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No Clues Yet as Health Industry Awaits a Report on Downsizing

By **RICHARD PÉREZ-PEÑA**

An economic shock wave, years in the making, is expected to hit New York this week. It could alter or eliminate tens of thousands of jobs, and change the way millions of people receive health care.

Yet the moment will catch most New Yorkers by surprise, and even those who know of it and care deeply have little real idea what to expect.

On Tuesday, a commission created by state lawmakers will release a plan for downsizing the hospital and nursing home industries across the state. Under the law that created the panel, the recommendations will become law unless the governor or the Legislature acts in December to reject the entire plan — it cannot approve some pieces and not others.

But beyond the general notion that it will direct the closing of some hospitals that are underused and losing money, the commission has given few hints as to what it will do.

Will it order 4 hospitals closed or 40? Will it merge some competing hospitals or force them to drop certain services instead of simply putting them out of business? Will it convert hospitals to outpatient clinics rather than just shutting them down? What will become of the closed hospitals' employees and the debts of those hospitals? And what will happen to nursing homes that are bleeding cash even though they are nearly full?

"I can make an educated guess based on what I think makes sense, like anybody else can, but that's all I can do is guess," said Kenneth E. Raske, president of the Greater New York Hospital Association, who often knows what state government is going to do to his industry before most members of the Legislature do. "They've played it extremely close to the vest."

The only certainty is that whatever the commission does will meet fierce opposition.

Closing a hospital is a painful and politically fraught thing to attempt anywhere, but more so in New York, with its powerful health care workers union, 1199 S.E.I.U. United Healthcare

Workers East, and its unusually high concentration of hospitals and medical schools. [New York State](#) spends more per person than any other state on health care, treating it as a source of jobs and economic development as much as medical attention. Over the last decade, New York State's more than 200 hospitals have been more fragile financially than those in any other state. About two dozen have closed, and most of those that remain have lost money and gone deeply into debt.

Officials hope that downsizing will shore up the surviving hospitals by leaving them with more patients and putting them in a stronger position to bargain with health insurance companies. They predict that economically sound hospitals will invest more in computer systems — an area where New York lags behind much of the country — and other innovations that will make them more efficient.

Such changes would matter almost as much to state and local governments, which spend billions of dollars on Medicaid payments and hospital subsidies, as to the hospitals themselves.

In considering those high stakes, the state's panel, the Commission on Health Care Facilities in the 21st Century, has heard a great deal, holding meetings and public hearings around the state for more than a year. But it has said little about its plans, and so its work has generated sparse coverage by the news media.

"We've been struggling with this all year," said Kate Breslin, director of policy at the Community Health Care Association of New York, an alliance of large clinics. "How do you light the issue on fire and get people involved when you really don't know what's going to happen?"

A year ago, the commission's chairman, Stephen Berger, said that by January, it would publicly label each hospital as being at high risk, moderate risk, or low risk of being reduced in size or closed. Reporters and lobbyists eagerly awaited the result, anticipating an early road map to hospital closures.

But hospitals and their industry groups complained bitterly that simply calling a fragile hospital high-risk could put it out of business — vendors would demand cash rather than extending credit, and doctors, patients and health insurers would steer their business elsewhere. The commission quietly shelved the plan, a decision that set a pattern for the work that followed.

Six committees, each for a different region of the state, were created to advise the commission, and the commission decided not to make that advice public until the final report was

published. Even top health policy makers in the Legislature and the Pataki administration have said they do not know what to expect from the commission.

That has created great anxiety among people who want to influence the group's work. Public officials and interest groups have held news conferences and vigils to protest the commission's recommendations, without knowing precisely what it was they were protesting.

Members of the City Council recently held a news conference to make their own recommendations, saying that they hoped to send a message to the Berger commission. But Councilwoman Helen Sears of Queens, who headed the task force that produced the Council's report, conceded that for all they knew, "our ideas are things that the commission has already taken to heart or decided against."

A particularly contentious area has been how to create more options for primary care — everything from individual doctors' offices to big, multiservice clinics. Many New Yorkers use hospitals for primary care, an expensive practice that policymakers have long wanted to end, but some poor neighborhoods lack alternatives. As the commission itself has acknowledged, closing hospitals will only add to the shortage of primary care.

Some advocates have pressed the commission to direct primary care development, or raise payments to family doctors, though just how it would do that is not clear. Commission officials say most of those suggestions go beyond the powers given them by state law.

But the commission could have a profound effect on primary care in some neighborhoods if it directs smaller hospitals to become big clinics with primary care doctors and some other services. It is not clear how much power the commission has to give such orders, or how inclined it is to use that power. The state would probably pay for such conversions, but the commission has no ability to tell the state how to spend its money.

New York City Council Speaker Christine Quinn said recently that the commission should have been more open about its deliberations, and that "more transparency would have been a good thing."

David Sandman, the commission's executive director, said he was sympathetic, but he disagreed. Last week, a published report speculated as to which hospitals might be closed, prompting panicked responses from their executives and employees.

Mr. Sandman said, "I think that was the best proof that not tipping our hand was the right way to go."

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