A Letter from the Chairman

January 24, 2008

The Honorable Jon S. Corzine
Governor of the State of New Jersey
Trenton, New Jersey

Dear Governor Corzine:

On October 12, 2006 you had established through Executive Order 39 the ***New Jersey Commission on Rationalizing Health Care Resources***. The Commission worked throughout 2007 to respond to your order. In my capacity as Chair of the Commission, I am pleased to submit to you herewith its Final Report. In this perhaps longer-than-usual transmittal letter, I shall first present a very brief synopsis of the substance of the report. In my capacity as a long-time student of health systems here and abroad, I shall then append some personal observations on the inconsistent expectations Americans have of their health system. These inconsistencies – a form of cognitive dissonance – stand as barriers to a rational health care system and will, before long, price more and more hard-working Americans in the lower middle-income classes out of the health care enjoyed by the solid middle- and upper-income classes in New Jersey and elsewhere in the nation.

The Content of the Report in Brief

As the Commission understood its mandate, you had asked it to explore (1) why so many hospitals in this State are struggling financially, (2) which among hospitals approaching the State for financial assistance warrant that assistance and (3) what steps might be taken to rationalize the functioning of New Jersey's hospital system and other components of the health care delivery system that interact with the hospital system.

The Commission responds to your request with this report, composed of 16 chapters and 8 appendices. These 16 chapters fall into five distinct parts, as follows:

I. Introduction

II. An Overview of New Jersey's Health Care System

III. Factors Affecting the Economics and Performance of New Jersey Hospitals

IV. Prioritizing Financial Assistance to Financially Distressed Hospitals

V. A Vision for a 21st Century New Jersey Health Care System

Probably of the most immediate interest to your office will be Part IV of the report, "Prioritizing Financial Assistance to Financially Distressed Hospitals." The chapters in this section present the Commission's criteria and analytic algorithm for categorizing hospitals into four distinct groups, to wit:

1. Financially distressed hospitals whose continued operation is essential in the sense that their closure would deprive New Jersey residents of access to essential health services;

2. Financially distressed hospitals whose continued operation is not essential in the sense that their services could be replaced with other capacity in the relevant market area;

3. Essential hospitals that are not currently financially distressed but worth monitoring on a continued basis for financial viability;

4. Non-essential hospitals that are not currently financially distressed.

The general idea underlying our proposed algorithm is that the limited budget your office has to assist distressed hospitals should be reserved for financially distressed hospitals classified as "essential." The criteria we have used to make this classification are not thought to represent the final word on the issue, because there are sundry other less quantifiable dimensions to the problem that you would wish to take into account when making decisions on financial assistance. We have suggested some of these other dimensions in the report. You undoubtedly will wish to consider still others.

A final point to emphasize on this classification is that it is a living thing, by which is meant that hospitals will move among categories as more current data become available or as hospitals in the original set drop out through closure. That being so, the Commission has chosen not to classify in this report hospitals by name, but instead to furnish your office with software that can at a moment's notice provide you with the latest classification on the basis of the latest available data.

Sprinkled throughout the other sections of the report are numerous recommendations on changes believed by the Commission to be capable of

enhancing the proper functioning of the State's health system. These recommendations include a call for greater transparency on the cost and quality of hospital care, in a form that facilitates comparisons with performance benchmarks and facilitates more explicit accountability by the hospital sector for the resources entrusted to it. These other sections of the report also include suggestions for more effective governance of hospitals, steps to be taken to avoid hospital closures and, should they occur, an orderly process of closing hospitals.

In its final chapter, the report sketches out a long-run vision for the health-care information infrastructure that will be the *sine qua non* of cost-effective, high quality, 21st Century health care. Several nations in Europe and Asia are now leading the U.S. in this effort. There is no reason, however, why New Jersey could not become a leader in this regard, in the United States and the rest of the world, should the State puts its mind and resources to the task.

On the Prospect for a Rational Health System

As a long-time student of health systems in the United States and in other parts of the world, I cannot resist the temptation to add to the Commission's formal report to you some purely personal impressions that may or may not be shared by other members of the Commission[1].

Specifically, it is my sense that certain deeply ingrained traits in American culture stand in the way of a rational health system. Therefore, it is not likely that any Commission could provide you with a blueprint for a truly rational health system, nor could our Commission, notwithstanding its ambitious title.

A "rational" health system would be one in which the following elemental functions of a health system work harmoniously toward an agreed-upon set of social goals. These elementary functions are:

1. The financing of the health system, which always and inevitably originates in private households in the form of taxes, premiums or user fees, and which flows through various channels to the providers of health care;

2. The manner in which the financial risks that individuals face as a result of illness are pooled by some insurance mechanism to provide individuals with financial protection and unfettered access to health care when needed;

[1] These observations reflect in part work on a paper entitled " The Potential Role of Private Markets and Private Health Insurance in China's Health Reform" (November, 2007), co-authored with Tsung-Mei Cheng.

3. The production and delivery of health care by its so-called "providers";

4. The purchasing of cost-effective, high-quality care from the providers of health care, either by individual patients or in conjunction with private or public insurers;

5. The payment of the providers of health care for their services (fee-for-service, fee per case, fee per diem or fee per patient per year); and

6. The regulation of the whole system by government.

Every nation's health system must perform these six functions. The performance of the entire system depends not only on how well each of these functions is performed, but also on how well they are attuned to one another in the pursuit of a widely shared social goal.

Distributive Social Ethics: To illustrate, if a nation aspires to an egalitarian health system in which the clinical and financial health-care experience of individuals is independent of their socio-economic status, then the individual's contribution toward financing health care should be based strictly on ability to pay, rather than be levied per capita or on the basis of the individual's health status, as is the case with commercial, "actuarially fair" insurance premiums. Similarly, the providers of health care should be paid on the basis of a uniform payment schedule that does not vary by the socio-economic class of patients.

Although no nation's health system is perfectly "rational" in this sense, those of Canada, Germany or Taiwan come fairly close to this attribute. Whatever one may say about these systems, their various functions tend to be aligned to work toward a well-articulated, ethical goal on which there is broad political consensus, namely, a roughly egalitarian distribution of health care based on what they call the ethical principle of "social solidarity."[2]

By contrast, the United States has always lacked a broad political consensus on the distributive ethic that should govern its health care system. Like Canadians, Europeans and many Asians, many Americans do believe that health care is a *social good* that should be available to all socio-economic classes on roughly equal terms and should be financed on the basis of the individual's ability to pay. But just as many other Americans believe that health care is essentially a *private consumer good* – like

[2] To be sure, some 10% of Germany's population has private health insurance, rather than the statutory coverage, but their health care proper is not noticeably different from that received by the rest of the population.

clothes, food and shelter – whose procurement and financing is primarily the individual's responsibility, and they routinely (and quite incorrectly) deride the former school of thought as "socialists." From that gulf of ethical premises emerge many of the confusing economic signals that have always bedeviled American health care, and are likely to do so in the future. There is no reason to believe that New Jersey will be different in this regard.

Through the payment system for the providers of health care, for example, Americans tell these providers that the value of their work is lower when applied to uninsured patients or to patients insured by Medicaid than it is when applied to patients who are commercially insured.[3] A "rational" health system responsive to this powerful economic signal would be openly two-tiered, with bare-bones facilities devoted strictly to Medicaid patients and the uninsured (perhaps with some public grants for treating the latter), and much more luxurious, better equipped and better staffed facilities for commercially insured patients whose insurers are willing to pay higher fees. As it happens, however, the same citizenry, which signals its preference for a class-based health system through the payment mechanism, soothes its conscience by holding physicians and hospitals to strictly egalitarian standards when it comes to the treatment of patients of all socio-economic classes. Woe to the hospital that would give inferior care to Medicaid patients, relative to the care given to commercially-insured patients. In this acute cognitive dissonance lie the roots of many of the financial problems besetting so many American hospitals. As the Commission's report indicates, these problems are particularly acute in New Jersey.

"Markets vs. Regulation": Another cognitive dissonance regarding health care in this country springs from the tenuous, age-old debate over "regulation versus market."

By international standards Americans tend to be unusually disdainful of their governments at all levels, as can be inferred from the editorial pages of many of the nation's daily papers. Running against government is a time-hallowed tactic on the election circuit. For example, claiming that a health-reform proposal expands government's role in health care usually is the proposal's kiss of death. It seems an article of faith that private commercial markets are inherently more efficient than government can ever be.

[3] The fees New Jersey Medicaid pays physicians, for example, are only a fraction (less than 50%) of those paid to physicians by Medicare which, in turn, are lower than those typically paid by commercial insurers. In fact, relative to Medicare fees and the national average of Medicaid fees paid by the states, New Jersey ranks at the bottom of the nation. Until your Administration recently added $5 million ($20 million once annualized and matched with federal dollars) for Medicaid payments to pediatricians, for example, New Jersey Medicaid paid pediatricians only about $30 for a pediatric office visit, while commercial insurers paid between $90 and $120. Many physicians comprehend the implied economic signaling and refuse to accept Medicaid patients altogether, devoting their time instead to patients whose treatments are deemed by society to have a higher value.

At the same time, however, the same Americans seem troubled and unwilling to accept for health care – and now even for mortgages – the harsh verdicts of the "free market," among which are:

1. That a market allocates resources not to individuals most in need of them, but to those who have the most money to bid high prices for them;

2. That individuals or institutions, including hospitals, unable to fend for themselves in the competitive market's free-for-all – among them hospitals in low-income neighborhoods – should be allowed to wither away; and

3. That in the free-for-all of the market place, not only the quick-witted and better-informed, but also the morally more flexible participants, often will take advantage of less quick-witted and less well-informed market participants who are naïve enough to trust even the morally flexible.

These mutually inconsistent positions – an instinctive distrust of government and faith in the superiority of private markets but an unwillingness to accept the harsh verdicts of the market – have led nationwide into a bewildering system of "half-hearted competition and half-hearted regulation" for health care, to use a phrase coined by Brandeis economist Stuart Altman.

This approach encourages in health care an economic free-for-all in a highly imperfect market which increasingly turns patients into blind-folded shoppers thrust into a health-care shopping mall that is only haphazardly controlled by ad-hoc, often mutually inconsistent regulations that further distort the health-care market. Unevenly applied Certificate of Need (CN) laws, for example, are an illustration of this free-for-all, as is the rampant and non-transparent price discrimination in American health care that rewards neither efficiency nor superior outcomes, and that all too frequently allows uninsured Americans of the lower middle-income classes to be charged the highest prices for health care. Financially troubled hospitals that concentrate on poor, low- or non-paying patients are yet another manifestation of this approach.

In this connection, it may be noted that the Commissioners noted, but should not have been surprised, that in oral briefings before the Commission some representatives of the hospital industry hearkened back with evident nostalgia to the "good old days" when the State's hospitals were subject to rate regulation (as hospitals still are in Maryland), without the completely chaotic and often pernicious

price discrimination now rampant in New Jersey's hospital sector. Nor, however, was it surprising that none these representatives formally propose that New Jersey return to that system. On this issue ambivalence reigns.

Rationing Health Care: A third major confusion in the minds of Americans arises over the issue of "rationing" health care.

Boasting that theirs is the best health system in the world, bar none, Americans have long tended to deride most other nations' health systems for "rationing" health care, a phenomenon believed to be absent from the American health system. In fact, nothing could be further from the truth.

A health system can be thought of as a giant enterprise that can purchase from nature-added "quality-adjusted life years" (QALYs) for patients. The QALY is a widely used concept in health services research, which allows one to collapse both longer longevity and a better quality of living into one metric.[4] Some QALYs can be cheaply had through good primary and secondary care, including immunizations. Other QALYs can be purchased only at enormous costs – e.g., the added life days or weeks or months that can be wrestled from nature in the intensive care unit or with highly expensive, new biological products that purchase only a few months of extra life. Relatively cheap tests or MRI scans deemed to add only relatively little information to a diagnosis also turn out to be very expensive per added QALY actually purchased with them.

Most nations implicitly or quite explicitly put an upper limit on the price per QALY they will pay out of collective insurance pools – be they private or public insurance. Thus, they either deny payment for such care or make people wait for it in a queue. Americans find that approach abhorrent as can be inferred from their frequent disparaging remarks on the Canadian health system in which queues and rationing do have a place. Indeed, there does not seem to exist even a truly astronomical price per QALY so high that Americans would not pay it, especially when the patient is well-insured. Sometimes this refusal to say "No" is carried to the point of throwing hundreds of thousands of dollars at what expert clinicians would regard as hopeless cases.

This refusal to ever say "No" for insured patients has helped drive the cost of American health care to extraordinary levels by international standards. For example, the U.S. now spends roughly twice as much per capita on health care as does neighboring Canada (on purchasing power parity basis). The ever-growing cost

[4] One year in a specific, less-than-perfect health status might be counted as the equivalent of 0.8 of a year in perfect health.

of American health care, in turn, has driven up insurance premiums in step and, thus, has driven more and more hitherto insured Americans into the ranks of the uninsured, whose numbers are rising inexorably and will do so with ever greater speed in the decade ahead. It is well known that, once in these ranks, many of the uninsured will forego timely, relatively lower cost primary and secondary care until they fall critically ill and then look to their neighboring hospital for expensive tertiary care, frequently on an uncompensated basis. Not only does this approach saddle American hospitals with the cost of such uncompensated care, but according to the Institute of Medicine of the U.S. National Academy Sciences, it causes an estimated 18,000 Americans to die prematurely each year, not even to speak of needless suffering borne by uninsured patients with unattended but curable afflictions.

***Cognitive Dissonance* on Health Insurance:** Confusion also reigns among Americans in their approach to health insurance.

On the one hand, many Americans decry as outright un-American the idea of mandating the individual to procure adequate health insurance coverage for at least catastrophically expensive health care. Those same presumably "rugged" individuals, however, would bristle at the idea that, say, a private, investor-owned hospital should have the right to withhold from them, for want of ability to pay, costly life-saving medical interventions, should these individuals be seriously injured or become critically ill. Such interventions are presumed to be an American right as well, and the people's representatives have passed laws to make it so. These unfunded mandates on hospitals effectively ask hospitals to provide uninsured individuals with the catastrophic health insurance they are free not to procure, at the expense of insured patients and, in the case of investor-owned hospitals, of shareholders as well.

Just as inconsistently, some states that grant the individual the right to go without health insurance coverage see nothing wrong with imposing on private, commercial health insurers the strictures of "community rating," which prohibits insurers to adjust the premiums to an individual's health status, and the "guaranteed issue," which mandates insurers to sell an insurance policy to anyone willing to pay that community-rated premium. New Jersey enacted such mandates in 1993 in its *New Jersey Individual Health Coverage Program (IHCP)*. Any high school senior should be able to figure out that this dubious constellation of rights and mandates subjects health insurers to "adverse risk selection" on the part of the insured, which means that individuals are free to go without health insurance when they are healthy, but have the right to throw themselves on the mercy of a collective insurance pool when they fall seriously ill.

Sooner or later this dubious mixture of freedom and mandates tends to lead to what is known among economists as the "death spiral" of health insurance, in which insurance pools become ever more heavily populated by relatively sicker individuals

with commensurately higher, community-rated premiums. In response, more and more relatively healthy individuals – especially lower-income individuals – exit these insurance pools and prefer to remain uninsured, which in turn drives the community-rated premiums for the remaining pool up even further. Thus, it is not surprising that, after their 2004 study of New Jersey's IHCP, Alan C. Monheit *et al.* conclude that

> the IHCP's current situation points to a market that is heading for collapse. Enrollment has declined from a peak of 186,130 lives at the end of 1995 to 84,968 at the end of 2001. In addition, premiums have increased two- to threefold above their early levels. These changes have raised concerns as to whether a comprehensive regulatory effort such as the IHCP can yield a sustainable health insurance market.[5]

That New Jersey has among the highest premiums for individually-purchased health insurance has been observed also in a nationwide survey of such policies by the Center for Policy Research of America's Health Insurance Plans (AHIP)[6].

The easy embrace by legislators of the individual's right to remain uninsured, coupled with mandated "community rating" and "guaranteed issue" on insurers, appear to spring from a natural suspicion of government-run or heavily government-subsidized private insurance, which, as noted, is routinely decried as "socialized medicine." Perhaps it is not realized by state legislators who adopt this dubious mixture of freedoms and mandates in health insurance that their mandates on private insurers actually convert the latter into quasi-agencies of government, albeit predictably dysfunctional ones.

The reluctance of Americans to countenance government financing of health care outright, by the way, has led them instead to prefer inherently temporary private health insurance tied to a particular job with a particular company (and then to look helplessly for rescue by federal or state governments when, in their 50s and early 60s, they may find themselves structured out of their jobs and the health insurance that came with it and unable to afford coverage in the private insurance market for individuals). When will it dawn on the American voter that, in an age of fierce global competition and ever novel disruptive technology, any individual American corporation is a fragile institution and, at best, a highly unreliable source of health insurance, especially during retirement?

[5] Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "Community Rating And Sustainable Individual Health Insurance Markets In New Jersey," *Health Affairs*, July/August 2004; 23(4): 167-175.

[6] American Health Insurance Plans, Center for Policy Research, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," (August 2005), available at website http://www.ahipresearch.com/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf

In short, Governor Corzine, in my professional view, the extraordinarily expensive, often excellent and just as often dysfunctional, confused and confusing American health system is a faithful reflection of the minds and souls making up America's body politic. New Jersey is no exception to this assessment. The Commission has done its best, with the time and resources available for its work, to recommend to you a variety of measures that you may wish to initiate to make New Jersey's health care system function somewhat better than it does today. Alas, no Commission can provide a complete blueprint for a truly *rational* health system for this State – or for any state in the nation – until the citizens of this country reach a politically dominant consensus on a more logically consistent set of preferences for their health system, starting with a consensus on the distributive social ethic that should govern the system. Until that happens, any attempt at "health reform" will always degenerate into mere tinkering at the margin, which means that for the foreseeable future Americans will have to muddle through with the kind of health system we now have.

Finally, this transmittal letter offers a good occasion to express on behalf of the Commission our deep gratitude to each and every one of your Administration's staff for the high motivation and dedication with which they have supported the Commission's work throughout the year. They are identified by name at the end of the Executive Summary of this report.

As noted earlier, it seems part of American folklore that government "cannot walk and chew gum at the same time" (to quote the late President Lyndon Johnson's famous dictum) and that government "bureaucrats" are slothful and unimaginative. My experience working with your staff has been completely at variance with that folklore. What is often not appreciated by the public is that, by comparison with the private sector, the work of civil servants is unusually complex and time consuming, because all of their activities must transparently be seen to be exquisitely fair to all members of society, and they must at all times be openly accountable to the public for all of their actions. Such constraints are not typically imposed on the private sector.

Respectfully submitted, with my best personal regards and good wishes,

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