NEW JERSEY OPINION; ON RISING HEALTH-CARE COSTS

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NUMEROUS recent articles and news reports have decried out-of-control health-care costs. My personal experiences since 1982 - fortunately, not as a patient - lead me, reluctantly, to concur.

Such costs have become a national concern in the 1980's; they now consume more than 10 percent of our Gross National Product. An estimated $350 billion was incurred in 1983, an 11 percent increase over 1982 and the equivalent of about $1,500 for every citizen.

Hospital costs comprise more than 40 percent of the total and show the highest percentage increase of all cost components. Hospital patient costs rose from an average of $174 a day in 1977 to $327 a day in 1983, an 88 percent increase.

Projections by the United States Health Care Financing Administration indicate that national health-care expenditures will exceed $450 billion in 1985.

While health costs continue to increase, many employers have taken drastic steps to curtail employee benefits and related costs. They have increased medical-insurance deductibles and shifted certain insurance costs to their employees, while also negotiating directly with providers for lower rates.

The average citizen is awed by the figures in statistics such as those of the Federal budget and is frustrated at finding solutions to the problems causing budget deficits. Similarly, state and local health-planning systems are also experiencing great difficulty in balancing necessary health-care services and available financial resources.

Since 1982, I have followed, on a "grass root" basis, several hospital expansion/renovation programs in northern New Jersey, specifically within the state Health Systems Agency area comprising Bergen and Passaic Counties.

There are 14 hospitals in this area, and their bed capacities and utilization levels for 1983, the last year for which such statistics are available, can be seen in the accompanying chart.

As can be seen, there are imbalances in bed utilization. Yet the system appears to have an inertia against either

(a) reallocating existing beds to other disciplines, such as medical/surgical, where additions have been approved or
(b) reducing capacity and related support costs.

To illustrate this problem, I will focus on the impact of the construction plans of four not-for-profit institutions: St. Joseph's and Barnert Hospitals in Paterson, Valley Hospital in Ridgewood and Pascack Valley Hospital in Westwood.

These institutions maintain 1,416 beds within the previously discussed bed complement. Valley and Pascack Valley are financially secure, serving relatively affluent suburbs, whereas the two Paterson-based hospitals serve an inner-city population and experience financial pressures.

Since 1981, these four institutions have obtained approval for construction, renovation and modernization projects totaling about $178 million, which will increase their daily patient rates by 60 to 70 percent merely to recoup the higher costs.

Of this total capital expenditure, nearly one-third will be devoted to architectural/legal/accounting fees and other nonmedical outlays. This does not include interest, which will eventually double outlays to $350 million at the end of the borrowing period.

Even more startling, these programs require a total of capital funds that exceeds the hospitals' present annual patient revenue.

No profit-making company would consider incurring fixed capital outlays that exceeded its annual revenue base. Perhaps the historical ability of hospitals to "pass on" capital-related costs automatically to the consumer negates more-prudent allocation of capital.

After completion of these projects, the present medical/surgical bed capacity of the four hospitals - 999 beds - will be increased by 151 beds, or 29 percent. This is despite projected nominal population growth in their respective service areas.

However, only 7 beds out of 240 in their obstetrical/gynecological/pediatric capacity are being dropped, despite demonstrated underutilization. Even more important, continuing declines in the average length of an in-hospital medical/surgical stay will largely negate the value of these additional beds.

The harsh financial reality of Diagnosis Related Groups (D.R.G.'s), which fix hospital fees by type of illness, will continue to make hospitals more efficient in keeping the patients' length of stay under control. Further, institutional claims as to the need for more medical/surgical beds because of a higher proportion of elderly patients conflict with the growing acceptance of, and reliance on, home-health care alternatives.

As a resident of Ridgewood and a neighbor of Valley Hospital, why should I stand opposed to the extent of Valley's plans to modernize and expand? Although many neighbors in the immediate area expressed opposition because of the enormous effect on parking and traffic in a residential area, I have strived to focus on the regional institutional impact and the resultant effect on rates.
My opposition has been, and continues to be, difficult and trying, especially since Valley is a fine community hospital. However, when does an institution's desire to grow and expand its market penetration take precedence over regional cost-effectiveness?

Consider the fact that Valley Hospital now draws 35 percent of its patient population from beyond its 17-town primary service area. Won't its additional growth further erode patient admissions in surrounding institutions, especially hospitals in troubled urban locations and in smaller suburban, not-for-profit institutions unable to sustain costly expansion programs?

Realistically, there is certainly some justification for Valley Hospital to modernize, rectify deficiencies and improve its services. But to what extent, and at what cost to future patients? Valley certainly has financial resources, as shown by its growing cash balance and extensive borrowing capacity.

The hospital obtained State Health Department approval for its expansion in late 1981 and immediately became immersed in a three-year effort to win local zoning approval. Despite some community opposition, this project, now approximating $70 million, has cleared all local zoning objections and work is about to begin.

However, as I have pointed out to the responsible health-planning and review agencies, conditions have changed significantly since 1981, when the project was justified by the hospital on the basis of outmoded 1977-1980 data.

For example, Valley's planned addition of 34 medical/surgical beds was justified in 1981 on an assumed 7 1/2-day average length of stay. Now, however, the average stay has declined to 5.7 days, and by 1989 it is expected to drop to 5.2 days.

Although the hospital is now running at more than 90 percent occupancy, it will soon experience an over-bedding condition unless it penetrates the market further. This would be at the obvious expense of other institutions in the area and in Rockland County, N.Y.

Would not better use of hospital finances include innovative compensation programs to reduce the continuing professional nursing turnover rate of more than 20 percent, instead of investing more than $7 million in an underground parking garage? The garage is required to comply with local parking requirements for the expansion.

In November 1984, years after an earlier State Commissioner of Health first gave his approval to the expansion, the latest Commissioner, Dr. J. Richard Goldstein, granted Valley another extension of time (to November 1985) to start this project.

No update of this Certificate of Need was performed with respect to current admissions, market share or bedding needs. Only an update of project costs by the hospital was performed.

Consequently, last December I requested a public hearing to inquire why there should not be an updated full review of Valley Hospital's Certificate of Need application, using latest data beyond project costs.
In February, Commissioner Goldstein denied my request for a public hearing, claiming I had not demonstrated any new facts that would serve as good cause for a full review.

Ironically, in so concluding he pointed out that I had the right to ask for a public hearing only within 30 days of the original November 1981 decision, a rather difficult prerequisite since I claimed that actual facts and conditions today were at odds with those projected three years ago.

Valley Hospital's latest cost update shows a 9.8 percent increase over the amount approved for the project, which is just under the state-mandated 10 percent threshold for a full review of its original Certificate of Need. This 9.8 percent is ludicrous when I have identified more than $2 million in capital items and commitments planned by the hospital for 1985-1988 that should logically be part of the overall project cost update.

These items and commitments were omitted in the original Certificate of Need, as well as in the latest update. They were merely reported as future needs by the hospital in its latest five-year long-range plan. That plan was filed in late 1984, after Commissioner Goldstein had granted his latest extension.

Obviously, a piecemeal approach avoids a comprehensive full review of all of the project's components and commitments.

My repeated attempts to work through the system have been, and continue to be, frustrating. Letters, calls and Health Systems Agency appearances all have been futile.

Health-planning professionals, who could readily detect the risk and financial impact of regional overbedding, have been silent, although staunchly upholding the need for cost restraint. In fact, the Health System Agency's board of trustees set 99 percent as the confidence level for having an acute-care bed available in its system, thus justifying its decision to approve all additions to date.

In business, we would equate this to carrying extremely high inventories to meet 99 percent customer service levels. The prudent businessman knows that the attendant cost of money invested far outweighs any benefits.

Can the health-planning system work?

Yes, if there are strong vocal pressures to control needless expenditures from the businesses and employees who pay the bill and from consumers who pay for it in the form of product prices. Reordering of priorities and rationing of insufficient capital are paramount to restoring confidence in the system.

The New Jersey health-care system must not embark on costly, competitive construction programs leading to further weakening of small, community-oriented institutions and eventual consolidation of those remaining.

An area-wide hospital construction moratorium, similar to that invoked by Governor Cuomo for New York in 1983-84, should be developed by Governor Kean. As you can see, I have not even
addressed the controversial subject of the use of advanced medical equipment and costly life-saving support programs.

Meantime, don't sit back and silently accept this situation. Get involved. Write to your legislators. Urge your employers to pressure providers actively, both individually and as part of business coalitions.

It's your system. You are paying for it.

I will continue my efforts to have Valley Hospital's Certificate of Need updated and subjected to full review. At least, let those responsible acknowledge the current facts and conditions. We must justify today's capital commitments, since they must be recouped in future patient charges.

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