have saved, and maybe some minuses about how much we have not saved. I suspect there will be some opinions on both sides.

On balance, I think it has been effective. Why do I say that? I think we have to go back to the preamble of the State law -- I think that is what we have to focus on -- which

Charlotte Kitler referred to in her remarks about a cost-effective system in New Jersey. The Federal part of health planning has been addressed by Congress and the Executive Branch. They abolished health planning at the Federal level. They believe that another mechanism, namely the free market forces, should prevail. They withdrew complete funding, and also, I understand, took the Federal Health Planning Law off the books, so there is no way of getting even appropriations back in at a later date.

I would like to address just a brief history of it. We are not here to be educated on that term, but I think it is important so we don't repeat some of the mistakes of the past. In the 1960s, the voluntary health planning effort started in New Jersey. This was an entirely voluntary effort, backed by some business and some interest. It was a statewide agency. The Health Department put some money into it. Blue Cross, Prudential, and people like that also contributed. And that was really the genesis -- the beginnings -- of health planning in New Jersey just to review hospital projects. This was prior to the Certificate of Need Law, which came in 1971.

In the 1970s -- the late '60s and the early '70s -- the Federal law came along establishing comprehensive health planning agencies, and later on the HSAs. In the 1970s -- and we alluded to this once before at a meeting about the great society programs-- I think there was a different focus at that time. It was more on who was participating in health planning, rather than what was being done. There was an awful lot of time spent in those days trying to find who should participate in the boards, consumer involvement, and there were even quota systems set up which absolutely defied logic. I would hate to see those kinds of mistakes made again. I think too much time was spent on the structure, rather than on the process and trying to get something done.

In was in the early '70s when the Federal government enacted Section 1122, which was really a Federal Certificate of Need Law. Every state was required to have a State Certificate of Need Program. New Jersey had one in place at that time.

I mentioned about the Federal government. Now, in the '80s, with HSAs, the Federal government has withdrawn from the program. One of the problems the Federal government had was that there was no basis for evaluation. Health planning was all things to all people. And when it came around to saying, "Well, what did they accomplish?" there was no way of measuring that. I think the State law is the keynote here. We should look at that preamble. Do we have a cost-effective system? Do we have access to the public? -- etc.

One of the problems in health planning in New Jersey has been that the State government has always had a free ride. I mentioned there was a voluntary agency in the '60s. When the Federal government started participating and started funding these local planning agencies, the State was getting a free ride, because they were reviewing State-mandated Certificate of Need Law, using the Federal allocations. So, there was no need for the State to put any money into it. I think if the State, over the years, had recognized its responsibilities and maybe started participating in the funding, we wouldn't be here today. That is no reflection on Commissioner Coye, who has recognized the problem and addressed it, and has provided some funding, at least until February -- until we get some legislation.

From the perspective of the Hospital Association, I would just like to raise some concerns which I think ought to be focused on in any new legislation that is being proposed. Local health planning-- We have heard that over and over today. I think it has been the foundation for health planning in New Jersey since the '60s, and it should be a very important principle in the new legislation.

There are two reasons why hospitals feel this way: One, they like to test the waters locally, and if need be, get community support at the local level for their particular projects. That is very important. They don't want to read or find out that a State agency somewhere in Trenton -- and when you are living in Cape May or Bergen County or Sussex, it is a pretty good distance mentally and physically-- They would be somewhat concerned about finding out that a State agency had reviewed a project for their particular area -- or are reviewing it -- or, in the worst possible case, has approved a project, for which the local people had no input. I think that is a very key principle in any new legislation.

Streamlining was referred to earlier. The SHCC and the Department have made great strides. A lot of things which used to be reviewed are now either not reviewed at all, or are done administratively by the Department. There remains some work to be done in that area. Higher thresholds, I think, would be important. Currently, the State is reviewing projects from 12 hospitals, totaling close to a half a billion dollars -- $500 million. These are the big projects, and I think this was the purpose of the Certificate of Need Law when it was enacted in 1971, and not to be looking at small x-ray equipment that had to be replaced. They were looking at the big picture.

In streamlining, I think the important part is the review process. In some cases, the local applicant -- the local hospital or other health facility -- has two or three reviews at a local level. There is the county, there is a review committee, and then the local board, and then it comes up to SHCC, and there are another two layers of review there. There are instances where hospitals have gone through five and six reviews, and this time have to appear before a panel, explain their project, etc. We think that could be streamlined, and we certainly hope it will be.

Another involvement is the public involvement. There is no question at the local level that the public ought to be involved. I hope we don't get bogged down in an inordinate amount of time trying to decide who the public is -- who is a consumer and who is not a consumer.

One of the other concerns is funding for health planning. I think a basic principle that we are addressing is that the hospital industry ought to pay its fair share. However, we are concerned about one thing. It seems that the Department is expanding or continuing the role as presently existing for the HSAs of doing a lot of things other than reviewing certificates of need. I am not saying they shouldn't be done -- epidemiological studies, public health studies, etc. That's fine, but I don't know if one sector, namely the hospital industry, should pay for the total health planning system. Maybe the time has come for the Department and State government to address that issue and come up with some proposed appropriations.

On the basis of evaluation -- which, again, I allude to as being the purpose of this hearing-- On the basis of local input, I think the industry is satisfied that there has been local input into the planning process. Albeit sometimes it was cumbersome, etc., the Department has made some attempts -- successfully in the last year -- at streamlining the system, getting higher thresholds. We think there is a lot more work to be done in that area.

Cost-effectiveness: I think, by all measures -- again alluding to the preamble to the State Certificate of Need law-- I could cite page after page of how New Jersey stacks up against the rest of the country in terms of cost-effectiveness of the hospital delivery system. Just to point out a few facts from the other testimony alluding to hospital beds-- This is a dilemma that we never get out of -- the Hospital Association. There are fewer hospital beds today than there were in 1970.

We keep hearing -- and again I will supply these exact numbers to you, from State data-- The problem we keep hearing about is the idle capacity -- the unused beds. How did that come about? It came about because of shorter lengths of stay. Just to cite a few examples, one of the issues that was brought up over the years was the obstetrical beds. There is low utilization, etc. Fewer hospitals today are delivering. I think there are about 15 hospitals that have closed their obstetrical units since about 1975. Women used to go and stay four to five days for a delivery. They now stay two days, and in some cases less than two days -- one point something or other. Those beds were built back in the early '70s. The 40-bed obstetrical unit is not needed now. It is not staffed, but it is on the license. So, when you hear about excess capacity, it is really not, in my opinion, as a result of over-construction -- over building -- as much as it is a contraction of utilization. Should it be addressed? Obviously. Closures, mergers, affiliations are all directions that the Association is addressing. We have a joint committee with the Commissioner of Health addressing those kinds of issues.

Again, looking at utilization, I think we stack up across the country, if you look at various indices, which I will supply you -- so many beds per thousand population. The only construction of new beds in New Jersey -- in my experience dating back to 1968 -- is in the New Jersey shore area. You had hospitals in Monmouth and Ocean Counties, where the retirement communities were growing during the '70s. That is basically the only place where there has been major expansion of hospital facilities. There are a few places around the State where you may have 50 beds added here or there.

The under-utilization is in your urban areas, namely in Essex County. That has been clearly identified. Everyone understands that. There has been a shift in population. There

has been a shift in the practice patterns. Cataract surgery used to be a four- or five-day length stay; now it is an outpatient procedure. They are just examples. I could name several others.

One other way, I think, of measuring the effectiveness also of health planning is in the specialized regionalized services. Early on, the State made an effort on that in terms of cardiac surgery, renal dialysis, perinatal centers, etc. There has never been a criticism in New Jersey of having too many of those. Even with the CAT scanners, when that came out, it was a careful review of all projects. On balance, I think every hospital eventually that needed a CAT scanner has a CAT scanner. There may have been a little bit of a difficulty in the beginning. Some wanted it sooner than others. It did promote an orderly development, I honestly believe.

Access -- again alluded to by several previous speakers-- That doesn't seem to be a problem in New Jersey.

There was one other question, and I will steal Charlotte's thunder. Assemblyman Frelinghuysen asked a question about open-heart surgery, I believe. I have no scientific basis for it, other than just some quick figuring that we did, and we did check it with several cardiac surgeons in the State. The figure of about 1500 patients per year going out-of-state seems to be a reasonable guess. That is the best we could come up with.

So, on balance, we think the health planning system in New Jersey should be very carefully looked at. This, I understand, would be a sunset type of provision, where we would have two years to really study the system. I think it is important that everyone understands that local health planning does not necessarily equate to keeping the HSAs in their present configuration, doing the same kinds of things they are doing today. I think it is important to get that out in the open -- up-front.

Thank you for your time. I would be happy to answer any questions.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes. Mr. Slavin, it is good to hear from you. My apologies for being out of the room during part of your testimony.

What about the old chestnut that relates to something which the Hospital Association is interested in -- the whole business of certificate of need; hospitals going through a long and expensive process, and getting a certificate of need, and then a group -- a syndicate -- with all due respect to the Chair -- of physicians, or others, not having to apply for a certificate of need? Where do we stand? Is this something that ought to be addressed in any contemplated legislation?

MR. SLAVIN: I am not sure if it would be legislation or the regulations that follow.

ASSEMBLYMAN FRELINGHUYSEN: Regulations.

MR. SLAVIN: But, yeah, we like to think that there should be a level playing field. We cite many examples of instances where a hospital cannot -- or has to go through the certificate of need -- I think MRI was the latest one, the lithotritters, etc. -- and if my figures are correct, I think it is a very good example. The MRI-- There is one hospital which is operational -- Englewood. There were four approved by the State on a demonstration basis. They felt there should not be a proliferation of these; let's start off slowly. There are probably 10 or 12 privately held corporations which are operating MRIs outside of their certificate of need program. It is because it comes under the definition of the private practice of medicine. When the law was enacted -- I feel like I am going back too far -- I remember the debate very, very carefully at that time. The concern was that the Medical Society did not want the Health Department and its health planning mechanism intruding into their private practice, which

everyone agreed to. Thus, the law says, "Except the private practice of medicine."

At that time, there were no such things as MRIs, CAT scanners, etc., so the court cases -- which I don't have to go into -- very clearly said, "Well, this is the private practice of medicine." The law, in 1971, didn't say, "except for this or this or this." It said: "Private practice is excluded. If you want to change it, go change the law." And that is where we are.

The Department and the Association work together. About two years ago, there was a committee appointed by the Health Commissioner regarding that issue, and legislation was proposed which would bring in some of these groups which are presently excluded because of the private practice. The legislation was not successful, and probably would not be; thus, the Association is moving into the position of saying, "To make this playing field level, everybody has to live by the same regulations. Let's open it up for the hospitals. Let's make it equal."

ASSEMBLYMAN FRELINGHUYSEN: One sort of general question: Mr. Dean made reference to the fact that it is a political system. Having served, at one time, under your tutelage, I found it extremely frustrating and exasperating to be party to a review situation where, at that time, it was a minor competition compared to what we have today. I would be interested, at a future time, if the Hospital Association, or any others in the audience who would care to, would really put down their thoughts as to, when we address legislation, while we can take care of quality issues and access, whether we can put aside the historical political preference that is drawn to certain institutions, even though cases have been shown that other institutions might be providing better service and quality. I think you know what I am driving at.

I think that people have been afraid to break the traditional political pattern of support for certain institutions in this State, even though they know full well that other institutions could provide better quality, and perhaps even access. I don't think I need to say more than that. It is in pretty general terms. I don't even ask you to comment on it, but I think it is something that is important.

ASSEMBLYMAN COLBURN: It sounds like we could spend a week or two on that one, doesn't it? Let's see, I was going to ask you something. What was it here? Oh, when a hospital-- The OB business dropped off so much -- obstetrics. Even without the length of stay, the number of people having babies seems to have diminished for quite some time. If a hospital wanted to change its use of beds, did it have to get a certificate of need for that change?

MR. SLAVIN: Yes, it still does to close a service.

ASSEMBLYMAN COLBURN: To close, as well as to open.

MR. SLAVIN: An existing service, yes. There are pluses and minuses to that, Doctor. I lived through some of the closures up in the Newark area, where the hospital proved conclusively on one side that it was cost-effective to close their obstetrical unit, that the physicians all had privileges at nearby hospitals, etc., and the community coming in and saying, "But that is our hospital. We don't want it closed." This is where the political process comes in.

ASSEMBLYMAN COLBURN: Is there a need for any greater flexibility about the use of beds? I seem to recall-- I am not a hospital-based physician, I've got to tell you. You all know it anyhow. Dermatologists, thank the Lord, don't really need hospitals too much. But, I seem to recall an obstetrical unit down in our direction that was not being-- It may have been OB/GYN, but I think the State would not let them use extra beds because they were afraid of contamination of one type of patient to another; you know, changing the use of the beds. Is that--

MR. SLAVIN: That is a licensing issue. I don't like to use the term, but they always talk about clean and dirty GYN. I think there is a better way of explaining it.

ASSEMBLYMAN COLBURN: Right.

MR. SLAVIN: But it is a mixing of patients who may have infections, or whatever. It is really a licensing function within the Health Department.

ASSEMBLYMAN COLBURN: Okay.

MR. SLAVIN: Incidentally, I did check one number. Again, the over-supply of obstetrical beds-- At one time, there were 125,000 deliveries in the State of New Jersey -- probably in the late '60s, early '70s. There are about 95,000 now. So, the hospitals were built for one reason, and I suspect all the projections they were using-- There were going to be 200,000 deliveries a year, and we are down to 95,000.

ASSEMBLYMAN COLBURN: I guess that is about all. You would favor then, perhaps, dropping the certificate of need for some of the outpatient things that hospitals would like to do?

MR. SLAVIN: Yes. We are definitely moving in that direction. When the legislation arrives, we will have specific proposals on that.

ASSEMBLYMAN COLBURN: Suggestions along that line. Okay, thanks a lot.

Mr. Albert Wagner, I guess. Is it Mr. or Dr.? I'm hoping for a doctor sooner or later here. (indiscernible response from audience) I feel a little outnumbered, I must say. (laughter) It's time we all laughed at something, don't you think? Good morning.

A L B E R T C. W A G N E R: It is good to be here, Doctor, to have this opportunity to say a little something about local health planning. I appear on behalf of the Coalition for Local Health Planning, and speak specifically from the volunteer point of view.

The Coalition is a group of consumers who have joined with the executive officers of the health systems agencies of the State to see that local health planning is streamlined -- we have heard that a number of times today -- brought up to date, and continued in operation in New Jersey.

Local health planning in New Jersey is a volunteer effort, with a small paid staff, dedicated to the mission of assuring that the health care system in the State is responsive to the need as defined in the local community.

The volunteers are both providers and consumers. Providers include physicians, hospital and nursing home administrators, nurses, technicians, home health care specialists, public health officers, and others representing just about every component of the health care field. The consumers come from all walks of life: businessmen, executives, lawyers, accountants, county officials, representatives of civic bodies, social agencies, minority groups, the churches, senior citizen organizations, as well as the informed homemaker and mother.

They come together with this threefold aim: 1) To improve the general, overall health of New Jersey residents; 2) to improve access to existing health care services for all persons requiring care; and 3) to find innovative ways to provide quality health care at a price society and the local community can afford to pay.

One of the important roles local health planning plays is its participation in the Certificate of Need Program mandated by the State. It is responsible, as you know, for making recommendations to the State Health Coordinating Council and to the Commissioner of Health on applications to establish new health services, such as hospitals and nursing homes, home health and other community services; applications to add beds, equipment, and other services in such facilities and agencies, as well as applications to discontinue certain services.

The local health planning agency, after a thorough-going analysis of applications, makes these determinations:

Is there real need in the local community for the project as proposed? If so, does the service as proposed meet the need?

Is the cost reasonable? Is there a more effective or more efficient, less costly way to meet the need in this particular community?

Is the applicant fiscally responsible? Is the method of funding financially feasible? Is there a less costly means of financing available?

When the answers to these questions are determined, recommendations for approval or disapproval are made to the SHCC and to the Commissioner, with specific stated reasons for such approval or disapproval. Local health planning provides in this function informed local input, vital input from the local community, into the orderly development and organization of the health care system.

Important as the certificate of need function is, the local health planning council does much more. Perhaps the most significant function it performs is the study it makes in the local geographic region of major health needs, identifying community by community essential health services not available or not readily accessible to persons who need them. And of at least equal importance is the identification, through this process, of serious uneconomic overlapping of services. These unmet needs and overlapping services then become goals for action and remedy at the local level, as well as being recommended for inclusion in the State Health Plan.

Closely related to this is the function local health planning has, to examine and to monitor the distribution of health care resources within the community and to influence and attain equitable allocation of available funding. We speak

here of the impact on the local community of reimbursement and health policy decisions made at both State and national levels. It is important that needy persons not fall between the cracks, and that needless funding or over-funding be redirected to other services where need is great. Here again local health planning provides a most valuable community service. It is an area in which there are few, perhaps no other, body watchdogging these potentially serious problems.

Local health planning provides also a unique opportunity and forum for discussion at the local level of disparate views on health care problems. It brings together providers of health care, payers, and consumers to focus on critical health care issues. In doing so, it increases awareness and understanding of the issues -- issues oftentimes which competition and regulation do not, or cannot, resolve. It fosters consensus, encouraging action to solve or ameliorate the problems at issue. Such consensus and plan of action, when reached, redound obviously to benefit both the industry and the consumer.

The State Department of Health, in its State Health Plan, establishes State health priorities. These are the public health and the health care areas which, from a statewide point of view, are seen as of greatest need and concern to the overall good health of the State's population. Goals and actions to attack these problems are outlined also in the plan, but their implementation lies in substantial measure with the local community. The local health planning council is a significant player here, and through a variety of mechanisms and strategies, including use of local mass media, special reports, public conferences, group and one-on-one discussions, moves these priorities forward. The council with its intimate knowledge of the local community through its many informed volunteer members, is in a unique position to identify, organize, and influence local community leaders, whose

participation and cooperation are necessary to getting things done. The prime movers at the local level can be "reached" by council members; sometimes they are themselves members of the council.

Finally, among the major concerns of local health planning is that of education. The local health planning councils have proved their value in promoting wellness and prevention programs generally in the State. They organize and sponsor major health care conferences, seminars, and workshops. They develop and offer health education programs and printed materials, to stimulate interest in the health needs of the community and ways to meet these needs, including such public health concerns as drug abuse and environmental protection. Being close to the local community, they can tailor and focus these activities and materials to have maximum impact in meeting specific local goals.

In concluding, I would like, as a representative of the Coalition, to emphasize that the State of New Jersey must not lose this dedicated interest and organization of informed volunteers, both lay and professional, which have developed in New Jersey over the years. They have demonstrated that they have the knowledge, experience, and ability to further guide the positive development of the health care system. We must support local citizen participation and build upon it to the end that all citizens of New Jersey are assured of ready access to quality health care at a price each can afford to pay.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I think you would agree with me, Mr. Chairman, that that was a most reasonable and valuable statement. I don't think that either of us could forget, of course, both you and the others who have volunteered, and how much we appreciate the work you have done. From what I can gather, you have been at this for quite a long time, as I remember.

MR. WAGNER: There is a lot more to be done.

ASSEMBLYMAN FRELINGHUYSEN: Yes, a lot more to be done. I just can't resist asking this question: In your time working with your Council in the central part of the State, how often, in your work, have your recommendations to the SHCC and to the Department of Health been overridden and, shall we say, not exactly given the consideration that you would have liked them to be given?

MR. WAGNER: Well, if you look at that over time, there were quite a few of those in the early days. They have diminished very much over the last few years. We are one of the councils which does not hesitate to take advantage of the opportunities for us to appeal, including appeals, not quite to the courts, but otherwise, and we have had some of the decisions of the State reversed. I don't think it is a serious problem at this point.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

ASSEMBLYMAN COLBURN: Can you tell me-- The next speaker-- It says here that he represents the Coalition for Local Health Planning. That is the same organization you are with, too, isn't it?

MR. WAGNER: Yes, but he will do it in terms of the professional. My approach was that of a volunteer.

ASSEMBLYMAN COLBURN: What makes up the Coalition?

MR. WAGNER: The Coalition is a group of volunteers -- citizens from all over the State, every region of the State included -- who have banded together with the executive directors of the HSAs to the aims that we have indicated here.

ASSEMBLYMAN COLBURN: Do they have a central office?

MR. WAGNER: Yes, we have a central office in Princeton.

ASSEMBLYMAN COLBURN: How is that funded, from each HSA contributing to it, or--

MR. WAGNER: No, there are no contributions of any kind. It is funded by the volunteers -- their efforts. There are no dollars involved.

ASSEMBLYMAN FRELINGHUYSEN: That's a miracle.

ASSEMBLYMAN COLBURN: That's pretty good. Is there an office they have, or is it someone's home? How does that--

MR. WAGNER: No, we work out of the office of the Central Jersey Health Planning Council.

ASSEMBLYMAN COLBURN: Okay. You use an existing facility.

MR. WAGNER: That's right.

ASSEMBLYMAN COLBURN: Okay, sir. Thanks very much. Mr. Peloquin?

E D W A R D J. P E L O Q U I N: Chairman Colburn, Assemblyman Frelinghuysen: I want to preface my formal presentation by saying a couple of things. Since 1974, when I came to the State of New Jersey, and the Health Planning Act had already been established prior to my time here -- I became involved in working in this field in Central Jersey for that period of time, some 12 years now -- I have always felt that there should be an opportunity for the Legislature to start taking a very good look at the health planning system as a whole. I will say that this is the first time in 12 years that we have had a hearing of this type on the whole subject matter. This is long overdue, but on the other hand, I think the timing is very, very proper, and I hope that from this hearing we can move on into resolving the crisis we have in front of us, which I will not talk about today. I will reserve that for another time.

What I would like to do this morning is talk to you about something that I refer to as "One of the world's best kept secrets" -- Ralph Dean either stole my thunder, or I borrowed it from him -- concerning the SHCC. That is one of local health planning's other roles.

For the vast majority of the public, State officials, and legislators, local health planning becomes visible when it takes a position relative to a certificate of need application. Whether that position be for or against any given proposal, it still generates interest and attention to this very tangible activity.

I am here today to tell the other side of the story -- the side that constitutes the non-regulatory local health planning work. I call it the community service side. First, and perhaps foremost, is the technical information and assistance service. Each local health planning organization maintains an ongoing, dynamic, up-to-date inventory of resources and a data base regarding the need and utilization of health services and unqiue factors affecting the delivery of health care at the levels below the county. This activity takes place day in and day out, and at least once a month becomes visible when it is applied to certificate of need applications. However, on the other days of the month, this information is applied in a variety of ways which are not so visible. Every local health planning agency will tell you about the numerous letters and telephone calls received everyday from local providers of health care, national consultants, community agencies and organizations, State officials, and, more importantly, in the past year, in our area with the new competitive environment, from physicians, asking questions about the health care delivery system in a particular area; questions such as: What do you know about--? Do you think there will be--? Does it appear that--? How many are there? Where are they located? What kind of local issues will be a problem? Is there a need for--? What does the situation look like in five years?

Inquiries also come from the media, as they do feature stories or background papers on health issues for public education. Local health planning organizations are an

invaluable source of information to either place into context a particular problem, focus attention on the appropriate issues, or direct persons to specific expertise and the right source in the government and private sector. However, because this is a public service, available to all who seek it, acknowledgement about the source of information is not required or expected. From time to time, we do see a reference in a proposed certificate of need application or private publication or report. But seldom, other than in the media, does this service become visible at the State level.

A second activity is identification of local problems and stimulation of solutions to be accomplished by providers, government, or private agencies -- the solutions to be accomplished, in effect, by others.

A brief history based on my experience can provide a better illustration of the point. I am sure it could be replicated by the other local health planning agencies in New Jersey. In 1977, by meeting and consulting with 180 county advisory committee members, the Central Jersey Health Planning Council, Inc. determined that the number one health care problem facing the Central Jersey region at that time was not unnecessary health care facility expansion or health care costs per se, but nursing home bed location, distribution, and availability. From the grass roots, this emerged as the highest priority for planning activities by our agency. Parenthetically, it was not the highest priority for planning activities by the State at that time. Nevertheless, we perceived it on our own direction at that point. As a result, the location of new nursing homes has been directed to where no facilities existed before, inappropriate migration from New York and northern New Jersey to southern New Jersey has been reversed, and 3500 new beds are now being placed where the people are going to be in the future, rather than where they have been in the past.

A second example demonstrates the diversity of local health planning. When State facilities began to deinstitutionalize former mental patients into the community setting, the question was raised about the impact on local service capabilities. A study by Central Jersey Health Planning Council showed dramatically that certain areas of our region had to increase their capacity to accommodate the former mental patients or deinstitutionalization to those areas would not be appropriate. Mental health authorities agreed, and adjustments were made to avoid adverse impact. State officials and local providers were the ones to implement the policies, and hence they are the ones to get the direct credit for doing it. however, local health planning was the one that pointed the direction.

A third example: Attempts to focus attention on our role in identification of emerging issues of statewide importance. In Central Jersey, there is a shortage developing of registered nurses to provide geriatric health care. This is an issue for further work next year, should the funds and the time be available to implement it.

A fourth example is the mediation and dispute settlement function. From time to time, issues arise about where to locate a new facility or service. This is especially true with regard to drug abuse treatment facilities. A couple of years ago, we were asked to intervene with a local municipality and resolve a dispute between an approved new facility owner and the municipal officials. I am proud to say this has been accomplished with a compromise that increased local land value and placed the drug treatment facility in an area more accessible to patients without disrupting municipal life.

A fifth, and final example of this presentation is to describe a just completed activity which may be a sample of what local health planning should be doing in the future. I

have the privilege of being the Project Director for the State Health Plan for the Elderly. This was a year-long joint venture by the five HSAs funded by the New Jersey Department of Health as a special project. The five individual area plan documents were presented to the State Health Department in September, 1986. The statewide report was just delivered this week for their final review.

The purpose of this massive, first of a kind effort, was to analyze the health status of the elderly population of New Jersey and the health system which serves them.

Five community-based task forces organized and staffed by each health systems agency gathered local data, and contributed to the analysis of the health system and the health care needs of the elderly. The most current inventory of services and health status data available, plus some new research, provided the blueprint for a variety of interventions in targeted health service areas. Policy changes have been prepared which will maximize existing social, health-related, and non-medical services. It defines objectives and $21 million in fundable projects within each HSA that can meet the projected needs of the elderly population as a whole and the unique needs of smaller locales.

If the funding priorities and health systems changes recommended in the State Health Plan for the Elderly are implemented, lower costs compared to the projected cost of today's system will be realized from the increase in support of home and community-based services and the resulting reduction of long-term care costs associated with the current heavy dependence on institutional resources.

Two side notes not in the prepared testimony that I would like to bring forward: We have talked about added dollars for the health planning system and how the legislation in the future we are looking at should be paid for by provider fees for a temporary time, and ultimately limit the scope of

activity of health planning to areas that perhaps were not overly described here. We will have to agree with that point. However, somewhere along the line, the activity I described here, which in one part was just funded by the State in a separate grant -- the State Health Plan for the Elderly -- and other services, are activities which potentially, under the health plan, will have to resume, because there will be a void in those.

Current example: We just received a request from Catholic Charities in the Diocese of Metuchen -- New Brunswick. They have a serious manpower and physician problem in New Brunswick caring for certain groups of elderly who are falling into the cracks in that area. At one time, we would have had staff to go and get into the situation and bring about a solution, or at least point them in the right direction. I don't have that staff today, and I may have to turn down the request to try to aid them, or try to get a delay in time.

These are the kinds of things that go on month to month that we cannot deliver under the current system.

Thank you for the opportunity to make this presentation today. I will be glad to try to answer any questions. Barry Parker, on my right, who is serving as legal adviser to the Coalition, may have some additional comments.

B A R R Y T. P A R K E R, E S Q.: I don't. I have talked to you, Doctor, on occasion, especially when I had an in-office visit.

ASSEMBLYMAN COLBURN: It will take at least 20 more of those, Barry, to get your point across. (laughter)

MR. PARKER: I think everybody has indicated here that from the inception, when we started to put the HSAs together, the fights and problems we had with your good friend, Dr. Biddle, and some of the others. Since then, I have served on the SHCC and worked with the various HSAs and the Coalition to bring about one thing, and I think it is really the major

factor; that is the local voice -- the voice of the people in the local area having some input about what goes on in the health delivery system in their area. Without this legislation and the funding mechanism to keep it going, you are going to lose that, whether some people think it is good, or some people think it is bad. Someone like Al Wagner, who was a Commissioner for many years of Institutions and Agencies, devoted his life to it, as have a lot of other people. That is the kind of input that you just can't get without this volunteer effort and without these people giving and sharing their time to bring you their local concerns.

ASSEMBLYMAN COLBURN: Thank you. Rodney?

ASSEMBLYMAN FRELINGHUYSEN: The Coalition obviously has its primary relationship with the Department of Health, but from some of the issues you have raised, there must have been some positive relations established with the Department of Human Services, DCA, and perhaps DEP. Is that a fair assumption?

MR. PARKER: I don't know of any with DEP particularly. There may have been some. Maybe Ed can comment more on that, dealing on a day-to-day basis. I just get involved in some of the legal aspects of the problems.

ASSEMBLYMAN FRELINGHUYSEN: The only reason I ask is, if you tie in the increasing roles of responsibility for public health officers and things of that nature, I assume that that must fall under your umbrella in some way. If it doesn't-- I think oftentimes we look to our primary source, in this case the Department of Health, because SHCC is under the Department of Health. So much of the legislation we are drawing these days mandates that the departments communicate with one another. We sort of assume that they communicate downward, as well as between themselves.

MR. PARKER: We do have a major impact with Human Services in Medicaid, Medicare, and all the other aspects.

MR. PELOQUIN: I think there is another function that is very well documented at the local level. I think through the desk of any health planning agency flows more information for more of a variety of agencies, groups, and organizations than at any one point in the State of New Jersey. From day to day, we will see activities in various State agencies. The local involvement, usually with the area offices on aging, for example-- There will be two or three board members who will be from the different offices on aging. The local Title XX Human Services Advisory Council-- There are board members from there, cross boarded with the HSA or the local health planning. There is a constant communication network that exists at the local level. I don't know how many times we get a call, or we'll spot something, and we'll say, "Do you know someone is doing this, when he should be doing that?" They are not documented. This is the busy work of the day that happens in the staff heart of the operation.

More importantly, I have seen agency members talk, in relation to these monthly meetings. I will talk to so and so from Middlesex County, or to someone from Somerset County, who are at that meeting, and the next thing you know, there is a joint project being developed. It is that informal network that exists with the volunteers, which are the providers.

Again, more importantly-- For example, in the State Health Plan for the Elderly, which is probably the truer, most recent demonstration, you will have a representative of every provider and major consumer group in every region -- aging, consumer affairs, you name it -- within these task forces. But they have to go to a neutral body. They have to go to a neutral place where the regions can be discussed, because there are competitions out there for funds and programs. Who can provide that neutral table? We are not the ones competing for those programs and funds. They deliver the services, but we can pull them together as a convener. That is what the Health

Department saw, and that is why the Health Department granted $105,000 throughout the State for this year-long effort, which is worth three times that much on a private basis. We did it.

That is an untold story, but it is there; it is constantly there.

ASSEMBLYMAN COLBURN: Thank you; thanks a lot.

MR. PARKER: Thank you, Doctor.

MR. PELOQUIN: Thank you very much.

ASSEMBLYMAN COLBURN: David Wagner?

D A V I D A. W A G N E R: My name is David Wagner. I am the Senior Vice President at Saint Barnabas Medical Center, and for the period 1974 to 1982, I was Deputy Commissioner of Health for the New Jersey State Health Department. So, I come before you with the somewhat unique experience of having been on the sending and receiving end of the planning and certificate of need process.

I am here today to particularly talk about local health planning, and I would like to tell you that I am supporting local health planning because every time Saint Barnabas has gone before the local agency, they have approved our projects. (laughter) Unfortunately, that is not true. Despite the fact that they have sometimes been misguided, I think that on balance, local health planning is a valuable asset, an asset that should remain with us, and one that I would hope you would support.

The discussion of local health planning ought to take place in the context of four kinds of issues:

1) The tradition of local initiatives in New Jersey.

2) The likelihood -- the very great likelihood -- of further Federal cutbacks and Federal direction to states to assume more responsibility.

3) The decision by this Legislature in New Jersey to treat hospitals like public utilities.

4) The value of local health planning in a changing health delivery environment. Some of those changes you have already discussed to some extent.

I don't have to lecture the Legislature on local involvement. You know it very well. You are very familiar, for example, with our emergency transport system in New Jersey. We have the best transport system in the country. There isn't anything like it. It came from the local people. It came from local initiative. Our hospitals in New Jersey are community owned and supported. They are not some outstation of a for-profit chain in the United States. It is our neighbors to whom we hospitals go with our proposals, our projects, as the first step in the review for the certificate of need process.

Local volunteers know where we are. They know what kind of condition we are in. They know what we do. They know which way the traffic flows. That sounds silly, but that is important when you are looking at projects. They understand the ethnic and religious make-up of the community; the social and financial composition of the community; the availability of other services nearby, etc. These issues may sound trivial, one each by themselves, but they are not. They are the kind of subtleties that cannot be understood if the project is reviewed solely in Trenton. I speak from experience when I say that, because I went from Trenton to Essex County and, even though I had been in the State for seven years, I learned one heck of a lot about how the health system works, that I didn't understand previously.

When you deal with your neighbors, you can't be cute, nor can you obfuscate. I have to tell you, the local people recognize sliced baloney when they see it. So, there is a great deal to be said for local involvement in the certificate of need process. It keeps the providers honest, and it gives assurances to the providers -- which is equally important --

that the first contact with the system is with people who know their problems and who know the territory.

Now, you all know the implications of Gramm-Rudman-Hollings. You know it all too well. We non-legislators still do not fully grasp the impact of that legislation. In health care, as in other sectors, the impact is going to be very severe. Medicaid will be cut, and cut again. Money for physician education will dry up, as will money for special programs such as research and chemical dependency treatment. Traditional public health programs will be slashed even further. State legislatures will be directed by Congress to find ways to finance services for the poor and near poor without Federal assistance.

In that environment, organized local planning -- and now we are talking about problem indentification and the recommending of solutions, not certificate of need review -- will become an important grass-roots recommendation process in the planning and decision-making of the Departments of Health, Human Services, the Legislature, and other departments.

The health delivery system is changing. It is becoming more market driven and more price competitive. Quality and access to care could suffer when physicians and hospitals try to respond to managed care systems' desire for a better buy. Traditionally, it has been the local planning groups which have raised the alarm on quality or access problems. We will need to have the continued presence of that local conscience.

Finally, the Legislature, with the support of hospitals, took the position in passing Chapter 83 in 1979, that hospitals were like public utilities. They existed to provide a needed, essential public service. As public utilities, they were entitled to a fair return, but they would also be subject to close oversight. It is true that that oversight can be supplied by the competent people in the Health

Department, but for a relatively small amount of dollars we can also have the benefit of, and continue the tradition of, local involvement -- a tradition that is almost 30 years old in New Jersey. The HSA in the Essex County area, for example, recently celebrated its twenty-fifth anniversary. It was there long before there were Federal and State programs.

I think there are some conditions that you ought to look at as you think about and hopefully pass legislation for continuing local health planning:

1) We absolutely must make the system less complex. You have heard that several times today from both sides of the fence -- the regulators and the regulated. The number and types of projects that need a certificate of need must be shortened.

2) We providers must have the opportunity at the local level to present our projects to the local decision-makers, not to some subcommittee thereof. That is a major thorn in the side of some of us, and I think that is something where fewer certificate of need requirements should be possible.

3) The local planning staff must be qualified by training and experience and must be paid a competitive salary. Now, we have heard a lot of talk today about how cheaply we can do it, and I caution you about that. I hasten back to the days of what used to be called the "B agencies," back in the early '70s, when they were understaffed and under-funded. The quality of the process at that time was very poor. In Essex County, for example, where they had a tradition of, and local support to, quality, the recommending process was excellent. If you went down into southern New Jersey, it was pitiful. So, it is important that we have good people and that we pay them a decent salary -- a competitive salary -- if we are going to make sure that this process continues the way we would like it to continue.

4) The local planning agencies must be given clear directions and data assistance to identify local needs, advocate change, and recommend clear solutions. Planning must not take a secondary position to the certificate of need review. This means that the State is going to have to provide the HSAs, or whatever they are called in the future, with a good data base from which to work, because they are not going to be able to afford to do it themselves.

5) There must be a greater opportunity for all segments of the health community to participate fully. You hear a lot of talk about quotas, such as 51% for consumers and less for providers. I would like to see us get away from that a little bit, and talk about what I call the four "Ps" -- the payers, the providers, the political, and the public.

This time around, there must be more physician participation, more business participation, and certainly more political participation. As some people have already said previously, this is a political process, and local and county political leadership must play a role in that process.

Central health planning and central certificate of need review is clearly neater, less time-consuming, and would not add an additional step in the process. However, I think that the benefits from the local community participating are well worth the dollars we may spend. I would urge you to keep a revised local health planning process alive.

Thank you very much.

ASSEMBLYMAN COLBURN: Thank you. I think you have done it so well, we are not going to ask any questions. Thanks a lot.

James E. Cunningham, President, New Jersey Association of Health Care Facilities?

J A M E S E. C U N N I N G H A M: Thank you very much, Mr. Chairman. My name is James E. Cunningham. I am President of the New Jersey Association of Health Care Facilities. I

appreciate this opportunity to present our views on the effectiveness of the State and local health planning system.

In general, we believe the Certificate of Need Program has worked effectively in New Jersey. However, there are three critical areas in which the system is failing.

The first concerns lengthy delays in the processing of approvals for the transfer of ownership of a long-term health care facility. This might relate to some of the other comments that people have been making today about streamlining the process.

More than a decade ago, after the certificate of need process was first established, nursing homes encountered this problem. The Legislature then responded to our complaints by directing the Department of Health to expedite such transfer reviews. The Department, at that time, complied with an expedited process which approved transfers within four to six weeks.

Today, that same review takes six to eight months. This is the administrative review process that everybody has been talking about today, that is supposed to speed the process and expedite the system. It takes less time to obtain a certificate of need to build a new facility than it takes to transfer an existing one.

These unnecessary delays jeopardize sales. One example -- and we can provide and document many others -- concerns a small, 36-bed facility with no Medicaid patients.

It is important to note that the only determination the Department of Health is required and empowered to make is whether such a transfer is financially feasible. Bed need and reimbursement rates do not enter into the review. The Medicaid reimbursement rates wouldn't be affected either. And yet, despite the fact that this small facility had an agreement of sale, it took the Department six months to approve the transfer.

We request that this Committee develop legislation removing the certificate of need requirement for any transfer of ownership of existing health care facilities. There should be no fear of danger to patients since, as we stated, the certificate of need review does not involve either bed need or government reimbursement. The only requirement of a transfer of ownership should be advance notification to the Department. I might add that in a transfer of this nature, only the Department of Health is involved, not the local health agencies, which is another reason that the system should not take this long in the process of approval.

A second and even more critical issue concerns certificate of need extensions for projects which are temporarily delayed by zoning litigation or environmental reviews, such as CAFRA or the Pinelands.

Presently, regulation allows extensions of certificate of need approvals, provided significant progress toward completion of the project is evident. However, nursing home developers today often spend hundreds of thousands of dollars only to have their right to complete their projects rescinded. In many cases, the projects are very close to completion. And as an adjunct here also, the State Health Coordinating Council did name a committee, which reviewed the policy of bed need formula. Its recommendation, at the time, in this area, was that zoning litigation should be an automatic exemption. When it was published by the Department, the word "may" was put in, instead of "shall." That is where the problem has developed.

For example, a developer seeking to construct a nursing home in Cape May, recently lost his certificate of need, even though he had invested more than $300,000 in property and other costs, had secured zoning approval after a legal battle, and had obtained Department of Health approval for his schematic plans. In fact, he had been given approval to go right to final plans, rather than go to preliminaries.

The applicant only needed its final CAFRA approval. As you know, CAFRA reviews are long and costly. In this case, the applicant had reached the end of the year-long process and was expecting a vote on his application within 90 days. Even though the Department knew of the pending CAFRA approval, it rescinded his certificate of need.

We believe this ruling was totally unjust. Department officials refused to adjust the decision, even though they were shown that numerous applications in the past had been extended because of pending CAFRA approvals. In addition, the Department was also aware that this particular applicant had successfully completed every project for which the Department had ever granted him a certificate of need. Finally, the officials were reminded that, on at least two previous occasions, rescinded certificate of need extensions were restored when good cause was demonstrated by the applicant.

Another example of this unjust penalty occurred with a project that was in zoning litigation. The applicant had already argued his case in court and was simply awaiting the judge's decision. Nonetheless, his CN was lifted. Again, this case involved an applicant who had obtained five previous certificates of need and had completed every one of the five projects.

This unfair treatment of applicants by the Department of Health leaves us no recourse but to request that you amend the CN law to mandate that applicants delayed by zoning, CAFRA, Pinelands, and other environmental reviews be granted automatic extensions to certificates of need until the review is completed.

Finally, I would like to address an issue currently before this Committee. In fact, you, Mr. Chairman, and your Vice Chairman, Mr. Felice, are the co-sponsors of A-3017, which would permit a health care facility to increase its capacity by 10 beds or 10%, whichever is less, without the requirement of a certificate of need.

This already is allowed by Federal law and is in place in many states, including Pennsylvania and New York. We thank you for sponsoring this legislation, and urge you to give it your prompt attention.

We think these three moves would truly streamline this process, and we appreciate the opportunity to offer our comments this morning.

ASSEMBLYMAN COLBURN: Thanks very much. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Since your legislation has been praised-- I think that is significant.

MR. CUNNINGHAM: There were two others who recommended it to the sponsor.

ASSEMBLYMAN FRELINGHUYSEN: We haven't focused too much on the bureaucratic response time, but I think it is something that most legislators are familiar with through constituent letters and institutional requests. I must say it is a wonder sometimes how long it does take to get a lot of these certificates approved. I assume there must be some justification for the delay. But what bothers me more now is, of course, the freezing of the whole process; in other words, holding in place a lot of different applications. There may be justification for that on the Commissioner's part, but I think perhaps a better public explanation would be of value to us. The costs that are associated with these delays, not only to your particular constituency, but obviously to other health institutions, are considerable, and I would suspect that some of those delays, if you were to total up the costs, might raise some of the figures that were given in the initial testimony by the Deputy Commissioner. The delays are costly to the institutions, and certainly to some of those consumers who would be served by the institutions being up and running.

Thank you.

MR. CUNNINGHAM: The normal routine system is much easier to get through than if you attempt to sell your business and transfer it. When the Legislature got involved originally, and Dr. Cowan was the Commissioner back in those times, the process was put into place and it only took four to six weeks for those things to be done. When you are looking at nothing but financial feasibility -- bed need is not involved, or anything else -- why that kind of a time frame has to be involved, you know, is just amazing. The four to six weeks was there. It has only been altered in the last couple of years. But, six months for that kind of a process is just unbelievable to us.

It causes a lot of work; besides, my phone rings like crazy. The Department's phones ring like crazy, because then we are calling them, the applicants are calling them, their lawyers are calling them. I am sure it drives them up the wall, too. If it is staffing, or whatever, we don't feel that the transfers need to be in the system. That is a perfect way to streamline it. The notification to the Department-- They can do their financial feasibility, and this is not for rates. This is just whether the facility would survive or go bankrupt.

ASSEMBLYMAN COLBURN: Thank you. Mr. Bernard Rabinowitz, President and Chief Executive Officer, Atlantic Industries, Inc. Good morning. It might be afternoon by now.

B E R N A R D R A B I N O W I T Z: It is afternoon, Doctor, yes.

On the subject of health care, others, I am sure, will give you more precise data and numbers. I thought that this afternoon I would use a broader brush stroke and address the issue as a philosophical issue. What is it? Where did it come from? Who benefits? Where is it going?

Properly to understand health planning, we must go back in time to recognize that it arose spontaneously to meet society's needs. It developed over time, was variously

supported financially and philosophically by philanthropy, by providers, by the business community, and by governmental agencies -- local, State, and Federal. It has been a long history of performance and service, with shifting roles for the major players as needs and goals developed.

The flu pandemic at Camp Dix gave rise to the American Red Cross, which sped the creation of welfare federations which, needing coordination of allocation, spawned community chests which needed direction and gave rise to councils of social agencies, which oversaw dollar utilizations. The Blue Cross of New Jersey, among the first in the United States in the early '20s, was an expression of meeting a need. All these historical developments were tied into health planning, and it was perceived as beneficent and benign.

Ah, those were the good old days, but today, the conventional wisdom has it that "everybody knows" health planning is a Federal program for controlling health care costs. "Everybody knows" it was imposed on a reluctant community; "everybody knows" it is ineffective in making changes in the health care system; "everybody knows" it is redundant in a competitive health care system. There is just enough truth to these assertions that they have popular currency, but I assure you that those who so assert do not know what it is they do not know. We are really talking, in New Jersey, about a well-kept secret. And you must recognize, gentlemen and ladies, that New Jersey was operating under the same laws, the same regulations that were available to every other state in the United States. So, these perceptions that I have characterized as "everybody knows," are, in fact, probably true in many other areas of the United States, but not in New Jersey. We have come a long way.

Over the entire history of health planning, there has consistently remained in New Jersey a community focus of activity, providing a vast platform for extensive volunteer

participation, governance, and guidance. It has always remained an expression of the spirit of volunteerism, responsive to people's needs and consistent with community resources, regardless of whose umbrella provided the resources, and it has been, in New Jersey, a smash success.

We have come a long way, and yet we have an enormous unfinished agenda to deal with in health planning. Look at the stakes. Nearly $8.2 billion was spent for health care in New Jersey in a recent year, and this bill will keep rising. And it is against the $8.2 billion that you must consider the minuscule amount of money that was used for health planning. A significant portion of this $8.2 billion was added to the cost of every product or service manufactured or produced in this State. Moreover, almost 40% of that figure was paid for in taxes. Think of it, health care for municipal, county, State, and Federal employees, plus Medicare and Medicaid payments. You and I are paying for it, so it is not an issue that brooks of indifference or dismissal.

Obviously, then, one major goal of health planning should be to moderate the increases in health care costs, while continuing to assure access to quality health care for all. Well, New Jersey per capita health care expenditures are in the middle third of the nation. Average, you might say, except compare New Jersey's performance with all the surrounding states which have essentially the same epidemiological and social problems as New Jersey, i.e., Pennsylvania, New York, Connecticut, and Maryland. They are all in the top third of per capita health care costs. Only our system in New Jersey of health planning, involving a governmental/private partnership, coupled with voluntary restraint and regulatory control, can be credited with this accomplishment. But obviously cost is not all.

Let me list some other unsung achievements, all of which, in my view, are directly attributable to the fact that

the volunteers -- the local people -- participated, made their needs and desires known, and followed through in the process:

1) All acute-care hospitals in New Jersey are voluntary and not for profit. Now, what does that mean? What it means is, in New Jersey we have a system where every hospital has agreed to share all the social costs of providing quality medicine. The national hospital groups of facilities are unwilling to accept that as a condition. Consequently, they were uninterested in coming into New Jersey. This is a great triumph, because under an all-payer program, you realized during the recent depression in 1982, when you saw headlines in other states where people who had lost their insurance coverage by virtue of being unemployed for a period of time -- those people were being turned away by hospitals that they would normally have gone to. This was true in almost every other state. It was not true in New Jersey.

2) Our inner-city hospitals have become full-scale viable institutions. After decades of almost bankruptcy, our inner-city institutions are functioning, are successful, are viable.

3) Implementation of minimum Medicaid admissions to long-term nursing care certificates of need. This was brought up originally at the local level and was pushed through the entire process, surviving even the challenge in the courts.

4) Clinical services and mental health services in community hospitals are a direct outcome of local planning agencies' active role in the process.

5) Regionalization of tertiary and secondary services was undertaken and continues.

The list could go on, but I want just a word about the future of health planning. Really, two words: One, unfinished, and two, uncertain.

Unfinished, because in health planning, in particular health planning as it deals with medical issues, we are working

with moving targets. The technology is moving as fast as everyday's headline can print it, moving with extraordinary speed, and as one commentator said, "Medical technology is a good servant, but a bad master." It needs to be thought about in the broadest possible context. Rapidly changing demographics in New Jersey portend enormous potential increases in health care costs because of the rising age levels of our population. These are typical of the problems that continue, and they will grow. Plus, of course, the inevitable fact that we could certainly be doing better with our existing problems, let alone the new ones we will have to face.

And uncertainty, because the last small Federal funding for health planning will cease, quite literally, in a matter of weeks. Consequently, I make a plea for support of S-2372/A-3022, a short bridge funding bill for bare bones continuation of planning, and I mean quite literally bare bones. It is really a vehicle to hold together the precious volunteers, and keep them in the process until other plans and resources can be brought to bear. To this end, you should know that the Commissioner and SHCC have established a blue-ribbon committee to study the wide ramifications of health planning in future, and this report will be presented to the Commissioner and to the SHCC early in 1987.

That concludes my organized remarks, but I do want to take the opportunity, if I may, Mr. Chairman, to address one or two issues that came up earlier today in just a brief comment.

ASSEMBLYMAN COLBURN: Sure.

MR. RABINOWITZ: Particularly the issue of the level playing field that Mr. Slavin spoke of in connection with certificate of need for institutions, as against consortia of doctors. I am in sympathy with Mr. Slavin's view about the level field, but I am more concerned, if you will, about the secondary aspect of that issue he raised. The larger issue, in my view, is the issue that we may ultimately find if we do not

address this issue, that we will be having various classes of medicine being offered to the people in New Jersey, and that I find not a satisfactory solution. So, I think the level playing issue is a much broader issue, and needs to be addressed in that fashion.

The question relating to the out-of-state referrals for cardiac services is being addressed by a committee which will be providing its report to the Commissioner within the next week or 10 days relating to cardiac services in New Jersey. This is a committee that has taken a broad look at the regulations, particularly relating to cardiac surgery in New Jersey. The regulations, as you know, are over a decade old. That report, which has taken a hard look at that issue, among others, will be in the Commissioner's hands within the next week.

I might also remark that there has been a strong resurgence of business interest in health care planning, motivated perhaps primarily -- originally -- on the basis of controlling costs, but with the New Jersey Coalition of Businesses, I find their interest is transcending the initial concern of cost, and they are taking a much broader interest in the total issues as we perceive them.

Okay, I just wanted to make those two comments.

ASSEMBLYMAN COLBURN: Thank you very much. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman. Mr. Rabinowitz, thank you for your testimony. You have attached to your written comments an appendix.

MR. RABINOWITZ: Yes?

ASSEMBLYMAN FRELINGHUYSEN: I note that the last page makes reference to the fact that it is a GPL publication. Would it be possible to have the first 31 pages of that?

MR. RABINOWITZ: I have a copy with me which I will give to Mr. Price, yes.

ASSEMBLYMAN FRELINGHUYSEN: I would like to have that entered into the record.

You head up this blue-ribbon task force?

MR. RABINOWITZ: On the future of health planning, yes.

ASSEMBLYMAN FRELINGHUYSEN: I congratulate you. Is this a different task force than the one you made reference to that is looking into cardiac surgery?

MR. RABINOWITZ: Yes, it is a different task force.

ASSEMBLYMAN FRELINGHUYSEN: Could you tell me something about that task force, other than what you have stated?

MR. RABINOWITZ: The surgery one?

ASSEMBLYMAN FRELINGHUYSEN: Yes.

MR. RABINOWITZ: The cardiac surgery one?

ASSEMBLYMAN FRELINGHUYSEN: Yes. Is that something you are involved in, as well?

MR. RABINOWITZ: Yes. I was Vice Chairman of that. Dr. David Rogers of the Robert Wood Johnson Foundation was Chairman. That was a task force appointed by the Commissioner, which included representatives of the community, representatives of the medical profession, and representatives of hospitals. We had a member from the Harvard School of Public Health; we had a member from the Pennsylvania School of Medicine; we had two members, one from the Office of Technology Assessment in Washington, and another member from the National Institute of Health.

It was a very high level committee. We have been meeting since May, 1986, and have been dealing with the charge the Commissioner gave us, bringing us up to date in New Jersey with respect to cardiac services. It will truly have a national impact. When that report comes out, in my view, it will have national impact, because it is a very strong report dealing with the notion that we must strengthen the services insofar as New Jersey is concerned, and make them not only more

viable medically, but also more viable in the competitive arena in which New Jersey is finding itself on the national scale. It is an excellent report.

ASSEMBLYMAN FRELINGHUYSEN: Good. I will look forward to it. I certainly wouldn't draw any conclusions, except as being on the board of one of those institutions in the hinderland who has an interest in this subject. The general feeling is, of course, that they already know what their conclusions are going to be, and are just coming up with the justifications for them.

I must say I would like for the record, perhaps through the Deputy Commissioner, to have the charges to both your particular task force -- if there are written charges and responsibilities -- as well as, for the record, any charges to the other blue-ribbon group that you mentioned.

MR. RABINOWITZ: I will see--

ASSEMBLYMAN FRELINGHUYSEN: I think it is valuable to have your testimony, and I certainly think we ought to give some consideration to your comments relative to the classes of medicine and if, in fact, we are moving toward a system where we are delivering different types of classes based on one's ability to pay. I presume that is what you are talking about.

MR. RABINOWITZ: You're absolutely right.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

ASSEMBLYMAN COLBURN: Thanks very much. Mr. Robert Schaal, Chairman, New Jersey State Council, Health Insurance Association of America?

R O B E R T S C H A A L: Mr. Chairman and panel: The Health Insurance Association of America has consistently supported the enactment of Federal and State comprehensive health planning legislation. We have worked closely with both State and local agencies in the planning process since the enactment of the first Federal health planning statute in the late 1960s.

Today, despite the sunset of Federal health planning legislation and Federal funding, our commitment to health planning remains strong. Much of the controversy over the effectiveness of the necessity of health planning today relates to the significant change in the health care delivery system. The system, as a whole, has become competitive and diversified. Alternative delivery systems have emerged which provide settings other than the acute-care hospital and the physician's office. Various insurance mechanisms, preferred provider arrangements, and managed care systems offer competition, diversification, and payment alternatives, as well.

In this complex and changing environment, there is a need for responsible health planning initiatives which consider the delivery system in its entirety and develop systemwide goals and objectives. Those who argue that health planning is no longer necessary in a competitive environment contend that regulatory oversight will serve not to improve the delivery system, but rather to hamper and constrain it. We disagree wholeheartedly with this contention.

An appropriate level of planning and regulatory oversight is necessary to ensure that not only the costs associated with health care are reasonable and necessary, but, more importantly, to ensure the maintenance of quality and the access to health care as these system changes continue.

In examining the specific needs of the State of New Jersey for local health planning, we believe that a well-developed, comprehensive health planning process is essential for the coming years. The Health Department has provided us with data which indicate that by 1990, New Jersey will have in excess of 3900 to 7500 hospital beds, or 13 to 25 excess hospitals. An effective health planning process is necessary to assure that the system is downsized and that this reduction is accomplished in such a way as to preserve the integrity of needed institutions in underserved areas.

The ratio of capital to non-capital cost in 1985 was 11.4%. The Health Department predicted that this number will reach 25% by 1991. This compares to a national average of 7%. Effective health planning and a vigorous certificate of need process are needed to control the skyrocketing capital expenditures and to ensure that capital costs which are incurred are, in effect, reasonable and necessary.

We will be speaking in support of Assembly Bill 3022, for the authorization and funding of health planning in New Jersey. We would argue that funding for health planning is the overall responsibility of the State and, as such, should ultimately come from the general revenues of the State. However, our commitment to health planning is such that in the absence of State funding, we will support the funding of health planning agencies throughout the hospitals' rates.

We urge the Legislature to express its support for health planning, as well, and we thank you for the opportunity to comment today.

ASSEMBLYMAN COLBURN: Thanks very much. Priscilla Anderson, member of the Board of Directors, Health Systems Agency of Southern New Jersey? Good afternoon.

C O U N C I L W O M A N P R I S C I L L A A N D E R S O N: Good afternoon. I am Councilwoman Priscilla B. Anderson of Willingboro Township. Since 1983, I have served as a Director on the Southern New Jersey Health Systems Agency Board of Directors. My interest and concern about escalating health costs are among the reasons I have been a volunteer with this organization. Willingboro has a major health care facility -- Zurbrugg Hospital, Rancocas Division. The population of Willingboro numbers approximately 40,000. The residents are of diverse backgrounds and age groups. It is basically a young community, but the population reflects the trends in the United States, and it is aging. There is a sizable minority population within the township. My constituents are of many

ethnic heritages. Yet, as a woman and a black, I am especially sensitive to the problems facing those less fortunate, of which a large percentage are black, women, children, and elderly. The cost of adequate health care has gone beyond the reach of many of these individuals.

The process of consumer input through the local health planning system has been essential. As a representative of the local health planning community, the S.N.J.H.S.A. has been a vital asset. Its achievements over the years to contain the costs of quality health care have been outstanding. It has been a well-designed, locally controlled health planning system. Citizens such as myself have been able to influence decisions on how health care dollars are spent. Although you may know or have heard these statistics before -- in fact, all morning you have heard all kinds of statistics -- it is important to reemphasize these facts:

The Southern New Jersey Health Systems Agency alone processed a total of $1.1 billion worth of certificate of need applications -- this was from 1977 to 1985 -- for various health care facilities in the seven southern New Jersey counties. Also, in the interest of savings for health care users, over $140 million of CNs were denied as not being cost efficient. I listened to the gentleman who talked about the problems of the zoning boards and the problems they have faced with time lag. We are well aware of those problems. I have been a member of the planning board in my town, and I have sat in on many zoning board decisions. So I understand the problems they face. But we still realize the importance of saving the consumer dollars, because health care is-- People such as myself -- and there have been people on television -- are so concerned because if they have a catastrophic illness in their family, they will literally become bag people -- people who worked all their lives.

I think I jumped a little bit, but what I am saying is, many people who are just working people, who don't have excess funds, but who have saved all their lives, are concerned about, "What is going to happen if I get ill, if my mother or father gets ill?" I have a mother who had a heart attack just in June, and thank God she is progressing pretty good. But it is a very real thing -- the cost of health.

The S.N.J.H.S.A. has given other services to the health care community in technical assistance. In March, 1986, the agency completed a booklet, "How to Make the Most of Your Health Care Dollars." The purpose of the brochure is to clarify and suggest ways by which employers can decrease their health care costs. These brochures were distributed, and are available to employers in our area. I have a sample for you here.

Local health planning is essential and must be continued. Your support of Assembly Bill 3022, and also of the Senate bill, is very important to the economic well-being of New Jersey residents. Even the least of us are entitled to quality, affordable health care.

Thank you for your consideration. It has been my privilege and pleasure to speak before you today. Again, thank you.

With me is Mr. Dan Apostolu, who is the Executive Director of the Southern New Jersey Health Systems Agency.

ASSEMBLYMAN COLBURN: Thank you. Good afternoon, Mr. Apostolu. Would you like to say anything?

D A N I E L R. A P O S T O L U: No, I have nothing to add to the comments which have been presented.

ASSEMBLYMAN COLBURN: All right, thanks very much.

MS. ANDERSON: Thank you.

ASSEMBLYMAN COLBURN: Joseph Pikus, Immediate Past President, New Jersey Public Health Association. Good afternoon.

J O S E P H D. P I K U S: As Immediate Past President of the New Jersey Public Health Association, which was founded in 1875, I am representing over 600 paid members, as well as hundreds of other professional health workers in this State, in the matter of the act establishing a statewide local health planning program and supplementing Title 26 of the revised statutes.

The Association is very pleased with your serious concern regarding the continuation of health planning in New Jersey. The Association equates planning and its significance with activities in the past concerned with cholera, smallpox, diptheria, and other infectious diseases, as well as clean water, clean air, fluoridation, and many other causes in the interest of the public's health.

In our opinion, we cannot have a sound government without a rational health planning program.

The distribution of dollars must not proceed without an analytical review of the beneficiaries of the disbursements for health personnel, facilities, and services.

New Jersey was, and I think continues to be, a pioneer in the health planning field. Many citizen volunteers and professionals worked hard to make it succeed. Many volunteers laboring today in these fields will be lost if health planning is discontinued because of lack of funding. Therefore, it is good to know there is a movement to rescue these very valuable resources.

The Association is also pleased that you are setting a termination date, so there will be adequate time for the commission or committee activated by the Commissioner of Health to have ample time to propose a more contemporary plan for State health planning. For example, we have computers, we have epidemiologists, we have a graduate program in public health -- resources all in place now -- but nonexistent when the State became involved with the Hill-Burton Program in 1947. I might

add that we are still continuing along some of the policies, procedures, and methods of that period.

I would be very happy to answer any questions you might have, to the best of my ability.

ASSEMBLYMAN COLBURN: Thank you. I think we might be all questioned out for the moment. When we hear the bills in Committee, you know, specifically the legislation, I think we will probably have some more. Thank you very much for coming.

Where's Dr. Palmer? By golly, it is good to see an M.D. in this crowd. You were based in Haddonfield, I guess, weren't you?

H U G H D. P A L M E R, M.D.: Yes, at one time. I am Dr. Palmer. I live in Willingboro, the largest of 40 municipalities in Burlington County. I am a retired public health physician. I served over 31 years with the State Department of Health.

My personal experience in health planning goes back, as far as the concerns of your Committee are concerned, to 1968, when, as it happens, both Mr. Slavin, who testified earlier, and I were assigned by Dr. Kandle to work in planning for Comprehensive Health Planning, as it was called in those days. I served for several years on the Board of Directors of the Comprehensive Health Planning Agency of Southern New Jersey. Since comprehensive health planning, or CHP, was replaced by the current health systems agencies setup, I have been a member of the Burlington County Advisory Council of the Southern New Jersey Health Systems Agency. I am currently their secretary.

During these many years, involvement in the process of health planning by the consumers and by the providers of health services has developed and grown in importance. New Jersey, as well as the nation, faces very serious problems in the provision of preventive and curative health services. These should be of high quality and available to all New Jersey

residents at costs which are affordable. This is a task which requires planning -- planning at each level of government -- and of community organization at which it can be done in a meaningful, effective, and efficient way, without unnecessary duplication of effort or expense.

There are two features of health planning over the past 18 years, in my personal experience, which deserve emphasis:

1) Health planning at the county and regional level -- presently for seven counties in the case of southern New Jersey -- has brought together many different representatives of the providers of health services. Their ongoing exchange of views and experience has benefited all concerned. Planning is no longer, and has not for a number of years now, been limited to discussion within a particular professional society or provider category. There has been a greater exchange of ideas and wisdom, if you will.

2) The involvement of consumers from many walks of life -- in the process of health planning carried on jointly with providers -- has resulted in increased understanding of the problems encountered by each group. Each has contributed significantly to the knowledge of the other. Health planning, at its best, has resulted in the provision of improved or new and necessary services, and has resisted unwarranted and expensive duplication of services. It has saved substantial sums of money -- as Deputy Commissioner Kitler said at the outset of this hearing -- when the final decisions have been made at the State Department of Health level.

With the termination of Federal funding for approved health systems agencies, it is essential that provision be made for alternative funding. This should be provided, in my opinion, at the State level. Funds should be provided by a program of taxation or fees, or both, assessed in a fair and equitable manner on those who seek approval for the provision

of new or expended health services. I might add, in view of previous testimony, that consideration, in my opinion, should also be given to financial contributions through fees, or some other mechanism, by other interested groups or parties, not just those who under the present system are required to go for a certificate of need.

Continuing and adequate funding can ensure the further development of health planning, in what has been a unique channel for the meaningful participation of consumers who can speak -- indirectly perhaps, but nevertheless -- on behalf of over seven million New Jerseyans, in cooperation with he providers who have the expert knowledge. Both contributions are essential to the future health of New Jersey.

Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No questions, thank you.

ASSEMBLYMAN COLBURN: One thing I have thought of periodically through this testimony-- When I was with the Burlington County Board of Freeholders, Walt Trommelen admitted to me in a private conversation that he spent about 40% of his time on health planning, I think for the local agency at that time. It struck me that that was an in-kind contribution by the county that the Freeholders really didn't know about.

Are there other things that other levels of government give to this process that we could count as sort of an in-kind contribution -- office space, or anything like that -- throughout the State?

DR. PALMER: I believe, Mr. Chairman, that at the time Mr. Trommelen spoke to you, he was probably chairing the Comprehensive Health Planning Group for Burlington County. I remember his exercising that function. That would account for his statement.

ASSEMBLYMAN COLBURN: Well, it didn't go on forever, but there was a point where it was happening.

DR. PALMER: There are in-kind contributions at the present time, through the courtesy of the Freeholders. Physical facilities have been made available to the Advisory Council in Burlington County. That has been going on for quite a number of years now.

ASSEMBLYMAN COLBURN: A long time.

DR. PALMER: Also, it occurs to me that one could consider, or look into, the existence of in-kind contributions by individual municipalities. With 40 municipalities in Burlington County, most of them do not have any activity of any significance with regard to health planning as such, but in the largest municipality -- Willingboro -- they do have an Advisory Board of Health, which is involved, as Ms. Anderson has indicated, in health planning and other health concerns. I can only speak about Willingboro, which happens to be my town, but there are other much larger municipalities in the State which have very active local health departments. They, through their licensed health officers and their staffs, should, and must be involved in health planning. So that, too, could be investigated.

ASSEMBLYMAN COLBURN: Okay. Thanks very much. Thomas King, Chairman, Burlington County Advisory Council. Somehow, Burlington County really got here. I don't know how that happened, but I have an idea.

T H O M A S K I N G: In the interest of the Committee members, their staff, and the long-suffering members of the audience, I am going to make this very short, so we can get to lunch. You can see that my remarks were short (referring to written statement), and as I sat here this morning I anticipated that most of them would be covered by other speakers, and they have been. In fact, some of the statistics that you see there related to national savings through health planning, I am sure will be much more accurately handled by the State Department of Health, and much more specifically handled in terms of our State.

There are a couple of things I would like to mention that are in here, and which came up this morning in the course of the testimony.

First, to identify myself, I have been on the regulatory side for eight or nine years with the Regional Health Planning Council in Newark, as a paid staff member. At that time I worked for Joe Slavin, and I had the opportunity to work with Assemblyman Frelinghuysen with regard to some health planning activities in that part of the State.

Since that time I have also been on the provider side, in terms of working directly for a hospital. Now I am on the volunteer side, in terms of working with the agency as a volunteer. I can see that the presence of the health planning mechanism is something that people do consider -- that providers do consider, in terms of putting together their plans, putting together their capital expenditures, if this is realistic in terms of the people who are going to review it. I think the process -- and this has been told to you a number of times -- that has allowed the local citizens to have a voice, should be continued. I think Dave Wagner said it, and I think local providers realize that they are going to be seeing the people who are on that council, they are going to be seeing them week in, week out. They represent the people in the communities they serve, and they therefore have a valid reason for appearing before that group.

I don't mean to tell you that everything is rosy at the local level. There are frustrations in terms of the levels and how much our input has to do with the final decision as it is made in what has been termed, and is, a political process. The answer to that, and I think the realization is, without local health planning and without the continuation of it, we would not have the ability to input at all. We do appreciate, and we do take seriously, the ability to input into the kinds and quantity of health services that are going to be available to our communities.

I would really like to thank you for the opportunity to appear before you. I would like to encourage you to vote for the continuation of health planning and, also, to vote at a level at which it can be effective.

Thank you very much.

ASSEMBLYMAN COLBURN: Thank you. Gary Baker, from IBM.

M A R V I N B U R T O N (speaking from audience): Mr. Chairman?

ASSEMBLYMAN COLBURN: Yes.

MR. BURTON: I am Marvin Burton. I am Director of the Bergen and Passaic Health Systems Agency. Mr. Baker is on my Board of Directors. He has been called out of town by IBM on corporate business. They are having some cost containment problems of their own, and he has to close down some offices down in the southern part of the country.

I have his statement, which I will submit for the record.

ASSEMBLYMAN COLBURN: Do you want to come up?

MR. BURTON: (complying with Chairman's suggestion to move to microphone) I would only like to point out the kind of person that Mr. Baker is, and the fact that he has seen fit to make an investment of his own time voluntarily as a Board Member and as Chairman of our Project Review Committee. Now he has just been appointed, and accepted appointment, to the State Certificate of Need Review Board. This is a man who purchases services for IBM in New Jersey, who manages the benefits, who is concerned about cost containment, but he is also concerned about equity of access and the fact that New Jersey should have quality of care within its borders, to the extent that we can afford to do that. This is the kind of an agency he has selected to give his time to, in order to achieve his company's goals, because he is released on company time and has given hours of service over the past two years. I would just say that about him.

ASSEMBLYMAN COLBURN: Thank you. Mary Strzelecki, from the Home Health Agency Assembly of New Jersey, Inc.

M A R Y S T R Z E L E C K I: I am happy to tell you that my comments are brief.

ASSEMBLYMAN COLBURN: Oh, thank you.

MS. STRZELECKI: Chairman Colburn, members of the Assembly Health and Human Resources Committee, ladies and gentlemen: I am Mary Strzelecki, Director of the Department of Community Health Services at the Medical Center at Princeton. Today I am representing the Home Health Agency Assembly of New Jersey, a statewide, nonprofit organization whose members are dedicated to providing quality home care, accessible to all those who need it.

Home care services are growing fast, partly in response to the aging of the population. Presently, 12% of the United States population is over the age of 65, and there has been an increase of 56% in the number of individuals over the age of 85. Revolutionary medical technology continues to increase longevity, and one thing is certain. As life is prolonged, there is an increase in the amount of disability and chronic illness that occurs. This means a greater need for home care services and long-term care, and that has resulted in a greater need for planning to assure that the citizens of New Jersey are provided with quality, cost-effective, comprehensive home care services.

New Jersey has a mature and progressive home health industry, providing service to over 133,000 citizens. Not only is service available in every geographic area of the State, but also accessibility to service, as measured by the Medicare use rate, places New Jersey among the top ranking states. There is a Medicare use rate in New Jersey of 50.3 per thousand Medicare enrollees. New Jersey ranks ninth in the nation. At the same time, per-visit charges in New Jersey remain substantially below the national average. New Jersey's average Medicare

charge-per-visit rate is $37, which is lower than the national average of $46. It is also below that of other states in the Mid-Atlantic Region. The achievement of high use and moderate cost is a very desirable objective, and speaks well for the success of New Jersey's current health planning system, which aims to control costs, while maximizing access to care.

The New Jersey Department of Health uses the certificate of need process for Medicare and Medicaid certified home health care agencies, to assure that the growth of these providers is orderly and that the cost of the care delivered is controlled. We support continued use of certificate of need review in the licensing of certified home health agencies. The experience of other states which have eliminated home health care from the certificate of need requirements confirms our belief in the efficacy of the CN process. Elimination of certificate of need in Texas and Tennessee in 1981, resulted in a proliferation of home health agencies and an increase in per-visit charges which greatly exceeded national rates.

Something that is not included in my written testimony is some of the statistics about Texas and Tennessee that I thought you might be interested in. Texas, between 1981 and 1984-- In 1981, there were 91 home health agencies in Texas before the elimination of certificate of need. After the elimination in 1984, there were 731. Medicare costs rose in Texas 36.2% during that three-year period. In Tennessee, it was 34.1%, as compared to New Jersey, which only had an increase of 21.7%. The nation as a whole had an increase of 27.2%.

Another thing that occurred in Texas and Tennessee was an increase in the number of visits, which was really quite substantial with the elimination of certificate of need. Tennessee had a 139% increase in the number of visits in a two-year period -- 1981 to 1983. Texas had 81.8%. During that same time period in New Jersey, it was a 28.8% increase in

visits, and in the United States as a whole, it was 42.4%. In Tennessee in 1984, they reinstituted the certificate of need laws for home care.

Local health planning through the activities of the health system offices is an essential component of health planning in New Jersey. Through HSA review and evaluation activities, local perspectives and insights are brought into the process. We believe that local health planning should be continued and supported by State revenues. It is important that the HSAs remain impartial planning organizations. Funding HSAs through provider fees could jeopardize their independent status.

In summary, the State and local planning system in New Jersey works. When something works, as the adage goes, "Don't fix it." Planning is essential to assure that New Jersey citizens throughout the State continue to have access to quality home health care services at a reasonable cost.

Thank you very much.

ASSEMBLYMAN COLBURN: I guess you are off the hook, too. Thanks a lot. We have one more person who has survived this long -- Mr. Scalera, is it?

C I R O A. S C A L E R A: Yes, Assemblyman. My name is Ciro Scalera. I am Executive Director of the Association for Children of New Jersey. I did not bring a written statement with me, but I wanted to come to share some concerns. I will be very brief, so you can have the lunch break that many people would like.

The Association for Children is a statewide child advocacy organization. We serve as a voice for children and families, primarily children and families who are disadvantaged or have special needs.

I come here today to express our strong support for the concept of planning. You heard a number of organizational representatives expressing that this morning. But I am coming

to say that I think health planning needs to gear a greater emphasis toward the needs of low-income children and families, and to look at ways, through the process, of expanding the capacity of local health planning to greater respond to that need. I think the bills calling for continuity, in terms of three regional centers, are important. We strongly support that. But we would like to see an expansion of planning beyond what the bills and a three-center regional system might bring.

The emphasis, we believe, should be in two broad areas: First, in terms of scope, we would like to see planning be given more emphasis, not so much in terms of the facilities -- and certainly we are not experts in that area, and you have had plenty of witnesses on that -- but we would like to see the planning focus on other aspects of health care services that relate to the issue of the quality and access of low-income families in New Jersey -- to their getting health care services. So, the question of what should be encompassed by planning, in our view, needs to go well beyond the facility aspects of it, and look toward entitlement programs, their functioning, their operation, how do low-income children and families have access, and what kinds of planning need to be done to ensure the quality and greater access to those families in our State?

The second area where we think there needs to be a greater emphasis in terms of planning relates to assessment. By assessment I mean I do not think that the current system of planning -- and certainly the one that would temporarily be proposed by the bills -- allows for -- at a county level -- a complete and thorough assessment of what the needs are of all the children and families who exist in that county. We know, from statewide studies we have done, that there are programs. For example, the early periodic screening and diagnosis and treatment program, which is part of the Medicaid Program, where New Jersey is only serving a small percentage of eligible

children. Many children are eligible, but only 30% or 40% of eligible children are receiving those services.

Similarly, there are health-related services that we are not fully providing for the needs of our children. We are not taking advantage of either Federal or State programs to meet their needs. We feel that if there were greater emphasis, in terms of planning around participation of citizens -- children and families -- in these programs, that this would, in the long run, be a very strong step toward providing preventive health care, and ensuring, through a planning perspective, more regular access of these children and families into the health care system.

So, those are really the two points that we wanted to comment on. They are a little different, I guess, from what you have heard during most of the morning. One thing that lays over all of that, in terms of a greater emphasis for county and local planning, would be that all of the entities that currently exist, not so much in the Department of Health and in its processes, but in the Department of Human Services-- There are now Human Services Advisory Councils. There is an increasing awareness of the need to link the different county planning entities that exist, which want to act on behalf of low-income children and families. It would be very beneficial if a greater emphasis in local health planning were linked in and coordinated with some of these other planning processes that are up and running in the county, in the social services and in other areas. Again, that could be another added benefit of having a greater emphasis to really local assessment and planning for children and families.

I thank you for giving me the opportunity to make that statement.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Nothing, thank you.

ASSEMBLYMAN COLBURN: Does anyone else in the audience want to say anything -- either anyone who has already spoken, or anyone who has not? (no response) If not, then we will adjourn this hearing.

Thank you.

(HEARING CONCLUDED)

APPENDIX

TESTIMONY OF

Gary L. Baker
Manager of Benefits and Expense
Reimbursement Plans
IBM Corporation
Woodcliff Lake, N.J.

before the
ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

December 4, 1986

I am Gary L. Baker, residing at 4 Vaughn Drive, Ramsey, New Jersey. As manager of employee benefits at the IBM Corporation in Woodcliff Lake, New Jersey I am deeply concerned about the cost of health care in America and in our state today. I am equally concerned that there be an adequate and available supply of health services for our people, efficiently and cost effectively managed, and of a quality high enough to provide needed and appropriate care within our state's borders to the greatest extent possible.

For the past two years I have been a volunteer member of the board of trustees of the Bergen-Passaic Health Systems Agency and am currently chairman of its certificate of need review committee. This agency has, for the past ten years, served as the federally designated planning agency for New Jersey Health Service Area I comprised of the Counties of Bergen and Passaic. As you know, it is one of the five local health planning organizations in the state. As an experienced purchaser of services, but a layman in the planning and delivery of services, I wish to report to this Committee that I have been immensely impressed with the contribution these five agencies have made to the prudent and equitable distribution of health services, to the sensible introduction of new medical technology into the state, and to the equity of access to services for all segments of our population, including the indigent and the vulnerable groups among our citizens. I believe the success of their mission is attributable to the fact that their process allows local residents, consumers and providers and purchasers and payors alike, to participate in the decisions affecting the composition and configuration of the systems we now have for the delivery of health care services.

Let me cite some examples.

- The number of acute care hospital beds is being held to the state's recommended level of four beds per thousand population or ~~better~~ less, through the creative use of the certificate of need process whereby only needed projects are endorsed, while the others are discouraged.

- The dire shortage of nursing home beds for Medicaid patients has in great part been reduced by the policy of local planning organizations to require that a minimum of 35 per cent of beds be allocated to Medicaid patients on admission. This is now a state regulation.

- Nursing home beds are equitably distributed throughout the state so that patients can be admitted to facilities close to their families.

- Lower cost alternatives to skilled nursing facilities are being built in the form of residential health care facilities that can house and care for appropriate frail elderly patients in a more homelike setting.

- Dialysis services for End Stage Renal Disease patients is made more accessible to patients through the development of of inter-hospital arrangements between regional dialysis centers and hospitals in remote areas.

- Migrant farm workers have gained access to comprehensive outpatient services through the brokering activities of local health planning organization staff during the certficate of need process.

- When a community hospital closed because of low utilization, it was converted to needed out-patient use instead of totally eliminating health services from the area. The need for and level of services to be provided was developed with the assistance of the local planning organization.

- A health systems agency mediator worked out a compromise settlement between a health department and a hospital-based home health agency when competition threatened the financial viability of both agencies.

- The expansion of a federally approved,non-profit health maintainance organization was accomplished through the community organization efforts of planning organization board members.

- A low-cost, free standing surgery center was developed in an area of the state with poor accessibility to a nearby hospital.

- Nursing home developers were attracted to an area with a deficit of long term care beds.

- Cooperative arrangements among hospitals have been developed to establish regional centers for cardiac surgery, pediatric cardiology and magnetic resonance imaging (also referred to as nuclear magnetic resonance).

- Planning agency staff obtained designations for inner city primary care clinics as medical manpower shortage areas so that they could obtain the free assignment of National Health Corps Service personnel and thus continue to provide free and low cost care to minorities and indigent persons.

- An area-wide plan for the deployment of mobile intensive care units was worked out by planning organization board and staff members that met the needs of twelve area hospitals and incorporated the services of volunteer first aid squad, and met the requirements of the state health department for reimbursement.

These are but a sampling of success stories. I believe they are sufficient to merit a state program of local health planning now that the federal program has closed. New Jersey has been a leader for the nation in pioneering the DRG system, in guaranteeing health services to all regardless of ability to pay or place of residence, and in reducaing the cost of health care. We now have an opportunity to continue to demonstrate that citizen involvement in decisions on health care is necessary to produce a fair, rational and affordable system.

STATEMENT BEFORE THE NEW JERSEY ASSEMBLY

HEALTH AND HUMAN SERVICES COMMITTEE

PUBLIC HEARING ON LOCAL HEALTH PLANNING

Prepared by: Cynthia J. Szal
Associate Director
Health Insurance
Association of America

The Health Insurance Association of America has consistently supported the enactment of federal and state comprehensive health planning legislation and we have worked closely with both state and local agencies in the planning process since the enactment of the first federal health planning statute in the late 1960's. Today, despite the sunset of federal health planning legislation and federal funding, our commitment to health planning remains strong.

Much of the controversy over the effectiveness and the necessity of health planning today relates to the significant change in the health care delivery system. The system as a whole has become competitive and diversified. Alternative delivery systems have emerged which provide settings other than the acute care hospital and the physician office. Various insurance mechanisms, Preferred Provider Arrangements and managed care systems offer competition and diversification among payment alternatives as well. In this complex and changing environment, there is a need for responsible health planning initiatives which consider the delivery system in its entirety and develop system wide goals and abjectives. Those who argue that health planning is no longer necessary in a competitive environment contend that regulatory oversite will serve not to improve the delivery system, but rather to hamper and constrain it. We disagree wholeheartedly with this contention. An appropriate level of planning and regulatory oversite is necessary to ensure not only that the costs associated with health care are reasonable and necessary, but more importantly, to ensure the maintenance of quality and access to health care as these system changes continue.

In examining the specific needs of the state of New Jersey for local health planning, we believe that a well developed, comprehensive health planning process is essential for the coming years. The Health Department has provided us with data which indicates that by 1990 New Jersey will have an excess of 3900-7500 hospital beds or 13-25 excess hospitals. An effective health planning process is necessary to ensure that the system is downsized, and that this reduction is accomplished in such a way as to preserve the integrity of needed institutions in underserved areas. The ratio of capital to non capital costs in 1985 was 11.4% and the Health Department predicted this number will reach 25% by 1991. This compares with a national average of 7%. Effective health planning and a rigorous certificate of need process are needed to control these skyrocketing capital expenditures and to ensure that capital costs which are incurred are, in fact, reasonable and necessary.

We will be speaking in support of Assembly Bill 3022 for the authorization and funding of health planning in New Jersey. We would argue that funding for health planning is the overall responsibility of the state, and as such should ultimately come from the General Revenues of the state. However, our commitment to health planning is such that, in absence of state funding, we will support the funding of health planning agencies through the hospital's rates. We urge the Legislature to express its support for health planning as well, and we thank you for the opportunity to comment today.

THE VISITING NURSE
AND HEALTH SERVICES

ROSEMARY CUCCARO, R.N., B.S., M.A.
Executive Director

354 UNION AVENUE • ELIZABETH, NEW JERSEY 07208 • PHONE: 201—352-5694

December 22, 1986

Mr. David Price
Office of Legislative Services
State House Annex
4th Floor, CN 68
Trenton, New Jersey 08625

Dear Mr. Price:

The Visiting Nurse and Health Services urges the establishment of a statewide local health planning program. Therefore, we request the following ideas be incorporated into the testimony of the public hearing on bill A3022.

Health care planning helps to insure that finite resources for health care will be used effectively for the good of the most people. It also helps to maintain local control of health services in an era of large nationally-based providers. Without some form of health planning, many types of health care would be provided only for the most profitable groups of people. Without planning, which includes Certification of Need process. There is no mechanism to ensure that service providers are fiscally responsible and competent to meet consumer needs.

Since the federal government has declined funds for the continuation of health care planning it has become incumbent upon the state to provide for planning. As an assessment is necessary, we recommend that it not only include hospitals and nursing homes but also other health care providers, such as home health agencies, clinics and HMO's. Once again, we urge you to vote for A3022.

Sincerely,

Rosemary Cuccaro
Executive Director

RC:tm

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TESTIMONY
OF THE
NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION
TO THE
ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE
CONCERNING
THE HEALTH PLANNING SYSTEM
PUBLIC HEARING
DECEMBER 4, 1986

GOOD MORNING. MY NAME IS LESTER KURTZ AND I REPRESENT NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION, A TRADE ASSOCIATION REPRESENTING 11,000 EMPLOYERS IN THE STATE. INITIALLY, IT WAS NOT OUR INTENTION TO OFFER COMMENT ON NEW JERSEY'S HEALTH PLANNING SYSTEM BECAUSE UP UNTIL RECENTLY THE DEPARTMENT OF HEALTH'S STATEWIDE COORDINATING COUNCIL AND THE HEALTH SYSTEMS AGENCY HAVE NOT LOOKED TO THE BUYERS OF HEALTH INSURANCE TO FUND THIS PROGRAM.

BECAUSE THE FEDERAL GOVERNMENT, WHICH CREATED THE HEALTH SYSTEMS AGENCY, HAS DECIDED TO WITHDRAW ITS CONTINUING FINANCIAL SUPPORT AND HAS SUGGESTED THAT EACH STATE DETERMINE WHETHER OR NOT THIS FUNCTION IS WORTH CONTINUING, THE STATEWIDE COORDINATING COUNCIL HAS CREATED A TASK FORCE TO REVIEW THIS ISSUE AND MAKE APPROPRIATE RECOMMENDATIONS. THEREFORE, NJBIA IS IN NO POSITION TO COMMENT ON THE MERITS OF THE HEALTH SYSTEMS AGENCY AT THIS TIME. WE WOULD LIKE TO REVIEW THE REPORT AND RECOMMENDATIONS OF THE TASK FORCE BEFORE WE MAKE COMMENTS ON THE MERITS OF THE HEALTH PLANNING SYSTEM.

IT IS THE RECOMMENDATION OF NJBIA THAT IF THE STATE DEEMS THAT THIS FUNCTION IS TO BE CONTINUED, IT SHOULD BE THE RESPONSIBILITY OF THE STATE

(DEPARTMENT OF HEALTH) TO FUND THE PROGRAM. THE FUNDING FOR THIS NEW STATE PROGRAM SHOULD NOT BE SHIFTED FROM GOVERNMENT INDIRECTLY TO THE BUYER OF HEALTH INSURANCE. IF THE CONTINUATION OF THE PROGRAM HAS MERIT, IT SHOULD BE FUNDED BY THE STATE, IN THE SAME MANNER AS THE STATEWIDE COORDINATING COUNCIL.

THE NET RESULT OF THE PROPOSED LEGISLATION (A-3022 AND S-2372), AND A NUMBER OF OTHER BILLS WHICH ARE NOW BEING CONSIDERED BY THE LEGISLATURE IS TO INCREASE HEALTH INSURANCE PREMIUMS, THEREBY PLACING SUCH INSURANCE BEYOND THE AFFORDABILITY OF CERTAIN INDIVIDUALS AND FORCING EMPLOYERS TO SHIFT THESE INCREASES TO THEIR EMPLOYEES. NJBIA SUBMITS THAT THIS IS NOT THE WAY TO FUND THE CONTINUATION OF THIS PROGRAM. WE URGE THIS COMMITTEE TO CONSIDER OUR POSITION IN ITS EXAMINATION OF THE HEALTH PLANNING SYSTEM.

Office of

HEALTH PLANNING

BUREAU OF RESOURCES DEVELOPMENT

ALPHA CENTER MONOGRAPHS

The Changing Role of Health Planning

A Monograph

U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

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ACKNOWLEDGEMENTS

The Alpha Center expresses its thanks to James R. Kimmey, M.D., for his work in developing and writing this paper. Thanks are also due for the helpful suggestions from those who reviewed early drafts — David S. Abernethy, Robert M. Crane, Florence B. Fiori, Dr.P.H., James W. O'Donnell, Samuel V. Stiles, Bert H. Swift, Ph.D., Wendy G. Valentine, and Shirley H. Wester.

The Alpha Center is supported in part by the Health Resources and Services Administration, DHHS, under contract HRSA 240-85-0040. Statements in this paper do not necessarily represent the policies or views of the United States Government.

W. David Helms, Ph.D.
Executive Director

THE CHANGING ROLE OF HEALTH PLANNING

A Monograph

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Preface

Health planning...What is it? Why do it? Who should do it? Who really benefits from it? What are its costs? Who should pay for it?

These questions, frequently heard in 1986, are not new. They have been consistently raised in communities, states, and at the national level virtually from the beginning of the health planning movement in the United States in the late thirties.

The answers have been different at different times, but so has health planning and the health system. Significantly, although health planning has been questioned from its inception, it has also been supported philosophically and financially, initially by providers and the business community, and ultimately by federal and state governments. The governmental financial support health planning has enjoyed for the past 25 years is now threatened. It may be substantially reduced or even eliminated in 1986. This paper is intended as guidance for states and communities which may be faced with the question of whether or not to continue health planning activities in a restricted funding environment.

In an era when the health system is perceived as increasingly competitive, the questions concerning health planning are again current. A "conventional wisdom" has grown up concerning the health planning system as it exists in 1986. "Everybody knows" health planning is a federal program for controlling health care costs. "Everybody knows" health planning was imposed by the federal government on reluctant communities and states in the mid-seventies when costs were out of control. "Everybody knows" that

health planning has been ineffective in bringing about lasting change in the U.S. health care system. "Everybody knows" that health planning is redundant in a competitive health care system. Like most things that "everybody knows", there is a grain of truth in these assertions, but that grain is outweighed by the considerable misinformation implicit in the statements.

Health planning is defined for purposes of this monograph as efforts undertaken above the level of the single institution, organization, or corporation level to identify future problems and opportunities in the health system and to develop strategies to meet them in an effective, efficient, and acceptable fashion. Put another way, the health planning that this paper addresses is **organized, suprainstitutional,** and **goal-directed.**

Given these definitional constraints, the review will **exclude** organizational strategic planning and project planning, organizational planning related to budgeting, planning related to legislation for specific governmental programs, and the like. It will **include** planning efforts which meet the definition in the first paragraph regardless of the auspices of the effort. Thus, consideration will **include** legally constituted health planning entities such as HSAs; governmental health planning efforts which deal with the health system broadly; efforts of business coalitions; and multi-institutional voluntary planning efforts.

Trends affecting the health system which bear on the need for planning will be identified and explored. In addition, the functions which a state or community planning structure might carry out in a changing health care environment are reviewed. The discussion provides a basis for states and communities to determine the desirable scope of a planning effort tailored to the needs and desires for their health care systems in the context of the late eighties.

Part I: A Brief Look at the Evolution of Health Planning

Health planning has evolved as a virtually unique expression of the spirit of voluntarism in America. It has in recent times become associated in many people's minds with a particular federal governmental effort to exert control over health cost inflation controls, but health planning has a much longer history as a community and state effort to make the health system more responsive to people's needs and consistent with community resources.

- The initial efforts to develop a community blueprint for shaping health services were undertaken by loose coalitions of community leadership, business, and health care providers in urban areas nearly half a century ago.

- Such planning bodies—in the form of hospital review and planning councils and community health and welfare councils—operated with local contributions for twenty years before the first governmental dollar was spent in their support.

- Early planning bodies began practices which became traditions and ultimately legal requirements governing such activities—citizen boards, open meetings and procedures, and published plans and studies are examples.

- Each step in the evolution of community and state health planning has built on the preceding step. In the community, this evolution was from hospital review and planning councils to areawide comprehensive health planning agencies to health systems agencies. At the state level, state facilities planning agencies and state categorical planning bodies led to state health planning agencies which evolved toward state health planning and development agencies.

- Across this entire history, while governmental financial support increased and the identification of health planning with regulatory functions grew, certain consistent features remained—specifically, extensive volunteer participation in governance and guidance, and a community focus to the activity.

The structural evolution of health planning was accompanied by a functional evolution as well.

- As the interests of the facility-oriented and community-oriented planning bodies became closer, the focus of health planning broadened to encompass all aspects of a community or state health system.

- A perceptible shift from planning as a non-directive activity towards planning as a resource allocation mechanism occurred with each revision of the federal planning legislation.

- The planning agencies' review function received increasing emphasis as concern grew that allocative decisions should follow the priorities and actions recommended by such agencies.

- The early concern with a planning **process** gave way to a heightened interest in the planning **product**—the plan document, and its use in decisionmaking.

- Growing frustration with attempts to stem the rising tide of health costs led policymakers and legislators increasingly to rely on planning agencies' activities as a cost control mechanism.

These changing functions, often imposed from outside the planning structure as a condition of funding, sometimes worked to the detriment of planning's effectiveness.

- Business interests drifted away from support and participation in organized health planning efforts as planning became increasingly identified with government and regulation of health care.

- Hospitals and other providers became increasingly uncomfortable with planning as it was given increased power to implement plans and force changes in providers' plans for development of their portion of the health system in an area or state.

- Planning agencies had problems reconciling their traditional development-oriented role and their growing role in controlling and directing development of the system.

- The perception grew at the community level—fostered by provider interests—that planning was a "federal program" imposed from outside, and was working against the community's best interests.

- A growing competitiveness in the health care system was interpreted by many as indicating a lessened need for a planning structure and activity at any level, particularly as it related to regulation.

This brief overview of the evolution of the health planning movement in the U.S. is intended to give the reader a sense of the process. A more comprehensive discussion of the development of the health planning system is included as an Appendix to this monograph for those desiring to examine the topic in greater detail.

Part II: Current Problems and Trends Affecting Health Planning

Part I briefly traced the evolution of community and state health planning in the United States. From the standpoint of developing a view of the changing role of health planning, the current situation is equally or more important. This part deals with the current situation in health planning in the United States; analyzes problems faced by community and state health planning; and identifies trends, external to the health planning component, which will affect it in the future.

The Current Status of Health Planning

If a single word were to be chosen to describe the current situation in which the health planning field finds itself, it would be "uncertainty."

At the local level, the major uncertainties are whether or not federal funding for such activities will continue in the future and whether or not there will continue to be a federal statutory basis for local planning. At the state level, uncertainty stems from similar concerns with federal funding and authority, as well as from concerns with the new responsibilities being devolved upon states as the Reagan Administration decreases the federal presence in the health arena.

The financing uncertainty is not a new one. The Carter Administration had proposed heavy cuts in the amount of money available to HSAs. At the same time, the agencies themselves have felt that federal appropriations have never been adequate to the tasks assigned. The Reagan Administration has consistently opposed federal funding for these activities. Congress did not choose to accept these recommendations, providing instead markedly restricted budgets for both HSAs and State Agencies beginning in FY 1982. The effect has been a reduction in the staffing and scope of activities in most areas. At the present time, funding is sufficient only for operations through the end of FY 1986.

The second major source of uncertainty concerns the future of federal authorizing legislation. Technically, the authorization for federal funds for health planning expired on September 30, 1982. Although the basic statute has remained on the books since that date, the program has been funded on the basis of a series of continuing resolutions for the past four fiscal years. The question remains whether or not there will be authorizations for future health planning activities and what those activities might look like. Unless the Congress enacts new authorizing legislation, and the President signs it, or unless funding is provided through appropriations legislation, federal participation will terminate September 30, 1986. If new legislation is passed, it is likely to provide the states with additional responsibilities, both for design of the future health planning system and for its management.

Problems Internal to Health Planning

There are a number of problems within the health planning system in the mid-eighties which must be considered in projecting the future of the movement. These can be classified as financing problems, technical problems, and political problems.

Financing Problems

Maintaining adequate financial support for community and state health planning activities is not a new problem. The planning component of the health system has never been richly funded when compared to the investment in planning in other sectors of the economy. As indicated in Part I, initial community health planning efforts were funded by contributions from institutions and business. With the advent of partial federal funding in 1961, there was both an absolute and a relative decrease in non-federal monies made available at the local level. Federal dollars supplanted rather than supplemented local dollars, a trend which continued in the 314(b) CHP era.

P.L. 93-641 made fundamental changes in the funding pattern for community health planning. Certain health industry monies were deemed unacceptable, including most

sources which had contributed support to earlier agencies. Thus hospitals and health insurance carriers were excluded out of fear of excessive influence on the process. The availability of federal funds--coupled with limits on allowability of the most likely sources of local funding--led to heavy HSA dependence on the federal resources. Furthermore, appropriated funds never reached authorized levels, and HSAs generally felt the resources provided were inadequate in the face of the breadth of responsibilities assigned the planning structure.

The decline in federal support has given the agencies the difficult task of rebuilding local financial support. The environment in which this task is pursued is quite different from the environment of the sixties, when health planning last enjoyed a substantial level of local financial support.

- The general problems of the economy have curtailed charitable giving by the business community.
- Business and industry coalitions are also competitors for whatever dollars business might contribute, and the growth of large conglomerates through acquisitions of formerly locally owned enterprises has also had an effect on corporate commitment to supporting community activities.
- Institutions are seeking to hold the line on costs, making them less likely sources of dollars for suprainstitutional planning than once was the case.
- Foundations have limited interest in support of operating programs and are themselves under heavy demand pressure as a result of general federal cutbacks in research and program funding in all social service areas.

State Agency finances present similar problems. One difference, however, is that there was virtually no state financial support for state-level planning activities prior to the federal involvement in Hill-Burton and state comprehensive health planning under section 314(a) of the PHS Act. State planning efforts, therefore, have a longer history of dependence on federal dollars than do local efforts. Further, a state government is much more restricted than a community health planning organization in the sources of funding it can hope to tap.

The alternatives for a state hoping to maintain planning efforts in the face of a severe cut in federal funds are very limited. Basically, the state can use general purpose revenue or program revenue. The pressure on general purpose revenue is severe in most states. A certificate of need program can generate program revenue through application fees, but in many states such revenues go to the general fund rather than being reserved for the program that generated them. Federal budget cuts in recent years have forced most states to make downward adjustments in staffing and program activities related to health planning and review in order to compensate for the lost federal revenues. To date, a relatively small number of states have made a significant commitment of their funds to replace declining federal support for health planning, and fewer still have provided state support to local planning efforts. The total amount spent by states to support local planning in FY 1985 was $ 5.3 million, but there is no current indication that states would be willing to take up the slack were federal funding to the locals to be terminated.

In terms of the future, total loss of federal support for health planning would probably lead to its disappearance as an identified organized effort in most communities. The experience in the states which opted to operate without federally-supported local planning is instructive. In the majority of health service areas within such states, the withdrawal of federal funds led to discontinuation of organized local planning efforts. The areas which maintained a planning activity tended to be populous urban areas with a long history of community-supported health planning reaching back to the Hospital Review and Planning Council/Community Health and Welfare Council days. Smaller communities and communities without a history of planning could not identify and secure the necessary financial resources.

States could be expected to retain some health planning in the absence of federal funding, although efforts could hardly be expected to be uniform. States which have a

continuing commitment to shaping the health system through external controls will need a planning process to support that commitment. As a minimum, such states might be expected to continue to do facilities planning. Without support, however, broader health planning efforts would become increasingly focused on programs which have impact on the state's budget—Medicaid would be one such program. The majority of planning related to state health responsibilities would rest on the program agencies assigned management of those responsibilities, a situation not unlike that which existed in the pre-Comprehensive Health Planning days.

Technical Problems

In this context, technical problems refer to those which relate to the methods and approaches utilized in conducting health planning and review of programs at both the community and state levels. Most of the technical problems cited can be tied to limited resources rather than lack of appropriate techniques for planning.

As indicated several times in this monograph, the collection and analysis of community health data has assumed a predominant role in health planning. The techniques required are well known, as are the types of data which must be considered. Health planning agencies, however, have had difficulty in acquiring and managing the data needed to answer/address pressing regional/state problems/issues. This has occurred despite supportive efforts from federal programs such as the Cooperative Health Statistics System, and recent efforts by the Office of Health Planning. Several factors are involved.

- Agencies, whether state or community, have had problems gaining access to certain key types of health data, specifically those relating to utilization and costs.
- Providers, concerned about both confidentiality and the proprietary nature of such data, have been reluctant to provide it to agencies, a problem which can be expected to become worse in a more competitive environment.
- Many agencies have been unable to make the necessary investment in computer hardware, or do not have the staff capability to use it effectively.

Taken together, these factors have led to a critical lag in the adoption of modern data processing technology in the planning process.

Data processing is not the only technical area in which health planning has experienced problems:

- The rapid organizational and financing changes in the health care field have also contributed to a "technological lag" in planning methodologies.
- An example cited elsewhere in this monograph highlights the problem of planning techniques for the introduction of new technologies.
- The transition in focus from resource-based to population-based planning produced a lag in applicable techniques.
- The shift in focus from planning largely directed at inpatient services to planning for the out-of-hospital setting has required development and application of new techniques in planning.

Diffusion of planning techniques has been slowed by budget cuts which restricted the training, consultation, and publication programs of the Centers for Health Planning after 1981. Similarly, agencies have had to limit their inservice training activities as a result of funding cuts.

Political Problems

The political problems faced by health planning agencies at the community and state level are extensions or reflections of other classes of problems facing health planning. One set of political problems stems from the planning structure's identification with regulatory efforts to contain health care costs. This identification of planning solely with cost containment is a legacy of the late seventies, when federal policy placed heavy emphasis on planning's role in direct regulation of the health industry. It has contributed to a complex set of local, state, and national perceptions which are now political liabilities.

At the local and state levels, planning's image as a regulatory process has eroded both participation and support of providers for the planning process. As Uwe Reinhardt has pointed out so succinctly, every dollar of health care expenditure is equally a dollar of

health care income. This means that health care cost containment equates with health care income containment, producing resistance among providers:

- Hospitals and physicians, while espousing support for "community health planning," have opposed the current model both locally and through their state and national organizations. (The American Medical Association has been particularly active in its efforts to secure repeal of federal support for planning activities.)

- The current planning structure has also evoked political opposition from local officials who feel that the program should be based in local government rather than a nonprofit structure or at least insure greater involvement and control by local government.

- These types of opposition locally have often stood in the way of effective implementation, nonregulatory as well as regulatory, and interfered with efforts of existing HSAs to raise funds locally to continue a planning process.

At the national level, the regulatory image of planning has also created political opposition. Curiously, opposition has come from both proponents and opponents of regulatory approaches to health care cost containment. Prior to 1981, the proregulatory Carter Administration was preparing to shift the federal policy and funding emphasis to states from the local areas because of the perceived failure of locally linked regulation to contain costs. Beginning in 1981, the Reagan Administration has moved even more aggressively to withdraw support from state and local health planning because it too perceives a failure to contain costs. In the latter case, the perceived failure is compounded by the belief that the health planning agencies are primarily regulatory bodies and are therefore inherently undesirable.

The outcomes of the political unpopularity of planning at the national level have been expressed in Congressional efforts to defund the program, to shift the emphasis and responsibility to the state level, and to decrease the regulatory stringency of activities like certificate of need. In the present environment, the lack of enthusiasm for health planning also flows from a growing interest in competition in the health sector on the part of political leaders and others. Planning, even without regulatory linkages, is seen at best as unneeded and, at worst, as interfering in development of competition.

In a political context, health planning is currently a program without an effective constituency. The possibility that Congress may extend federal support for such activities is based less on the conviction that it works than on the fear of the effects of its demise in the absence of alternatives. Even this "back door" reasoning is losing its appeal as the federal government moves toward incorporation of capital reimbursement into the DRG payment system. There is a widespread assumption that such action would eliminate the need for regulation of capital investment and, therefore, for planning.

External Trends Affecting Health Planning

In addition to the factors that impact directly on the health planning function and the structure in which it is carried out, there are a number of significant trends in the society and in the health system in general that will affect the activities of health planning in whatever form it takes in the future. These factors need to be understood, since they have a major role in shaping the planning response in the future. Trends will be identified and summarized in the areas of demographics; health facilities and services; health-related technological equipment; health manpower; and health expenditures.

Demographics

There are a number of important established demographic trends that will shape the health care system, and the task of planning that system, in the future.

Population Shifts. Significant population shifts are occurring today from the snowbelt to the sunbelt, from urban cores to suburban areas, and from rural to urban areas. Such shifts of population create problems for the health system in both the areas gaining population and in those losing population:

- The areas gaining population may require additional capacity to handle the larger population.
- Health services in the areas losing population may see utilization drop to uneconomic levels.
- Each creates resource distribution problems that require careful adjustment of

resources to meet the needs of the areas, with increases and decreases alike, in an economical fashion.

Aging of the Population. Another demographic trend that will affect the health system in coming decades is the aging of the American population:

- As the number of older persons in the population increases, it will require both quantitative and qualitative changes in health services.
- Older individuals already account for a third of the resources devoted to health care, and as their numbers swell, the resource demand will increase apace.
- Older individuals require services in different settings, such as community and home programs, which are yet to be fully developed in most areas.

The concomitants of aging may constitute the single most serious problem facing social and health planning in the next three decades.

Acute Care Facilities

The acute care system has been the focus of a great deal of health planning's attention from the earliest days. The traditional centerpiece of the acute care system has been, and continues to be, the short-term general hospital. Trends occurring in the hospital component of the system thus have particular relevance to the health planning system.

Multi-institutional systems represent one of the fastest growing components of the acute care hospital sector. The increasing financial pressures on institutions, particularly those relating to the availability of capital for renovation, replacement, and expansion will create additional pressures for hospitals to participate in multi-institutional arrangements, and this will affect planning in several ways:

- The trend toward larger and larger centrally managed systems that cut across planning areas and even state boundaries' will complicate both planning and decisionmaking by community and state agencies in the future.
- Large systems may make their decisions concerning expansion and contraction of capacity and services on the basis of corporate concerns that may have little relation to local, or even state, planning concerns.
- Planners will be dealing with distant corporate managers rather than local and familiar institutional managers.

These new factors in dealing with institutions will require innovative approaches on the part of planners. They also provide opportunities for planning agencies to provide services such as local data analysis to the multis.

Investor-owned hospitals are also increasing in numbers as large chains acquire previously freestanding community institutions. If debt capital continues to be difficult to obtain, or become still more costly, the need to go to equity markets for financing may accelerate the trend toward for-profit institutions. Their spokesmen say that such institutions have better management practices than nonprofit institutions and are more efficient in their delivery of health care. At the same time, there have been accusations that such institutions engage in "cream skimming" and other practices that work to the detriment of nonproprietaries in the same community. Although many of the claims and counterclaims concerning proprietary ownership have yet to be settled, the upward trend in such ownership continues. The need for new planning approaches to multi-institutional systems applies with even greater force to the investor-owned systems. In addition, an increase in such institutions will bring a different kind of competition to communities, one which will affect the planner's task.

Internal management practices of hospitals are also changing rapidly in response to prudent purchasing practices on the part of government, insurers, and business. Many of these changes will also impact on any future suprainstitutional planning efforts in communities and states:

- Institutions are expanding their own internal planning capabilities and are beginning to undertake long-term strategic planning on an institutionwide and service-area basis rather than an individual project basis.
- Institutions are devoting more resources to identifying their markets and market shares, and to designing programs to enhance the institution's position vis-a-vis other institutions in the community or region served.
- Diversification is taking place in both chain and independent hospitals, broadening the base of income-generating activities beyond those covered by the third-party payment system in an effort to stabilize their financial status and improve their cash flow.

— Another explicit policy being applied by many institutions in an effort to improve their financial position is to decrease their dependence on less-than-cost reimbursed patients such as those under Medicaid and certain other third-party reimbursement programs.

-- Hospitals have come under heavy criticism for cost-shifting, under which paying patients must make up the losses incurred as a result of less-than-cost reimbursement by government programs and other large purchasers.

Renovation and replacement trends will also affect planning and decisionmaking in the future:

— Hospitals with legitimate need for replacement or renovation of obsolete or deteriorated facilities will need to consider the costs of the alternatives more carefully than in the past.

— Replacement often means relocation away from traditional service populations, creating access problems of concern to planning.

— The increased interest in non-replacement options which stems from the cost of total new construction is a trend which can affect distribution of services as well as cost.

Noninstitutional Providers

Another significant trend in the industry is the growth in the number of organized multiphysician, multispecialty prepaid service arrangements, generically known as alternative delivery systems (ADS). Best known among these arrangements are the health maintenance organizations (HMOs). Partially in response to the success of HMOs, a number of less structured alternatives to the fee-for-service system have emerged. Independent Practice Associations (IPAs) and Preferred Provider Organizations (PPOs) are currently most popular, but there are a number of other such arrangements, including insurance company prepaid plans and primary physician plans, which do not meet the definition of an HMO.

All of these efforts are designed to provide quality services at a lower cost than the fee-for-service system. All of them share a common interest in decreasing use of inpatient facilities on the part of their enrollees. Although the proportion of the population served by alternative delivery systems grew slowly for a decade, it has now entered a period of explosive growth in many areas. Such groups have, in most cases, had a demonstrable

impact on utilization of institutional capacity, accompanied by cost savings. The expansion in the number of such groups has already been accompanied by changes in demand for inpatient capacity which, in turn, have direct effects on planning activities focused at the institutional level.

Prevention and Promotion Programs

Another trend which is noninstitutional in the traditional sense is the growth in prevention and promotion activities:

- Such programs are often sponsored and operated by institutions as a part of a diversification strategy.
- They have a long-range potential for decreasing services utilization, as well as short-range advantages in improving individual health status.
- They represent an important area for program development by planning agencies, which can assist in their development.

Health-Related Technological Equipment

Perhaps more than any other field, the health field has developed a "technological imperative." Because of the place of health in the value system of our society, the general approach to emerging diagnostic and therapeutic technologies has been "if it can be done it should be done, and damn the cost." Though some would consider this a simplistic view of the diffusion of technology in the health industry, the fact remains that technology has accounted for up to fifty percent of the increase in hospital costs in the past ten years. Each year, new advances which have the potential to prolong life, improve individual functioning, or sharpen diagnosis appear in the medical literature and become available commercially for application in the health system. Many high cost technologies come before planning agencies as a part of the certificate of need program. Such technologies present planners with several problems:

- Assessment of the need for the technology when there is relatively little experience on which to base such an assessment plagues the planning process.

- The introduction of new technologies can be expected to continue to challenge planners in the absence of a stronger governmental or industrial commitment to controlled trials and other tests prior to introduction.

- The problem may well be complicated further if controls on capital are relaxed, and increased dependence placed on the financial consequences for individual hospitals of poor decisions substituted.

- In the case of technology, such a policy might cut two ways. On the one hand, hospitals might opt to acquire an expensive technology such as an image enhancement device, assuming that losses on its use will be offset by increased patient loads attracted by the hospital's "high tech" image. On the other hand, some efficacious but money-losing technologies might be denied the community as no institution is willing to bear the potential losses, not unlike the "orphan drug" situation in which drugs desperately needed by a small number of patients are not manufactured because they are not remunerative.

Health Personnel

Trends relating to health professions personnel can also be expected to affect health planning in the future. The term "health professions personnel" includes undergraduate, graduate, and postgraduate trainees, as well as individuals engaged in practice in the health professions. Variation in the numbers, specialty distribution, type of practice, and geographic location of such personnel have significant impact on planning for the future development of the health system in the United States. Trends important to planning include:

- There is mounting evidence that the increased investment in training has produced an "excess" of physicians and nurses that will extend through the end of this century.

- The problem of excess production has been complicated by changes in the "need" for health professionals in a changing reimbursement environment.

- The implications of excess on services to medically underserved areas or on numbers of physicians who practice in undermanned specialties are still largely matters for conjecture.

- An excess of physicians and nurses may create problems in the allied personnel area, particularly for various types of physician extenders, as they reclaim functions delegated in a time of shortage.

Health Care Financing

Trends in health expenditures, which include financing of both resources development and systems services (capital as well as operating costs), may well have the greatest effect on future developments in the health system and in planning for that system of any of the factors discussed above. In part, this is because other trends--particularly those in the acute care facilities--are the result of financing trends:

- The federal government's substitution of prospective payment based on diagnosis related groups (DRGs) for retrospective cost-based reimbursement as the basis for payment under Medicare has stimulated rapid and fundamental changes in the health industry.

- The imposition of fixed payments by diagnosis rather than cost reimbursement has shifted the incentives for institutional managers toward elimination of unnecessary hospitalization and testing.

- Increasingly, insurers and business are adopting prudent purchasing techniques, seeking and receiving discounts for volume, monitoring provider practices and consumer use.

- Alternatives to hospitalization have gained impetus, and can be expected to grow.

- Many observers consider DRGs an interim step on the road to a payment system for Medicare based on capitation, covering both physician and institutional services, a policy change which would give added impetus to efforts to control use of institutional services.

- The availability of capital for investment in new facilities and equipment or for replacement and renovation of existing facilities and equipment may be the factor with the greatest influence on development of the health care system in the next decade.

- The treatment of capital under the prospective payment system for Medicare is a significant consideration for planning.

- A formula-based capital payment system is widely perceived as negating the need for external control over hospitals' capital investment activities, since they would avoid decisions which did not make good economic sense to the institution.

- Many believe, however, that major capital investment should be based on broader, community considerations such as availability of and access to services and the economic effects on communities and states.

Summary

This discussion has touched on a few of the most significant trends which will influence the future development of health planning at the community and state level regardless of the structural or financial mechanisms involved in supporting such planning. The rapidly changing health care environment confronts states and communities with a wide range of challenges, and efforts to exert control over the actions of providers and payers appears to be declining. In this situation, the importance of providing users of health care services with information which can support effective decisionmaking is growing. Similarly, a re-emergence of dependence on the decisions of autonomous provider organizations to shape the community's health care system will inevitably raise questions concerning the effectiveness of their independent, largely financially motivated, actions in meeting the broader social need served by the health care system. The sum of the trends suggests a new set of roles which communities and states need to consider if they are to meet their broad responsibilities for the health of the public. Monitor, educator, evaluator, data source—these are but a few of the potential roles which would arise. In the rush of enthusiasm for increased health care competition which has emerged in the past five years, many voices have been raised in opposition to an active planning and monitoring process outside the industry itself. Analysis suggests that the proper response is not abandonment of community and state responsibility to assure that health services are available, accessible, acceptable, cost-effective, and of high quality, but rather that a redefinition of the structure, scope, and methods used in pursuit of these accepted goals for a community's health system be achieved. The remainder of this paper deals with the definition of a concept of health planning consistent with the current and future health care system in the United States.

Part III: Defining the Health Planning Concept

The first two parts of this monograph provided a background on the health planning system and the forces in today's environment that will shape it in the future. This section will deal with a synthesis of the information gleaned from the decades of experience with health planning and will present a concept of health planning that might carry forward regardless of changes that may take place in the organization and financing of health care services.

Social Values Associated With Health Planning

Although health planning has undergone a great deal of evolutionary change as the health care delivery and financing systems have evolved, certain values have remained fairly consistent across the entire history of the movement. Although some of them will be challenged, these values will continue to be important to many in health planning efforts in the future regardless of its auspices or degree of formality.

Community Orientation. For the most part, health services are delivered in communities, by and to community residents. Appropriately, much of the support for efforts to shape the community's health care system has come from within the community. Communities have been less than willing to give up their voice in these matters to the state or federal government. Although the recent pattern has been for the financial resources for planning to come from outside the community, the vastly more important contributions of time and effort have come from within. The concept of an organized community role in decisions concerning the nature of its health care system is now undergoing its severest challenges. These challenges are coming from two major sources, although the relative importance of each varies across the country. First, as indicated earlier in this monograph, state governments are asserting their interests in planning, particularly as they relate to services and facilities regulated or financed by

the state. The implications of this factor vary. On the one hand, New York has determined that organized local planning is sufficiently important in carrying out state responsibilities that it provides financial support for such efforts. In contrast, some states have opted to plan without organized local input. They have not chosen to provide any realistic means for local preferences to be expressed in the state planning and decisionmaking processes. Second, the expansion in multihospital systems has removed a major element of control from the hands of the local residents with the conversion of Boards of Trustees of local hospitals to advisory groups. Major resource allocation decisions are vested in a body outside the community, and are made in the context of corporate strategy rather than community strategy. Both factors appear to dilute community input in the process of determining the nature of the community health services system. It is too early to conclude what, if anything, is lost by this and how communities will react to perceived or actual changes that may take place outside of their control.

Voluntary Nature. A second value that has persisted across the history of the planning movement is its voluntary nature. Both community and state planning efforts have involved and been dependent upon efforts of volunteers in governance and advisory capacities. Although local governments have been successful in health planning in some areas such as Minneapolis-St. Paul, the vast majority of local planning agencies have been non-governmental, nonprofit organizations. This design both reflected the roots of the movement in the voluntary hospital and voluntary agency sectors and the pluralism of the health care system. A voluntary agency structure was found to provide the best opportunity for representation of the many different interest groups involved in health at the community level. Although the system is changing, it will remain pluralistic, and thus the basic justification for a voluntary approach will continue, although there may be states or areas where its use is diminished.

Broad Scope. A third persistent value in health planning is that the scope of planning should extend to all aspects of the health system and not be limited to a single component, such as facilities. Generally, this has been more strongly held at the community level than at either the state or federal levels. As major payors have been confronted with a cost escalation problem, government at both levels has tended to focus more narrowly on delivery of personal health services. Community planning bodies, on the other hand, have become involved in a wide range of health related issues. In the current environment, with its intense focus on costs and delivery, there is a tendency to lose sight of the importance of non-delivery issues, and planning has a responsibility to assure that this does not occur.

Open and Participative Approach. The last of the social values that have become strongly linked with planning is the development of plans and rendering of decisions in a way that promotes open discussion and resolution of issues. This value has been institutionalized in requirements for public meetings in the course of plan development and project review; open access to planning agency records; and avenues of appeal of contested decisions. Despite this sometimes ponderous approach, the openness of the planning process has been one of its strengths, not only improving the quality of decisionmaking but giving legitimacy to the planning process.

Structural Values Associated With Health Planning

As health planning has evolved, a set of structural values has become associated with it that tends to support the social values above. These, too, are worthy of consideration in the context of planning's future.

Citizen Boards/Councils. This is the structural manifestation of the voluntarism and participation values. Both community and state health planning have been guided by volunteer citizen groups and advised by committee structures of varying complexity. These bodies have been at the heart of the process, providing a mechanism for representation of both interest groups and the community at large. It has been the Board/Council members who have given the process much of its vitality and its "staying power" in difficult times.

Independence from Program Responsibilities. It has been characteristic of community health planning bodies that they have been independent agencies without direct responsibility for implementation or operation of health programs. This structural approach underlined the planning bodies' objectivity and lack of vested interest in the issues in which it was involved. At the state level, the function was less commonly independent, tending to be located in the state's major health agency. The potential problems this raised were discussed earlier in this monograph.

Professional Staffing. Ideally, health planning agencies at the state and community levels would have been staffed by full-time professionals who had the skills necessary to support the activities of the agency's volunteer leadership and advisory groups. This ideal state has rarely been achieved, or, once achieved, maintained. Initially, there was no definition of the set of skills required to support health planning efforts, and the initial staffing at both levels came from a variety of backgrounds. These individuals did much to define the field's requirements, and their ideas in turn formed the basis for the curricula in health planning which emerged during the CHP era. Two factors conspired to dilute the effect of the growing supply of trained planners on the planning agencies. First, the trained planners did not all gravitate to the agencies, opting instead for consulting firms or hospital jobs, and those who joined agencies often moved on after a short time to higher paying positions in the industry. Second, the rapid changes in the health care system and the associated changes in the planning agencies' tasks changed the agencies' requirements faster than the system for training planners could adapt. A prime example was the tendency of the training programs to emphasize process and community development skills while the field was moving rapidly to a quantitative orientation.

Centrality of the Plan

Once planning settled on a document orientation, the linkage of all resource allocation decisions and policy advisory decisions to the plan became a strongly-held value. This provided a basis for coordinating responses of various action agencies, and for developing specific criteria and standards to guide development and decisionmaking. Both state and local planning agencies developed such plan documents, and the documents were perceived as authoritative expositions of an agreed upon health future. The nature of the plan development process also invested the plans, and related criteria, with status as consensus documents representing distillation of a variety of viewpoints concerning development of health services.

Part IV: Considerations for Future Development

Since 1981, the health planning program at all levels has been in a holding pattern, living from year to year on continuing resolutions and under continuous political attack. That the system has survived and functioned during this period is a tribute to the degree to which the concept has become institutionalized and to the tenacity of both volunteer and staff participants in the process. The structure created by P.L. 93-641 has been locked in during this period, as have the major functions. Concurrently, there has been tremendous change in the health care delivery system, requiring adaptive change in the approach to planning. Such change has been difficult in the uncertain environment of the last five years. It is clear now, however, that the health planning system is on the verge of fundamental change, whether or not the Congress acts on new authorizing legislation. If Congress acts, the system the federal government will fund will clearly be different. If Congress fails to act, the decision on whether to continue health planning, and the shape such planning will take, will be decided at the state and community levels. In either case, the states' role in the health planning system will be expanded, and states will have a range of choices not available under current legislative authority in defining the scope and structure of health planning activities within their borders.

In this section, the range of decisions with which states and communities must deal in a more permissive environment are explored.

State Options and Decisions

Control Issues

A primary issue for states in the current environment is the degree of control the state will exert over development of the health care delivery system within its borders. Under provisions of P.L. 93-641, states were required to operate certificate of need programs as a condition of receipt of federal funds, and most complied. In recent years, under

provisions in the continuing resolutions suspending the imposition of penalties, several states have dropped or narrowed the scope of their programs. New federal authorizing legislation is likely to make capital expenditures control optional.

States vary widely in their interest in use of controls, particularly as the health system is viewed as increasingly competitive. Factors which affect a state's position on the control issue include:

- The state's political history on control issues in relation to the health system.
- The current political climate in the state.
- The size of the state's health care system.
- The cost of state medical care programs and the extent of the medically indigent population.
- The strength of the health care provider organizations in the state.
- The extent of the concern by business groups, as payers of health benefits, with system-wide cost issues.
- The degree to which alternative delivery systems have gained market share within the state.

States with large health care systems and large state financial responsibilities for medical costs are more likely to feel that controls are necessary as a protective mechanism. States with maldistribution problems are also likely to consider use of controls as a redistribution mechanism rather than a primary cost control effort. On the other hand, states with well developed competitive structures and growing populations are less likely to generate the political support needed to maintain tight control on the health care industry in today's environment. At the risk of oversimplification, the "Rust Belt" states—with older plants, large systems, and a heavy concentration of poor—are most likely to take a control approach, while the "Sun Belt" states—with growing populations and active competition are more likely to abandon controls.

Decentralization Issues

States will also need to determine the degree to which they will be supportive of operation of a substate system of planning agencies. Again, the range of choice available will vary depending on the provisions of any federal authorizing legislation. As a minimum, states can be expected to have a larger role in reviewing and approving applications for federal support from local agencies. Under a block grant scenario, states may have the option of deciding whether or not any federal dollars flow to local agencies, and without federal legislation, they would need to determine whether state funds might be used to support such efforts. In addition to the factors which affect a state's response to health planning in general, this issue may be affected by the following:

- The history of state/local relationships under current health planning legislation.
- The state's perception of the importance of locally-directed input in health planning issues.
- The state's financial situation, which would affect either allocations under a block grant or direct or supplemental funding for local agencies.
- The political strength of existing local planning agencies.

States have been contributing financially to local planning in increasing amounts over the past five years, reaching a total of $5.3 million in FY 1985. A few states, however, have accounted for the majority of the funds. The states will be evaluating the level and type of commitment they should make to health planning at both the state and local levels at a time when state budgets are stringent and federal support declining across the board. The case for health planning will need to be persuasively made to state political leadership if such support is to be forthcoming and adequate to the task.

Scope of Health Planning

A third area for consideration by state policymakers at a point of transition from a program where federal law and regulation were highly prescriptive to one where the

state has greater latitude is the scope of planning. This is related to the control issue as well. Issues include:

- Whether or not the state's concerns in the health planning area encompass more than control (to the extent the state embraces control) to broader issues of health policy.
- The nature of the state's responsibilities in the health data collection, analysis, and dissemination fields needs full consideration in a time when data is both more important to consumers and third parties and more jealously guarded by providers.
- The extent to which a non-operating planning effort's products should govern the activities of state program agencies with their own goals, constituencies, and appropriations.

The outcome of a state's consideration of such issues has implications for the structure and level of funding required by any state health planning agency, as well as for legislative authority which might be required.

As indicated above, local options concerning the nature of any health planning system, previously constrained by federal funding requirements, may become constrained in the future by state decisions as to the pass-through of federal funds. Although these can be expected to vary widely from state to state, even with new federal legislation, there are a series of issues which will face those desiring to continue local planning efforts under any scenario.

Funding

The development of adequate funding to perform the range of tasks appropriate to planning agencies in a changing environment will be a challenge under any set of assumptions concerning the future. This is not a new problem for local planning—it has been an issue throughout the period of dwindling federal support. Among the strategies which have been successfully carried out in the recent past are:

- Development of funding from local governments, business and industry, local foundations, and local provider interests.

- Development of "products" such as consulting services, training services, or data analysis, and the marketing of those services in the area.

- Establishment of contractual relationships for staffing of emerging or established business coalitions in an area.

There has been an extensive literature of reports on fundraising activities developed by the Centers for Health Planning over the past four years which deals in detail with planning agency efforts to expand their funding base. Clearly, if local agencies are unable to effectively develop alternative sources of funding, it will be difficult to sustain a local effort under any reasonable scenario for the further development of community health planning.

Relationships

Local planning agencies will also have to reassess their relationships with all segments of their communities if they are to function effectively, much less be able to develop funding sources. As indicated in the discussion of the history of health planning, the program has had difficulty throughout its existence developing a stable constituency. There are a number of interests which have been involved in health planning for a time, but whose interests, for a variety of reasons, have turned elsewhere. In the current environment, health planning agencies need to reassess their relationships and seek opportunities for joint efforts with others which can expand the effective use of their limited resources. Among the interests which should be considered are:

- Local governments, which in many states are feeling the brunt of the problem of meeting indigent care needs, and which have an interest in the quality and cost of health services generally.

- Hospitals and hospital groups, which are finding communications around shared concerns difficult in an environment of heightened competition.

- Business coalitions, which have emerged as a response to a reawakened concern with health care, which often are minimally staffed and need data and technical help, yet which have strong potential leverage for change in the health industry.

- Community chest/United Way organizations, which are increasingly important as a source of funding for community health activities other than direct care.

— Third party payors, who have maintained support of health planning activities, but who are in transition in many cases to more active roles in providing services or controlling provision of services in the community.

In the past, the community health planning agency was expected to serve as a forum in which these many interests could exchange views. With the perception that the HSA was a federally mandated agency with a regulatory mission, the function as a forum suffered. In an increasingly market driven system, with larger provider organizations that may be governed from outside the community, there is even greater need for the forum function.

Implementation Strategies

Community health planning agencies will also need to reassess their implementation strategies. Clearly, any scenario in the present situation will involve less control over resource allocation, whether through certificate of need or other means. Health planning had many traditional tools which may have renewed usefulness:

— A re-emphasis on special studies focused on key issues of current concern can foster development of allies, garner desirable publicity for the agency, and sometimes attract special funding that would not be available for general support of the agency.

— Use of persuasion was once planning's major tool, with the agency using its plans as the basis for creating public pressure on providers to develop programs in directions indicated by the plans, and may have renewed applicability in influencing provider decisions in the absence of strong controls.

-- Development and dissemination of data concerning the effectiveness of the health system is related to the persuasion tool, but is also key to monitoring the system's effectiveness in meeting community needs.

Summary

Health planning has persisted through many different changes in the health care system across nearly five decades. Another major change is on the immediate horizon. Although the specifics of the coming change are not clear, its general directions are:

— States will have a more central role in any planning activity which may emerge than they have had in the past.

- States will vary widely in their approach to the nature, scope and structure of health planning, and to its financing, particularly at the local level.

- Local planning will be more dependent on states for direction to their activities than has been the case under the current federal planning law.

- Local planning agencies will need to rethink their relationships and their implementation approaches in this new environment.

For states and communities, there are considerable potential benefits to maintaining an organized structure for health planning. The benefits include:

- Providing a mechanism for assuring that the actions of providers operating in a more "business-like" fashion support the community's and state's over-riding interest in maintaining access to quality services for all citizens, not just for those with financial means or insurance support.

- Supporting effective decisions by health care consumers in their choices among alternative sources of care, and in their use of the source selected.

- Assuring that the development of a more competitive health care system proceeds in a way that provides for protection of consumers against inaccurate advertising claims or collusion among providers.

- Providing a method for assessing the needs of special populations, and the degree to which those needs are met in the community or state.

- Maintaining a level of public awareness of, and participation in, the process of developing a rational as well as a profitable health services system in the community and state.

The "bottom line" for both states and local agencies is that they should undertake a thorough examination of their planning responsibilities and structure, and assess the opportunities for maintaining and financing a useful health planning capability in a more stringent financing environment. The fundamental values developed within the health planning movement since its inception are equally important whether the health system is built on regulation or competition. Society has an inherent interest in accessibility, availability, continuity, cost, and quality of health care. Change is clearly required in the planning system as it has been in the delivery system. Designing changes in health planning which are consistent with the changes in the health care system, but which maintain a desirable degree of organized public scrutiny of the operations of the system is the challenge before states and communities in 1986.

Summary

Health planning has evolved over four decades as a societal tool for providing a public interest direction to a complex and pluralistic health care system. Its roots lie in a shared concern for guiding the development of the health system in directions that meet citizen needs. This basic mission has been distorted in the past decade in response to serious problems in the personal health services system, and particularly the institutional health care component of that system. The validity of the basic idea has not diminished, however. The need for the types of activities which constitute the domain of health planning is greater in a system that is increasingly focused on dollar values rather than social values. The future, difficult as it is to predict given the rapid changes in personal health services organization and financing, may well place less emphasis on controlling the system through regulation. At the same time, the need for data, for unbiased comparisons among alternatives, for monitoring of system operations, and for providing benchmarks of system effectiveness in meeting the needs of all citizens provide ample justification for maintenance of an independent planning capacity at the local and state levels.

There is serious question as to whether the federal government will see the value associated with these consumer protection/ community development functions, or will participate in its financing regardless of its value. Health planning is caught in a curious trap as a result of its association with regulation and cost containment in the eyes of political decisionmakers. On the one hand, they believe that the combination of reimbursement controls and increased competition will minimize the need for regulation, that is, as they see it, for health planning. On the other, they respond to the continuing need for support of health planning to pursue its other responsibilities by saying " If it doesn't control costs, who needs it?" The answer, of course, is that this society "needs it" if its health care system, regardless of whether it is regulated by Uncle Sam's rules...or by Adam Smith's invisible hand...is to develop in ways that serve the public's interest.

Appendix:

Evolution of Community Health Planning

Health planning at the community level has a history reaching back nearly half a century. Such planning has roots in two separate streams of activity--voluntary community facilities planning and voluntary community health and welfare program planning. The former emerged in metropolitan areas in response to a shared concern on the part of business and hospitals for the appropriate development of a community's health care facilities. The latter grew from a need to effectively develop health and welfare programs supported by community fund raising drives. Each type of agency defined its own operating area, sometimes a single city; other times a multi-county area. The National Commission on Community Health Services, reporting on developments in health planning in 1961, referred to the proper service area for a health planning body as the "community of solution," an area within which the resources necessary to deal with health problems could be mobilized in support of plans. Later, federal legislation introduced the "medical market area" as the proper area for planning. Thus, from early in the history of the movement, community had a broad meaning.

Facilities planning and health and welfare planning interests were merged in the comprehensive health planning agencies of the mid-sixties. Those and subsequent planning bodies dealt with health concerns broadly, although the emphasis on facilities has remained strong to the present day.

Figure 1 compares agencies representing various evolutionary steps in community health planning across a range of characteristics selected to show the similarities and differences over time. It is important to note the trend to greater dependence on governmental funding and on external control approaches over time, factors which have created problems for planning. It is equally important to note the consistent features

Figure 1

EVOLUTION OF COMMUNITY HEALTH PLANNING

AGENCY TYPE	COMMUNITY HEALTH AND WELFARE COUNCIL	HOSPITAL REVIEW AND PLANNING COUNCIL	COMMUNITY HEALTH FACILITIES PLANNING [s.318]	AREAWIDE COMPREHENSIVE HEALTH PLANNING [s.314(b)]	HEALTH SYSTEMS AGENCIES
Time Period	1920s-1960s	1950-1961	1961-1966	1966-1975	1975-present
Characteristic					
1. Focus	Noninstitutional health services	Health care facilities	Health care facilities	Health, generally	Health, generally
2. Auspices	Private, not-for-profit	Private, not-for-profit	Private, not-for-profit	Private, not-for-profit*	Private, not-for-profit*
3. Governance	Consumer	Provider	Provider	Consumer	Consumer
4. Authority	Persuasion	Economic pressure	Economic pressure	Persuasion	Legal sanctions
5. Financing	Private	Private	Private/ Federal	Increased Federal	Predominantly Federal

X66

* A small number (less than 12%) of these agencies were governmentally based.

over time—community base and voluntary nature. These reflect strongly held values, which maintain that the structure of the health care system in a community is an issue that should be dealt with at the community level, and that the interests involved are sufficiently diverse that government alone cannot adequately deal with the task of planning for that system.

Evolution of State Health Planning

Like community health planning efforts, state activities in this area extend back nearly five decades. Their evolution was not unlike that of community planning, with an initial split between program planning and facilities planning. Beginning in the late thirties, a variety of federal formula grant programs were enacted which required development of program plans by states as a condition of participation. The Hill-Burton legislation in 1946 instituted a State Facilities Plan requirement, with the plan serving as a basis for allocation of federal funds for facilities construction and improvement. The two types of planning remained separate at the state level longer than at the community level, although a requirement for a "comprehensive" State Health Plan covering services and facilities was instituted in the mid-seventies. Figure 2 displays the characteristics of the various forms of state health planning over the years.

State-Community Relationships

State-community relationships in health planning have undergone a great deal of change over the history of the movement. In addition, they have varied substantially across the complex of states and communities involved. This complexity makes it difficult to generalize about and characterize the relationships. Thus, the discussion which follows can only characterize the development of the relationships very broadly. For purposes of analysis, four phases in the evolution of state/local relationships in health planning can be posted. They are an era of independent activity, an era of community dominance, an era of transition, and an era of state ascendancy.

100X

Figure 2

EVOLUTION OF STATE HEALTH PLANNING

AGENCY TYPE	CATEGORICAL HEALTH PLANNING	FACILITIES PLANNING AGENCY	COMPREHENSIVE HEALTH PLANNING AGENCY	HEALTH PLANNING & DEVELOPMENT AGENCY	STATEWIDE HEALTH COORDINATING COUNCIL
Time Period	1928-1965	1945-1974	1965-1974	1975-present	1975-present
Characteristics					
1. Focus	Specific diseases or programs	Hospital and other health facilities	Health activities broadly defined	Health activities broadly defined	Health activities broadly defined
2. Auspices	State Health Departments	State Health Departments*	State Health Departments*	Agency of state designated by Governor	Citizen group appointed by the Governor
3. Advisory Body	Advisory body required for some programs	State facilities council required	Citizen advisory council required	SHCC serves an advisory function	Not applicable
4. Authority	Various PHS Act Titles	Hill-Burton Act and subsequent amendments	P.L. 89-749	P.L.93-641	P.L. 93-641
5. Major Functions	Planning for the use of various categorical block grants by states	Preparation of plan and administration of funding for construction of health facilities	Preparation of a State Comprehensive Health Plan	Preparation of State Health Plan and management of mandatory resource allocation	Advisory to the State Agency in carrying out its functions

* In majority of instances

The **era of independent activity** encompasses the period from the initiation of the various planning efforts in the thirties through the midpoint of the comprehensive health planning program, ending in the early seventies. During this period, the planning efforts at the two levels proceeded with relatively little effort toward linkages, although logic suggests that such linkages would be essential to a rational process. The two planning processes were very different from one another, and rarely did one reflect the other.

The **era of community dominance** began in the latter part of the CHP period, as community planning bodies in many areas were able to develop strong local funding sources, and use these resources to develop active volunteer and staff organizations. Local agencies were able to outspend most state governments and developed cadres of proficient planning personnel. States, on the other hand, were not as strongly committed to health planning as a generic function. As a major provider of public health, health professions education, and medical services, state governments had strong internal constituencies which were suspicious of broad planning efforts which might have an impact on their program planning efforts. This resistance had a retarding effect on the development of non-program health planning in the states, and they lagged behind the communities.

The states' perceived lack of performance in the CHP era had a major effect when the Congress began the process of reshaping the program in the mid-seventies. Although the most radical proposals for a new approach to the health planning function were not accepted, their emphasis on a strong local planning activity, with the state relegated to a coordinating and synthesizing role, did impact on the final form of P.L. 93-641. States were slow to recognize the significance of the new legislation. Once it was recognized, states, as represented through the National Governors' Conference (now Association), began a long process of attempting to secure changes in federal enabling legislation, which was seen as diluting the state role in the planning process.

Despite the problems with the new legislation, it forged more mandatory linkages between community and state planning than had existed before. These included structural links through community planning agency (HSA) representation on the Statewide Health Coordinating Council and functional links through state planning guidance and the use of community plans in constructing a state health plan. During the early years of the program established by P.L. 93-641, however, the community agencies continued to be better funded and more adequately staffed than the state agencies, maintaining community dominance in most areas.

The **era of state ascendancy** began in the late seventies during the latter days of the Carter Administration. The combination of a growing state commitment to health planning and regulation, and a perception that the local emphasis was not paying off in terms of cost control, were among the factors involved in a growing emphasis on the states' central role in planning. Changes in the basic legislation expanded the governor's power in the state planning process, and state planning guidance received more attention than it had in the initial years. States' experience in health planning grew, and the twin assets of regulatory decisionmaking responsibility and control of extensive data relating to planning helped strengthen the states vis-a-vis the community agencies.

With the advent of the Reagan Administration, pro-competitive and anti-regulatory in philosophy, a concerted attack was launched on federal financing for health planning at both the state and community levels. Although efforts to defund the programs totally were unsuccessful, the funding was sharply reduced, and the tone of subsequently proposed legislation shifted decidedly toward a state managed health planning system. Some Congressional supporters of health planning would advocate no more than block grants to states for planning, with certificate of need and support for local planning left to the states' option. The Congress' inability to agree on a new structure led to a series of continuations in the funding for health planning at FY 1983 levels, during which DHHS

was prohibited from enforcing the regulatory standards governing conduct of the program.

At the time of this writing, the clock has run out on continuing resolutions as a means for maintaining federal support for health planning. Unless agreement can be reached on new authorizing legislation by September 30, 1986, further federal support for either state or community health planning will cease.

Other Evolutionary Themes

In addition to the structural evolution charted in the Figures 1 and 2, there are two other evolutionary themes important to an understanding of the health planning movement—the process/ product dichotomy and the resource-based/population-based planning dichotomy.

In the early agencies, whether facilities oriented or community program oriented, the emphasis was on the planning **process.** The practitioners of health planning were convinced that the interaction which took place around the table was the most important element of planning. Participants were expected to develop consensus despite divergent agendas, and in that process of consensus building, to develop shared conceptions of the future direction of the health system. The actual writing of a plan document received little emphasis, or was even actively avoided. With the growth of the use of planning output for decisionmaking on resource allocation and in regulation, there was an increasing need for a defensible documentation of the planning process, and the emphasis shifted to planning **documentation.** This was particularly true after enactment of the health systems planning legislation in the mid seventies. The federal government wrote extensive rules and guidance concerning documentation required of planning agencies, and, although the process continued, the plan document became the recognized goal of the planning agencies' activities.

Similarly, the focus of early health planning tended to be on health resources such as beds or services. There was a basic assumption that the existing capacity in the system was a given, and that the task of planning was allocating additions to that capacity. Relatively less attention was given to applications of epidemiological principles to planning situations and to basing forecasts for the system on data describing the population in the planning area and its documented needs. In the early days, this was, in part, the result of a lack of data concerning population health status and the absence of good techniques for linking such data to health resources. By the mid-seventies, efforts were under way to remedy these deficiencies, and the emphasis in health planning made a perceptible shift from a resource orientation to a population orientation. A major result was to increase the importance of data and data handling as basic aspects of health planning. Planners quickly learned that such data was often unavailable to them. Access to data, particularly cost and utilization data, became (and continues to be) a major issue. With the perfection of small area analysis techniques in the late seventies and the expanded interest in group and area-specific utilization in the early eighties, the data collection and analysis mission became one of the most important for health planning agencies.

Health Planning Relationships

Several groups other than government, outside the planning structure itself, have both affected and been affected by state and community health planning efforts. An understanding of these relationships over time is useful in considering the current status and future of the planning movement. Although state and community health planning relate to many other activities, three have been selected because of their relevance to the current environment and the potential future environment of state and community health planning efforts. The sectors selected for analysis are the business sector, the provider sector, and the payor sector.

Business and Industry

As indicated in the earlier discussion, business and industry played a key role in the initial development of both facilities planning and health and welfare planning. They were motivated by a concern that their charitable contributions were being used in the most effective fashion, and that the process for arriving at both the target and the amount of those contributions be regularized. Business had a key role in governance of both types of early community health planning bodies and made financial contributions to the administrative and planning costs as well.

In the transition to partial federal funding under section 318 of the Public Health Service Act in 1961, the role of business in the formal communitywide health planning process began a decline that continued into the early eighties. Federal requirements concerning governance of the 318 agency board limited the size of business representation and therefore its degree of impact and control. Combined with the influx of federal monies, the perceived loss of a central role in planning led to a decrease in business' financial commitment to the planning process, both in direct support and in support through channeling of contributions to projects endorsed by the planning bodies.

The decline of business participation in community health planning was virtually total in most areas under the next evolutionary step, the Areawide Comprehensive Health Planning Agency ("b" agency). The ever more prescriptive governing body requirements, though supportive of a consumer majority, did not support the type of "power structure" governance that characterized earlier efforts. The federal funds available increased, decreasing agency dependence on community, including business, dollars. Agencies created in communities with no preceding history of health planning—more than half the "b" agencies—often showed little interest in linking to the business community. Finally, the predominant mode for institutional capital financing was shifting from fund raising to debt financing underwritten by third-party reimbursement. This further eroded the perceived value of health planning to potential business participants.

The advent of HSAs accentuated most of these trends and included a link to regulation which business in general did not approve of in the context of the mid-seventies. In thirty years, business and industry had moved from being the central participants in community health planning to fringe participants.

While business' interest and participation in planning was declining, its policies in relation to other aspects of health care were becoming a major part of the cost and excess capacity problem. The rapid expansion of "first dollar" insurance coverage reflected a lack of understanding of the cost consequences of such policies, and business was a willing partner with labor in the growth of such plans as fringe benefits. Business representatives served as trustees on most community hospital boards, thereby participating in the rapid expansion in capacity in the sixties and seventies which has had a major role in cost escalation.

Business' interest in the health industry has been rekindled in the last four to five years. The continuing inflation in health care costs, reflected in increasing costs for health insurance benefits for employees, has stimulated this reemergence of business concern in health. While the stimulus is financing, it is related to business' operating costs rather than the charitable side of the ledger. Significantly, the new concern has not been reflected in greater business participation in the existing community health planning structure, but rather in creation of a parallel structure, the business/industry coalition. Frustrated with government's efforts, isolated from community planning, and alarmed by the effects of health-related costs on the "bottom line", business and industry have structured new entities to act on their concerns. They have focused on cost constraint, and on specific actions that can be taken by business and industry by virtue of their status as major purchasers of health care. The actions have mainly focused on controlling utilization of expensive health services, particularly institutional services, thereby controlling costs to employee benefit plans. These new entities' relationship to

the planning sector and the institutional sector range from cooperative to adversarial. They represent a growing force in many communities, one which must be considered as a part of the environment for broader community health planning in the short-term future.

Health Care Providers

Like business, providers of health services (particularly short-term hospitals) were central actors in the initial community facilities planning efforts. They concluded that giving up some degree of freedom in pursuing institutionally-defined objectives was worth it to assure that industrial contributions would not dry up in the face of multiple demands for project support. At the same time, most hospitals also accepted the idea that community leadership had a legitimate right and a responsibility to influence the shape of the community's health care system. Like business, providers contributed financially and to the governance of the early planning bodies. Many such planning efforts grew out of predecessor hospital councils in metropolitan communities. The facilities focus and the voluntary nature of the early planning agencies was consistent with most institutions' view of the nature of planning, and the endorsement decisions of the voluntary councils were accepted. Hospital interest and participation remained high after the transition to the section 318 community planning model. The relationship of such agencies to the Hill-Burton process and, through that process, to federal construction dollars, helped maintain institutional interest, as did the continuing links to business contributions.

Hospital reaction to the revisions to community health planning incorporated in section 314(b) of the Public Health Service Act were quite different. Community health planning with a broad "health" focus rather than a facilities focus seemed less relevant. Federal reimbursement systems (Medicare and Medicaid) which supported amortization of debt lessened institutions' dependence on local contributions, which had become less linked to

planning. Consumer-majority governing bodies with broad representation of community interests were seen as less influential than the hospitals' own trustees. From an institutional perspective, comprehensive health planning was significantly weaker than predecessor efforts. The 314(b) agencies were seen as relatively powerless to interfere in an institution's own plans for its future. As a result, comprehensive health planning had virtually unqualified support from hospitals at the conceptual and political levels, but little support in terms of implementation of its plans at the community level.

This era of good feeling on the part of institutions toward planning bridged the transition to health systems planning in 1974. Hospitals, both individually and through their associations, were generally supportive of the expansion of federal support of community health planning, even with the links to hospital-related certificate of need programs. Certificate of need was viewed as an appropriate activity given the hospitals' community responsibilities, and it also served as a franchising mechanism which would help existing hospitals maintain market share and expand, while making it difficult for others to enter their market. Regulation linked to local planning, where hospitals felt they could exert a strong influence, was seen as infinitely more desirable than state or national direct regulation. Given that regulation was viewed as an essential in the mid-seventies, the type of structure incorporated in P.L. 93-641 was seen serving the interests of the institutional sector.

All this positive support for community health planning in the institutional sector began to unravel in the late seventies, as escalating costs continued and government became more alarmed. Unable to secure enactment of a national hospital cost containment program, the Carter Administration turned to the planning structure as its major cost-containment tool. The cost-containment policy focus, coupled with such cost-related federal initiatives as the National Guidelines for Health Planning, rapidly eroded planning agency-hospital relationships. Despite the fact that states and not HSAs were the

regulators, the increased dependence on planning as a cost-containment device contributed to the concept that HSAs were "federal." By 1981, the American Hospital Association was actively supporting repeal of the federal health planning legislation, while voicing continuing support for "community health planning."

Despite the cooling of the institutional sector's interest in community health planning, hospitals' interest in planning at the institutional level has grown rapidly in the past five years. The institutional sector is in the most advantageous position in its history as far as the level of interest in institutional planning, and of competency to perform such planning, is concerned. This expanding institutional interest in marketing and strategic planning will have effects on community health planning as it may be practiced in the future.

The other major provider interest, organized medicine, has been health planning's most consistent foe over the years. This is not to minimize the contributions that individual physicians have made to planning efforts at both the community and state levels. Collectively, and through their organizations, however, physicians have generally opposed both specific planning initiatives and legislation in support of planning at the state and federal levels. Opposition has flowed from a general distrust of government programs; from fears that traditional independence in decisionmaking would be eroded by planning's efforts; and from suspicion of non-medical decisionmakers (a fear not helped by the early sloganeering to the effect that "health planning was too important to be left to the health professionals").

Health Cost Payors

The payors' relationships to health planning have been more like those of business than those of providers. Initially, they were major participants in facility planning efforts, both financially and in governance. Unlike business, the payors did not abandon planning as government's involvement grew, and insurance monies were a major source of

financial support to planning through the CHP era. With some notable exceptions, however, few payors in the sixties and seventies used their leverage to support planning's output. Generally, they saw their responsibility as limited to paying the bills for care rendered by providers, rather than exerting control on providers to follow community plans. This attitude has undergone considerable change in recent years, with payors emerging as prime supporters of planning--through direct financing, through linkages of some reimbursement to planning decisions, and through support of state and federal financial assistance to the planning structure.

☆ U.S. Government Printing Office: 1986—491-070/40152

State of New Jersey
DEPARTMENT OF HEALTH
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MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER

January 8, 1987

Harold L. Colburn, M.D.
Chairman, Assembly Institutions,
Health and Welfare Committee
223 High Street
Mount Holly, New Jersey 08010

Dear Dr. Colburn:

I presented testimony on behalf of the Department of Health at the public hearing held before the Committee on December 4, 1986, concerning State and local health planning. At that time Committee members asked for additional information on certain matters. As Chairman of the Committee you inquired about the method used by the Department in the past and the present for determining the need for nursing home services, particularly in Burlington County. Mr. Frelinghuysen asked for further information about several points, including the manner in which we estimated the savings from the health planning program; the number of New Jersey residents who go outside the State for cardiac surgery; the number of deinstitutionalized psychiatric patients who need nursing care but cannot be placed in nursing homes; and the vacancy rates in nursing homes.

Specific information in response to these important questions is attached. If further information or clarification is needed, please feel free to call me at (609) 292-7837 or Mr. John Scioli, Director of Health Policy, Planning and Certificate of Need. Mr. Scioli can be reached at (609) 292-5960.

Very truly yours,

Charlotte K. Kitler

Charlotte Kitler
Deputy Commissioner

Attachments
cc: Members of Committee
Committee Staff
Mr. Morris
Mr. Scioli
Mr. Calabria

1. BED NEED METHODOLOGY FOR LONG TERM CARE

During the public hearing on December 4 a question was asked by Dr. Colburn about the past and current methodologies for long-term care (LTC) bed need and their effect upon Burlington County.

The Department of Health projects the future need for nursing home beds looking at the elderly population, the projected growth rate in this population and the projected use of facilities. The method projects for three years into the future, the time period it typically takes to begin operation of a facility after Certificate of Need approval. The method results in a gross bed need for each county in the State. The number of existing and approved new LTC facilities is deducted from this gross bed need figure leading to a net bed need.

Until 1979 the Department projected county bed need by making a certain assumption about the use rate for LTC beds. The use rate is the rate at which a nursing home bed is typically used by the elderly population, i.e., patient days per thousand population age 65 and over. Prior to 1979 the bed need methodology assumed that the use rate which actually occured in a base year would still prevail in the projected planning year. This assumption had the effect of projecting a larger bed need in those counties which already had a large number of facilities (and thus, higher use rates), and smaller bed needs in other counties without a large number of existing LTC facilities.

In 1979, an adjustment was made in calculating the use-rate so that patient days were allocated to a patient's home county rather than the county where care was received. This tended to alleviate somewhat the problem of nursing home need accruing mainly in those counties which had a large number of facilities.

As a major participant in the 1983 Governor's State Nursing Home Task Force, the Department of Health proposed a new, population based methodology. This methodology targeted, in each county, for three years into the future a need for 4.0 beds per 100 persons age 65-74 and 4.5 beds per 100 persons age 75 and over. This new methodology thus separated the elderly population into two age cohorts and recognized that the older one would have a greater need for beds. It also specifically projected bed need based on each county's estimated elderly population.

The Department recently proposed revisions to this methodology which will become effective in January, 1987. Data indicate that the average age of nursing home residents is approaching 84 years. The new revisions add a third age cohort to the methodology and change the bed ratios to realistically reflect utilization by age. This new methodology targets:

1.2 beds per 100 persons age 65-74
5.2 beds per 100 persons age 75-84
18.1 beds per 100 persons age 85 and over

This methodology will ensure an appropriate number of beds in those areas of the state that are growing most rapidly in that segment of the population most in need of nursing home care - i.e., the 85 and over population.

If, in years past, facilities in Burlington County attracted a large number of out-of-county residents, then in 1979 its projected bed needs would have decreased since the patient days of those out-of-county persons were counted toward their home counties' need. Of course, these persons would still have resided in Burlington County facilities. We believe our new methodology, with its three age cohorts targeted to each county's own projected elderly population, will ensure an appropriate number of beds to care for each county's population in need.

In addition, our rules permit an exception to the need methodology where it can be demonstrated that the methodology does not accurately reflect the status of the health system or the population needs in a county or health service area. The local health planning agency has been the one organization most able to demonstrate the need for such an exception. Its knowledge of specific local conditions is one of the major reasons for this Department's strong support of the local health planning bill.

2. SAVINGS FROM HEALTH PLANNING PROGRAM

Mr. Frelinghuysen requested documentation of the savings from New Jersy's program for health planning and certificate of need. At the public hearing on December 4, the Department presented testimony that approximately $400 million in capital costs and $100 million in annual operating costs had been saved by the health planning program.

These figures were derived from a review of Departmental records of the projects proposed for initiation which were in fact denied during the period from 1979 through December 1986.

Please see the attached report which indicates the cost and type of projects denied in each year from 1979 to date. This information was obtained from Certificate of Need records which are, of course, public documents.

It should be pointed out that from 1979 through 1985 financing costs, although eligible for reimbursement, were <u>not</u> included as part of the official Certificate of Need approval or denial letter sent to applicants because interest rates were so unstable. If financing costs had been included, an approved applicant would have been required to seek further Certificate of Need approval each time financing costs increased. The Department viewed this as an unreasonable burden to place on an applicant in light of the unstable interest rates.

When the Department revised its Certificate of Need rules in late 1985 interest rates had stabilized. Thus, the Department felt that the financing costs noted in an application would now reflect the actual costs incurred by an approved applicant. Since that time, approvals and denials have noted <u>total</u> project costs, including financing costs. This enables the public review process to provide a more realistic review of the total economic impact a particular project will have on the health care system. Thus, the dollar amount of denials from 1979 through 1985 would have been somewhat higher had financing costs been included at that time.

Moreover, we also believe the total dollar estimate to be conservative in terms of systems savings in that it does not account for approved projects that were reduced in cost and scope as a result of the public review process or the fact that some projects are never undertaken simply because of the existence of such a process.

We also estimated annual operating cost savings to be approximately 25 percent of the capital cost savings, which represents a norm for the relationship between capital costs and the annual operating expenses they reflect.

3. OUT-OF-STATE MIGRATION FOR CARDIAC SURGERY

Mr. Frelinghuysen asked for information on the number of New Jersey residents who go out-of-state for cardiac surgery.

Please see the attached report "Cardiac Surgery Outmigration from New Jersey." The report was prepared by Department staff from available data on cardiac services. It estimates that the number of New Jersey residents leaving the state for their cardiac surgery each year is 1000-1200, although the number has been declining in recent years. The report also calls attention to the fact that nearly 500 cardiac surgery patients from outside the state underwent open heart surgery in New Jersey in 1984 and emphasizes the fact that insurance carriers (particularly HMOs) are becoming increasingly influential in determining the provider of open heart surgery for their clients.

4. DEINSTITUTIONALIZED PSYCHIATRIC PATIENTS AWAITING PLACEMENT TO NURSING HOMES

Another question concerned Department of Health policies encouraging long-term care placement for those patients designated by the Department of Human Services, Division of Mental Health, as "discharged from a state or county psychiatric hospital pending placement" (DPP) in a nursing home. Medicaid maintains waiting lists for persons needing nursing home placement, including a waiting list for persons from State and county psychiatric institutions.

Current Medicaid waiting lists indicate 345 DPPs awaiting placement into a nursing home. Both the Department and the Division of Mental Health believe that this population can be accomodated by beds already approved or that will be approved within the next year.

However, there is some concern over those patients discharged from psychiatric facilities who enter boarding homes or residential health care facilities. Although the Division of Mental Health develops a discharge planning program for each of these patients, the patients are usually not legally required to participate in the programs - and oftentimes don't. This can lead to social problems in the communities where these persons reside. The Division of Mental Health is currently working on means to address this problem.

5. VACANCY RATE FOR NURSING HOMES

Mr. Frelinghuysen asked about the vacancy rate of long-term care beds and whether it was the result of the abolition of private pay contracts.

Data from 1985 indicate statewide long-term care facility occupancy rates of 94-95 percent. These occupancy rates have been fairly consistent over the past several years. A 95 percent occupancy rate is the norm for many non-acute care services and is the rate the Department requires before a facility can be approved for additional beds. Recent survey reports of long-term care facilities during 1986, as well as review of new applications for nursing home beds, show the same general occupancy rate of 94-95 percent at the current time. Thus, at this point we do not see that the abolition of private pay contracts has had any effect on occupancy rates for long-term care facilities.

DATE: December 15, 1986

SUBJECT: DENIED PROJECTS - 1979 thru 1986

1979

4	Equipment acquistions	$ 2,379,000
3	Est.new services	704,500
2	Constr/renov/chge in beds	5,609,280
9	New projects	$ 8,692,780

1980

4	Equipment acquisition	$ 3,785,095
1	Construction/renov	1,977,800
1	Chge in bed category	48,000
5	Est. new services	418,236
1	Change in cost/scope +	2,830,067
12	Projects	$ 9,059,198

1981

5	Constr/renovation	$ 13,592,524
1	Bed conversion	4,000
1	Equipment acquisition	850,000
4	Est. new services	126,724
11	Projects	$ 14,573,248

1982

1	Construction	$ 3,113,775
2	Est. new services	193,890
3	Projects	$ 3,307,665

1983

8	Constr/renov	$ 52,592,525
1	Est. new svc (SDS)	1,680,000
4	Equip. acquisition	3,426,450
13	Projects	$ 57,698,975

1984

16	Constr/renov.	$ 110,054,065
11	Est. new services	8,724,355
2	Exp. exist. services	1,552,500
29	Projects	$ 120,330,920

1985

10	Constr/renov.	$ 25,453,400
19	Est/exp. services	17,797,969
4	MRI services	11,509,100
33	Projects	$ 54,760,469

1986

	Construction/renov.	$ 109,459,936
2	Acq. Lithotripter	4,548,500
6	Est/exp. services	921,162
2	Changes in cost/scope	+ 3,471,241
21	Projects	$ 118,400,839

SUMMARY

1979 - 9 Projects	$ 8,692,780
1980 - 12 Projects	9,059,198
1981 - 11 Projects	14,573,248
1982 - 3 Projects	3,307,665
1983 - 13 Projects	57,698,975
1984 - 29 Projects	120,330,920
1985 - 33 Projects	54,760,469
1986 - 21 Projects	118,400,839
8 Yr.Total-131 Projects	$ 386,824,094

CARDIAC SURGERY OUTMIGRATION FROM NEW JERSEY

The elective nature of invasive cardiac diagnostic (catheterization) services and cardiac surgery services allows potential clients/patients the opportunity to be selective in the choice of the physician and hospital site to undergo the procedure. Increasingly, these decisions are being predetermined by a patient's insurance coverage rather than the patient's proximity to a nearby quality cardiac program. For example, as HMO enrollment increases in the State, decisions regarding elective surgery will largely be a result of the HMO's competitive pricing negotiations for cardiac surgery services for its clients rather than the traditional factors such as institutional track record or referring physician medical school affiliation. In short, the number of patients seeking cardiac surgery out-of-state changes significantly each year and is dependent on a number of factors, many of which are not in the control of the patient. Available data on out-of-state migration for cardiac surgery is also extremely limited, if available at all. New Jersey's unique geographic location, between two major metropolitan areas renown for medical care and medical education, virtually guarantees some degree of outmigration.

Actual quantification of cardiac surgery outmigration is difficult because many New Jersey residents seek all of their medical care in New York City and Philadelphia, particularly those residents who are employed in these neighboring states. According to 1984 statistics from New Jersey and Southeast Pennsylvania area hospitals, approximately one-third of all New Jersey patients residing in the eight southernmost counties in the State (See Table 1) that required cardiac surgery sought their surgery out-of-state. These figures would not include those New Jersey residents choosing to go to Houston or other distant cardiac surgery centers, although it is estimated that this number of patients would not be significant. It should also be emphasized that this 1984 data, while relatively recent, does not reflect more recent shifts in patient referral patterns that have taken place in this area of the State. More specifically, Cooper Hospital/University Medical Center in Camden, a historically underutilized cardiac surgery center, has greatly enhanced its market share over the last eighteen months (See Table II, New Jersey Open Heart Surgery Utilization 1979-1985) as a result of physician recruitment efforts and the completion of a contractual relationship with HMO of New Jersey--the State's largest HMO. While 1985 New Jersey discharge data are unavailable at this time, there is every indication that the number of New Jersey residents travelling from southern New Jersey to Philadelphia for cardiac services has diminished. There are also a number of patients being referred to Philadelphia cardiac centers from central New Jersey, but their numbers are estimated to be relatively small (perhaps fewer than 100 cases per year).

The attraction of medical institutions in New York City has historically been strong for New Jersey residents. While recognizing that this attraction will no doubt continue for some residents of the state

(particularly those employed in, or residing in close proximity to, New York City), the Department sought to reduce this attraction by approving two new cardiac surgery programs in the past four years at hospital sites that had been annually referring 1,000 cardiac surgery patients to New York cardiac centers. Estimates of the number of New Jersey residents seeking cardiac surgery services in New York City centers range from roughly 500 to 1000. This figure is considerably lower than previous estimates, which were on the order of 1-2,000 surgical patients annually. A 1983 study by the New York City HSA, for example, reported that 1,457 New Jersey residents had their cardiac surgery in New York. Since the St. Joseph's Hospital cardiac surgery program in Paterson only became operational in October of 1982, and the approval of the State's most recent cardiac surgery program at Hackensack Medical Center became operational late in 1984, the 1983 estimate can best be characterized as an overestimate. The fact that both of New Jersey's new programs recruited the New York cardiac surgeons that had been performing these procedures in New York (Drs. David Bregman and John Hutchinson III at St. Joseph's and Hackensack respectively) virtually assured the future retention of these surgical referrals in-state. It has also increased the number of out-of-state referrals coming into New Jersey for cardiac surgery. In 1984 a total of 489 cardiac surgery patients were from out-of-state, comprising 11.3 percent of total cardiac surgery patients that year (4,340).

Cardiac surgery referrals to New York City have also been influenced by HMO contractual agreements with low cost providers. The Rutgers Community Health Plan, for example, has negotiated with both an in-state provider (nearby Robert Wood Johnson Medical Center in New Brunswick) and a New York City provider (Montefiore Hospital in the Bronx) for their cardiac surgery referrals. This HMO had previously referred all of their cardiac surgery patients to Houston, Texas because the negotiated cost to the HMO was considerably less than the costs in New Jersey, New York City, or Philadelphia.

In short, the total number of New Jersey residents seeking their cardiac surgery out-of-state is approximately 1,000-1,200 cases annually. This represents approximately 20-25 percent of the total number of patients undergoing cardiac surgery during 1985 in New Jersey's ten cardiac surgery centers (4,711 patients). It must also be emphasized that New Jersey's capacity to perform cardiac surgery is far greater than its current Statewide caseload and could easily accommodate the additional New Jersey patients that are currently being referred out-of-state. The degree of outmigration of New Jersey residents for cardiac surgery is clearly not a result of too few cardiac surgery centers in the State, but rather a function of physician and/or patient choice or a result of insurance carrier negotiations with a less costly provider who may or not be located within the State.

1984 ADULT CARDIAC SURGERY VOLUME AND MARKET[1] SHARE - SEPA AND SO. NEW JERSEY PROVIDERS

TABLE I
PROVIDERS MARKET AND MARKET SHARE (%)

COUNTY	TOTAL SURGERY PATIENTS (2)	SEPA (3)		DHLC (4)		LOURDES		COOPER		OTHER N.J.	
		NO	%	NO	%	NO	%	NO	%	NO	%
Atlantic	116	86	74	17	15	9	8	--	--	1	--
Cape May	68	54	79	12	18	2	3	--	--	--	--
Cumberland	62	18	29	10	16	24	39	6	10	4	6
Burlington	132	30	23	29	22	61	46	8	6	3	2
Ocean	174	32	18	80	46	12	7	1	--	49	28
Service Area SubTotal	552	220	40%	148	27%	108	20%	15	3%	57	10%
Camden	363	103	28	23	6	187	52	43	12	8	2
Gloucester	118	56	47	8	7	44	37	9	8	1	--
Salem	29	18	62	--	--	9	31	--	--	2	7
Total	1,062	397	37%	179	17%	348	33%	67	6%	68	6%

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SOURCES: Delaware Valley Hospital Council
New Jersey Department of Health, Uniform Billing Patient Summary, 1984

(1) Volumes represent discharges for DRG's 104, 105, 108, 109.
(2) Total cardiac surgical patients from individual counties discharged from New Jersey & SEPA hospitals.
(3) SEPA combined market share from all providers. (SEPA = Southeast Pennsylvania/Delaware Valley Hospitals)
(4) [illegible] Heart and Lung Center, Browns Mills, New Jersey.

TABLE II
Number of Open Heart Patients

Hospital	HSA	1979	1980	1981	1982	1983	1984	1985
St Joseph's Hospital	I	N/A	N/A	N/A	39[b]	420	639	767
Passaic General	I	161	231	234	173	240	253	314
Hackensack Med Ctr	I	N/A	N/A	N/A	N/A	N/A	N/A	190[d]
Newark Beth Israel	II	477	658	695	852	987	972	1017
St Barnabas Med Ctr.	II	117	90	44[c]	closed	closed	closed	closed
St Michael's Hospital	II	224	205	225	267	329	423	385
Veteran's Admin. Hosp	II	53	18	63	69	109	90	72
United Hospital (Peds)	II	(51)	(81)	(82)	(90)	(104)	(75)	(70)
Middlesex General Hosp.	IV	N/A	10[a]	43	81	167	203	224
Deborah Heart & Lung	V	698	732	976	1135	1093(142)	966(126)	905(76)
Our Lady of Lourdes	V	131	287	344	365	420	449	450
Cooper Medical Center	V	149	60	72	133	162	144	241
	STATEWIDE TOTALS	2,061	2,377	2,783	3,204	3,927 (246)	4,139 (201)	4565 (146)

SOURCE: Health Data Services, New Jersey State Department of Health, Catheterization Quarterly Reports

( ) Pediatric open heart surgical cases

a Middlesex surgical program began in August, 1980

b St Joseph's Hospital & Medical Center cardiac surgical program began in November, 1982

c St Barnabas' cardiac surgery program closed voluntarily January, 1982.

d Hackensack Medical Center's cardiac surgery program initiated in August, 1985

N/A