

**ROCHESTER
BUSINESS JOURNAL
DAILY EDITION**

March 06, 2007

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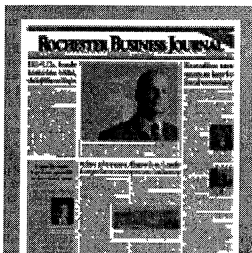
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Why, exactly, did we need the Berger Commission?

By KENT GARDNER
Numbers

If you're a health policy junkie, then you know some of this and can skip this paragraph. For the uninitiated, the Berger Commission (formally the "Commission on Health Care Facilities in the 21st Century," chaired by Stephen Berger), was created to identify "excess capacity" in the state's health care system and recommend how the problem could be fixed. Released last week, the commission's report recommended that nine hospitals be closed outright and that 48 undergo some kind of restructuring. In total, the commission recommended eliminating 4,200 hospital beds and an additional 3,000 beds in nursing homes.

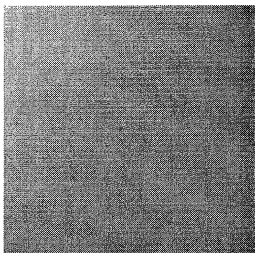
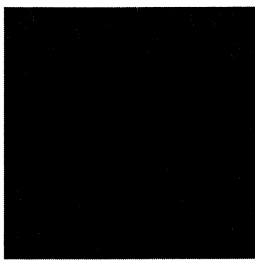
The legislation creating the commission paralleled those federal "base closing" commissions-the Legislature and governor can approve everything or nothing. They can't pick and choose from the recommendations.

Understandably, strong opinions have been expressed on the issue (see the story on page 5). Some think that the commission didn't go nearly far enough; others are organizing demonstrations and letter-writing campaigns to "Save our Hospital."

If you accept the idea that excess capacity is a bad thing, then you have to ask why we need such a clunky (and likely expensive) process to decide which ones should close. One acquaintance asks why the state cares about closing health facilities but doesn't bother with overcapacity in the fast-food business. Why does the state need to get involved?

One answer is simply that hospitals have been closing, but not nearly fast enough. When the average occupancy rate in a community's hospitality industry hits 65 percent (as New York hospitals did in 2004), the market "shakes out." Some hotels and motels close their doors. And when an airline is running planes with more than a third of all seats empty, it declares bankruptcy and puts some planes up for sale. The hospital overcapacity problem varies by region-Western New York is the worst with barely half the beds filled (56 percent) while Long Island fares the best with 73 percent occupancy. (In hospitals of local interest, Park Ridge led at 84 percent, Strong Memorial had 83 percent and Rochester General 79 percent.)

Why should we close hospitals? Remember that the taxpayer picks up a large share of the total cost. Between Medicare and Medicaid, taxpayers paid about half of all personal health care



expenditures and 58 percent of all hospital costs in New York in 2004 (according to data from the U.S. Centers for Medicare & Medicaid Services). You and I have a big stake in making the health care system more efficient. Excess capacity costs money. And when beds are empty, hospitals tend to spend to attract patients, engaging in a kind of "medical arms race" to cover a special niche or just to keep up with St. Egbert's.

We might want a commission involved if we worry that the wrong hospitals will close. Like fire stations, hospitals should be close by. If we simply let the weakest hospitals die of natural causes, then some places-probably the poorest ones-will be left without any at all. The commission tried to take these issues into consideration.

What puzzles me is why failing hospitals stay open as long as they do. We need a big commission to push the weak ones over the edge, I suppose. Hospitals aren't like dry cleaners. Unless you have an unusual story to tell, you have no fond association between Speedy's Dry Cleaners and the birth of your daughter. And you've never sat on the board of directors of the dry cleaners. Yet the boards of the state's hospitals are filled with virtuous and community-minded citizens who believe that keeping Horatio Memorial open is nearly their life's work.

And many hospitals depend on endowments or "sugar daddys" who bail them out when they can't meet payroll; creditors conclude that a failing hospital will pay more of its debt than one that closes outright, so they don't foreclose on loans. The vast Catholic hospital systems often move money from successful to failing institutions, postponing the day of reckoning.

We also have the odd predicament in New York of requiring that all our hospitals be non-profit. We don't want such important community institutions driven by the evil profit motive. Almost by definition, we prohibit hospitals from making decisions based on the "bottom line." The non-profit status of hospitals complicates the consolidation issue. While consolidations among hospitals certainly occur, the conversation is more complicated if there isn't a clear "owner" with whom the acquiring hospital can negotiate.

Our experience in Rochester supports the idea that consolidations can rationalize capacity problems. The creation of ViaHealth from the formerly independent Rochester General and Genesee hospitals certainly spurred Genesee's closure, as the consolidation of Park Ridge and St. Mary's hospitals into Unity Health facilitated the repositioning of St. Mary's.

So, while I think that the Berger Commission could have gone further, its members have done good and necessary work. Gov.-elect Eliot Spitzer's new health commissioner should think about ways to make such a draconian approach less necessary, perhaps by reinvigorating portions of the regulatory structure that was left fallow under Gov. George Pataki. I don't want to see us return to the days of Albany setting prices for every hospital and nursing home in the state, but it may be appropriate to place additional controls over duplicative capacity.

Kent Gardner is president and chief economist of the Center for Governmental Research Inc.

12/08/06 (C) Rochester Business Journal