# THE CHANGING POLITICAL ECONOMY OF HOSPITALS: THE EMERGENCE OF THE "BUSINESS MODEL" HOSPITAL

by

Raymond Edwin Austin

Dissertation submitted to the Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Public Administration/Public Affairs

APPROVED:

Charles T. Goodsell, Chairman

Gary L. Wamsley

Orion F. White, Jr.

James F. Wolf

Ronald S. Boster

March, 1989

Blacksburg, Virginia

# THE CHANGING POLITICAL ECONOMY OF HOSPITALS: EMERGENCE OF THE "BUSINESS MODEL" HOSPITAL

By

Raymond E. Austin

Committee Chairman: Charles T. Goodsell

Public Administration / Public Affairs

(Abstract)

The hospital industry is now in a major transitional phase which is substantially changing its operational values and organizational forms. This transition was triggered primarily by a crisis brought on by rapidly escalating costs. Many forces centering on the cost containment theme are now forging new political and economic operating rules for health care providers. Collectively these forces are bringing about decisive changes in the quality, quantity and structure of health care delivery systems. The result has been the emergence of a new pattern of hospital organization and administration, described here as the business model hospital. This model is driven by incentives and performance criteria wholly different from those of traditional community hospitals. This research describes this new political economy of health care and

identifies, via analysis of field interviews, the crucial issues faced by hospital administrators today and specific actions they are taking to adapt to their new environment. The emergence of the business model hospital has many positive attributes but could have adverse consequences for the broader public interest. Emerging public policy issues are discussed and recommendations are made as to how public policy makers may deal with these issues. These recommendations focus on retaining the major benefits of the business hospital model while preserving useful aspects of the community hospital framework.

Acknowledgements

Although many people contributed in various way to this dissertation, three people deserve special acknowledgement. Charles T. Goodsell, my Chairman and mentor, who very patiently guided me through the dissertation process, , my brother and keeper, who provided encourgement and support to see me through, and , wife and friend, who helped with the proofreading and somehow tolerated the whole ordeal.

TABLE OF CONTENTS

# Chapter One

## THE BUSINESS MODEL HOSPITAL: AN OVERVIEW

Health care has become big business. It now accounts for approximately eleven percent of the United States Gross National Product.[1] Consequently, the health and well-being of the American hospital industry are of vital importance to the public interest. Although it has grown remarkably, the American hospital industry has been relatively stable over the last forty to fifty years. Now, however, many industry observers believe that by the early 1990s as many as twenty to thirty percent of the nation's approximately 6,000 hospitals will cease to exist. It is also speculated that by the 1990s the nation's health care industry will be dominated by fifteen to twenty powerful health care system conglomerates.

Institutions that pay for health care services, including government entities, commercial health insurers, and private employers have begun to exert a considerable amount of influence over the providers of health services. Government (federal, state, and local) pays for about forty two percent of the nation's health care bill.[2] As patients are being asked to share an increasing proportion of the cost of their health care, they too are becoming a much more powerful influence with which health care providers must reckon.

With these developments and others, a significant shift in the political economy of health care in the United States is now taking place. This shift is bringing about the most fundamental changes in the hospital industry to have occurred in the last fifty years. This dissertation explores these changes and the challenges they pose for individual hospitals. It examines how hospital administrators are coping with and adapting to the new health care environment. The principal goal of the research is to provide public policy makers with insight as to how hospitals are perceiving and coping with their new environment. It is hoped that the insights presented here will be useful in formulating more effective health care policies on behalf of the public interest.

The observations presented here are based on personal field interviews with a cross section of hospital administrators and other industry personnel that are involved in the day-to-day running of hospitals and hospital systems. The central argument of the dissertation and a preview of emerging policy issues are summarized here to provide the reader with an overview of the topic. The chapter also gives a detailed definition of the concept of a "business model" hospital that is emerging as a result of the major changes that are taking place in the field of health care today.

## The Central Argument

The political economy of the American hospital system is dramatically changing. These changes are occurring in response to several national-level forces which have begun to exert pressure on how hospitals view, organize, and carry out their activities. The most significant of these forces include: the switch from cost-based reimbursement to prospective payment for the Medicare program; increased incentives by government and commercial insurers to treat patients on an outpatient basis; the increasing development of managed care organizations (such as Health Maintenance Organizations or HMOs, and Preferred Provider Organizations or PPOs); a rise in the power of for-profit hospital chains; and a substantial increase in competition among health care providers. The vast majority of the non-profit community hospitals have responded to these developments by undertaking various types of vertical and horizontal integration and expansion and by adopting a "business perspective" in their operations. I refer to this ensemble of changes as a shift to the "business-model" hospital.

The most important class of adaptive strategies observed in the field are those that affect organizational scale, e.g., joining a multi-hospital group such as an alliance or a chain of hospitals. The alliance could be national, regional or local in scope and either be for-profit, non-profit or some mix of both in

structure. The major attracting factor of the multi-hospital systems centers on the benefits of a more powerful support network. This new support network is vital to the survival of most hospitals because the local community-based support network which was relied upon in the past is no longer capable of meeting the expanding needs being experienced by most hospitals in the new political economy of the health care field.

I contend that hospitals are now employing strategies of adaptation that will lead to a shift in power and autonomy from the local community to regional and national hospital networks. I also contend that while the business model hospital may bring greater efficency and business rationality to hospital management, it might serve equally well to create instabilities and inadequencies which might undermine the ability of hospitals to serve the broader public interests of the communities in which they are located.

## Emerging Issues for Public Policy Makers

The field interviews identified several crucial issues which are in need of attention from health care policy makers. These issues will be discussed more fully in later chapters but are previewed here to provide the reader with a fuller sense of what public interests are at stake.

Four basic kinds of issues are emerging from the transition that hospitals are undergoing. These are (1) national public interest issues, (2) local public interest issues, (3) hospital interest issues, and (4) predicted future issues for hospitals. I will deal with each in turn.

National Issues

National public interest issues are defined as broad considerations affecting the whole nation. The most important issue observed in the field research is the increased potential for the development of a multi-tiered health care system of unequal access for different socio-economic groups. Such a system could arise from hospitals more rigidly following a business rationality. In it the poor and unprofitable patients are turned away, with services and facilities targeted primarly to those patients most able to pay.

There is also a concern that the hospitals controlled by a for-profit corporation - especially those which are totally or partially for-profit - will take dollars out of the health care system instead of reinvesting in the health care system as was the case with the traditional non-profit hospitals in the past. Additionally, there is the increased potential that business-minded hospitals may undermine their financial stability through risky expansionist oriented management, thereby raising

the possibility that someone, perhaps government, may have to come to their rescue.

Concern also arises that publicly owned hospitals will become the dumping ground for unprofitable patients, again creating a situation whereby government may have to pick up the direct cost of greater subsidies for these facilities. Finally, there is a growing debate about whether non-profit status hospitals deserve their tax exempt status in view of their expanding business interests, often pursued through for-profit subsidiaries.

Local Issues

One of the primary local interest issues centers around the increased likelihood that the emerging health care political economy will result in the loss of local control over hospitals as regional and national hospital alliances require more power and authority over member hospitals to accomplish their objectives. More instability may be created by chain-owned hospitals which are already being bought and sold overnight as hospital systems adjust to new strategies, invest in new opportunities, or seek higher profits from their hospitals.

Hospital Issues

Among the issues affecting hospitals' own interest, access to capital appears to the most critical. As hospitals are forced to look beyond their local communities for the resources that they need to survive and compete effectively, they must increasingly rely on the "outsiders" that control access to such resources. These "outsiders" include investment bankers, multi-hospitals systems and alliances, and a host of other legal and technical experts who are increasingly coming to have critical roles in determining financing access and in turn shaping what kind of future individual hospitals will face. "Outsiders" also include managed care organizations (e.g. HMOs, PPOs) which will have the ability to affect the financial fortunes of hospitals greatly as they use the leverage of moving large blocks of patients from one hospital to another in search of the best deal.

Those who control resources, especially capital resources, have their own criteria for determining which hospitals will be able to get what. The needs of the community are often not a major determining factor as business managers look at return on investment and other financial factors in determining which hospital's needs are to be financed. The "outsiders" will be in an increasingly powerful position to dictate to hospitals how they should run their operations. The burden of debt financing

itself may have a negative impact on many hospitals who are less likely to weather the ups and downs of economic cycles, changes in government reimbursement rates, and increases in competition while carrying substantial debt responsibilities.

Future Issues

Future issues which public policy makers may have to deal with include such things as what to do with hospitals that are financially insolvent but are deemed to provide necessary services to area residents. Should public support be provided directly, indirectly, or not at all? Should public policy makers intervene in the reinvestment decisions of non-profit and for-profit hospitals chains and hospital alliances? And finally, how will public policy makers deal with the hospital mega-systems which are coming to control billion of dollars in revenues and are thereby able to exert tremendous amounts of influence on the health care system and the political system of this country?

Other significant issues will be discussed in more detail later. It is clear that these changes have the potential to effect far-reaching modifications in the field of health care. It is my view that much of this deep-seated change can be understood in terms of what I call the business model hospital. The business model hospital is replacing the community hospital model as the

predominant type of hospital is this country. Although community hospitals still exist in name, most hospitals are moving to adopt a perspective and course of action that until recently were associated with traditional, for-profit, commercial business. In other words, regardless of whether the hospital is technically a for-profit business corporation or a non-profit corporation, hospitals, as health care service providers, are increasingly being run <u>like</u> corporate businesses. The developing political economy of the health care field is providing strong incentives for most hospitals to adopt the business model as an operating guide. Many hospital administrators express the feeling that the future success and growth of their organizations, and perhaps their survival, depends upon how successful they are in adopting the business model.

## <u>The Business Model Hospital</u>

The emergence of the business model hospital is a major departure from the community hospital model. Again, it is important to keep in mind that the business model hospital as discused here applies to non-profit and as well as for-profit hospitals. The "business model" refers to the perspective that guides the hospital. As will be seen in later discussions, there is increasingly a blurring of the distinctions that separate hospitals operated for profit and those that are operated under

the not-for-profit designation. I will begin by outlining the characteristics of the community model hospital which are being replaced by the business model hospital. The community model hospital is characterized by:

1)-Emphasis on community service

2)-Capital provided by philanthropic gifts, community fund raising and government grants

3)-Performance measured by service

4)-Management personnel often not trained or experienced in the ways of business rationality

5)-Little economic competitive pressure is felt; competition usually based on community pride

6)-Self contained entities, mostly local in nature

7)-Focus almost exclusively on providing in-patient care services

8)-All of the hospital's business structured under one relatively simple organizational structure

9)-Emphasis on local control and a local support network

In contrast the defining characteristics of the business model hospital are as follows:

1)-An emphasis on "free market" economic rationality

2)-Access to external financial capital is regarded as essential

3)-Performance measured by profits

4)-Use of advanced management techniques to improve

performance

5)-New emphasis on competitiveness with other health care providers

6)-Vertical and horizontal integration of business lines and services

7)-Diversification of products and services offered

8)-Restructuring of the hospital along corporate model lines

9)-Formation of new alliances and partnerships

The community hospital model which dominated the hospital industry from the 1930's to the early 1980's was born out of a mentality of volunteer community service. Community hospitals were organized on a non-profit basis and took as their primary mission that of serving the hospital care needs of the surrounding community. To a large extent community hospitals were self- contained entities. They were organized, controlled and largely financed locally. In the volunteer tradition, local community leaders gave their time and effort to building and maintaining the hospitals as a community trust.

Community hospital efforts were primarily focused toward meeting the needs of those who were treated on an in-patient basis. Although most of the ongoing routine financial needs of hospitals were met through billing for patient services, most of the capital needs for building or renovating facilities and

purchasing major equipment were met through philanthropic gifts, community-wide fund raising drives, and direct grants from local, state and federal government. Service to the community was the primary focus of attention, with the costs of such services being met by whatever means available if patients were unable to pay. Although competition existed among some hospitals, it was often a competition of community pride more than head-to-head economic competition.

With these contrasting characteristics of the community hospital model in mind, I would like now to elaborate on the characteristics of the business model hospital as outlined above.

Definitive Characteristics of the Business Model Hospital

(1) Emphasis on "Free Market" Economic Rationality. In the business model hospital, the dominant frame of reference is the "free market" model of classical economics with its emphasis on economically rational players. This emphasis on the "bottom line" is the most distinguishing characteristic of the business model hospital. It is in sharp contrast with the emphasis in earlier models on providing community service. Business model hospitals look toward establishing and maintaining services that have a potential for a high rate of financial return. Service programs are designed to target the profitable patients

- those who can afford to pay and have illnesses that do not cost the hospital too much to treat. Unprofitable patients, i.e., those without health insurance and/or with difficult cases, are avoided when possible.

(2) Access to Capital Regarded as Essential. Historically, funding for the community model hospital was dependent on a rather closely related set of factors: a) the economic health of the community, b) community perception of the quality of service provided and c) the political effectiveness of the hospital administrators in maintaining health care as a high priority in the public budgeting process. Proponents for a shift from this older financing system, which is staggering under the ever mounting strains of an unending hi-tech gadget "wish-list" and soaring rates of compensation for doctors and their expanding staffs, have found ready allies in Wall Street investment bankers who regard this as an entirely new source of hitherto nonexistent underwriting and brokerage profits. The result is that the capital markets which finance the $3 million dollar CAT scanner, say, require and respond to a profit-oriented set of performance measures. The trade-offs and benefits of this shift between financing sources are both significant. To mention just one, the poorest communities no longer need to have the poorest health services, but they have far less control than before.

(3) Performance Measured by Profits. Community service values of the past are increasingly subject to economic rationality as services and staff are subject to cuts in order to assure profitability. With business model hospitals, the "need" for services in the community is no longer the primary consideration in decisions to maintain or establish new services as it was with community hospitals. Community hospitals were, in principle, committed to serving the needs of residents of the community including those that could not afford to pay. Although business-model hospitals do give some free care to those that can not afford to pay, the amount of free care that is given is based on rational consideration within the budget process, not on the amount of need that exists in the community. Obligations to give free care to indigent patients in return for receiving federal government monies for facility construction are sometimes hidden from the public by neglecting to post information concerning free care.

(4) Advanced Management Techniques. An aggressive management style is adopted by business model hospitals. Their managers actively seek new opportunities to expand the economic base of their entities through economically rational investments and revenue collections. Management actively surveys the surrounding environment for new opportunities to enhance the hospital's position, power and influence within and outside its service area relative to other health care providers and to the

infrastructure of the community at large. Business model hospitals are pursuing patient acquisition on a wholesale basis rather than on a retail basis as in the past. Business model hospitals are mounting substantial efforts to attract large blocks of patients through contractual arrangements with HMO's, PPO's and major employers. They are adding new services and revamping old ones in an effort to attract customers. Business model hospitals are expanding into new geographic service areas in search of new patients and greater profits.

(5) New Emphasis on Competitiveness. Competitiveness with other health care providers is of vital importance and competitive advantages are actively sought. There has been a sharp increase in competition within the health care industry over the last few years. The emergence of the business model hospital is in large measure a response to the increased competition among health care providers. Expanding and holding a market share is a key objective sought after by business-model hospital administrators. For some hospitals, being strongly competitive is a matter of survival. But beyond the obvious economic incentives of being a sharp competitor, being competitively fit is viewed as a test of general viability, even for hospitals not in heavily competitive environments. Many hospitals are expanding well beyond their traditional service areas in search of new patients and revenues. Competing hospitals in neighboring communities even establish "feeder"

outpatient clinics in each other's back yards.

(6) Vertical and Horizontal Integration. Vertical and horizontal integration is actively pursued to help manage "uncertainties" and to enhance profitability. Major payers for health care services have tried to reduce health care costs by shortening or eliminating patient stays in hospitals by shifting to outpatient services. As a consequence, hospitals have "followed" patients (or their health insurance) by shifting toward providing outpatient services. This is done by vertical integration, that is, by buying out existing outpatient health care providers or starting their own outpatient programs. Business-model hospitals have expanded to include outpatient clinics on and off their hospital sites, as well as nursing homes, home health services, rehabilitation services, pharmacies and a variety of other non-hospital based health services. Horizontal integration has sometimes taken the form of buying out or merging with other hospitals in the community or region. In some cases the horizontal integration has involved one hospital providing a management umbrella for smaller hospitals while each hospital maintains its separate identity.

One of the most important forms of horizontal integration for non-profit hospitals is that of joining local, regional and national alliances of hospitals. These alliances serve as a support network for member hospitals and provide a variety of

services and benefits for member hospitals, ranging from management advice and mass purchasing to assistance with major capital financing and involvement in HMOs and PPOs. These alliances of business model hospitals operate as a counter to the chains assembled by for-profit hospital chains. The for-profit chains have become health conglomerates that command vast amounts of financial resources and managerial talent. Many industry observers who favor the non-profit hospital system fear that the for-profit chains will be able to dominate the future of health care economically and politically.

(7) Diversification. Diversification of the hospitals' business is sought and investments are not limited to health-related ventures. The business model hospitals have come to see themselves as business oriented in the broader sense, seeking to make money by pursuing a variety of business opportunities. The diversification of the hospital's business into health related areas such as outpatient clinics and home health care was noted above. Diversification of this sort is generally logical and commonplace with hospitals in today's environment. Diversification has also included buying or establishing drug stores, health clubs, health service consultant companies, medical equipment franchises, and investments in medical facilities not used directly by the hospitals such as doctor's office complexes and the like. Business model hospitals have carried diversification well beyond health related ventures.

Business model hospitals have invested in ventures such as bill collection and office management companies, interior decoration services, landscaping services, fast food restaurant franchises, and gas stations. Real estate investments have expanded those related to health care to include residential condominiums and speculation on commercial properties.

(8) Organizational Restructuring. The hospital's operations are organized along lines similar to the corporate structure model. This is one of the most readily visible signs that business model hospitals have come to see themselves in a new perspective. Business model hospitals view the services provided by the hospital in terms of product lines to be developed, marketed and sold, just as non-health related businesses do. Individual product lines may include services such as laboratory, X-ray, home health services, renal dialysis, food services, and material procurement. The individual product lines are usually managed to maximize revenues within the line as opposed to just serving as a supporting service to the operation of the hospital. Investments are made in the individual product lines in accordance with ability to provide a return on investment to the hospitals. In many instances business model hospitals sell services to organizations outside the hospital. The hospital may sell microfilming services, laundry services, and office management services, for example, to businesses not connected with the hospital.

Many business model hospitals have adopted a parent/subsidiary model or a holding company model of organization to enhance their operations. Under this organizational arrangement, the various ancillary and support service departments of the hospital, such as x-ray, food services, and housekeeping are established as separate organizational entities. The core inpatient portion of the hospital then purchases services from the ancillary and support units. New service companies, both health and non-health related, are formed as part of the hospital's vertical and horizontal integration efforts. The new businesses run by hospitals include everything from health-fitness clubs and diet centers to fast food restaurant franchises and condominium projects.

Business model hospitals are reorganizing their operations for other reasons as well. Organizational flexibility and the protection of revenues generated through other sources are two of the more important ones. Business model hospitals are reorganizing their various subsidiaries as not-for-profit and for-profit entities. Many of the hospitals that are adopting the business perspective to deal with today's health care industry environment have had a tradition of being not-for-profit hospitals. Many hospitals have attempted to mix the best of both worlds by reorganizing their operations together with an assortment of non-profit and for-profit subsidiaries.

Obvious advantages in retaining not-for-profit status include the tax advantages and the generally positive public image of being a non-profit facility. Hospitals are finding, however, that for-profit subsidiaries provide business flexibility that is advantageous for certain aspects of a hospital's operations. Reorganizing into not-for-profit and for-profit subsidiaries is also used by some hospitals to protect revenues generated through endowments and gifts made to the hospital which government regulations may require to be counted as part of state and federal payment formulas.

9) Emergence of New Alliances and Partnerships. New constituencies outside the community are developed and served preferentially. This shift of constituencies is probably the most significant change in the business model hospital over the community service hospital. The business model hospital, with its emphasis on vertical and horizontal integration and expansion, needs resources beyond what can be raised through local community support mechanisms that community hospitals relied upon in the past. The problem of resource acquisition has been strained further by the curtailment of government grants and aids to hospitals and the tightening of reimbursement payments from third party payers.

Business model hospitals are cultivating relationships with

outside community partners and investors, such as joint venture partners, investment bankers, and bond purchasers. I have already mentioned the relationship being cultivated by most business model hospitals with local, regional and national hospital alliances. All of these "outsiders" place demands and expectations upon the hospital to perform in particular ways to assure their future support. In as much as most hospitals feel that they need to maintain the support of these "outsiders" in order to be competitive or in some cases survive, the business model hospitals are treating the outside investors and alliances as constituencies that must be served well if they are to remain in their good graces. In cultivating and serving these new constituencies, business model hospitals have not abandoned their community constituencies, but it does appear that business model hospitals respond more and more readily to the new constituencies as the health care field environment becomes more complex and competitive.

It should be emphasized that, for most hospitals, adopting the "business model" perspective is a matter of degree. Individual situational factors facing each hospital play a strong role in determining how vigorously the implementation of the business model is pursued. For example, a hospital in a highly competitive market is probably more likely to embrace the business model fully while a hospital that is relatively financially sound and is the sole provider to a community may be

less likely to embrace the business model. Non-profit hospitals that are church related are often more resistant to adopting a full scale version of the business model until they are under a great deal of financial pressure to do so. The attitude and aggressiveness of the administrative staff of a hospital also affects to what extent the hospital will adopt the business model. It is suggested by observers of the field, however, that with few exceptions, only those hospitals that are able to adapt to the business model will be able to cope effectively with the future.

## The Research Methodology

The research reported in the pages to follow is qualitative in nature, inasmuch as it is based on in-depth interviews. Those interviewed included hospital administrators and individuals actively working in the hospital industry as administrators of multi-hospital companies, hospital alliances, and hospital associations. The interviews were aimed at understanding the administrators' perspective and actions. The research was confined to acute-care general hospitals.

A total of thirty three interviews were conducted. Twenty four of these were with individuals involved in running hospitals on a daily basis while nine interviews were conducted with individuals who had involvement with a multi-hospital system or

alliance. Of the thirty-three formal interviews, fourteen were held with the CEO of the hospital while ten were held with senior level administrators, most of which held the title of vice president or assistant administrator. Of those individuals associated with more than a single hospital, four were senior level regional representatives of national for-profit hospital chains, two were administrators of multi-state hospital alliances, two were consultants with a nationally known consulting firm active in the health care industry, and one was a representative of the American Hospital Association. Advance letters were written to the chief executive officers of the hospitals and organizations to be interviewed explaining the nature of the research and requesting an interview with the CEO or with a senior level person involved in administration and planning for the hospital or organization. The interviews were conducted from March to October, 1986. A list of the hospitals and other organizations included in this study is provided in the Appendix.

The interviews usually lasted from one to two hours and were loosely structured in order to allow for an open ended discussion of the issues. The sessions began by focusing on the interviewee's observations as to the major concerns and problems facing the hospital industry in general and those faced by his or her organization in particular. With the hospitals, most of the interview then focused on specific strategies and

actions used by the hospital in an effort to adapt to the changing health care environment. The interviews with those individuals who worked with hospital chains or alliances followed similar lines.

As mentioned, the interviews were aimed at understanding the strategic basis of the hospital administrators' thoughts and actions. This dissertation identifies individual adaptive behaviors and speculates on the future path of the hospital industry. Also it suggests the probable impact that such new directions will have on the public interest.

One of the major purposes of the research was to determine the effect the changing political economy in health care has on various classes of hospitals. The phrase "classes of hospitals" is used here to refer to differences in number of beds, type of ownership, independent/affiliated (with a multi hospital system) status, rural/urban location, and for-profit/non-profit structure. In developing the research design it was felt that different classes of hospitals may be affected differently by the changes in the health care political economy. It was also felt that hospitals in small towns may be affected differently than hospitals in larger metropolitan areas.

To obtain a more complete picture of how various classes of

hospitals are reacting to changes in health care, then, the site visits were made to a cross section of hospitals. Institutions in a large metropolitan area, medium size urban areas, and small rural towns were included. Boston, Massachusetts, was selected as the major metropolitan area, and Roanoke, Virginia, and Charleston, West Virginia, were chosen as medium size urban sites. Small rural hospitals were visited in southwestern Virginia, southern West Virginia and western Massachusetts. It was also felt that interviewing at several hospitals which operated in the same general market area would provide a better understanding of all inter-hospital relationships. Therefore, at least two hospitals were interviewed in each market area included in the research project.

Of the twenty four hospitals involved in the study, nine were in Massachusetts, nine in West Virginia, and six in Virginia. Eighteen of the hospitals were non-profit and six were for-profit. Four of the hospitals had over 500 beds, nine had 251 to 500 beds, eight had 100 to 250 beds and three were under 100 beds in size. Fourteen of the hospitals were independent nonprofit owned, one independent hospital was a for-profit, three hospitals were owned by non-profit multi-hospital systems, four hospitals were owned by for-profit multi-hospital systems, and two were publicly owned. One of the publicly owned hospitals was being operated by a for profit multi-hospital system under a contractual arrangement. Nineteen of the hospitals were

affiliated with a non-profit alliance of hospitals or owned by a for-profit hospital system. Five of the hospitals had no formal affiliation with an alliance or multi hospital system.

## A Look Ahead

The organization of the rest of this dissertation is as follows. Chapter Two discusses the historical evolution of the American hospital. This chapter is intended to give the reader a sense of the evolutionary process through which the hospital has gone to become what it is today. Some of the major developments which facilitated the development of the American hospital are noted as well as the changing role that hospitals have played in health care. Chapter Three discusses the current political economy environment of the health care field. This chapter is intended to give the reader a feel for the sources and types of pressures that are shaping health care today.

In Chapter Four the results of the field interviews with hospital administrators and other industry personnel are presented. I examine how the various classes of hospitals are coping with and are adapting to the changing health care environment. The field interview data are organized around five major themes which emerged from discussions with hospital administrators as to how they are perceiving and coping with efforts to adapt to the new political economy in health care. Chapter Five examines some of

the emerging issues which policy makers most likely will have to confront in the near future. It also offers concluding analyses and suggestions as to how policy makers may deal with those issues.

## Notes

1 Statistical Abstract of the United States 1987, United States Department of Commerce, 107th Edition, p. 84.

2 National Health Expenditures, 1984 Health Care Financing Review, Fall 1985, Volume 7, Number 1, p.2.

## Chapter Two

## A HISTORICAL PERSPECTIVE:
## THE EVOLUTION OF THE HOSPITAL AS AN INSTITUTION

This chapter seeks to place the modern health care industry in its proper historical perspective by describing the major events in the evolution of the American hospital over the past fifty years. These major events are, of course, closely related to major changes in the contemporary political economy of health care.

Hospitals today are as much a symbol of modern health care as the "black bag" that doctors carried in the days of the horse and buggy. The technologies and human resources assembled and controlled by today's hospitals have made them a potent political and economic force in American society. This modern influence is in sharp contrast to earlier periods of medical history.

### Early Hospitals in Europe

The American hospital can trace its tradition back to the early roots of Western civilization. The Romans established military hospitals to help care for soldiers wounded in battle. However, it is the role of the Christian Church in the development of the

hospital as an institution that is of major significance. Since early in its history, the Christian Church, with its notion of charity and "service your fellow man," has fostered the development and operation of hospitals. The early Christian hospitals were established to provide a place for Christians to practice charity and to serve others as much as to provide a place caring for the sick. Early Christian hospitals were open to not only the sick but to travelers as well. Those seeking to enter the hospital were usually required to take an oath of allegiance to God before being admitted. They were also expected to participate in religious activities once admitted. Monastic orders operated most hospitals in the medieval period.[1]

By the Middle Ages hospitals had begun to be secularized. This development corresponded with the rise of the secular state and major trading cities in Europe. Secular elements began to exert greater control over hospitals and to reshape its mission to more adequately meet the needs of the times.[2] The role of the hospital was narrowed to serving only the sick and injured. The "service in the name of salvation" concept of the Church had given away to more of a pulic welfare responsibility on the part of the community and the state to care for the poor and the unfortunate members of society. The religous influence on hospitals still remained, but the effectiveness of the hospital declined as the Christian value of service wained. The effectiveness of the hospital was not really restored until

science replaced religious charity as the primary motivation for service.[3]

As the cities of Europe began to grow and become more powerful, they began to take over administrative responsibilities for runing the hospitals. Religious personnel, however, still provided a good deal of the care hospital patients received.[4] The administration of the hospital developed in this period to the point that it was divided between two groups. A governing board, which took responsibility for the overall administration of the hospital and a hospital staff which attended to the daily matters of operating the hospital.[5] Under secularization, hospitals began to be associated with almshouses and patients were treated as public burdens to be cared for. Hospitals at this point were largely institutions of social control. The patients were the socially destitute, those who succumbed to dreaded and incurable diseases, and the insane.[6]

The influence of the Christian Church on the development of the hospital has been long lived. Three of the more important contributions of the Church to the development of the hospital as an institution have been: (1) a service to others orientation, (2) adoption of a broad, "universalistic" definition of who could be cared for in the hospital, and (3) the development of the notion of the hospital as a custodial institution.[7] These defining concepts of a hospital have survived through the years,

though much has changed about the capabilities of hospitals.

Hospital conditions in Europe remained generally deplorable until the 19th Century. Instead of improving over the years, conditions in hospitals declined from the medieval period when hospitals were run by monastic orders. Filthy facilities and exposure to patients with contagious diseases were commonplace. Hospitals were considered by the public to be more often a source of illness and death than a source of cure. Hospitals were usually run by authoritarian and judgmental staffs.[8]

Although hospitals have had a tradition of "service" for more than 1500 years, the care that was provided in hospitals changed little until the latter half of the 19th Century. Early hospitals were mostly custodial in their operation as the practice of medicine had actually regressed somewhat from the time of the Greeks and their Humorial Theory of illness.[9] The discoveries that led to the development of modern medicine were primarly responsible for transforming the hospital into the institution that we know it as today.

## Early Hospitals in the United States

In 1821 only three hospitals existed in the United States. By 1873, 120 hospitals were identified by the Bureau of Education. By the 1920's the number was over 6,000.[10] As was true in

Western Europe, early hospitals in America were for the socially marginal - the poor and the socially dependent. Hospital conditions until the latter 1800's were, as elsewhere, mostly deplorable. The institutions were usually run by overbearing and poorly trained staffs which provided little by way of medical care. Early hospitals in the United States, like early hospitals in Europe, were generally dismal, ill-equipped, and considered to be more a source of sickness and death than a cure. Hospitals were something to be avoided if possible. Except for the indigent, those that became ill were treated at home by doctors, or by family members.

As indicated, it was not until the latter part of the 19th Century that institutions resembling modern hospitals began to take shape. The origin of the modern hospital in the United States closely followed medical science and social evolution. Rodney M. Coe, in his book Development of the Modern Hospital, cites three major developments in the evolution of medicine that played a major role in the development of the modern hospital.[11] First, discoveries of and advancement in the areas of human physiology and bacteriology helped put medical science on a firm foundation. Practices that are taken as basic today such as a doctor washing his hands before going from one patient to another and the isolation of patients with contagious diseases began in the 1860s and 70s.

Second, the development of antiseptic techniques and anesthesia allowed surgeons to become effective and successful in treating patients. Although anesthesia was first discovered in 1846, it was not brought into general use in major hospitals until the late 1860's and 70's. Anesthetics allowed surgical procedures to be more bearable by patients. Advancements in the study of bacteriology lead to the establishment of special rooms for doing surgery, rather that doing it in the patient wards. Antiseptics played a major role helping to control post-operative infections, a major cause of death in surgery patients.

Finally, nursing was established as a basic service role to be performed in hospitals. Prior to the creation of the nursing profession, most of the care given patients in hospitals was custodial in nature. The training of nurses became important in aiding the recovery of hospital patients. Hospital nursing care began to rival and surpass the care which patients could receive at home from family and friends.

In general, the advancement of medical science made doctors and hospitals much more effective in treating the illnesses of patients. With this new-found medical success, the public perception of the hospital began to change from a doomsday place promoting sickness and death to that of a sanctuary where people could go for life-saving medical help. This was evidenced most

prominantly by the fact that middle and upper class patients began to go to hospitals to receive medical care.

Social evolutionary changes in the latter 19th Century also played a major role in the development of the modern hospital. The United State was becoming much more industrialized and urbanized. Urbanization had an impact on the growth and development of hospitals in that city dwellers, often living alone or with others that worked outside the home, were less likely than rural residents to have family members at home who could take care of them in times of sickness. Hospitals provided a social alternative to home care.

Closely associated with the late 19th Century factor of urbanization was industrial development. This meant jobs for urban residents, but it also meant an increase in job related accidents by making early factories more hazardous places to work. Industrialization and urbanization also caused larger numbers of people to live and work closer together, allowing contagious diseases to spread more rapidly to larger groups of people. Compounding these interrelationships were the general hazards of city life, such as getting run over by a street car, that helped increase that need for hospitals.

Most of the hospitals of the middle 1800s were supported primarily by the upper classes as voluntary charities. The

primary patient constituency of most hospitals until the late 1800s, the poor, was not expected to pay for stays in the hospital. Toward the latter part of the century more cities began to establish hospitals that were supported by public funds, although contributions by wealthy individuals and business continued to play a major role in the financing of most hospitals. Reliance on charity contributions had a destablizing effect on some hospitals, especially in hard economic times as existed in the late 1800s.

The latter part of the century saw the development of a significant proportion of paying hospital patients. This was due to two things. First, as physicians sought to centralize their practices in hospital settings, more middle and upper class patients were using hospitals. Second, as demands on hospitals grew and hospitals found themselves confronting financial crisis, many found it necessary to charge the working class poor who were a major part of hospital clientele. The "unworthy" non-working poor were discouraged from entering the hospital to begin with, or at least had their stays shortened when possible. This switch to having patients pay the hospital directly for services was significant in changing the relationship between the hospital and its patients. It meant that patients could make demands on the hospital as opposed to accepting what ever service the hospital might offer.[12]

Around the turn of the century, hospitals began to assume a role as repositories of medical technology advances and medical expertise. Scientific discoveries and advances in medical procedures and equipment such the development of anesthesia, germ sterilization, improved surgery techniques, and radiology, became hospital-based as doctors increasingly found that they could do more for patients in a hospital setting than in the patient's home. Public hospitals operated by cities and counties began to become more prominent during this time as did hospitals operated by religious and charity groups. In many cases physicians established their own hospitals as proprietary institutions. This trend toward making hospitals the repository of medical technology advances was an important step in starting hospitals on the road to respectability.

In 1873 the U.S. Bureau of Education concluded that 178 hospitals existed in the U.S. By 1920 the number had grown to over 6,000.[13] The American Hospital Association reports that 5,678 community hospitals existed in the United States in 1986.[14] The number of hospitals has remained relatively constant (actually declined) even though the nation's population has about tripled.

## The New Deal Era

The history of American hospitals was greatly affected by the New Deal Era. In an effort to combat the devastating social and

economic effects of the Great Depression of the 1930's, the federal government undertook to provide for a broad range of publicly financed and administered programs. These programs included public jobs programs, subsidy programs for agriculture, greater regulatory control of business and commerce and of course, the Social Security program. The New Deal Era was the beginning of the federal government's broad-based and direct role in financing large scale social and economic programs.

The governmental policies which arose from the New Deal had a substantial and continuing impact on hospitals as a growing industry. With the New Deal Era, the federal government began to assume a role of financial support for a broad range of social programs including health care services such as maternal and child health services and other "categorical" programs targeted toward particular groups. The governmental philosophy ushered in by the New Deal has been elaborated upon over the last fifty years to the point that government now pays about forty percent of the total health care bill for the nation.

Also during the 1930's Blue Cross and Blue Shield health insurance programs came into existence with the active encouragement and support of hospitals. These programs were fostered by hospitals as a means of helping assure payment for services rendered by and in hospitals. The advent of health

insurance on a broad scale significantly enhanced the financial viability of the hospital industry. Eventually the Blue Cross and Blue Shield programs severed ties with the hospital associations that spawned them as they became strong enough to stand on their own. To be sure, Blue Cross and Blue Shield were not the first or only private sector health insurance programs to emerge in the 1930's. But "The Blues" were significant in that they were the first private insurance programs conceived to operate on a scale large enough to include a substantial portion of the population.

Emergence of the Blue Cross programs represented a significant milestone in the development of the hospital industry in that it meant that hospitals could increase the amount of patient service revenue that they were able to collect on their own. This served to reduce the reliance of hospitals on philanthropic contributions for operating revenues. Hospitals were still dependent upon philanthropy for most significant expansions of facilities and the purchase of new major equipment items, however. But with broad scale hospital insurance, paid directly to the hospitals, hospitals were able to assume greater control of their finances.

## World War II and the Hill-Burton Act

The Second World War had an effect on the hospital industry in

that it, as in most wartime situations, spurred the advancement of medical knowledge, technology and skills. Hospitals continued to expand their role as the repository of advances in medical knowledge and technology during the war years even though the effect of the depression and the war effort had curtailed major investments in the facilities and equipment of the hospital industry. By the time of the war's end, a significant infrastructure deficit prevailed in the hospital industry. This laid the basis for a second major federal intervention in this field.

A watershed in the evaluation of the political economy of American health care was passage by Congress of the Hill-Burton Act of 1946. Initially aimed at rural areas and later poor urban areas, this act authorized the direct involvement of government in the development and financing of hospital facilities. From the years 1949 to 1962 the Hill-Burton Program assisted about 30% of all hospital construction projects that were undertaken. Hill-Burton financial contributions amounted to about 10% of the total spent on hospital construction in the United States. From the time of its implementation in 1948 to 1971, the Hill-Burton program provided approximately $13 billion in support of health facility construction.[15]

The Hill-Burton Program brought the federal and state governments into a cooperative and direct role in the planning

and paying for hospital construction. Federal money was allocated to individual States on the basis of a formula which aimed at giving lower income States more money. The Hill-Burton Program required that each State develop a state-wide plan for hospital facilities. The federal government provided an allotment of funds to States each year to help finance the construction of hospital facilities which conformed to the approved plan, based on a need criteria.

The funds provided through the Hill-Burton program were usually not sufficient to finance an entire project. Frequently Hill-Burton funds were used as either seed money or as completion money for the development of a facility. The Hill-Burton funds were matched and or supplemented by state and local funds. The Hill-Burton Program, coupled with the local fund raising efforts of the hospitals themselves, became one of the main sources of capital formation for hospital facilities until the expiration of the program in 1976.

The Hill-Burton Program was phased out of existence largely due to mounting evidence that there was a growing surplus of hospital beds. Hill-Burton as a planning and control mechanism had become largely ineffective in that political maneuvering and local community passion for bigger and better hospitals tended to dominate regulatory intentions. It appeared that there was no end to the expansion that hospitals would undertake if allowed

to do so. "A bed built was a bed filled," under the cost-based reimbursement used by the major payers of health services. Hospitals got paid more for doing more, so they did more.

Fueled by community pride and zealous administrators and boards of directors, community based hospitals strived to be all encompassing and self contained. Only lip service was paid to the idea of joint ventures and shared services with other hospitals. Institutional ego and community pride countered any predilictions toward cooperation among hospitals.

## Predominance of the Community Hospital

Although they began to profliferate in the 1930s and 1940s, non-profit community hospitals became the dominant form of hospital organization in the United States in the 1950s and 1960s. Community hospitals achieved their prominance with the aid of government financing and substantial amounts of community philanthropy. Community hospitals leaned heavily toward the pure service model in their operational orientation. Many of the proprietary hospitals started during the first half of the 19th century sold out to or were otherwise dissolved into non-profit community hospitals. The primary motivation for converting to non-profit status was to gain access to funds available from government and tax-free public contributions that were not available to proprietary hospitals.

Although multi-hospital systems existed during this period, such systems were generally non-profit, in most cases being operated by charity and religious organizations. For-profit hospitals continued to exist but their presence had little impact. The Hospital Corporation of America, the largest for-profit multi-unit hospital system today, was started in the early 1950s but did not began its ascendancy until after 1968. The 1950s, 1960s and early 1970s represent the zenith of the non-profit community hospitals in terms of the political and economic power which they were able to command.

## The Great Society Era: Medicare and Medicaid

During the Great Society Era of the 1960s, the political economy of health care was dominated by egalitarian concepts of equal access to quality health care for all members of of society. As a result of governmental policies formulated during this period, tremendous quantities of funds were authorized for a host of new social and health programs. The most important of these new programs were the Medicare and Medicaid programs enacted in 1965.

The Medicare and Medicaid programs had a dramatic and continuing impact on the hospital industry. The principal benefits were clear. Hospitals were given financial access to large groups of

patients who were major consumers of services that hospitals had to offer and they received large amounts of money through a stable and dependable payment mechanism for treating those patients. The financial stability that the Medicare and Medicaid programs brought with them enabled hospitals to establish rational planning procedures for hospital finance. Through Medicare and Medicaid, patient groups formerly were the source of financial losses were converted into opportunities for financial gains. On the negative side, the Medicare and Medicaid programs greatly contributed to the tremendous inflationary rise in health care costs that occurred during the 1960s and 1970s.

## Emergence of a Health Care Cost Crisis

The demise of the Hill-Burton Program marked the end of direct federal involvement in the capital planning and formation process. In the late 1970s debt financing began to emerge as the major source of capital formation for hospitals. Debt financing has grown rapidly in the 1980s. The ramifications of the capital formation problem in this period greatly affected the future of the hospital industry.

Although the 1970s were inflationary in general, the health care industry was one of the most, if not the most, inflationary areas of the U.S. economy. The 1972 Social Security amendments,

specifically, Section 1172 and the more encompassing National Health Planning Act of 1974, were major attempts of the federal government to control the proliferating expansion of the health care industry in general and hospitals in particular. This was done through cooperative efforts with state certificate of need laws. The fact that these containment efforts were less than successful is testimony to the enormous economic and political power which hospitals had been able to amass.

The early 1980s have seen the emergence of a new political economy in the health care industry. This new political economy is largely the result of greatly increased pressures on hospitals for cost control. These pressures have emerged from a variety of sources generally characterized as third party payers. They include state and federal governments, business coalitions, and health insurance companies. The major sources of third party health care payments are now dedicated to containing the spiraling cost of health care. The pressures have brought a dramatic change in the way hospitals are paid. They have also created a variety of alternative forms of health care organizations such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and franchised organizations, which are directed towards the delivery of cost-efficient health care services. As a result of these forces, hospitals are now faced with a new, complex and intensively competitive environment in which they must now operate.

This new environment is dramatically different from the relatively tranquil and supportive environment which hospitals have experienced over the past 40 or 50 years. It is an environment which is reshaping the health care industry in this country and one that requires a new kind of hospital to cope effectively. The "business model" is the next step in the evolution of the American hospital institution. In Chapter Three we will look more closely at the forces which have given rise to the business model hospital.

## Notes

1 Rodney M. Coe, Sociology of Medicine (New York, NY, McGraw Hill Inc., 1970): p. 235

2 George Rosen, "The Hospital: Historical Sociology of a Community Institution", in Eliot Freidson, (ed.) The Hospital in Modern Society, (London: The Free Press of Glencoe, Collier-MacMillian Limited, 1963): p. 14

3 Rodney M. Coe, Sociology of Medicine (New York, NY, McGraw Hill Inc., 1970): p. 237-239

4 George Rosen, "The Hospital: Historical Sociology of a Community Institution", in Eliot Freidson, (ed.) The Hospital in Modern Society, (London: The Free Press of Glencoe, Collier-MacMillian Limited, 1963): p. 14

5 George Rosen, "The Hospital: Historical Sociology of a Community Institution", in Eliot Freidson, (ed.) The Hospital in Modern Society, (London: The Free Press of Glencoe, Collier-MacMillian Limited, 1963): p. 16-17

6 Rodney M. Coe, Sociology of Medicine (New York, NY, McGraw Hill Inc., 1970): p. 237 and George Rosen, "The

Hospital: Historical Sociology of a Community Institution", in Eliot Freidson, (ed.) The Hospital in Modern Society, (London: The Free Press of Glencoe, Collier-MacMillian Limited, 1963): p. 15

7 Rodney M. Coe, Sociology of Medicine (New York, NY, McGraw Hill Inc., 1970): p. 236

8 Coe, Sociology of Medicine p. 234-240

9 Coe, Sociology of Medicine p. 234-240

10 Morris J. Vogel, The Invention of the Modern Hospital, Boston 1870-1930 (Chicago Il., The University of Chicago Press, 1980): p.1

11 Coe, Sociology of Medicine p. 247

12 David Rosner, A Once Charitable Enterprise, Hospitals and Health Care in Brooklyn and New York, 1885-1915 (Cambridge, Cambridge University Press, 1982): p. 36-61

13 Vogel, The Invention of the Modern Hospital, Boston 1870-1930 p.1

14 Hospital Statistics, 1987 Edition (Chicago,Il, American Hospital Association): p. xvii

15 Lave, Judith R. and Lester B. Lave, The Hospital Construction Act: An Evaluation of the Hill-Burton Program, 1948-1973 (Washigton D. C., American Enterprise Institute for Public Policy Research, 1974) p. 16

## Chapter Three

## THE POLITICAL ECONOMY OF TODAY'S HEALTH CARE INDUSTRY

This chapter continues the discussion begun in the last chapter by describing the forces operating in the political economy of today's health care industry. It also provides a background perspective for this researcher's field observations of how hospitals are dealing with this new environment, which will be presented in the next chapter.

The growth of the health industry over the last several years has been enormous. Nationally, health expenditures in 1985, including medical research and medical facilities construction, totaled $425.0 billion. This amounted to 10.7% of the Gross National Product (GNP). Comparable figures for health care expenditures in 1980 were $248.1 billion, comprising 9.1% of the GNP. In 1970 they were $75.0 billion or 7.4 % of the GNP. Per capita expenditures on health in the United States was $349 in 1970, $1,054 in 1980, and $1,721 in 1985.[1]

In the late 1980s health care costs continue to exceed the general inflation rate by a substantial margin. It is estimated that medical cost will rise at the annual rate of 6.7% in 1988 while the general rate of inflation is projected to be around 3.9%. Total spending on health care was approximately half

trillion dollars in 1987. It is estimated by some that by 1992 total health care spending will amount to 13% of the GNP.[2]

The largest category of health care expenditures, approximately 40 %, is for hospital care. In 1985 $166.7 billion was spent for hospital care. This amounts to more than twice the money spent on the second largest category, physician services, which totaled $82.8 billion (19.1%) in 1985.[3] The large proportion of money accounted for by hospital care has brought tighter scrutiny and greater pressure for hospital cost containment on the part of those who are responsible for paying for health care services - government, private insurers, employers, and health care consumers themselves.

Cost control pressures in the health care industry have intensified primarily because of the soaring health care costs that began in the mid and late 1970s which were running as much as 15% to 16% annually. Between 1972 and 1984, total annual expenses of community hospitals increased at an average annual rate of 14.8%. In the mid 1980s the rise in health care costs continue to exceed by more than 50% the general inflation rate of the economy, even though the rate of increase has dropped to an average of 6.8% annually from 1984 through 1986.[4] It is fair to say that much of the new political economy of the health care industry that has emerged in the 1980s is directly related to efforts to control costs in the health care industry in general

and in the hospital industry specifically.

## Factors Behind the Increasingly High Cost of Health Care

Why are health care costs consistently increasing rising at so fast a rate? Hospitals are by nature expensive operations. They are both labor and capital intensive. Operating budgets for the relatively small community hospital of 150 to 200 beds range in the area of $20 to $40 million annually, depending on the diversity of services offered. Large metropolitan area hospitals offering tertiary care often have annual operating budgets in the $250 million range. Hospitals are obliged to employ alot of people, many of them highly trained, and they purchase much equipment and a large variety of supplies, most of which are specialized and sophisticated. The expense of all of this becomes accentuated by factors associated with the development and use of new technology.

New technology in the delivery of health care services is a major factor behind the increasing costs of health care services. First of all, the development of medical technology is inherently expensive. New medical technology is increasingly sophisticated and costly to research, develop and market. It employs leading-edge developments in various scientific and technical fields. Since the new technology will have life-and-death consequences for those patients on which it is used, it

must be carefully designed and exhaustively tested. Beyond this, it is important to point out, much of medical technology development is aimed at improving patient care rather than cost reduction as it is in non-medical fields. In health care "better" is usually chosen over less expensive.

Once developed, new medical technology has another phenomenon associated with it which makes perhaps an even greater impact on health care costs. While much health care is routine, increasingly what medical science is called upon to do to diagnose illness and treating the human body is very complex as well as very inexact. Physicians, trained in well equipped and staffed medical centers, are usually inclined to use all the relevant resources that are available to them to aid in their work. In today's litigious environment, medical providers have a great incentive to "err" on the side of overusing the diagnosing and treatments resources available for their patients. Given these factors, it can be reasonably argued that doctors have a bias and an incentive to use medically technology simply because it exists.

Unlike in many other businesses, the availability of more effective, efficient technology and even cheaper technology often does not reduce costs because the new technology is used more frequently and not necessarily more efficiently. Recent technological developments in diagnostic imaging is an example.

Magnetic resonances imaging (MRI) is superior to older methods of diagnostic imaging used in patient diagnosis. It generates higher quality pictures and has none of the potentially hazardous side effects of x-rays. For these reasons, doctors are likely to be quick to use the MRI scanning machine and to use it more frequently, even though it is not always necessary and is considerably more expensive to use than other means of diagnostic imaging. As outpatient care has grown in primary care clinics and doctor's offices, physicians and administrators feel compelled to purchase additional units of the new technology. Once having purchased it, they feel obliged to use it frequently.

Highly trained medical personnel and sophisticated medical equipment generally require modern and specialized facilities. Both medical personnel and consumers expect and are generally attracted to the most up-to-date medical facilities. Vigorous competition among health care providers dictates that health care administrators must not allow the perception that the quality of medical care rendered at their facilities is less than top rate. Hence they must equip themselves with the best and the latest. The expense of all of this is accentuated by the fact that rapid technological developments in the health care field, and more recently political and economic developments, often quickly outpace existing equipment and facilities.

## The Political Environment of the 1980s

The emergence of the business model hospital coincided somewhat with a change in the national political and economic climate. The Reagan Administration, which took office in 1981, provided a strong pro-business environment by promising to reduce government interference with private business. The Reagan Administration went even further to promote private sector free market solutions to public sector problems. It even suggested that some traditional government-operated services such as the National Weather Service be sold to private companies. The federal government is also exploring greater private sector involvement in areas such as space exploration and the operation of prisons. Many state governments have also relaxed or eliminated state regulation of healthcare providers, expecially in the area of Certificate of Need Requirements for expanding or terminating health services. This shift away from the kind of heavy regulation which prevailed in the past has provided a fertile environment for the use of new approaches to the delivery of health services by private sector providers.

The crisis created in the 1970's by spiraling health care costs, coupled with efforts by the Reagan Administration to cut government spending on social programs, began to focus public attention on the cost of health care and the fact that financing for health care services could not continue to be treated as

open-ended. Government sought to cut back direct aid to health care providers by ending or reducing subsidies and to shift some of the costs of paying for health care services to individual consumers and employers through increased co-insurance payments and reduced tax deductions.

The concept of equal access to quality health care for all that was espoused during the 1960s is now being questioned by an open acknowledgement that government cannot do everything for everyone. The concern over the growing federal deficit appears to have helped promote this change in attitude. The Reagan Administration has been successful in cutting or at least holding the line on some social programs, heretofore considered untouchable, including health programs.

Cost Containment Efforts

Inflation in the cost of health care reached crisis proportions in the late 1970s and early 1980s. Health care costs have generally risen at a rate double the rate of inflation in other areas of the economy in recent years. Although the rate of increase in health care costs decreased significantly in 1984, it was still 50 % more than the general inflation rate (6% versus 4%). Because of their high visibility and the large amount of money they spend on inpatient care, hospitals, more than other health care providers, are being faced with tremendous pressure

to contain rising health care costs. The pressure is coming from the third party sources who pay the bulk of the health care bill - government, health insurance companies, and employer/business coalitions.

Government has a dual role with regard to the health care industry. It is both a regulator and a major purchaser of heath care services. The federal government, after several years of trying to control health care cost through planning and regulation, is now shifting primary attention away from regulating healthcare providers to limiting directly the costs of providing services for its Medicare beneficiaries. This new policy was implemented in 1983 through the use of the prospective reimbursement system for paying hospitals, i.e., flat rate payments based upon diagnosis. The amount of revenue which hospitals derive from Medicare and Medicaid is substantial. In fiscal year 1985 the federal government paid out $72.3 billion through the Medicare Program, about two thirds of which went for hospital care.[5] The dramatic impact of the federal government's prospective reimbursement program on the hospital industry is discussed in more detail elsewhere in this chapter.

The federal government began implementation of the Prospective Payment System (PPS) reimbursement method of payment for Medicare patients in October 1983. This is the most significant development in health care financing since the passage of

Medicare legislation in 1965. It essentially reverses the financial incentive system for hospitals. Under this system the federal government will pay hospitals a fixed fee for treating Medicare patients based on the diagnosis under which they are treated. The fixed payment is based on a classification system of 470 diagnoses known as Diagnosis Related Groups (DRGs).

In the past, hospitals operated with a "parts and labor" mentality because they were reimbursed on a cost basis. Under the Prospective Payment System, hospitals can make more money by doing less for the patient and discharging the patient as quickly as possible. The Prospective Pricing System (PPS) was introduced as a cost saving/containing mechanism. Its implementation has meant a drop in revenues for most hospitals. On the positive side, PPS will allow hospitals to budget and plan more effectively. For the hospitals with strict cost controls, prospective pricing may allow a greater profit margin. Many for-profit hospital chains were quicker to embrace PPS than the non-profits, because they felt that it provides an opportunity to keep the rewards of their cost management efforts.

Deregulation

The Prospective Payment System is in effect a national pricing system for health care. Its impact on hospitals is great

because it is a precedent-setting move on the part of the biggest purchaser of health services, government. It is also of concern because it is, some observers feel, the first move toward a capitation payment system for Medicare patients. (A capitation system is one that charges a flat rate "per head" regardless of the actual cost per person.) This policy change is somewhat paradoxical given the Reagan Administration's belief that market forces are more efficient than government regulation in setting market price.

The net effect of PPS is, however, an important step in deregulating the overall health care system. The federal government is now encouraging Medicare patients to join HMOs in an effort to help control health care expenditures. There are innovative efforts to control costs at the state government level as well. California, in a precedent setting move, has established a bidding procedure among hospitals for awarding Medicaid contracts.

These changes in the way government, the largest single purchaser of health services, pays for health services is forcing hospitals and other providers to re-examine their thinking and their operations. As with any major change in the political economy of an industry, there will be losers and winners in the outcome. This would appear to be particularly true as it relates to the ability of hospitals to raise capital.

The changes now taking place are likely to squeeze the profit margins of many hospitals not fully prepared to cope with them. Some classes of hospitals and their clientele will be more adversely affected than others.

Private Sector Health Insurance

Health insurance companies are also undertaking bold and innovative efforts at controlling hospital costs. A variety of financial incentive plans is being developed which are aimed at rewarding hospitals financially for limiting treatment and discharging patients early. Conversely, financial penalties are being imposed on hospitals not complying with various cost saving efforts of health insurance companies. For example, some Blue Cross Plans are paying hospitals a $100 cash bonus if they discharge maternity patients without conplications within twenty-four hours after delivery. Financial incentives are being offered in other areas such as outpatient pre-admission testing and outpatient surgery where feasible. At the other end of the spectrum, some insurance companies are not paying hospitals for services rendered to patients who did not go through a pre-admission review process in non-emergency situations. After absorbing substantial losses in the late 1970s and early 1980s, health insurance companies are becoming very aggressive in negotiating with hospitals as to what they will pay for and how much they will pay.

In addition to developing innovative health insurance packages, many health insurance companies are also actively supporting or starting their own alternative delivery organizations such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) to compete with hospitals in attracting patients. (HMOs provide care for a prepaid fixed fee; PPOs provide discounts for using certain providers.) Although HMOs and PPOs purchase hospital services for their patients, they are able to negotiate substantial price cuts due to the volume of patients they can deliver. This can serve to squeeze the profit margins of the hospitals with which the HMOs and PPOs deal and severely affect those hospitals with which they do not deal. Such arrangements have prompted some of the excluded hospitals to bring suit in court. (Such a suit was brought in the state of Maryland by hospitals that were excluded from a Blue Cross sponsored PPO, for example.)

Employer Health Coalitions

Employers who pay for health care benefits under employee benefit packages (which account for about 70% of the people who have health insurance), have begun to take a more active role in efforts to contain the rising costs of health care benefits for their employees. Most of these efforts have been directed toward hospitals because hospitals are seen as the biggest

contributor to the increased cost of health care. Employer and business coalition groups are springing up around the country. Their activities vary, ranging from health promotion to political action aimed at setting hospital rates and controlling the expenditures of hospitals.

In Arizona a state business coalition was successful placing six anti-hospital propositions on the 1984 general election ballot. These would have resulted in the establishment of rigid control over hospital rates and severely restricted capital development for hospitals. None of the propositions passed, but they did serve to focus attention on the problem of rising health care costs. The propositions also generated a major feud between the business community and the hospitals. The issue is far from dead in Arizona and, unless health care cost trends are reversed, this situation is likely to be repeated throughout the nation.

By offering employees a greater choice in selecting their health insurance benefits, employers and health insurance companies have made employees more conscious of and more responsible for their health insurance coverage. A trend can be seen away from the uniform health insurance benefits with zero or minimal deductibles which were offered by most employers in the past. Employers and health insurance companies are offering cafeteria-style health benefit packages. In a growing number of cases, employers are offering employees a choice of joining an

HMO or PPO for less out-of-pocket expenses for the employees on the one hand, or the traditional fee for service coverage for higher co-insurance and deductibles on the other.

New Forms of Competition

The competition from the proliferation of alternative health care delivery organizations, such as HMOs, PPOs, high tech home care programs, and franchised outpatient centers, is having a substantial impact on the hospital industry. These organizations are competing strongly for health care dollars in many areas of the country largely because they are new organizations that are responsive (by design) to the new health care environment. They do not carry the overhead burden that most hospitals do. As noted earlier, health insurers, including the federal government, are beginning actively to support and finance alternative approaches to health care delivery.

In short, the traditional functional niches of the hospitals are being challenged directly by the alternative care delivery organizations. A significant part of the alternative delivery sector provides services outside the hospital which formerly were done in hospitals. Outpatient surgery centers, with the aid of new technology, are able to perform operations that until recently were done only in a hospital. Home care agencies, with

the aid of high tech equipment, are, in many cases, able to do such things as chemotherapy, renal dialysis, and physical rehabilitation as effectively and more efficiently than hospitals. HMOs are cutting costs by doing much of their diagnostic testing on an out-patient basis, prior to admitting patients to the hospital.

Hospitals may be in danger of losing their technological edge in the health industry. The alternative delivery organizations are invading the hospitals' traditional role as the repository for new medical technology, as more sophisticated services are moved outside the hospital. As an example, about half of the nuclear magnetic resonance machines (million-dollar plus machines representing the latest in diagnostic technology) are being shipped to non-hospital sites.

Much of the competition that hospitals face comes from other hospitals. Presently, this competition is heightened by the overcapacity that exists within the hospital industry. Enactment of the prospective payment system and other cost containment measures has resulted in a national average hospital occupancy rate of about 67%. In some areas of the country the occupancy rate is only a little more than 50%. Hospitals are planning new services and marketing heavily in most instances to use this excess capacity effectively.

It appears, however, that the health care industry is moving towards smaller hospitals. Trends such as the squeeze of cost containment efforts, the drop in occupancy rates, the sharing of the role as the medical technology repository, and the apparent belief by the major health insurers that hospitals are inherently more expensive would seem to lead to this result.

Also contributing to the excess capacity problem is the over-abundance of physicians who are willing to work in health care organizations as opposed to entering private practice. New medical school graduates are mostly going to work for a health care organization rather than entering into private practice as was the case a few years ago. The high cost of malpractice insurance, and the large amount of debt that many new physicians must carry, coupled with the difficulties of starting a private practice, are primary considerations that discourage new physicians from private practice. The alternative health care delivery organizations and health insurance companies together put competitive heat on well established independent and small group practices of private physicians in many urban areas.

## Vertical and Horizontal Integration

Finally, perhaps the biggest development in the hospital industry in recent years is the advent of multi-hospital affiliations of hospitals. The big news in health care is the

bigness which is coming into being in health care. As noted earlier, it is speculated by many that by the early 1990s health care in this country could be dominated by a relatively small number of large multi-hospital systems. Such predictions might be exaggerated, but multi-hospital systems could have the potential to exert a tremendous amount of influence in national health policies including, and especially in, capital investments in health care resources.

The for-profit investor-owned hospital chains are already exerting a major influence on other hospitals, as they are often considered to be the most formidable competitors. Large for-profit hospital chains like Hospital Corporation of America (HCA), Humana, and National Medical Enterprises (NME) have become health care conglomerates. They are integrating horizontally and vertically. In addition to owning and operating a large number of hospitals, they are involved in almost all aspects of health care, ranging from the manufacturing of health care products to operating health insurance companies. Their depth in management capabilities, large asset base, and ready access to capital markets will give them a potentially major role in shaping the health care delivery systems of the future. Although multi-hospital systems have been around for many years (HCA began in the early 1950s), it is only in the last few years that the political and economic climate has changed significantly in their favor.

Voluntary community hospitals have taken note of the strengths of the for-profit chains and many have actively sought to counteract the power and influence of for-profit multi-hospital systems. This has been done by creating separate, multi-unit alliances. Voluntary Hospitals of America (VHA) is the foremost example of this effort. VHA is an alliance of more than seventy of the largest and strongest non-profit hospitals around the nation. Most of the shareholder members have a number of smaller "satellite" hospitals which it sponsors. VHA seeks to create and disseminate to their members management and financial expertise, mass purchasing benefits and other support services that are enjoyed by the large for-profit systems. The formation of capital and the building of equity appear to be the prime concern of VHA.

Unquestionably, voluntary community hospitals have been shaken by the recent proposed sales of large, strong, non-profit hospitals and teaching hospitals to for-profit systems. It is the non-profit and teaching hospitals themselves which have initiated the sale in most cases. Although these hospitals are generally not presently in financial difficulties, they reportedly feel that their future will be better if affiliated with for-profit systems. Future access to capital is cited as a prime motivating factor.

It may be expected that many smaller non-profit hospitals would sell out to or put themselves up for adoption by multi-hospital systems in order to help secure their future. The fact that some of the major non-profit hospitals would do so is a surprise. The Wesley Medical Center in Wichita, Kansas, a founding member of VHA, is being sold to the Hospital Corporation of America. The Denver-based Presbyterian St. Luke Medical Center, the nation's 63rd largest multi-hospital chain with estimated revenues of 160 million in 1984, is considering a sell-out to HCA. Humana now operates the University of Louisville teaching hospital, the site of recent artificial heart implants. Ownership or affiliation with a prestigious hospital enhances, of course, the prestige and influence of for-profit systems.

Not all hospitals will be good candidates for adoption into multi-hospital systems, especially for-profit systems. Whether or not they become affiliated with a multi-hospital system, it is likely that many will be forced to alter their established roles in the types of services they are able to offer for reasons related to competition and capital financing. During the 1970s and early 1980s, when the for-profit hospital systems were undergoinging rapid expansion, they were not very selective about their purchases of hospitals. Today the situation has turned around in that many of the larger for profit systems are selling off their poorer performing hospitals and are highly selective about the hospitals and communities in

which they invest their resources. This tendency is likely to increase the burden faced by voluntary and public operated hospitals in the future, in that these hospitals will likely be serving a disproportionate share of the very poor and the very ill.

## Observations of Other Commentators

Much of the current literature relating to hospitals and health care is addressed to two topics - advising health care administrators how to cope with changes in the new health care environment and the economics of health care, in inparticular, the matter of controlling costs. However, there are some authors that are focusing on the placing the changes that are now taking place in the hospital industry in a broader perspective.

Hollingsworth and Hollingsworth, noting the increasing concern over the "business-like" orientation of hospitals, direct their attention to comparing how ownership and source of funding affects the performance of hospitals. They examine public hospitals, voluntary hospitals and propietary hospitals with regard to their operations over time from the 1930s to the present. The factors on which they focus include the historical orgins of the hospitals, their sources of capital, their case mix of patients, and their efficiency and costs of operations.[6]

One of the Hollingsworths' principle findings is that as the level and sources of funding among different types of hospitals converge (i. e. arrive at similar proportion of funding from major third party sources) the more similar they are in behavior. The Hollingsworths go on to point out that the future direction of American hospitals is uncertain and that continued pressure on cost control may in fact bring about a divergence in the operations of public, voluntary, and properitary hospitals. Properitary hospitals, with their mandate to produce profits for the investors, may narrow the scope of their operations to include only the most profitable services for "good" paying patients. Public hospitals meanwhile, presumably have to broaden their operations to pick up patients who have no alternative access to hospital care. The Hollingsworths conclude that the result maybe the development of a two-tiered health care system whereby those persons with good health care benefit packages will be able to get access to high quality health services, while those with little and no health care insurance coverage will have to make do with lower levels of quality in health services.[7]

Aaron and Schwartz outline what they refer to as a "painful prescription" for American health care. They conducted a study comparing cost and efforts to control cost in Great Britian, with its socialized health care system, and in the United States. After pointing out the lack of success of U.S. efforts to control

health care costs through regulating capital investment, Aaron and Schwartz suggest that rationing of health care on the basis of cost benefits will eventually have to be invoked if health care costs are to be controlled. They note that it is easier to decide not to buy new medical equipment than it is to deny patients access to it once it is purchased.[8]

Lewis and Sheps, in a discussion on federal health policy, argue that even with the federal government embracing competition as a valuable approach to control health care costs and efficiencies, policy makers will still need to determine the "rules of the road" (as they call it) by which health care competition is played out. Government will be called on to protect special interest claims as various groups, including determining uniform rules for health insurers to deal with comsumers, who and how indigent patient care will be paid for, and incentive programs to encourage health providers to organize efficently and to meet various public needs. Lewis and Sheps note the paradox that before a truly completive health systems can be put effectively in place it will be necessary for government to establish a strong set of regulations to govern it.[9]

The next chapter will begin to examine more specifically how hospitals are responding to the new competitive health care environment by focusing on the strategies and actions that they are currently undertaking.

## Notes

1 Statistical Abstract of the United States, 1987 107th Edition, U.S. Department of Commerce, p. 84

2 James, Frank E., "Medical Expenses Resist Controls and Keep Going One Way: Higher", Wall Street Journal September 29, 1987, p.41

3 Statistical Abstract of the United States, p. 85

4 Hospital Statistics, 1987 Edition, American Hospital Association, Chicago, Illinois, p. xxv

5 Statistical Abstract of the United States, 1987 107th Edition, U. S> Department of Commerce, p. 84

6 Hollingsworth, J. Rogers and Ellen Jane Hollingsworth, Controversy about American Hospitals; Funding, Ownership and Performance (Washington D.C.: American Enterprise Institute, 1987), pp. 1-15

7 Hollingsworth and Hollingsworth, Controversy about American Hospitals, pp. 143-146

8 Aaron, Henry J., and William B. Schwartz, The Painful Prescription (Washington D.C. The Brookings Institution, 1984), pp 8-9, 134-135

9 Lewis, Irving J, and Cecil G. Sheps, The Sick Citadel; The American Academic Medical Center and the Public Interest (Cambridge, MA, Oelgeschlager, Gunn, and Hain, Publishers, Inc., 1983), p. 221

## Chapter Four

## ADAPTIVE STRATEGIES OBSERVED IN THE FIELD

The focus of this chapter is presentation of the observations made during field interviews. As noted earlier, the field interviews include twenty four hospitals, four for-profit multi-hospital systems, and various other elements of the industry. I discuss this material under four headings: (1) the range of services, (2) management practices, (3) marketing practices, and (4) organizational structures. There is some overlapping in the discussion as the four areas are closely interrelated.

The information that follows is a compilation that draws together major competitive strategies of the hospitals interviewed as they attempt to adjust to the most significant changes to take place in the delivery of health care in the last forty years. I will cite general findings and support them with specific examples. It should be noted that not all hospitals interviewed are doing everything discussed here. Individual hospitals are unique with respect to their market environment, financial status, management capabilities and strategies. Therefore, the information presented should be seen as indicative of general trends found with respect to particular classes of hospitals. The implications of these trends will be

discussed in the next chapter.

Four strategies have been adopted to survive in the new political economy of hospitals. They are:

-Integrative Expansion of Hospital Services

-More Efficient and More Aggressive Management

-Better Marketing

-Cultivation of New Constituencies

## Strategy One: Integrative Expansion of Hospital Services

The most significant adaptation strategy observed in the field study is the use of a variety of expansion and integration strategies to expand the hospital's scope of service. This expansion is usually achieved by the use of one or more of the following three strategies; (1) Vertical integration, (2) Horizontal integration and (3) Diversification of the hospital's business. Each of these strategies is discussed below.

It is important to note that the type and extent of expansion undertaken is heavily dependent upon a particular hospital's size, market situation, and financial strength. As we will see in some examples, financial strength is crucial to a hospital's ability to adapt. As one person interviewed put it, "It takes

money to adapt to changes." Hence we should not be surprised to find that the larger, more financially stable hospitals are able to undertake more ambious expansion strategies. However, some smaller hospitals are pursuing very aggressive strategies of integration and expansion, nonetheless.

## Motivations for Integrative Expansion

Three basic motivations prevail in the stragetic expansion in the typical hospital: (1) to increase the revenue base of the hospital, (2) to give the hospital greater control over patient management, and (3) to gain a competitive advantage in marketing by offering more services under the "one stop shopping" approach to health care services.

The first expansion motivation, increased revenues, is a straight-forward strategy. Hospitals are expanding into outpatient care services such as primary care clinics, home care programs, and nursing homes because major third party health insurers are providing financial incentives to treat patients in these less expensive settings. They are also discouraging the treatment of patients on an inpatient basis. Thus hospitals are expanding their domain through vertical integration to reclaim some of the money they are losing as a result of third-party payor efforts to cut expenses for inhospital care.

Under payment programs such as Medicare's Diagnosis Related Group (DRG) Prospective Payment Program, a hospital can lose money by continuing to treat patients inside the hospital if they can be treated on an outpatient basis. This is because the hospital will only receive a fixed amount of money for a hospital stay regardless how long it lasts. A hospital can make more money by developing outpatient treatment facilities. In some cases money from outpatient services is seen as necessary to replace money lost to the hospital because of a decline of inpatient care. Hospitals are integrating and expanding services as a means of following patients where the health care insurers are sending them.

The second major reason that hospitals are pursing integrated expansion strategies has to do with giving the hospital greater control over the management of patient care. As noted in the illustration above, hospitals can lose money treating patients as inpatients if payment rules of third party insurers are violated. By operating their own outpatient clinics, home care programs and nursing homes, hospitals can better control when patients are discharged and to what treatment programs they are sent. They are also more likely to keep the patient from being lost to their competitors by meeting his or her medical needs within the hospital's "system." If the hospitals are depending on outside organizations to promptly admit the patients they are discharging, the hospitals are giving up a great deal of control

over the management of patients. This could be disruptive to the care of patients and costly to hospitals in terms of lost revenue.

Finally, being able to offer a more comprehensive integrated health care service package creates a competitive advantage to a hospital trying to market its services. Being able to offer a package of integrated health care services is an important asset in attracting patients. Offering such an integrated package of services is almost essential when a hospital is competing for large blocks of patients from HMOs, PPOs, and large employers. Patient "wholesalers" are organizations that are able to deliver to healthcare providers large blocks of patients. Such wholesalers often demand deep discounts from hospitals that compete for their business. Therefore it is essential for hospitals to be able to control almost every aspect of patient care tightly if they are to be profitable.

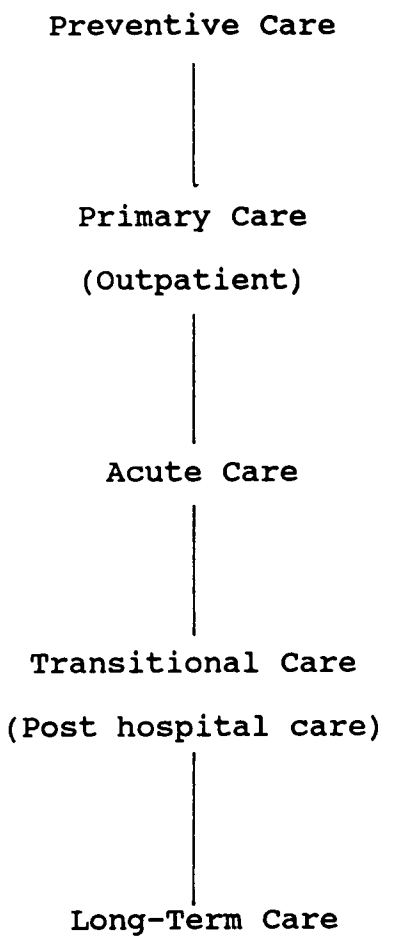
The following section will define and give specific examples of service expansion. These concern vertical integration, horizontal integration, and service diversification.

Expansion by Vertical Integration

Vertical integration is the combining under one organization of the capability of successive stages of production. This

permits the output of one component of the organization to become the input for another component. In the case of hospitals, vertical integration focuses on meeting a patient's health care needs at any level or intensity of service that may be required. (See Figure 4.1 for an illustrated example of vertical integration applied to the hospital industry.)

One major consequence of the vertical integration strategy is that it expands the organizational domain of the hospital. Under the old community hospital model the hospital's focus of attention was primarly on treating patients under its own roof. Now that financial incentives discourage inpatient treatment, hospitals have reacted by focusing on expanding through a variety of outpatient care services in lieu of hospitalization. They also provide a new class of specialized post-hospital discharge treatment facilities such as rehabilitation centers, intermediate care facilities and nursing home facilities. Frequently the vertical integration strategy results in the placement of facilities and services off the main hospital campus. The extent to which a hospital is likely to integrate vertically is determined by its competitive market situation and patient mix (i.e. the type of patients served-- primary, secondary or tertiary), by the inclination of management, and most importantly, by the financial capability of the hospital.




Vertically integrated hospitals are those that have expanded to provide health services through a full range of need levels as opposed to offering primarly inpatient care.

Figure 4.1 Vertical Integration in Health Care

Virtually all of the hospital administrators interviewed indicated they had undertaken some efforts to vertically integrate the hospital's operations. However, there was considerable difference in the intensity of their efforts. Some of the hospitals in and near Boston, for example, were less aggressive at efforts of vertical integration than hospitals located in Western Massachusettes and in Virginia and West Virginia. Larger hospitals, with greater financial strength and stability, are better suited to more ambitious strategies of vertical integreation. Smaller hospitals that have suitable market situations and financial strength relative to their size are also undertaking efforts at vertical integration, however.

Expansion to Pre-Hospital Services

Let us now look at specifics. Perhaps the most obvious move toward vertical integration on the part of hospitals is the expansion into primary care outpatient services. The term "primary care" refers to first level contracts with health care providers. Primary care can be thought of as a visit to a doctor's office which focuses on ordinary ailments and complaints by patients. Although most of these patient visits are diagnosed and treated at this level, it is at this point that decisions are made as to whether the patient should be referred to more specialized diagnosis and treatment, which may include hospitalization. So primary care services offer two main

advantages to hospitals: (1) an opportunity to gain additional revenue through a new service line, and (2) a potential source of referrals to the hospital's inpatient services. Creation of a primary clinic and, in some cases, the establishment of ties to existing primary care clinics, figures directly in a general "patient acquistion" strategy of most hospitals.

Most of the hospitals included in the interviews had expanded into outpatient primary care services. Their approaches in doing so varied considerably. Some of the hospitals established a primary care center within the hospital. Princeton Commmunity Hospital, for example, established "Express Care 24" in a facility next door to the hospital's emergency room in an effort to compete with free-standing primary care clinics in the town. This unit provides treatment for minor injuries and illnesses at fees below normal emergency room charges. It also offers discounts for cash payment and serves as a triage point for determining the next level of additional services that may be needed, if any. Princeton Community Hospital is pleased with this arrangement because the total number of patient visits to the emergency room and Express Care 24 center substantially exceeds the number of visits that the emergence room alone was receiving.

Many of the other hospitals interviewed were expanding into pre-hospital services. Burbank Hospital and Charleston Area

Medical Center, in another approach, established primary care centers off campus. In this case primary care clinic services were established in facilities located in other areas of the city and in nearby towns. The hospitals own the facilities and employ the staffs which operate the clinics. Both hospitals indicated that off campus locations were selected largely on the basis that they might help attract patients away from competitors and serve to expand their market area.

Radford Community Hospital in Virginia provides yet another approach to vertical integration with primary care. It provides start-up and operational support for private-practice physicians. This is done by providing a facility, equipment, office management services and back-up staff support in the outlying parts of the hospital's service area. In addition to recovering some of the direct costs through fees for providing such services, Radford expects to gain through patient referrals that the doctors make to the hospital. St. Francis Hospital in Charleston, West Virginia, approached the vertical integration by providing similar support through "loose arrangements" (the administrator's terminology) to some groups of physicians in the outskirts of its market area.

Shifting Services to an Outpatient Basis

In addition to expanding to include primary care outpatient

services, a number of hospitals indicated that they were shifting some of the services that were formerly rendered on an inpatient basis to outpatient clinics. Outpatient surgery was a major example cited by many hospitals. Radford Community Hospital and Princeton Community Hospital are typical of this phenomenon. Both stated that approximately 60 % of all surgery procedures performed is now done on an outpatient basis. Two or three years earlier outpatient surgery amounted to only about 10% of the surgery done by both hospitals. Several of the other hospitals studied have already expanded their outpatient surgery facilities, and others were in the process of doing so.

Much of the testing and diagnosis for many types of patients is also done on an outpatient basis. Imaging centers, using CAT Scan and MIR imaging hardware, are being set up for outpatient use by some hospitals. Roanoke Memorial Hospital and Community Hospital of Roanoke were working on a joint venture to establish an outpatient imaging center at the time interviews were conducted. A major reason behind the move by hospitals to increase outpatient testing is that, as with other aspects of health care delivery, financial incentives for such arrangements now exist.

To help attract patients many hospitals are also offering some routine health screening for "well patients" as part of efforts to increased health awareness and to make future patients

"friends" for the hospital. These health prevention programs include services such as testing for high blood pressure, diabetes, and the like, provided at little or no cost as a marketing tool. An example of this approach is found at Giles Memorial Hospital in Virginia. This institution is very small (65 beds) and very poor in terms of capital resources to purchase much in the way of elaborate equipment. Nonetheless, Giles Memorial has established a community oriented "wellness program" which includes aerobics, eating-behavior modification, and a speakers bureau. Also, Giles is establishing walking trails around the hospital and encourging people to excerise and become familar with the hospital and its staff on a more casual basis. The expected payoff for this type of program is in the future patients generated for the hospital and in the community good will that can be encouraged.

Some healthcare providers are directly marketing more sophisticated diagnosis and testing, such as the giving of mamagrams, as a revenue producing service. The Charleston Area Medical Center has established a subsidiary called Physicals which specializes in giving physicial examinations. It is marketed as part of Charleston Area Medical Center's corporate health program and provides pre-employment physicals, physicals required by health insurance companies, and physicals for company executives. Although the Physicals subsidary is located on the hospital's campus, efforts were made to give it a

non-hospital environment. It boasts pleasant surroundings, attractive furniture, and "piped-in" music.

Emergency Transportation Services

One other interesting example of vertical integration undertaken by the large regional hospitals is that of emergency medical transportation. Both of the large regional hospitals studied in Virginia and West Virginia, Roanoke Memorial and the Charleston Area Medical Center, offer emergency helicopter transport service. Although the direct costs of operating an emergency helicopter service are high and make such a service a money-loser, helicopter flights serve well as an image enhancing and marketing tool.

Emergency helicopter service also provides a competitive advantage for the larger hospitals that offer trauma center services and sophisticated tertiary care. (Tertiary care refers to the more complex and sophisticated level of treatment.) It not only enhances the patient referral network with smaller hospitals in the region, but also helps them compete with other large hospitals outside the region. As the administrator of the Charleston Area Medical Center put it, our "Air Force" helps us compete with other large hospitals outside West Virginia for the tertiary care business. The helicopter brings in the "good kind of patients" that need intensive,

sophisticated care. Consequently, they generate significant revenue for the hospital on a per patient basis. CMAC's administrator noted that prior to CMACs entering the medical helicopter transport business, helicopters were coming from Pittsburgh, Columbus, Lexington, and Roanoke,Virginia, to pick up trauma patients.

Expansion To Post-Hospital Care

Hospitals have also expanded their business domains by vertically integrating various types of post-hospital care. As with pre-hospital care, hospitals financial incentives from third party payors encourage efforts to get patients out of the hospital as quickly as possible. Expanding into post-hospital care helps hospitals control more directly the type, location, and scheduling of care for their departing patients. Hospitals that provide directly for post-hospital care are better able to operate efficency and to control their costs in providing patient care. Hospitals also, of course, see post-hospital services as a significant potential source of new revenues.

One type of post-hospital care undertaken is home health care services. Some hospitals started their own home care programs while others purchased or affiliated with existing programs. Many hospitals found that excess staffing capacity created by cut-backs in inpatient care could be applied to home care

programs. Home care services enable hospitals to discharge patients earlier and still maintain continuity of care for them. Continuity of care means keeping control of the patient's treatment as well as maintaining health care revenues for the hospital.

Another desireable feature of home care services is that the capital requirements for entry are generally low. This situation is changing somewhat with the development of new medical technology and the refinement of older technology. Much of home care involves skilled nursing services such as changing of dressings, administering drugs, monitoring patient progress, and stating instructions for patients and their families. Many home care programs provide home care aides to help patients with routine tasks such as bathing, dressing, and feeding. Some programs also provide light house keeping services for patients.

In addition to these types of services, medical technology advances in recent years have allowed more sophisticated treatments to be done in the patient's home. Services traditionally done in the hospital such as intravenous feeding, kidney dialysis, and chemotherapy for cancer patients have evolved to the point that they can efficiently and effectively be done in the patient's home in many cases. Home care services also include various kinds of therapy such as physical therapy

for patients recovering from surgery or a stroke, as well as therapy for chronic illness such as respiratory disease. Hospital investment in home care services can be profitable in its own right. Home care services can also help increase the profitability of other services by making it possible to discharge prospective pay patients in a timely manner and still keep them within the control and revenue producing domain of the hospital.

Long Term Care Services

Several of the hospitals studied were either acquiring or building a long term care facility such as a nursing home or had plans to do so. This seemed particulary true of the hospitals that were around 200 to 300 beds in size. As noted previously, Medicare's Propective Payment Program, with its fixed payment schedules, strongly encourages hospitals to discharge patients from expensive acute care beds as quickly as possible. Other healthcare insurers appear to be moving in this direction as well.

A hospital that owns its own long term care facility can presumably manage both patients and costs more effectively if they control admissions to an intermediate or long term care facility such as a nursing home. The administrator of the Princeton Community Hospital, for example, noted that by

controling a 120 bed nursing home facility that it was possible to "get patients in and out [of the hospital] on a more timely basis." Bluefield Community Hospital, a major competitor of Princeton Community, also owns a nursing home. Newton-Wellesley Hospital, located in the suburbs of Boston, was negotiating the purchase of two nursing homes at the time of interview. Giles Memorial Hospital, a small rural hospital with only a 39% occupancy rate, has proceeded with efforts to covert one of its floors to a long term care facility.

The long term care business increases the revenues of the hospital and also helps to enhance the hospital's marketing by offering a more comprehensive package of services and facilities. The more the hospital can offer a comprehensive service and facility package, the more attractive it is to large-scale purchasers of health services like HMOs and PPO's and other health care insurers.

Also economies of scale can be realized, in that hospitals and nursing homes use the same or similar types of equipment, supplies, and personnel. Moreover, hospitals gain financial flexibility in that resources can be shifted back and forth between programs and units to achieve maximum productivity. In addition, long term care facilities can be a profitable stand-alone business if properly managed. Diversification of the hospital's business to include long term care fits conveniently

with the strategy expressed by many interviewees of expanding the revenue base beyond the narrow focus of acute inpatient care.

Speciality Care Services

Many of the hospitals at which interviews were conducted have further expanded and diversified their business by establishing speciality care facilities. Frequently mentioned in this regard were centers for psychological counseling and substance abuse treatment. As public attention has increasingly focused on these areas of health care and as health insurers and employers have broadened their coverage to include treatment for these problems, many hospitals have responded by providing such services. Hospitals have found that excess capacity created as a result of the decline of acute general inpatient care can often be converted to use for psychological and substance abuse treatment.

As for other examples, Burbank Hospital is now developing a comprehensive $5.5 million gerontology center. This center "incorporates a comprehensive continuum of services," including a 168 bed skilled and intermediate nursing facility, respite care, day care, a wellness center, and an elderly citizens information resource program. The Center will also include a child day care facility for hospitals employees that will develop programs such as "Adopt a Grandparent" to enhance the

overall caring environment.

Princeton Community Hospital entered into a joint venture project with an out-of-state, for-profit company to build a $9 million regional physical rehabilition center on its campus. The partner put up the money for the project and will manage the facility. Princeton Community Hospital provided the land and assistance in securing the required Certificate Of Need. The rehabilition center is expected to employ about 100 people and have an annual budget of about $3.5 million. In addition to the indirect benefits of having such a facility adjacent to the hospital, such as patient referrals and prestige enhancement, Princeton Community will profit by selling various services to the rehabilition center like radiology, house keeping and food service. In another enterprising but unrelated entrepreneurial effort, Princeton Community Hospital has developed a Sleep Laboratory. The Labortory provides diagnostic testing and offers corrective surgery for sleeping disorders if the need is indicated.

Several hospitals have developed cancer treatment centers. In the process of doing so are three hospitals serving southern West Virginia, i. e., Charleston Area Medical Center, Raleigh General Hospital, and Bluefield Community Hospital. Bluefield's center will include a fully furnished apartment complex for cancer patients coming from out of town for treatment. CAMC has

developed a number of speciality medical facilities including a neuroscience facility and a trauma center that is "the best in the State." At the time of the interview, CAMC was also in the process of acquiring a smaller nearby general hospital which will be converted to a facility specializing in women and children. This illustrates the phenomenon of horizontal integration and diversification to which I now turn.

Expansion by Horizontal Integration and Diversification

The potential mutual benefits to both large as well as smaller hospitals in horizontal integration is further reflected in the example of Brighams and Women's Hospital in Boston. By coincidence, the Vice President interviewed at Brigham had just been given a list of smaller hospitals located west of Boston and asked to make recommendations as to which might be approached regarding various management affiliation arrangements. Brighams and Women's objective was to develop a more formalized network of referring hospitals to support its tertiary care business.

Diversification often involves moving into areas that do not directly involve treating patients. Some of these businesses have a direct or indirect relation to health care and some do not. Hospitals enter into these business to make money; if not through direct income, then by adding to the asset base of the hospitals.

We look first at examples related to health care in some way.

Many of the business ventures stem from selling services that are developed in the course of running a hospital or by selling the "excess capacity" of a part of the hospital's existing operation. CAMC, for example, rents out its laboratory facilities during the night hours to one of its subsidary companies which does labortory testing for other health care providers in the area. These providers include primary care clinics and private practice physicians. About $1.5 million a year of revenue is generated from this business arrangement. Beckley Appalachian Regional Hospital also sells laboratory services to other health care providers in its service area, although on a much smaller scale.

Consulting Services

Several of the hospitals visited have entered the hospital management consulting business. They plan to capitalize on the marketing of management skills and techniques they have developed in operating their own facilities. Larger regional hospitals have also moved into consulting. This is consistent with the fact that larger hospitals generally have more resources and staff to engage in such efforts than do smaller hospials. Roanoke Memorial Hospital established a subsidary called Health East which provides hospital management services

to other hospitals. Roanoke Memorial was managing eight hospitals and was acting as a management consultant to twelve others at the time of interviews.

Charleston Area Medical Center has developed a similar arrangement with some smaller hospitals in West Virginia. CAMC also has secured a ten year contract to manage the teaching hospital of the West Virginia University School of Medicine. In most instances, smaller hospitals are the ones that initiate efforts to be "taken in" under the management guidence of larger regional hospitals. The complexity of operating a hospital in today's changing and competive environment, coupled with an increasing scarcity of resources, are the primary motivating factors that encourage smaller hospitals, especially in poorer and more rural areas, to seek management ties with larger hospitals. In some cases, however, larger hospitals seek affiliation arrangements with smaller hospitals in outlying areas as a means of developing and strengthing referral networks. Larger hospitals that offer a lot of tertiary care services benefit the most from such relationships.

Hospital management contracts are a valuable asset to large regional hospital operations like Roanoke Memorial and CAMC. Their value goes well beyond the management fees that are generated directly. Managing other hospitals can develop and strengthen referral relationships as well as achieve greater

economies of scale for the managing hospital. On a much smaller scale, hospitals such as Bluefield Community are providing specialty consulting services to even smaller hospitals within its service area, with similar objectives in mind. Some of the smaller hospitals studied were attempting to gain patient referrals by assisting private physicians with the management of business aspects of the private practices.

Products and Services Developed to Meet In-House Needs

Hospitals also market other skills and services that had first been developed in-house to meet their own needs. Roanoke Memorial has established a billing and collections agency which services outside clients as well as the meeting needs of the hospital. Brighams and Women's has plans to sell to other hospitals computerized management programs that it had developed for its various own departments, such as the Pharmacy Department. Bluefield Community Hospital purchased a commercial laundry service that formerly provided laundry services to the hospital. Now Bluefield sells laundry services to outside clients, including one of its local competitor hospitals.

Indirectly Related Health Care Diversification

Many of the hospitals studied are engaged in businesses that are

only indirectly related to health care. Some have purchased physical fitness health clubs. Roanoke Memorial and Montgomery County Hospital illustrate. They use their health clubs to enhance their overall business portfolios. In both cases, the health clubs were purchased after their initial owners ran into financial difficulty. The clubs are billed as a major part of wellness programs operated by the hospitals. The hospitals also hope to make money on the health clubs as a plain business venture; this is evidenced by the fact that one of the two health clubs owned by Roanoke Memorial Hospital is located about 100 miles away and hence cannot really be integrated with the hospital's other programs.

Another example of strategy indirectly related to diversification is Radford Community's plans to invest in an off-campus pharmacy business. Radford Community was also at the time exploring a deal to build some physician office buildings. Other hospital administrators interviewed also indicated interest in investing in these types of ventures, especially in physician office buildings. Mass General Hospital had plans for a retirement center to be built with a large for-profit company as a partner. Several hospitals mentioned that they were entering the durable medical equipment business where they would rent and sell such items as hospital beds, lift chairs and walkers. Roanoke Memorial purchased a surgical supply company based in Richmond which sells custom-

packaged surgical supplies to other hospitals and physicians.

Several hospitals have formed joint business ventures with Perferred Provider Organizations (PPOs), Health Maintaince Organizations (HMOs) and other managed care programs. The larger regional hospitals like Roanoke Memorial and CAMC were most active in setting up health insurance related subsidaries. At the time of the interviews CAMC was well under way in establishing a state-wide PPO called Health Net. Roanoke Memorial Hospital had just purchased an established commercial insurance company with the intention of using it as a vehicle to offer health related and other insurance products.

Involvement in managed care health insurance is not limited to just the larger hospitals. Smaller hospitals have also set up their own PPOs and HMOs. Beverly Hospital had already developed an operational HMO at the time of the interview. Leominister Hospital in Leominister, Massachusetts expressed interest in offering some managed care health insurance products through its local alliance organization, Intercare.

Larger for-profit hospital chains such as Hospital Corportation of America and Humama Corporation, as well as Regional and National alliances such as Voluntary Hospitals of American and Sun Health Alliance, have established national managed care programs. Athough the hospitals that are affiliated with these

organizations expected to participate and benefit in varing degrees from the nationally organized managed care programs, they do not usually have to take an active role in setting up or running these programs.

Non-Health Related Businesses

Some of the diversification being undertaken by hospitals is into businesses that have no relationship whatever to health care. Both Charleston Area Medical and Roanoke Memorial had purchased motels, for example. Other hospitals studied indicated an interest in purchasing or developing commercial property on the grounds that it could become a good investment for the hospital. While administrators told stories of other hospitals that had invested in fast food franchises and convenience gas stations and food stores, none of the hospitals included in this study had made such acquisitions. However, the hospitals studied had been creative in the development of their non-health related business portfolios. One hospital included in the study did operate a commerical landscaping service, another an interior decorating service, and a third was actively considering going into the flower shop business. It appears that the entrepreneurial spirit is blooming among hospitals.

Most administrators interviewed were unwilling to predict that the non-health related businesses in which they were investing

were likely to produce a lot of income for the hospital. They usually noted that any additional sources of income for the hospital would be welcomed. In the broader picture, the non-health related business investments being made by hospital administrators can be seen as an indication of how the administrators' perception of themselves has changed in the new health care environment. They are increasingly seeing themselves as business executives in the traditional sense.

## Strategy Two:

## More Efficient and More Aggressive Management

The field study shows that a new attitude is emerging on the part of hospital administrators. At the height of the community hospital era, hospital administrators could afford to be somewhat lax, even cavalier about the operations of their hospitals. Few hospitals ever went broke, especially after the advent of cost-plus-payment mechanisms of big healthcare insurers like Medicare and Blue Cross. In those days it was more a question of how well the hospital prospered. Backed by community pride, hospital administrators where generally judged on the basis of how much they added to the physical landscape of the hospital's campus. The survival of a community hospitals was rarely questioned.

Health care cost containment efforts of the 1980's and the resulting changes in delivery of health care services have had a major impact on hospital management. Faced with serious competition and threats to survival, hospital administrators have quickly developed a new attitude toward the organization and administration of the delivery of health care services. The change in attitude is reflected in the terminology used in talking about the task of hospital administration. References to marketing, market share, product line, patient wholesalers, patient acquistion, competive advantage, and stragetic planning

are commonplace.

As noted, hospital administrators have adopted a much more business-like perspective in running their hospitals as they shed the community hospital model mentality. The business model hospital is viewed less as a charitable community servant and more as a company with product lines, profit centers, and market share. In conforming to the business model, the emphasis is on doing that which is most profitable.

More Efficient Management

Although for-profit hospitals have existed for a long time, they were for the most part small, independent entities, often owned by practicing physicians. In the early 1970's multi-hospital, for-profit hospital companies (also called for-profit hospital chains) began to emerge. Their rapid expansion through aggressive and innovative application of corporate style management and finance techniques had a major impact on the hospital industry. For-profit hospital chains were effective in cutting operating costs, improving bill collection and raising capital. Tighting reinbursement by third party payors in the late 1970s and early 1980s, particulary with the introduction of the prospective reimbursement system for Medicare patients, added to the appeal of the management style of the for-profit chains. The success of the for-profit hospital

chain formula was measured most significantly by their dramatic expansion. The chains grew rapidly by both purchasing existing hospitals and building new ones. This nurtured the speculation that the for profit hospital chains would soon come to dominate the industry if left unchecked competitively.

As employers and major third party insurers began to implement measures to cut hospital care cost, the management style and techniques of the for-profit hospital chains were increasingly looked as the protype of future hospital management. Most of the non-profit hospital administrators interviewed spoke reverently of maintaining the non-profit status of their hospitals, yet most also admitted that they had or were in the process of establishing for-profit subsidarities and had undertaken other business model strategies. Most often, the competitors that were respected and feared the most were hospitals operated by for-profit chains or those behaving aggressivly under the tenets of the business model hospital.

This change in the attitude is clearly reflected at Newton-Wellesley Hospital. This institution is a very well situated in terms of market location in an affulent suburb of Boston. It has an annual operating budget of approximately $85 million. Newton-Wellesley is a non-profit hospital that proudly traces service to the community for more than 100 years. The Vice President, interviewed for this study, declared that community

service values must have sway over business values. He reconciled the service value espoused and the business perspective employed by noting that the hospital made a "business decision" when it decided to give $1.8 million in free care a year.

The significance of this statement, in the context of the emergence of the business model hospital, is that the amount of free care provided by the hospital was not determined by community need as much as it was by a conscious, rationalized decision as to what it was willing to do. As the Newton-Wellesley Vice President noted, giving this much free care is something that for-profit hospitals do not do. By the same token most hospitals operating under the community hospital model would not have given free care as a "business decision." The new political economy of health care has created charity that is not altruistic but materialistic.

## The Identification of Costs and Other Information

The new political economy of health care has, in addition, forced hospitals to examine more closely the details of their business. Cost identification is one of the areas that has received a great deal of attention by hospitals recently. In the days of retrospective reimbursement, hospitals had little incentive to determine with much accuracy what it cost to deliver a particular

service. With the dramatic increase in competition among health care providers and aggressive cost containment by employers and health insurers, the need has arisen for accurate information about cost per unit of service, patient mix in terms of types of patient illness treated and source of patient referrals.

The rise in the number and the size of HMOs and PPOs who contract directly for health care services for their employee has also brought added pressure on hospitals to identify costs more closely. These patient wholesalers negotiate substantial discounts from hospitals in return for delivering large blocks of insured patients. Hospitals hoping to compete for such business must become highly knowledgeable as to the details and cost of their service delivery and not suffer financial losses from uncontrollable costs.

An example of the pressing need for hospitals to develop better information systems is reflected in Burbank Hospital's hiring of a Chief Information Officer (CIO) to be responsible for assembling and analyzing information on the hospital's services and costs. Brighams and Women's Hospital installed a computer system to track the origins of patient referrals and discovered, much to management's surprise, that 80 per cent of referrals came from only 400 doctors. As a result of this study, Brigham's began actively to organize formal relationships with these 400

doctors to help assure that the referrals would continue to flow.

Sometimes cost identification can lead to significant results in terms of reducing costs. It is the for-profit hospital chains that have led the way in aggressive cost cutting. Some of their cost saving has resulted from economy of scale benefits such as volume purchases and large scale financing. However, a substantial portion of the saving came from eliminating unprofitable services and reducing staff-to-patient ratios. The administrator of the Summers County Hospital in West Virginia (an HCA managed hospital) noted that one of the first things he did upon arrival was to cut costs by reducing staff hours from 40 to 37.5 hours per week. After voluntary staff attrition did not produce the desired ratios, he began to lay off additional staff to achieve the targeted goals.

Hiring personnel as well as laying them off can reflect the business approach to hospital managment. Several of the hospitals studied prefer to hire key management personnel from outside the health care field because of their strong business backgrounds. Brighams and Women's Hospital, for example, hired their chief financial officer from a beer brewery company.

Internal Reorganization

One of the most visible signs of the new business perspective is the kind of reorganizations undertaken in many hospitals. They sought to turn the hospitals into mainstream business corporations. Most of the hospital personnel interviewed for this study held titles of President or Vice President rather than administrator or assistant administrator. But title changes were only a cosmetic symptom of the way most hospitals have reorganized themselves.

Most of the larger hospitals and several of the smaller hospitals interviewed had established a holding company arrangement whereby the hospitals' core inpatient care business, on paper, becomes one of several subsidiaries operated by a holding company. The subsidiaries are established to accomodate many of the new satellite businesses acquired or develpoed as discussed in the previous section. The subsidiaries also often include units that were formerly part of the hospital, such as the laboratory, diagnosistic imaging (X-rays, CAT scans, etc), food services, and maintenance and housekeeping services. Now these units are often established as separate corporations that "sell" services to the hospital. The reasons behind the separation of the hospital's business into distinct units allows for greater managerial and financial accountability, controllability and efficiency.

One other major reason for establishing subsidiaries is to achieve flexibility of operation, especially in the case of for-profit subsidiaries. A for-profit company is not constrained by the legal requirements imposed on companies operating under non-profit status. The benefits are flexibility and the ability to operate with greater speed, allowing the hospital to seize moments of opportunity for making new deals and moving into new market areas. This was noted to be especially true in efforts to develop joint ventures with for-profit companies.

For-profit subsidiaries also allow hospitals, generally constrained under heavy regulation- especially at the state level- to gain more freedom from financial scrunity. In Massachusetts and West Virginia, both of which heavily regulate hospitals, separate subsidiaries exist to protect endowments and other gifts to the hospitals from being included by State authorities in determining rates that hospitals can charge for their services. Rate review authorities in these States take into account the general financial health of individual hospitals when considering whether to allow them to raise their rates.

In the emerging business world of hospitals the advantages of what might be called "creative accounting" were enhanced under the new organizational arrangements. One of the persons

interviewed noted that for-profit subsidiaries could be organized in such as manner as to reduce tax liability by lumping those enterprises that tend to lose money (but are of overall benefit to the hospital) with those that generate a profit. The configuring of enterprises under a subsidiary can also allow the holding companies to take advantage of other tax benefits such as major capital depreciation tax credits, advantages that are not utilized by non-profit enities. Tax balancing is therefore a potential additional enhancing feature to the inherent flexibility of for-profit subsidiaries.

Two specific examples illustrate how hospitals included in this study have reorganized themselves to cope with the new political economy of health care. Roanoke Memorial Hospital, a 675 bed regional hospital, established a non-profit holding company called the Roanoke Hospital Association. Three major subsidiaries operate directly under the holding company: Roanoke Memorial Hospitals (non-profit), Roanoke Hospitals Foundation (non-profit, fund raising), and Commonwealth Health Services Company (non-profit). Commonwealth Health Services also has three major subsidiaries, Imaging Center of Southwest Virginia (non-profit), Bedford County Memorial Hospital (non-profit) and Roanoke Memorial Services Corporation (for-profit). Roanoke Memorial Services Corporation itself has twelve for-profit subsidiaries under it. These companies include a wide variety of business interest ranging from a medical helicoptor

service and health management company to commerical property management and insurance companies.

Radford Community Hospital, a 175 bed community hospital, has reorganized on a similar but smaller scale. Radford Hospital is now one of three major subsidiaries under a parent company called Southwest Virginia Health Services Corporation. The other two major subsidiaries of the parent, along with Radford Community Hospital (non-profit), are Radford Community Health Foundation (non-profit) and Southwest Virginia Health Enterprises (for-profit). Southwest Virginia health Enterprises also has three subsidiaries: Home Health Plus, Community Pharmacy and Randolph Properties, all of which are for-profit. Randolph Properties operates three more subsidiaries, Community Medical Center, Floyd Family Practice and Christiansburg Family Practice. The organizational patterns outlined here for Roanoke Memorial and Radford Community hospitals is typical of those found in a majority of hospitals included in the study.

Territorial Expansion

While extinction is a very real threat facing many hospitals as a result of the competition and cost containment actions by government and private insurers, the picture is not entirely bleak. In fact, many hospitals have viewed the changes in the health care business as a opportunity to expand their domain.

Many hospital administrators see expansion as a way to increase their "market share" and to help to assure their survival. Several administrators interviewed indicate that they were establishing or sponsoring outpatient clinics in areas surrounding their hospital in an effort to gain more patient referrals. Radford Community Hospital's experience is typical; its support of family practice physicians in the neighboring town of Christiansburg and the neighboring Floyd County is viewed as an attempt to gain a greater share of patients who, lacking a hospital in the immediate area, must travel to one of the surrounding hospitals.

Some of the institutions, such as Burbank Hospital, look at territorial expansion in an ever more aggressive manner. At the time of interview, Burbank was pursing a strategy of setting up out-patient care centers in the territory of its closest competitor hospitals, as well as expanding the service area of its other programs such as its home health services program and HMO marketing. It hopes to lure patients from the competitors by catering to patient needs and by offering greater convenience. The availability of outpatient centers and services in surrounding outlying areas would give Burbank an edge in efforts to solicit business from other HMOs and PPOs. It would also allow for the possibility of referring patients to other services provided through the growing Burbank health care system, CentMass.

Burbanks' CEO declared that to be successful in the long haul of the acute care business, a hospital "is going to have to be able to gain a disproportionate share of that finite or shrinking marketplace. You do that by taking it away from others." Gaining a foothold in the area would allow Burbank to seize more quickly any opportunity that may arise if one of the competitor hospitals should stumble in efforts to stay competive. A "stumble" might come in the form of an error in management judgment or a lack of price competitiveness due to a high debt burden, inability to raise capital, lack of expertise to establish new services or facilities, or loss of key medical personnel.

The Burbank CEO described possible opportunity scenarios for his hospital to move against other hospitals in the surrounding area. One hospital was embarking on a debt-financed major rennovation and expansion project. Should economic adversities develop such that the hospital found itself in a less competive price situation because of a large debt burden, Burbank would be ready to move in. In another scenario, a neighboring hospital had been slow to react to the changing political economy of health care and had only recently replaced its management personnel. The existence of this managerial uncertainty might allow Burbank to seize opportunities that may develop, as Burbank was already geared up for expansion.

Burbank, for its size (226 beds), was one of the most aggressively managed hospitals included in this study. It appeared that several of the programs that Burbank had initiated, such as a state-of-the-art gerontology center, an HMO, and several other projects, will need a service area larger than that possessed by the traditional hospital. It was clear that Burbank viewed territorial expansion as a major goal in its efforts to assure its long-term success.

## Strategy Three:

## Better Marketing

The most significant thing about hospital marketing today is that hospitals are doing it at all. Aggressive marketing efforts are one of the most noticable aspects of business model hospitals. It is hard to miss the increased advertising of hospitals in the public media today. Television commercials, print ads, and billboards advising potential patients as to the services and advantages of particular hospitals can be seen at every turn. These marketing activities far surpass those conducted by the community hospital, where marketing was usually very low key when it existed at all. Hospitals today feel the need to distinguish themselves from their competitors by not only telling the public of the services and expertise that they offer but, more importantly, projecting a favorable public image.

The major factors behind hospitals' new interest in marketing have been discussed earlier. These include the shift in power from health care providers to health care purchasers, the increased ability of purchasers to dictate how and where their members will receive treatment, and the intensified competition among health care providers, old and new. An overcapacity of hospital beds, resulting in large part from the demand that hospitals do more on an outpatient basis, the emergence of low

cost speciality providers, and the shrinking amount of patient care money available to hospitals have served to inspire hospitals to aggressive marketing.

Many of the specific examples of actions taken by the hospitals in regard to their marketing efforts have been cited in the management section of this chapter, as management and marketing are highly intertwined. Rather than repeat them here, they will be referred to in a general manner.

Institutionalizing the Marketing Function

Hospitals have indeed recognized the need for a marketing function in the traditional business sense. Most of the hospitals included in this research had undertaken specific marketing programs. Many had established separate marketing departments and had hired professional marketing staffs. Many of the hospital administrators interviewed used the language of marketing such as "market share," "product packaging" and "customer relations" to describe their efforts in directing their hospitals.

Most of those interviewed had developed market strategies for selling the hospital services. Marketing communications (television, radio, and print ads) are being used by hospitals to establish name recognition and image enhancement as well as

provide information about specific services offered. Such communications are important, but hospital marketing is becoming much more sophiscated than this. Larger hospitals like Charleston Area Medical Center are developing substantial market research capabilities and are basing their business decisions on the results of this research. A Vice President at Brigham and Womens Hospital acknowledged that one of the primary goals of management was to develop a better understanding of the health care marketplace and to relate this to the business mix of the hospital. As the Vice President stated, Brigham and Womens Hospital "is not trying to force the 110 things that Brigham and Womens Hospital does on the market but is responding to the market." For many hospitals, market research is becoming an indispensable part of their operations.

Hospitals are seeking experienced professional marketing people to direct their marketing programs. Several of the hospitals studied indicated that they are hiring marketing personnel from non-health related business corporations. Leominster Hospital, for example, hired a person from the Polaroid Corporation to direct its marketing efforts.

Hospital marketing, like marketing in other enterprises, is being pursued through a variety of approaches. Hospitals are tailoring services that they offer to match customer desires. Greater attention is being paid to convenience. Existing

services are often being "repackaged" into more appealing offerings. New services are being added and old ones are being expanded in effort to accomodate perceived consumer interest and demand. Hospitals, like other industries, are targeting specific client groups in hopes of attracting their business by catering more directly to their needs and desires. The following discussion will elaborate on these and other marketing principles being employed.

Improved Convenience

Hospitals have improved patient services by catering to patient convenience in such ways as extended hours of service, more convenient location of services, and easier payment for services. Some of the hospitals, such as Roanoke Community Hospital and Emerson Memorial Hospital in Concord, Massachusetts, have made concentrated efforts to reduce waiting time and streamline billing. Several of the hospitals included in this study had established extended hours at walk-in clinics that handle routine and non-life threatening accidents and illnesses. Some of these clinics are open 24 hours a day. Generally they do not require appointments and accept major credit cards as well as the traditional health insurance means of payment.

Several hospitals have established outpatient clinics both on

and off the main hospital campus to ease patient accessability. These clinics include not only the routine care clinic memtioned above but also outpatient surgery clinics, diagnostic imaging facilities, and rehabilitation facilities. Efforts are made at the clinics to speed up the delivery of services so as to reduce the time patients must spend waiting to be seen and treated. Often the attractiveness of visiting the clinics is enhanced by adding other services for patient convience such as a pharmarcy or a home medical equipment and supply outlet. In several cases, hospital administrators indicated that they located an outpatient facility in the "backyard" of their competitor hospitals as part of a marketing effort designed to lure patients away from competitiors.

Outpatient centers, on and off the hospital grounds, figure in the overall strategies of most hospitals efforts to sell more inpatient services. While they can be good revenue producers on their own in some cases, one of the primary functions of outpatient clinic and other outpatient services such as home care, is that of providing referral of patients to the hospital when inpatient care is needed. The idea is that once a patient has been introduced to one part of the hospital's service portfolio, he or she is more likely to accept being referred to other services within the hospital's orbit. Since most patients use a doctor's office visit as the entry point to the health care system, it makes good marketing sense for hospitals

to begin selling themselves as early as possible in the health care "production stream." The President of Burbank Hospital spoke of this approach in terms of developing a "continium of care" that addresses a full range of patient care needs.

The opportunity to include outpatient care in the service portfolio of a hospital also enhances its overall marketability in that it represents an attempt to meet the broader needs of patients. This wider range of service is often important to employers, health insurers and patients who would prefer to deal with one organization rather than several to meet their health care needs.

Hospitals are also attempting to personalize their relations with patients and their families. Efforts are being made to treat them with kindness and courtesy. Hospital staffs are encourged to treat patients and their families in literally, "hospitable" manner. Princeton Community Hospital, for example, established a "Guest Relations Program" under which it is training its staff personnel to treat patients and their families as guests (as would a hotel, for example), rather than just patients in the traditional sense.

Adding New Services and Repackaging Old Ones.

Virtually all of the hospitals included in this study are adding

new services and expanding old ones in an effort to attract business. As noted above, many of the hospitals have added or expanded services in the area of outpatient care. Primary care and outpatient surgery clinics, home care, and various types of rehabilitation services are some of the more prominent services that hosptials have developed in an effort to cater to more patients (and their insurance companies). Also, as noted previously, hospitals are engaging in new and somewhat more exotic services such as a sleep laboratory and drug abuse clinic. Prior to the changing of the political economy of health care, hospitals were generally content to limit their involvement in providing care to the inpatient setting.

While it is hoped that these new and expanded services will be money makers on their own, hospitals often develop these to enhance their overall market appeal. Hospital administrators feel that offering a broader range of services on a more convenient basis will aid in the overall marketing efforts of the hospital, particularly to major employers and health care insurers. The offering of new services can be viewed an opportunity to present a progressive, up-to-date image to the public.

One of the more intriguing marketing techniques is niche focusing. Hospitals develop marketing efforts around a particular service or a selection of services aimed at a specific

patient population. Often a "center of excellence" is thus described as existing. Such niche focusing often involved less in the way of developing new services to be offered than of repackaging of existing services for the purpose of marketing them to targeted patient groups. Usually the areas of focus are built around a core of physicians practicing in conjunction with the hospital. In some cases, hospitals develop areas of concentration based on perceived market needs.

As for examples of marketing repackaging, Montgomery County Hospital is developing a women's care program and a cardiac care program. Bluefield Community Hospital and Raleigh General Hospital are both developing cancer centers. Burbank Hospital is developing a large geriatric care program. Leominister is developing an extensive occupational health program and Emerson Memorial is creating a maternity pavillion that includes a birthing center, new labor rooms, and a women's health component. St. Luke Hospital serves as a major center of opthomothology within the Humana Hospital System.

Marketing Targets

One of the most notable things about hospital marketing is its targeted nature. Three major marketing targets exist: (1) members of the general public, (2) physicians, and (3) the companies that control payment for health care services in large

blocks. As has beed said, this third category is sometimes referred to as "patient wholesaling" because it involves delivery of a large block of insured patients to a hospital. Substantial discounts can be negotiated from the hospital in such "sales." Major health insurance companies and large employers as well as HMOs and PPOs are examples of patient wholesalers.

Marketing directly to the public is the most general type of marketing. This is a "retail" approach to marketing. Often this type of marketing focus on announcement of new services and conveniences. The advertisements are often designed to convey a picture of the hospital making strides to keep up-to-date and to present an image of caring and concern. Sometimes the messages are more public-service related than health-service related. Roanoke Memorial, for example, sponsors television commerials that focus on adults taking time to interact with children. While these ads do not mention health care, they are intended to associate a "caring" attitude with the hospital. The overall objective is that of increasing name recognition and enhancing public image.

Marketing to Physicians

Marketing to physicians is rooted in the recognition that it is

physicians that actually admit patients to hospitals. The physician plays a major role in influencing the patient's choice of a hospital, even though patients in general are currently taking a more active role in selecting their health services. Marketing to physicians takes on various forms with different hospitals. It was noted previously that some hospitals assist private practice physicians with equipment, office facilities and other costs associated with establishing or expanding their practices. Hospitals often compete to get physicians to use their facilities by catering to the physicians' requests to have the hospital purchase particular types of sophiscated equipment or to provide specialized support personnel. Although some of these efforts will turn out to be profitable for the hospitals in and of themselves, the major reason for them is to get the doctors, and through them, their patients, to use the services of the hospital.

Some hospitals take special steps to identify the physicians that refer patients to them. This is particularly true of hospitals that provide secondary and tertiary level care. Brigham and Womens' Hospital, as was mentioned, undertook a study of the patients being referred to it for tertiary care. It was found that approximately 400 physicians were providing a major portion of the referals to the hospital. With this information, Brigham plans to develop more organized arrangements with these doctors to assure they will keep on

sending patients. Brigham will also use the information to recruit additional physicians to fill gaps in their referral network.

Some hospitals take a more direct approach in marketing to physicians. Burbank, Leominister, and Summers County hospitals have encourged physicians to particapate in joint ventures for new services and facilities being comptemplated. It was felt that if the physicians had an active role and particularly, if they had a financial stake in the development of the new ventures, the projects would be more likely to succeed. Other hospitals focus on ways simply to express appreciation for the physicians currently using their facilities. St Francis Hospital, for example, identifies a "Doctors Day" during which the hospital and it staff go out of their way to express their thanks to their physicians. St. Francis begins the day by greeting each doctor at the door with a carnation flower.

Marketing to Patient Wholesalers

One of the more dramatic changes that the new political economy of health care has brought about is the creation of patient wholesalers. As noted above, these include major purchasers of health care services such as large employers, health insurance companies, and HMOs and PPOs. These organizations are able to exercise considerable financial clout by being able to deliver

large blocks of patients to hospitals. Patient wholesalers are generally able to negotiate substantial discounts with hospitals because of their ablilty to deliver a predictable volume of patients to the hospital.

Being able to capture a large number of patients under one contractual arrangement is an attractive arrangement for a hospital. Not only is there an obvious advantage in terms of the number of patient admissions, but also wholesaling represents a potentially significant competitive advantage over other hosptials in the area because of the possibility of exclusive patient rights. If a hospital is receiving the patients from a particular patient wholesaler, then competitors are losing those patients. Also of importance is the fact that being able to count on a certain number of paid admissions allows a hospital to forecast income and expendures more accurately. This kind of financial stability, if it can be sustained over an extended period of time, is very valuable for the hospital in long range planning and financing.

Image Enhancement

Image enhancement is an important aspect of marketing, one that takes various forms. One of the most effective marketing tools that a hospital can use to enhance its image is a modern-looking facility. The "street appeal" of a well kept, up-to-date

facility is a significant asset that most hospital administrators regard as being of major importance to the marketability of the hospital. On the inside, the hospital facility must also have new-looking equipment. The hospital must be clean, attractive and have the appearance of efficiency. As noted above, many hospitals attempt to improve the image of the hospital through "guest relations" programs that focus on improving the way the hospital staff interact with patients and their families. As one adminiistrator put it, today every nurse is a marketing person.

One the most impressive ways that a hospital can enhance its image is to buy the latest high tech medical equipment. The public tends to relate the presence of high tech equipment directly to the quality of care that a hospital provides. The more readily visible the equipment, especially through direct and indirect news media stories, the better. For example, having a helicopter as part of the hospital operation (assuming it does not crash!) benefits the hospital in a larger way than just emergency transportation. It provides a dramatic contribution to hospital's overall image of up-to-date efficency.

The Hospital Board as A Marketing Tool

A final marketing tool to be mentioned is membership on the

hospital's governing board or advisory board. Most hospitals have a board that oversees the operation of the hospital. Even hospitals owned by large for-profit corporations often have local boards that act in an advisory capacity. The role of these governing and advisory boards appears to be changing as hospital become more oriented to the business hospital model.

As hospitals become more deeply engaged with patient wholesalers, hospital alliances, joint venture partnerships, high finance and the like, it is reasonable that hospitals might seek business people to serve on their governing boards. Some of the hospital administrators acknowledged that they perfer Board members who not only understand good business proctices, but who can either send the hospital some business or influence others to do so.

The Vice President for Development and Public Relations at Brighams and Womens Hospital in Boston was given the task of reorganizing the BWH's Board of Directors. The strategy was to "ease out" some of the long time members and replace them with more high powered members - specifically, major leaders from the business community around the Boston area, such as the chief executive officers of the telephone company and major banks. It was hoped that these business leaders would come to know and understand BWH better and hopefully use their influence to send their own employees and the employees of other companies to BWH.

A second part of BWH's strategy was to allow the hospital's management team to gain a better understanding of how major employers look at health care services for their employees and how they influence the establishment of health care arrangements for their employees.

## Strategy Four:

## New Constituencies

To survive and compete effectively today, hospitals need more: more money, more management, more technical expertise, and more economic and political clout. Not only has medical technology become more sophisticated in recent years, the sophistication of the organization and administration of hospitals has greatly increased as well. This has come about as hospitals attempt to adapt to changes in the political economy of health care. During the community hospital model era, hospitals operated much like a cottage industry. Hospitals were mostly independent, largely self-contained entities that were governed by local citizens under relatively simple organizational and administrative processes.

The largely self contained community support system that most hospitals relied upon during the community hospital model era are not up to meeting the increased financial and expertise needs of hospitals as they cope with the new environment. New support networks have developed because the needs of hospitals have outstripped the resource capabilities of their local communities. Even small town hospitals require one to two million dollars a year just to keep up with capital equipment needs. The cost of delivering health care has increasingly risen as medical technologies and modes for providing health

care services have become more expensive. On the other hand, the pressures to contain rising health care costs have become more formidable. Hospitals have been caught in the middle of these pressures. They must keep their facilities and equipment up-to-date, provide a broad array of services on a convenient basis, and do so at the lowest possible cost in order to survive in an increasingly competive environment.

The most striking aspect that emerged from the interviews done for this research is that the new political economy of health care is causing hospitals to develop new partnerships and alliances. Subsequently, hospitals are developing new and increasingly greater dependencies upon organizations beyond the local community. These new alliances and partnerships are being developed as a primary part of a new support network that will presumably help hospitals deal with the opportunities and the perils that the new political economy of health care presents. Hospitals have felt obliged and often eager to develop the new support network linkages.

The organizations that make up the new support networks have demands and requirements of their own that the hospitals must meet if they want to work with them. The support network organizations have their own agendas, objectives, and decision criteria. These are not necessarly fully compatable with the objectives of local interest hospitals. The support

organizations operate outside the local communities and generally at a different scale and with a different perspective than do the hospitals themselves.

Beyond this, the selectivity of support organizations as to type and location of hospitals with which they are willing to work creates something of a competitive environment with regard to the support network business. Just as hospitals seek out the support organizations that are thought to be best for them, the support organizations likewise want to deal with the best hospital prospects available in an effort to ensure their own success. Analogous to how school children choose sides for a ballgame, the best players are taken first, with the poorer players chosen last or not at all.

The new support networks for hospitals take varied forms depending on the individual hospital's status. Support networks can include membership in local, regional, and national alliances of hospitals, entering into joint ventures with other organizations, developing coordinated management relationships with other hospitals, and developing relationships with investment bankers. Not all hospitals are developing a support network that includes all of these elements, but most hospitals are utilizing at least some of them. In many cases hospitals decide to sell out or merge with other hospitals as a way of linking up with a larger support network.

Hospital Alliances

It is the consensus of industry observers, as well as those interviewed for this study, that the days of stand-alone hospitals are over. As hospitals have effected the transition from a cottage industry to corporate businesses, their needs have evolved such that they find it advantagous and, in some cases essential, to interact with other hospitals and other health care organizations if they are to adapt to changes being thrust upon them. Hospitals, large and small, have joined (or are looking to join) other health care related organizations in a variety of relations. It is only the specific reasons for choosing whom to join and the exact terms of affiliation that vary. Hospital alliances have emerged as a major tool to help hospitals deal with the changes in the political economy of health care being described in these pages.

It can be argued that development of hospital alliances can be linked to the impressive rise of the for-profit hospital chains in the 1970s. The for-profit hospital chains demonstrated the enormous potential of a large number of hospitals operating under one organizational structure. The resulting coordinated management based on efficient business practices and the economies of scale, coupled with increased economic and political clout, made a dramatic impact on the hospital

industry. For-profit chains were able to attract high- caliber managerial and technical people and match them with large amount of resources. The aggressive and innovative style of the for-profit chains caught the attention of the non-profit sector of the hospital industry as the for-profit chains were able to build and buy hospitals and quickly turn them into formidable competitors.

It is the ability of the for-profit chains to raise capital that most strongly caught the attention of the non-profit hospitals. It was feared that the ready access to large amounts of capital through Wall Street markets might allow the for-profit hospital chains to dominate the industry unless counteractive steps were taken. The economic power that the major hospital chains were able to amass is indeed truly impressive. In 1987, for example, Hospital Corporation of America (HCA), one of the largest for-profit hospital companies, owned 186 hospitals, managed another 176 hospitals and engaged in a diversity of health related business. As a result, HCA generated revenues of $4.675 billion in that year. Other large national for-profit hospital systems also generated impressive amounts of revenue. The Humana Corporation generated $2.97 billion in revenues in 1987, National Medical Enterprises $2.76 billion, and American Medical International $2.88 billion. Of course there is more to a companies financial status than revenues generated. Profits were indeed much smaller, generally in the $100 to $180 million

range.[1] However, the ability to generate so much revenue, coupled with a strong link to the capital markets of Wall Street, makes the for-profit hospital chains a formidable economic force in the hospital industry.

National Alliances: Voluntary Hospitals of America

The Voluntary Hospitals of America (VHA) was founded in 1977 by 30 of the national largest non-profit hospital. These 30 hospitals, along with another 47 large non-profit hospitals that have joined since, are referred to as shareholders. The shareholder hospitals actually buy stock in VHA. As flagship hospitals of the VHA system, shareholders have a large say in the affairs of VHA.

VHA was organized to help provide its members with a competitive edge in their local markets. As of December 1987, VHA has 791 member hospitals organized as 29 regional systems. VHA has different classes of affiliation for its members. VHA membership include shareholder hospitals (large, over 500 beds, well established, major market institutions), partner hospitals (medium size, financially sound, strong competitors), and affiliate hospitals (smaller hospitals that are linked to VHA through one of the larger VHA hospitals, usually as satellites). While partner hospitals have a vote in the VHA regional organizations, it is the shareholder hospitals that vote on

policy matters for VHA itself. Originally it was thought that the smaller, non-shareholder hospitals would serve primarily as feeder hospitals to the large shareholders.

VHA is selective about the hospitals that it admits to its circle. The organization wants only the best, most competitive hospital in a market area to be an exclusive VHA member. VHA seeks hospitals that are financially sound, well managed and progressive minded. VHA policies prohibit the admission of more one hospital in each market area. VHA wants member hospitals to have a chief operating officer (CEO) that is strong and has the authority to commit the hospital to participate in VHA programs.

VHA provides a large variety of services for its members. Group purchasing of supplies and equipment through VAH's supply company offers substantial savings. VHA opens up access to capital financing for its members through its American Health Capital subisdiary. VHA's Partners National Health Plans, a joint venture with Aetna Insurance Company, is developing HMOs and PPOs in which member hospitals can participate. VHA Network is a private satellite broadcasting system which can be used by member hospitals for communications, for conferencing, and for educational programs. VHA Enterprises provides a number of member services including management consulting, assistance in product diversification and marketing, joint venture

consultation and participation, and the development and management of alternative delivery systems. Member hospitals can also obtain other services such as physician recruitment and liability insurance coverage.

In VHA, as with most other alliances, member hospitals usually pay for services as received, except for some annual evaluations and assessments that are included as part of the annual membership fees. VHA provides a team of consultants to do a management audit and a strength assessment and goal achievement evaluation for each member hospital. The annual fee for VHA membership is determined on a relative scale with each hospital paying on the basis of a formula that takes into account factors such as size and financial status of the hospital. The annual fees usually run between $15,000 and $65,000 for most alliance memberships.[2] The savings that members realize on the purchase of supplies and equipment through alliance membership usually pays the cost of the annual fee. Bluefield Community Hospital, for example, reported that as a result of its membership in an alliance, it saved $100,000 on the purchase of intervenous infusion supplies during the week prior to being interviewed for this study.

One of the important advantages of membership in VHA or other alliances is that of interaction with other hospitals in the sharing of experience and ideas. During the course of the

interviews many alliance members noted that just being able to pick up the telephone and call other member hospitals to discuss planned actions saves valuable time and resources. The alliance provides the medium for this sharing.

Of further importance is that alliances like VHA constitute an organized means of mobilizing political clout on behalf of the member hospitals and the hospital industry in general. VHA, with its nearly 800 member hospitals, provides a potentially large political voice and the organizational means to exercise it effectively. An organization of the size and resources of VHA is an organization to be reckoned with.

It is of major importance to realize that while alliances are established to help members meet certain objectives, the individual alliance often takes on a life and agenda of its own once established. VHA is becoming more market driven, according to the President of VHA Mid-Atlantic region, interviewed for this study. In other words, VHA is developing its own market strategy for delivering health care services. It is trying to establish the VHA name as a "brand name" of health care. When VHA sees an opportunity in the market, it moves to take advantage of it. VHA's decision to accept new members is reflected in this policy; only hospitals that are strategically located in a market that VHA wishes to penetrate are allowed to join.

VHA emphasizes that each of its member hospitals is locally owned and governed. However, as was pointed out by the President of VHA Mid-Atlantic, VHA programs must have the support and active cooperation of its members if the alliance is to be most effective. Members that do not fully participate in the programs that VHA puts forth will likely be dropped. This does not mean that each VHA hospital will have to participate in everything that VHA offers, but it does mean that there is pressure on member hospitals to support actively most of the things that VHA does. Members will not be allowed to "cherry pick" only the things that they want from VHA without being dumped, according to the interviewee. To make economy of scale deals work and to negotiate wide-scope service contracts, VHA as an alliance needs to be able to count on broad participation by its members if it is to be effective. The President of VHA Mid Atlantic admitted that as the medical marketplace gets tighter, VHA, in the future, will have to ask that members give up more autonony to the larger entity, which means to VHA.

It would appear that the greater the need a hospital has for the kind of services that an alliance can provide, the less choice a hospital may have in yielding to the demands of the alliance. Obviously some of the services that alliances can provide for members would be difficult for the members to acquire on their own. Alliances seem to be creating some critical dependences

for their members, especially in the areas of access to capital and expertise. Given that hospitals need the kind of support services that an alliance like VHA can provide, a hospital may drop out of a VHA type of alliance but will most likely have to join another similar alliance.

Regional and Local Alliances

While different types of alliances provide related services, there are many differences between alliances. In particular, differences exist in the extent and focus of national, regional and local alliances. In fact, many hospitals belong to more than one alliance. The term "regional hospital alliance" is somewhat confusing in that it is used to refer to large multi-state hospital systems as well as to state-wide or multi-county hospital systems. Sun Health is described here as a regional alliance, but it has more than 120 members in 15 states in the southeast United States. Sun Health operates on a scale similar to that of VHA.

On the other hand, hospitals like Roanoke Memorial, Charleston Area Medical Center, and Leominister are developing coordinated managerial relationships with hospitals within their regional trade area. Local alliances involve hospitals in relatively close proximity who coordiniate their activities. Local alliances function similar to regional alliances in that they

are cooperative in common management objective.

Regional and local alliances of hospitals tend to be established for specific and pragmatic objectives. National and multi-state alliances tend to be organized to provide general support to member hospitals. The Health Front Alliance is an example of a regional alliance. Health Front includes eight general hospitals, 200 to 350 beds in size, that ring the Boston metropolitian area. Also belonging is Massachusetts General Hospital, a large tertiary care hospital located in downtown Boston. The member hospitals were attracted to join in an alliance because all have aggressive and innovative management. Health Front members are looked upon as leaders among hospitals in Massachusettes. The eight smaller hospitals formed the alliance initially and then asked Mass General to join. The members of Health Front also joined VHA, with Mass General serving as the shareholder member of VHA. (Smaller hospitals can not serve as shareholders in VHA.) Health Front is a for-profit alliance.

A major goal of Health Front is to help the members compete effectively for the managed care business (HMOs and PPOs), without being dominated by the large managed care providers. Massachusetts is one of the fastest growing states in the country for managed care programs and the Boston area has a relatively large and growing proportion of people that belong to HMOs and

PPOs. Health Front members felt that they could gain a larger share of the managed care business and more control in contracting with managed care providers by working together. As the CEO of one of the Health Front hospitals put it, we can say to a managed care provider, "Here [are] nine or ten of the best [hospitals], geographically distributed properly, in eastern Massachusetts, to market your product. If you want to come in and market that product, we might be able to talk about giving you overnight success, but we want a damn good chunk of your equity for that." Health Front members feel that major managed care providers will want and need to have the leadership hospitals in the area working with them to get their programs off the ground.

Although Health Front was relatively new at the time of interviews, the Alliance was working on other ways to help its members. One project which is particularly noteworthy is the effort to share data. Health Front carried out a standard cost accounting project whereby members are able to compare procedural level data on both time and cost of providing certain services. Health Front is also considering sharing some operational services among members, such as a home care program and possibly building a laboratory for all the members, to replace the laboratories services provided by each hospital now. Health Front members feel that the community hospital network will play a strong role in health care delivery in the future and they are actively strengthing the network relationship among

themselves.

It is interesting to note that although the Health Front hospitals were also members of VHA, the members that were interviewed seemed more interested in the benefits that Health Front gives than what VHA provides. Administrators of Newton-Wellesley Hospital, a Health Front member, went so far as to say that joining VHA was largely incidental to its wanting to be a part of Health Front. The Health Front hospitals were, however, using some of the services provided by VHA, with the purchasing services being the most used.

Other regional/local alliances may involve interweaving the management of hospitals working in the same general medical trade region. This can take place in the form of a coordinated management approach whereby hospitals agree to share resources and management strategy in conducting the business of the hospitals involved. The kind of sharing referred to here goes beyond that of sharing a piece of high tech equipment or agreeing to let one hospital provide maternity services while another ceases to do so. This type of alliance is represented by InterCare, a central Massachusettes alliance being established by Leominister Hospital and Worcester Memorial Hospital. A third hospital is on the verge of being brought in the alliance.

InterCare was formed by establishing a parent corporation which

oversees the development of a coordinated delivery system involving the member hospitals. Although the hospitals have not pooled assets as yet, the parent corporation board is empowered to oversee the operations of the member hospitals, with budget approval and decison making power as to what services a member hospital may provide. Additionally, InterCare is developing its own operational service program. InterCare has established its own PPO as well as an occupational health program, for example. Other possible programs are being discussed.

The significance of this type of alliance is that the member hospitals are bound by the decisions of the board of Intercare. InterCare plans to become a part of Yankee Alliance, a regional multi-hospital alliance that operates in the New England states. Yankee Alliance is an affiliate of American Healthcare Systems, a national alliance which provides services similar to VHA. Members of InterCare will be able to participate in the services offered by Intercare, Yankee Alliance and American Healthcare Systems. There is a layering of alliances under this type of arrangement.

Some hospitals have chosen to ally themselves with multi-hospital systems through the use of management contracts. Under this arrangement contracting hospitals are able to receive many of the benefits of belonging to a larger system while still

retaining ownership of the hospital. These management contracts can be with for-profit or not-for-profit companies. One of the hospitals interviewed for this study, Summers County Hospital, has chosen this route.

Summers County Hospital, a small, rural, county owned hospital in southern West Virginia, signed a management contract with Hospital Corporation of America, the largest national for-profit hospital chain. Through this arrangement Summers County is able to get not only the managment expertise of HCA, it is also able to participate in the array of programs that HCA provides for the hospitals it owns. These programs include such things as group purchasing benefits, professional recruitment, and staff training programs. The financial saving on group purchasing, improved bill collection and general management efficiency help the hospital recover all or most of the costs of the management contract. In many cases, introduction of such savings and management efficencies are essential to the survival of the hospital.

Hospitals managed by a company that owns or operates other hospitals often benefit from the shared experience and knowledge of other hospitals in the system, much like members of hospital alliances enjoy. When a hospital management company owns or operates other hospitals in the same region it will usually attempt to develop referral and other working

relationships where feasible. In the case of Summers County, it benefits from HCA owning the Raleigh General Hospital which is located about twenty five miles from the Summers County Hospital. Raleigh General is one of the larger hospitals in southern West Virginia and is a natural referral center for the region.

One important exception is that HCA does not provide capital financing for the hospitals that it manages, nor do most management companies. HCA will try to help the hospital obtain financing through conventional channels, such as revenue bonds issued through local and state authority. Under a management affiliation, the managed hospital still retains its own identity and its own governing board. Apparently many small and even larger hospitals around the country have found this type of affiliation a useful alternative to escape the problems facing independent hospitals.

Another type of "alliance" is a merger whereby one hospital gives up its identity as well as its independent governance. Charleston Area Medical Center, for example, merged with Kanawha Valley Memorial Hospital under an arrangement where CAMC will take over Kanawha Valley Hospital. CAMC will probably convert it to a speciality hospital such as a pediatric or women's hospital. Hospitals that are having difficulty competing effectively or are in poor financial straits are more likely to

choose this route to group affiliation.

Some well established hospitals have decided to sell out to a larger multi-hospital system in an effort to assure that the hospital has access to the capital and management resources that are needed to carry the hospital into the future. Some well known hospitals have undertaken this kind of "alliance." The teaching hospital operated by the University of Louisville was sold to Humana, for example, a large for-profit hospital chain. Similarly, the West Virginia University Medical Center has been taken over by Charleston Area Medical Center under a ten year management contract.

Reasons for Joining an Alliance

The reasons that hospitals join alliances vary with the institution's relative size, local market situation, financial status, political and economic clout and long range goals. As noted above, hospitals often are members of more than one alliance. Decisions to join alliances depend on the nature of the alliances and what the hospital expects to gain from them. Based on those interviewed for this study, it would seem that the perception of greater future security realized by membership in an alliance is a major determinate of how fully a hospital embraces such a group.

In the interviews several recurring answers were heard when the question was asked as to why join an alliance. Being able to realize major savings through group purchasing of equipment and medical supplies was one of the most frequent reasons given. Several administrators pointed out that the saving on purchasing equipment and supplies alone more than covers membership fees. It was noted earlier that Bluefield Community Hospital saved $100,000 on certain supplies by purchasing them through the Sun Health Alliance. Other hospitals told of similar savings. Princeton Community Hospital, a member of VHA, reported that it expects to save several hundreds of thousands of dollars through a five year contract that VHA secured for purchasing intervenous solutions for members. Burbank Hospital, also a member of VHA, reported savings of more than $120,000 the previous year as a result of purchasing through VHA contacts.

The savings that national and large multi-state alliances can provide their members on the purchase of equipment and supplies are substantial enough that many industry observers feel that such economies are a major incentive that attracts hospitals to join alliances. Many hospital administrators believe that the savings realized through group purchasing by alliances is also an important competitive advantage they must have. Some industry observers argue that group purchasing is probably the most effective and least controversial thing that alliances do for their members. This view does, it should be recognized,

raise doubts about the ability of alliances to maintain the support of member hospitals in other more problematic alliance endeavors.

## Summary and Conclusion

The field interviews revealed that almost all of the hospitals studied were actively pursuing the general prototype described as the Business Model Hospital. Those hospitals with greater resources were proceeding with large scale expansions and innovations while those with fewer resources were following less aggressive strategies dictated by their lower budgets. All of the administrators interviewed were very much aware of the gravity of the forces they faced. Hospital are increasingly being driven by financial considerations over and above all other issues, even at the cost of sacrificing previously cherished community and national values. The next chapter identifies problems emerging from the potential overextension of the Business Model Hospital and suggests public policy recommendations for how to address those problems.

## Notes

1 Green, Jay, "Systens Went Back to Basics in '87, Restructuring to Stay Competitive", Modern Healthcare, Volume 18 Number 22, May 27, 1988, pp. 46-50

2 Greene, Jay, "Alliances Soon May Face Their Day of Reckoning," Modern Healthcare, Volume 17 no.26, December 18, 1987 p.24

# Chapter Five

## EMERGING ISSUES AND POLICY RECOMMENDATIONS

This chapter discusses issues identified by the field study which need the attention of public policy makers in the near future. It also offers specific policy recommendations for dealing with the problems identified. This discussion is based on a perspective that constitutes the principal conclusion of the research: namely, that hospitals should be regarded not just as business entities, but as public trusts. As such, those who oversee hospitals will need to balance public interest needs with the efficiency needs of a purely free market approach to providing health care services.

The Business Model Hospital identified in this study, and more generally, the free market concepts on which it is based, offer potentially powerful solutions to current health care problems. This potential should be pursued wherever it is appropriate. However, there are dangers in overextending the model. Health care policy makers need to strike a balance that realizes the benefits of the Business Model Hospital while preserving as many public service values as possible. Failure on the part of public officials to embrace this role will likely result in a situation whereby business model hospitals absorb a good deal of the resources and profits of providing health care services

without adequately addressing the needs of a large part of the public constituency. The role of the public policy makers is becoming even more critical as the amount of money available to pay for health care becomes more finite.

This chapter discusses a succession of emerging issues which emerge from the field study. These are issues that are likely to require the attention of public policy makers in the near future. There are four basic categories of issues that are discussed here. These are: (1) broad public interest issues which affect the public in a general manner, (2) local public interest issues which pertain to the impact on local communities, (3) issues related to hospitals - individually and as part of an industry, and (4) future health care / hospital issues that public policy makers will need to address for long term interests. The chapter concludes with some specific policy recommendations that would be helpful in balancing the needs of hospitals and what is in the public interest.

## Broad Public Interest Issues

One class of issues facing public policy makers falls under the category of broad public interest issues because they have an impact on the general population. These are issues that affect:

-The equality of access to health care services by various socio-economic groups to health care services

-The impact of multi-hospital systems on health policy and health resources

-Public and private investment decisions in the nation's health care delivery system

-The consideration of tax policies as they pertain to hospitals

-The overall role of hospitals in the structure of the nation's health care delivery system and as a major point of health policy intervention

Inequality of Access

Equality of access to public resources (such as legal, educational, government and medical systems) is a deeply held national value, if not in practice. The political and economic forces now operating in health care threaten to create a system where unequal access is designed into the system as a strategic goal.

There are many social rights activists who would argue that the United States has long had a multi-tiered health care system based on socio-economic status. This argument is not new. Many government programs have been introduced over the past twenty years aimed at reducing this inequality. What is new is that it now appears that the nation is moving at a sharply accelerated pace toward a system of hospital care that is

inherently directed toward serving primarily those that can pay and avoiding those who cannot. The increasing gap in unequal access is becoming a major negative consequence of the emergence of the new political economy of health care and the business model hospital.

The issue of patient dumping, an outright refusal to treat patients who have little or no means to pay, is the most blatant example of the negative consequences of the business model hospital and the associated inequality of access. A 1986 Federal Law is designed to prohibit hospitals from turning away patients who need emergency care. The field interviews indicate that in some areas patient dumping is a reality. Dumping is more prevalent in non-emergency cases where subtle forms of dumping are possible. These less overt techniques for avoiding the patients who cannot pay is now and will continue to be a problem for public policy makers. It would now appear that avoiding the unprofitable patient is becoming a major goal in the strategic planning of many hospitals.

The patient dumping problem is a particularly difficult one for policy makers because it is hard to define where "good business practice" stops and outright patient avoidance begins. As noted before, business model hospitals are much more "bottom line" motivated than were the community model hospitals. Consequently, business model hospitals direct most of their

"product development" and "sales" efforts toward profitable services and client populations that can afford to pay. While most hospitals expand and update their physical plants and services to stay competitive, it appears that most of the new service and facility expansions are targeted for maximum return on investment. Translated, this means that much of the new investments in health services and facilities are strategically located in areas where there are more affluent health care purchasers and not in the areas wcontaining a high concentration of poor patients, such as inter-cities and poorer rural areas.

The need for access to capital will be a major contributor to the emergence of a multi-tiered health care delivery system. The hospital business is capital intensive. Hospitals have an ongoing need for capital to purchase sophisticated (but often quickly out dated) medical equipment and to expand or remodel facilities to accomodate needs to grow and to adapt to changes in health care delivery. This is borne out by the fact that many relatively small hospitals (150 to 200 beds) must spend $1,000,000 to $1,500,000 annually to upgrade medical equipment in their facilities. In today's health care business environment, many hospitals are finding that getting the money needed to be up to date is becoming increasingly difficult. A hospital's ability to raise capital is dependent on its credit rating and its ability to repay debt rather than the medical needs of the community it serves.

It is likely that the hospitals that serve less affluent communities will have a more difficult time in getting the money to modernize their facilities. The lack of ready access to capital frequently triggers a self re-enforcing cycle of decay that dramatically worsens the plight of these hospitals and the people that must depend on them. Hospitals that serve a substantial number of indigent patients will not have the resources to keep up with new medical technology and new facilities. Without reasonably up to date technology and facilities, good staff will become more difficult to recruit and retain.

This self perpetuating cycle is further worsened by the likelihood that the more affluent patients that the hospital may have been able to attract in the past will likely seek health care at "better facilities" outside the community as the level of services deteriorates. This in turn will result in more lost revenues for the local hospital. The poorer patients, less able to travel, will have to rely on whatever level of medical services the local hospital is able to maintain. One further factor in this equation is that as health care costs continue to rise, poorer patients are more likely to postpone seeking medical care until their condition reaches a more critical stage. They often arrive at the hospital needing a greater amount of medical attention and are less able to pay for the care

they need. Many hospitals that have been considered financially sound in the past days of "cost plus" reimbursement are likely to be increasingly affected by this course of events.

Even if hospital administrators were willing to take the risk of investing in programs targeted for low income health consumers and in less populated rural areas, the financing criteria being employed by investment bankers and bond rating agencies today would likely discourage substantial investments in areas where the potential return is not clearly evident. Access to capital is so critical to today's hospitals that they can ill afford to take on many projects that lenders do not fully endorse. Obtaining capital financing is competitive and lenders typically want as much assurance as possible that borrowed money will be repaid in full and on time.

As competition for patients has grown, hospitals have developed marketing programs to maintain and expand their business. Not surprisingly, hospitals develop their service programs and marketing efforts to attract the more affluent and most profitable patients. Hospital marketing in some cases is directed toward name recognition and image building. This type of marketing is usually very general in nature.

As hospitals become more adept and more sophisticated in their marketing efforts, however, it is likely that hospitals will

concentrate their marketing efforts (as well as their service and facility development efforts) on those patients that are likely to be the most financially rewarding. In a competitive marketplace such as most hospitals face today, no one is likely to compete for the poor, unprofitable patients. Public policy makers must take this into account and structure policies that encourage equality of access.

Impact of Multi-Hospital Systems

The creation of large-scale hospital systems now makes it possible to have major impact on the formulation of health care policy and the delivery of health care services. This is a sharp departure from the previous fragmented community hospital system. The hospital chains, because of their more advanced organization and superior resources, have more power to do good (e.g., by sharing services and experience) as well as more power to do harm to the public interest.

The restructuring of the hospital industry from independent, largely isolated community hospitals to form consolidated multi-hospital units is resulting in the creation of larger and more economically and politically powerful health care organizations. Although hospital trade associations have traditionally been a strong advocate for hospital interests, the multi-hospital organizations that are emerging now are much more

united and much more focused on the objectives they seek to pursue. These larger organizations have the resources to assemble professional staffs that operate with greater sophistication in their efforts to influence not only elected officials but other businesses and community leaders as well.

The possession of greater resources will make the consolidated hospital systems a more proactive force in the development and implementations of health care services. Where individual hospitals were often restrained by lack of financial and expertise resources, the new multi-hospital systems will not be as constrained. They will be in a better position to attempt to fulfill the plans that they conceive.

While consolidated multi-hospital systems can hold a great deal of promise for the health care delivery generally and for individual hospitals specifically through greater access to financial and technical resources, there is a negative side. Multi-hospital systems generally conceive and implement plans on a broader scale than that of local community needs. Some of the larger for-profit hospitals chains now have expanded overseas in their operations in response to pressure from investors to maintain growth and profits. Even in this country, some of the large for-profit hospital chains are in fact health care conglomerates with investments and interests that go well beyond just runing hospitals.

Managers of smaller multi-hospital systems also generally develop goals and plans on the basis of system wide needs. The priorities of communities in which individual hospitals are located are often given only secondary considerations. Not only are services added or droped, but in the case of multi-hospitals systems that own the hospitals that they operate, hospitals or parts of their assets are bought or sold to accomodate changes in plans. This can mean instability and confusion for hospitals and their coummunities. Of particular concern is the fact that continuity of services is unsure and the long-range needs can be neglected. Once a community gives up local control of its hospital, it may be difficult to regain control should situations develop that have adverse consequences for the community. This is not to ignore the fact that many communities feel compelled (and justifiably so) to cast their lot with a multi-hospital systems. The potential benefits of becoming part of a multi-hospital system are perceived as crucial to the survival and growth of many hospitals, large and small.

In the case of voluntary multi-hospital systems, communities may do better in influencing the operation and fate of their local hospitals. However, they may not be able to retain influence for long. Hospitals in voluntary systems are expected to participate in the major initiatives put forth by the system or

face the possibility of being dropped from membership. As money and other resources continue to become more restricted in a competive health care industry, voluntary multi-hospital systems are likely to command more power and autonomy at the expense of local hospitals in order to keep the system competitive.

Public policy makers must take into account that plans and actions of multi-hospital systems may not be in the best interest of the public and be prepared to assure that hospitals live up to their public trust responsibilities. As communities increasingly lose control of their hospitals, public policy makers at the state and national level must effectively fill the gap created by declining community control. The potential problems of multi-hospital systems elevating decision making to a broader system-wide corporate level is not likely to be as threatening now as it may be down the road, especially if money to pay for health services is further restricted.

## Reinvestment of Health Care Dollars

One of the most important issues for the public interest in the short, but particularly in the long term, is what hospitals do with the profits they earn, or "income over expenses," as non-profit hospital administrators refer to it. As with any enterprise, the decisions on the part of hospital management as

where to invest their profits is critical not only to the future success of the hospital but to the public constituency which the hospital serves. Reinvestment decisions of hospitals, taken as a collective, determine a major part of the health care infrastructure for the future health care delivery system of the nation. With a trend toward relying on free market competition to help regulate hospitals, public policy makers must take steps to insure that hospitals are reinvesting appropriately for the future and not just for short term profits.

Decisions about reinvesting health care dollars take on added significance in view of some of the findings of the field interviews conducted for this study. As discussed previously, the entrepreneurial-minded hospitals of today are investing their money and other resources in a wide variety of health and non-health care enterprises. While these investments are made with good intentions of producing additional income for the hospitals, it must be taken into account that all investments have the prospect of losing money as well as making money. All investments have costs associated with them, including the likelihood that making one investment decision means not making others.

At a minimum, new business ventures take a certain amount of the hospital staff's management time and some amount of its resources. At the other extreme, some investment decisions may

claim a disproportionate amount of time and money relative to the primary mission of the hospitals. Not all hospitals are well suited to pursuing new business interests whether they are health related or not. Many hospitals lack the depth of financial resources as well as the know-how to manage new business ventures effectively. As the hospital industry has come to be accepted as a viable borrower in private capital markets, many hospitals have found that they have access to credit at levels unattainable in the past. (This is in contrast to many other hospitals that have found themselves essentially shut out of private capital markets.) With this access to capital, some hospitals may be tempted to use it more liberally and may suffer for it.

Of particular concern is the possibility that some hospitals, in their eagerness to achieve bigger profits, may become involved in ventures that divert resources from the long-term needs of building and maintaining the hospital's overall health care delivery infrastructure. Hospitals may be tempted to invest in very specialized and exotic equipment and facilities that cater to only a narrow, but presently profitable, segment of the patient community at the expense of more traditional health care services. Even with more traditional health care services, as the emphasis on profitability increases, hospitals are more likely to develop services that are targeted more to affluent patients in terms of efficiency and accessibility. For

example, hospitals may locate outpatient facilities more conveniently near affluent patients rather than in an area where they are most needed.

Of further concern is the potential hazard that may lie in the fact that many hospitals are entering into business relationships with joint venture partners from outside the community. These partnerships are being used to establish services and facilities such as rehabilitation centers, geriatric centers, drug and substance abuse centers, retirement centers and various types of diagnostic facilities. These outside partners can have negative as well as positive impacts on hospitals. Financially weaker hospitals are likely to be more vulnerable to influence, for better or worse, by more powerful outside partners. Some hospitals may be a poor match for the influence of larger joint venture partners who need a local hospital to get their foot in the door of a community but do not share the broader interests of the local hospital. Hospital investment decisions in these cases will need to be approached with caution. Public policy makers may need to establish guidelines for these partnerships to protect the community's interest.

The emergence of multi-hospital systems as a major new organizational form is another factor that can positively and negatively influence the reinvestment of health care dollars.

The interlocking structure of large hospital systems and diversity of their activities make it possible to transfer health care profits earned in one location to other locations. This type of transfer has the potential to help or harm individual hospitals and their communities. While multi-hospitals systems appear to be more likely to enhance rather than hurt local hospitals and their communities, public policy makers need to take steps to insure that the investment strategies of multi-hospital systems are not served at the expense of the needs of individual communities.

The rise of for-profit or investor owned hospitals presents another consideration in the reinvestment activities of hospitals. The introduction of the investor profit motive in the the field of health care is a factor that is both potentially good and bad for the public interest. It is good in that it provides an important, and in many cases, an indispensible source of capital financing for hospitals. As noted previously, some non-profit hospitals that have sold out to for-profit hospital companies have noted that gaining ready access to capital for future survival and growth of the hospital was a major consideration in making the decision to sell to a for-profit company. Importantly, the selling for stock to raise capital means that the hospital is not burdened with debt which it must pay back with interest, as is the case with most non-profit hospitals which must borrow the capital that they can not

generate internally.

For-profit investment in hospitals creats a potentially bad situation in that it gives a powerful voice to individuals and groups who invest in hospitals. They are now in a position to place demands on those hospitals. Investors in for-profit health care expect dividends on their investments, and rightly so. Investors often press for short-term gains in company stock in an effort to turn a profit on their holdings. Investors in many cases place demands on hospital companies to continue to grow by whatever means is feasible in order that the value of company stock can continue to increase. For example, after experiencing tremendous growth through buying hospitals in this country, many for-profit hospital companies were obliged to start investing in health care facilities overseas, once there were fewer good hospitals to buy in this country.

A side issue related to the investment decisions of hospitals deserves mention. Many hospitals are encouraging and even depending on physicians who are on the staff of the hospital to share in the investment for new equipment and facilities intended to expand the services of the hospital. A potential conflict of interest arises out of physician ownership of subsidiary facilities of a hospital to which patients are referred. With both the hospital and the referring physician having a financial interest in directing patients to particular

facilities and services, consideration should be given as to who is left to monitor what is in the best interest of the patients, and to assure that the needs of the patient are taking precedent over any financial gains that may be had by investors.

Underlying this concern about the reinvestment of profits earned in providing health care services is the notion that a substantial portion of these profits should be returned to maintain and improve the health care systems in the communities where the profits are made. The issue comes down to whether or not health care providers should be allowed to do as they wish with the money generated in providing services. While I do not advocate stifling controls on health care provider investment decisions, I do think that public policy makers should establish monitoring procedures that insure that adequate amount of resources are reinvested in building and maintaining viable health care delivery systems. In keeping with the idea that hospitals should be regarded as public trusts, managers and investors for profit should not be allowed to undermine the resources of the hospitals under their charge.

To draw a somewhat analogous example from another industry, we cannot allow hospitals to suffer a fate similar to what many savings and loan associations have experienced under deregulation, where overzealousness, misguided management and fraud wrecked many savings and loan associations and brought

about major damage to the industry as a whole. Many of the hospitals that are experiencing difficulty today trace their problems back to periods of management neglect in the past. Today's health care environment allows increasingly little room for error. Once a hospital has been undermined, accidentally or wrecklessly, it is likely to be expensive to restore.

Tax Issues

Non-profit hospitals under the community hospital model have had the benefit of being exempt from paying federal, state, and local taxes as most other businesses are required to do. This tax exempt status of non-profit hospitals amounts to a governmental subsidy. Tax exempt status seemed appropriate when non-profit hospitals possessed a mission of charity and service to the communities that they served. As the perspective and operating behavior distinctions between for-profit and non-profit hospitals become blurred in today's competitive market-driven health care economy, however, the issue of continuing tax subsidies to profitable non-profit hospitals should be re-examined. Put simply, many non-profit hospitals are in fact very profitable and therefore should be treated accordingly by public policy makers.

As noted earlier, hospitals have become big business. Some small town hospitals included in this study had annual budgets of

$15 to $20 million while big city hospitals had budgets of $250 million. This is not to deny that some non-profit hospitals do "earn" their tax exempt subsidies by providing substantial amount of charity care. Many do. However, as some non-profit hospitals have sought to build their business base by branching out beyond the traditional walls of the hospital, they have found it convenient to establish for-profit subsidiaries. They do this to gain greater flexibility in pursuing their new endeavors. Through a mix of non-profit and for-profit subsidiaries , hospitals can perform a tax balancing act by appropriately matching up financial gainers with financial losers such that organizational flexibility is maximized and tax liabilities are minimized. This chameleon approach to organizing health care organizations seems to offer the opportunity to abuse the tax exempt status provided to non-profit hospitals.

As public policy makers attempt to alleviate some of the "pain" caused by the actions of business model hospitals, an additional source of revenue from institutions that are profiting from delivering health care services would be welcomed. A closer examination to determine which hospitals are providing a disproportionate amount of health care and those that are not would allow public policy makers to help reduce some of the competitive disadvantage that a large charity-care burden causes by adjusting the amount of taxes paid by hospitals. A

more appropriately targeted tax policy could serve as a mechanism for redistribution of profits earned by health care providers who "skim" profitable parts of the health care business by catering to profitable services and profitable patients. In some situations it may be in the best interest of the public to give tax breaks to for-profit hospitals for providing services to particular patient groups.

So, the tax policy issue centers around what role tax policies should play in promoting or subsidizing particular hospitals. Further, how can tax policies be best used to promote a healthy hospital industry which meets the needs of the general public without providing windfall benefits to hospitals? Today's health care environment has produced a variety of new issues concerning the application of tax policy to hospitals. For example, Should non-profit hospitals be taxed differently if they have for-profit subsidiaries? When should tax policies help solve the problems of access to capital financing and technology development for hospitals? The hospital business has gotten more complex and public policy makers will need to be more strategically oriented in applying tax policy to hospitals.

## The Changing Role of Hospitals

The hospital historically has been the major focal point of health care delivery and, hence, a major focal point of health

care policy intervention. Today, health care is much more broadly based. Hospitals are only one group of players in a distributed system. Policy makers need to adjust their focus to cover the system as a whole.

For sure, hospitals continue to be a primary player in the politics and economics of health care. But as discussed earlier, there has been a shift in power such that those that pay for health care services - government, employers, and private insurance companies - now play a much more influential role in determining when, how, and where health care services are appropriately delivered as well as how much it should cost. Of particular importance is the growing importance of managed care programs such as HMOs and PPOs that essentially organize and control care delivery for large patient groups. The managed care groups can market to health care providers on a wholesale basis. Additionally, the free market approach to regulating health care has spawned a variety of new specialty health care providers that provide alternatives to traditional inpatient hospital care. The situation is further complicated in that hospitals themselves have greatly expanded their "domain" in the health care business through vertical and horizontal integration.

Public policy makers must take a broader and more sophisticated view of formulation and implementation of health care policies.

Applying policy initiatives to health care today is somewhat like squeezing a balloon. You apply pressure at one point and it bulges out at another point. Hospitals have in the past been able to tolerate the burden of being a major point of policy intervention because, in part, the resources (largely by means of pass-through of costs) were available to help offset the administrative and financial burdens associated with policy interventions. Now with the increased use of prospective payment for services and other cost control measures, many hospitals do not have the resource flexibility to absorb the costs of policy implementation.

Finally, policy makers should develop ways to differentiate among hospitals as to their individual situation with regard to their policy needs and their ability to cope with various types of policy interventions. The current health care environment has created a situation where some hospitals exist in a fragile state and are vulnerable to even relatively small adversities. On the other hand, some hospitals are expanding and prospering very well under the new health care environment and consequently be treated differently by policy makers.

## Local Community Issues

### Survival and Growth

The issues of survival and/or growth are now becoming critical for many hospitals and the communities they serve. The American Hospital Association reported that hospital closings set a new record for one year in 1988, with eighty-one community hospitals closing. About half of the hospital closings were in rural areas.[1] It is likely that many more hospitals, large and small, will close over the next few years.

An up-to-date hospital is a vital part of a community's infrastructure and consequently figures prominantly in a community's social and economic quality of life. Communities without good medical facilities will have difficulty in attracting and keeping qualified medical personnel. Communities without accessibility to good medical facilities are likely to find themselves at a disadvantage in attracting and maintaining business and industry, as employers expect a certain level of medical care to be available to their employees.

It must be stated that many of the nation's hospitals should be allowed to go out of business. In some areas there is an over-supply of hospital facilities. However, the point to be made is that hospitals which fullfill a vital role in their communities

should be kept in business at an appropriate level of service. This is particularly true of hospitals that serve a large proportion of medically indigent patients and hospitals that are the sole providers of care in their area.

Policy makers need to establish criteria for making intelligent decisions about which hospitals should be maintained and which hospitals should be allowed to fail. They also need to provide incentives and mechanisms for supporting the growth of the survivors. The problems of hospitals gaining access to capital, expertise, technology and paying for indigent care will be discussed later. These are all potentially life threatening problems for some hospitals and policy makers must find solutions to these problems.

Loss of Local Control

Until the early 1980s hospitals were primarily local community institutions that derived most of their support from the communities they served. If they did not generate enough money internally to meet their needs, community hospitals were supported largely by philanthropy and other local fund raising efforts. When financial needs of the hospitals exceeded what could be raised through local sources, community leaders approached government officials at the state and federal level for assistance. Hospitals were locally controlled and their

operations were tailored to local needs. Community support and community leadership were hallmarks of the community hospital model.

As observed earlier, hospitals, and health care services in general have grown tremendously in terms of cost and complexity in recent years. During the early years of the health care cost explosion in the mid 1970s and early 1980s hospitals rapidly outstripped the local support networks that had sustained them in the past. As discussed in the previous chapter, hospitals have found it necessary to develop more powerful support networks outside the communities they serve. Mergers, sell outs, development of joint venture partnerships and joining hospital alliances are reflections of efforts by hospitals to develop more effective support networks. But these new support networks are not without potentially high cost for the hospitals and their communities.

In the emerging health care system of today, major decisions concerning the financing, the operations and indeed, the future of many hospitals are being made directly and indirectly by persons and organizations outside the community. These decision makers use criteria that are not sensitive to community needs and priorities. Rather, the decision criteria are based in a economic and business rationality that resides in regional and national organizational and financing strategies.

I do not mean to argue that this is wholly bad for individual hospitals and their communities. The fact is that the influence of outsiders has helped introduce new ideas and greater efficiencies to local hospital operations, aspects that some hospitals were in great need of. My point of concern is that as hospitals become more dependent on and controlled by these outside agents, communities will lose touch with, and control over, the destiny of the hospitals that they must rely on for health services.

As the financial burden and operational complexities of running a modern hospital have grown, many communities have welcomed the assistance of outsiders in administering their local hospitals. Membership in one or more alliance is now considered a virtual necessity by most hospitals. With the need for money and expertise to manage a modern hospital increasing all the time, it is uncertain as to whether local communities could once again assume control over the destiny of their hospitals should the need arise. And the need could arise under a number of scenarios including such situations as: decisions by outside agents that they cannot afford to or no longer want to continue their relationship with the hospital; incidence of mismanagement or neglect in running the hospital; or decisions by outsiders that the hospital's operations need to be altered in ways that the community finds unacceptable, such as curtailing services,

selling a part of the hospital or converting it to other uses.

The new outside support networks that hospitals are coming to rely on hold great potential for helping hospitals adapt to changes in the health care environment. But it will be up to policy makers to provide mechanisms for insuring that hospitals continue to be responsive to local needs.

Destabilization of the Hospital

A major side effect of the loss of local control is that some hospitals may become destabilized as a result of changes made at the higher levels in the multi-hospital systems or alliances which they are dependent upon. Destabilization may result from frequent and major changes in strategy, rapid turnover of key personnel, frequent changes in the portfolio of services, speculative investments, selling of part of the hospital's assets, rapid changes in management / ownership and neglect or mis-management. Hospitals need to be stable if they are to survive and grow. And, importantly, they must be perceived as being stable in order to attract good staff (medical and administrative), "good" patients (ones which generate income for the hospital) and good financial backers (good terms and adequate resources). Otherwise they may be doomed to an eventual demise, because these elements - good staff, good patients, and good financial backers - are critically

interactive.

The emergence of the idea that hospitals are to be viewed more as businesses and less as community institutions has served to open up hospitals to a variety of tactics and strategies that are usually applied elsewhere in the economy. As hospitals are viewed as money making instruments and the services that they offer as product lines, they are subjected to being made targets of hostile takeovers and "corporate raiders" who are looking to make quick profits by selling off assets of the hospital or possibly the whole hospital. Some large multi-hospital systems have recently divested themselves of their smaller and poorer performing hospitals in a move to concentrate management resources and attention toward the larger and potentially more profitable hospitals in their portfolio. (For example, the Hospital Corporation of America spun off 104 of its 190 hospitals to a separated company and American Medical International executed a similar plan with 36 of its hospitals.)

I think that there is more to worry about with respect to smaller for-profit hospital companies which may purchase a few hospitals in the hopes of managing them in short term gains. These smaller hospital companies are often marginal in the amount of financial and management resources which they can muster. This point, coupled with the fact that the hospitals that are offered for sale to smaller hospital companies are not likely to be in very

good shape to begin with, add up to poor prospects for the hospitals that fall under their control.

The emergence of the Business Model Hospital may in fact be bringing about the de-institutionalization of the American hospital. Hospitals are now moving away from being the "cornerstone" institutions that reflect central community values such as service to all, toward becoming rationalized business instruments that serve narrower values such as profitability. The positive aspect of the broader view embraced by the community hospital model should be preserved whenever possible because a viable hospital is an important economic and social asset to a community's overall well being.

For hospitals that are determined to be a vital asset to their communities, public policy makers need to take steps to assure that adequate provisions are being made for preserving key parts of the hospital's asset base and, as well, providing the long term planning necessary to maintain a hospital as a stable and dependable service entity. This may involve establishing prerequisite requirements for those who purchase and operate hospitals. In keeping with the notion that hospitals are public trusts, it would seem reasonable to take steps to assure that the public's trust is being placed in capable hands. To think of a hospital in terms of instrumental rationality may result in greater efficiencies and greater profits, but it must be

remembered that hospitals have a broader impact on the patients and communities they serve.

## Hospital Perspective Issues

### Competition

The federal government, with its implementation of a prospective payment system for Medicare patients, is now using "free market" competition as a major tool in regulating health care and controlling costs. Other major purchasers of health care services, such as employers and private health care insurers, are also endeavoring to utilize competition as a major means of containing rising health care cost in general and, in particular, hospital care costs, which account for the largest part of the nation's health care bill.

Faced with strong cost containment efforts on inpatient care and a resulting overcapacity of facilities, hospitals are being forced to develop a variety of new management capabilities and strategies in an effort to survive and grow in this new environment. As of the early 1980's most hospitals could not provide accurate information on such basics as the referral sources of their patients or the cost of a particular unit of service being provided to a particular type of patient. By the late 1980's many hospitals can readily provide this and scores of

other types of detailed information on their operations.

In today's competitive environment, such capabilities are now recognized as essential by hospital administrators who expect to compete effectively for what many perceive as a finite amount of money that is available to pay for health care services. As noted earlier, hospital administrators are obliged to make their operations competitively fit even in areas where the competition is regarded only as low to moderate, in part because major purchasers of health care services demand it.

The field of medical competitors has increased significantly in recent years. Not only are hospitals competing with other hospitals, a number of specialty care providers are attempting to take business away for hospitals. These specialty providers include free-standing outpatient immediate care centers, outpatient surgery centers, high tech home care, and private physicians. Developments in medical technology have enabled some of the specialty providers and private physicians to do procedures that not long ago could only be performed in a hospital setting. Changes in payment policies by health service purchasers has made it possible and has even encouraged specialty service providers to compete with hospitals. There is a danger that specialty providers, with lower overhead, will be able to "skim" the cream of the profitable patient crop and leave hospitals to deal with the more expensive and less

profitable patients to treat. Many hospitals have countered the competitive threat of specialty providers by setting up their own free standing specialty centers.

It is important to point out that not all hospitals will be able to adequately meet the competitive threats they face from whatever source. All hospitals are not equally able to develop competitive skills and capacities. Some hospitals do not have the resources that it takes to develop detailed management information systems or to expand existing services or add new ones. This is not to say that these hospitals are not providing important services to their communities. In fact, many of the poorer hospitals are poor because they are trying to meet the overall medical needs of their communities, including providing unprofitable services and treating significant numbers of patients that can not afford to pay. It simply takes a certain amount of resources to adapt to new conditions.

Consequently, policy makers need to provide stronger incentives and assistance in helping some hospitals adapt to a more competitive medical environment. Areas in which policy interventions will need particular attention include the following:

Access to Capital

Public policy makers will have to develop mechanisms allowing

hospitals that provide vital services to their communities to find the capital required to adapt to changes and to continue to grow. Policymakers will also have to be sensitive to the fact that a heavy debt burden can severly impair a hospital's ability to be competitive. Hospitals that carry a heavy debt burden will be more readily affected adversely by relatively minor changes in health care payment policies and fluctuations in the general economy than will those hospitals that have low debt burdens.

Access to Expertise

In order to maximize the use of scarce capital resources, hospitals will seek access to various types of management expertise. Public policymakers will need to see that those hospitals which provide vital services to their communities have access to the expert advice they will need to utilize effectively the resources that are available to them. Timely access to expertise is critical to a hospital's competitive abilities.

Access to Technology

Access to reasonably up to date medical technology will figure prominantly in hospital's ability to compete effectively. Obtaining new technology will be vital to some hospitals if they are to avoid being driven out of business. This will be

particularly true in the case of those hospitals that serve less affluent populations. Without the technology, hospitals will loose patients and staff and after that other resources will be more difficult to attract. Policymakers must be aware of the critical role that up-to-date medical technology plays in a hospital's ability to compete.

### Paying for Indigent Care

Few issues in the 1980s have caused more concern than the issue of who will pay for the care that indigent patients need. A heavy indigent care burden could keep a hospital from being competitive at the very least and at worst could put a hospital out of business. Public policy makers must either find a way to pay hospitals for indigent care or at a minimum, devise a way to distribute the burden equally among all parties involved in providing or paying for health care services.

## Future Issues

### National Information Systems

In this age of sophisticated high tech medicine, much is yet to be learned about which treatment strategies are the most effective, and particularly about which are the most cost effective. For example, questions are now being raised about the

effectiveness of medical procedures that have been routinely used, such as heart bypass operations and prostate surgery. The establishment of a national data bank to collect outcome information on large number of patients and the funding of new research in the area could be a major step in help determining what is the best use of medical resources. The federal government is the logical entity to coordinate and carry out this enormous but necessary task.

The existing Health Care Financing Administration Agency could serve as the focal point for collecting, analyzing and distributing such an information system. The Health Care Financing Administration is already in the business of collecting data on hospital costs and has a major policy role with the Medicare Program. The money spent on this project would be very well spent if the information systems are properly established and utilized.

Coordinated National Health Care Policy

The development of a coordinated national health care policy is long overdue. Such a policy would need to take into account all the participants involved in providing, using, and paying for health care services. As noted earlier, hospitals have long been a major point of public policy intervention in health care. Health care has become a complex multi-player system in which

hospitals continue to play a major role, but no longer the only major role, in health care delivery. Public policymakers must shift their focus to the system as a whole rather than concentrating mostly on hospitals. This broader focus would also facilitate better response to a system-wide crises such as cost control and assuring adequate access to health care by all segments of society.

The call for a coordinated national health care policy merely states the obvious. With the demand for and cost of health care services steadly rising and corresponding efforts to limit the resource input, policy coordination is a necessity. The formulation and implementation of such a policy is a trememdous task. Elected lawmakers must decide on the broad parameters of a national health policy, but the task of developing the details of a national health policy and its implementation will rest with the executive branch of government.

While I do not intend to outline the details of a national health care policy here, I do have suggestions concerning the role of government and the implementation of a national health care policy. As indicated elsewhere in this research, I feel that there are positive as well as negative aspects of a health care system that embraces competiton. With this in mind, I suggest that government take a more proactive role in health care as a purchaser and a provider of health services. In the past

government has mostly assumed the role of "last resort" purchaser and provider. I suggest that government embrace a role in the health care system as that of a competitor - both as a purchaser and provider of health care services. (The enlarged role of government as a provider of health care services will be discussed in the next section in the form of a proposed public hospital corporation.)

For a national health care policy to be effective, as a competition based health care system, it will need to be more than just statutory authority of regulation. A large diverse health care system such as we have has many voids that can be better filled with economic power than statutory power. Therefore, national health care policy authority should be located in the same agency that is responsible for carrying out the government's role as a major purchaser of health services. I suggest that <u>all</u> of the federal government's purchasing of health services be handled through an agency like the Health Care Financing Administration. I suggest that this agency also be assigned the primary role in the development and implementation of a national health care policy based on the broad directives of Congress. National health policy initiatives should be direclty coordinated with and not be separated from, the economic power which the federal government has as a major purchaser of health services.

## Public Policy Prescriptions for Hospitals

Having outlined some of the major issues that are emerging out of the new political economy of health care in the 1980s, I will now turn attention to how these issues might be dealt with by discussing some policy recommendations that may help remedy some of the problems. These policy recommendations are rooted in the idea noted at the beginning of this chapter: that public policy makers adopt the position that the management of the nation's health care delivery system is a public trust as well as an opportunity to operate a profitable business.

Under the old community hospital model, hospital administrators and governing boards were somewhat self regulating in terms of identifying and serving the interest of their communities. Hospitals are in a new era now. The organizational and governance structure which guides hospitals today cannot be relied upon as fully as before to look after community and public interest matters. It is therefore essential that public policy makers actively embrace this role in efforts to prevent the potential excesses of the Business Model Hospital from undermining the strategic parts of the nation's health care delivery system for profit motives.

It must be noted in fairness that, in most cases, the management cadre responsible for administering the nation's hospitals has

well-founded intentions of carrying out its duties in a manner that will enhance the health care delivery system and be consistent with the public interest. There are, of course, exceptions which must be dealt with. However, the larger concern being expressed here is two-fold. First, it cannot be assumed that those responsible for guiding the nation's hospitals will automatically know what is in the best long-term interest of the public. After all, health care administrators must be expected to focus more narrowly on what makes sense for their own organizations. Public policy makers, on the other hand, are in the business of making judgments as to what is in the broader interest of the public. And they must communicate this effectively to health care administrators.

Secondly, there is concern that under the new rules of health care engagement being established today, many well-intentioned administrators will be greatly challenged to maintain their facilities and serve the broader needs of their communities. Public policy makers will need to identify those hospitals that serve the vital interest of their communities and find ways to help these hospitals cope effectively with the new health care environment.

Linking of Service Request

In an effort to preserve some of the efficiency and creativity of

free market health care, and yet avoid some of the skimming of the most profitable services and patients by profit driven health care organizations, I suggest that public policy makers employ the concept of "linking" service responsibilities. Under this approach public policy makers could tie approval requests by health care providers to provide a new service, expand a facility, enter into a new market area, and so forth, with a requirement that specific additional services be offered or actions be undertaken to provide services that are in the broader public interest.

For example, a hospital may want to establish a new outpatient clinic. The approval of the proposed clinic might be tied to a requirement that a certain number of "free clinic" hours be provided to indigent patients. A request to expand home health services into a new territory might be tied to a requirement that a certain amount of home services be offered in an area that includes a significant indigent population. A request to build a psychological counseling / substance abuse center (currently a profitable business) might be linked to the applicant agreeing to maintain a particular level of obstetric services (a service that many hospital have dropped because of low profits and risk-negligence suits).

While the concept of linking health services could most easily be applied to requests to start new projects, its application could

be applied to requirements that health providers be periodically re-licensed to continue the services that they are now providing. This practice would be parallel to the way radio and television stations are required to renew their licenses. Public agencies overseeing such activities would have to be careful not to prescribe linking requirements that would exceed the financial and managerial capabilities of the providers. Such policy making efforts would also have to be administered in such a manner as not to discourage providers. However, with the trend toward merger of health care providers merging to form larger operating units, the burden imposed by such a policy is likely to be lessened.

The use of linked services as a public policy tool could be used to deal with several of the issues identified as emerging from or being worsened by the changes in the political economy of health care and the advent of the business hospital model. The widening gap of unequal access to quality health care services is one of the main areas where linking of services could most effectively be used to serve the general public interest. Linking of services could be used to harness the profit motive of the business model hospitals to serve the broader needs of the communities in which they operate.

The linkage strategy is certainly not a perfect solution, but it would be a step toward helping society benefit from the profits

of health care rather than just absorbing the losses, as is often the case. Linking of service requests by health care providers can be an effective way of dealing with the emerging issue of allowing hospitals to pursue the profit motive in their activities while balancing this against broader community needs. It could provide a mechanism to help insure that less profitable services are being provided to communities which need them. Linking could also be an effective way of holding in check those health care providers who would attempt to "skim the cream" of health delivery by concentrating on the highly profitable segments of the health care business, thereby undercutting the efforts of health care providers with more broadly based service missions.

To be most effective, the linking of services as a policy tool would need to be coupled with a provision which would allow for policy makers to withdraw the right of health care providers to continue services included in the linking agreement should the obligatory service part not be adequately carried out. An alternative to the providing of obligated service under the linkage arrangement could be a provision that would require a health care provider to pay a portion of the profits generated by providing lucrative services into a general fund that could be used to support the neglected, less profitable services that are needed in a particular community but are not adequately rendered. Local governing bodies could be in charge of how the

money is spent.

Public Reporting

One of the most simplistic prescriptions, and yet potentially most significant recommendations, is to establish public reporting requirements for health care providers regarding key aspects of their current operations and their plans for the future. Most state governments have fulfilled this function in some respect through Certificate of Need Programs (CON) which have required hospitals to submit plans for review and approval prior to implementation. State-operated CON programs have varied considerably in their requirements, enforcement, and results. They have also focused almost exclusively on requests for developing new services (and facilities). Once a health care provider win CON approval for a new service or facility, it is generally assumed that the provider has the "right" to continue to operate the service just as long a minimum public safety standards are met. The public interest would be better served by a periodic review for the purposes of continuing CON certification.

The public reporting proposed here would go considerably further in disclosing details on all aspects of a hospital's present and proposed operations. It would focus more on providing information to the public concerning the overall business

operations of specific hospitals rather than just the approval of new projects, as do most government review programs at present. Information would be made available on existing services and other operational aspects of hospitals as well as efforts to establish new services and facilities.

Such public reporting requirements could, for example, require health care providers to make financial disclosures relating to investment decisions. Disclosures such as this nature would allow the public to know if local hospitals are re-investing profits in health care delivery improvements or in non-health related or potentially risky ventures. Disclosures could give the communities to know if plans are being formulated for selling off parts of a hospital's operation or perhaps the whole hospital. Such disclosures could allow the public information and insight as to the long range plans and directions proposed for the health care institutions serving their communities.

Making information available far enough in advance could allow the various constituents of health care providers to have an impact on the operations of the health care institutions concerning actions and proposed changes. At least disclosing such information would allow the public to make informed and prudent choices as to which facilities they will select in cases where there are competing providers.

Even though many health care providers have established all or parts of their operations as private for-profit enterprises, this should not be a barrier to such public reporting practices. Parallel to such reporting of plans for investments and changes in operations already exists in the utility industry, another vital public services that falls in the realm of a public trust. Activities, plans and investment of utilities have generally been available to the public for years.

Increased public disclosures about the business activities and plans of hospitals could be a positive step toward combating the potentially negative effects of loss of local control over hospitals by the communities under the new business model hospital regime. Greater knowledge on the part of citizens about what is going on in local hospitals would seem to be a prerequisite for greater community involvement. Under the community hospital model, the local community was generally kept informed of the operations of the hospital because the hospital turned to the community for financial and other types of support necessary to carry out its activities.

As noted earlier, hospitals today mostly look to support networks beyond the community to sustain themselves. Public reporting requirements in this regard can be viewed as a partial replacement for the natural flow of information that formerly came from hospitals as they sought community support to maintain

existing services and establish new ones. Public reporting could prove to be a vital function that enables communities to keep from losing control over the hospitals on which they rely. Public reporting could allow for timely intervention on the part of citizens to assure that local hospitals continue to serve local needs. Public reporting concerning the plans and activities of hospitals should become a vital part of efforts toward guiding and educating the health care consumers as to how to relate to the changes brought about by the new political economy of health care in a manner that serves their best interest.

With increasing competition among health care providers, it can be well anticipated that many providers will strongly resist efforts to disclose publicly information that they feel may affect their ability to compete. While it may be true that some measure of competitiveness may be compromised by broader disclosure requirements, such disclosures are in the public interest and are in keeping with the perception of hospitals as public trusts.

Government Guaranties for Capital Financing

Capital financing appears to be one of the major obstacles facing hospitals. While access to capital financing can be constraining for moderately sound hospitals, it can be

particularly critical for hospitals that are located in poorer socio-economic rural and inter-city areas. Such hospitals generally have a more difficult time obtaining debt financing for capital projects because they usually do not have strong enough balance sheets to be attractive to investment bankers and other lenders. These hospitals usually have a large proportion of indigent patients and, in the case of some small rural hospitals, do not have a very large volume of patients over which to spread the fixed costs of running a hospital. It is for this reason, i.e., the fact that they do provide service in the poorer and more isolated areas, that it is important to keep some of these hospitals operational at a respectable level of service. As noted earlier, keeping the physical plant of a hospital and its capital equipment is necessary to attract good medical staff as well as paying patients.

The federal government has had programs under which it provides guarantees against default for the sale of bonds to finance major capital expenditures by certain types of qualifying hospitals. Such guarantees on the part of the federal government usually allow the qualifying hospital to sell bonds at low interest rates, thereby not only providing the hospital the ability to raise needed capital, but to do so at less expense. It appears that the use of, and possible expansion of, such a loan guarantee program could provide a means for allowing strategically located hospitals the ability to continue to provide a reasonable level

of care for the patients they serve.

Unlike an outright grant, a guarantee for bonded indebtedness would still require that the borrowing hospitals undergo the scrutiny of the private debt market to some extent. This in itself could help educate and discipline the management of the hospitals using the program and aid in their long term growth and full assimilation of today's sophisticated and competitive health care environment.

Qualification for the use of guarantee programs should be tied to the user hospitals being subjected to tests of management fitness as well as to community needs. The loan guarantee program in some cases might be used as an inducement to attract larger regional hospitals to working management relationships with smaller hospitals. Larger hospitals otherwise avoid taking on the burden of working with smaller hospitals if they feel that the smaller hospitals have little to offer and in fact might be a continuing drain of resources.

Management Expertise

Management expertise is always a desirable commodity in any kind of endeavor. It is essential, if a hospital is to compete effectively in today's health care environment. The financial pressures placed on hospitals with declining patient

populations, tightened reimbursement policies, and greater competition among providers, have resulted in a more demanding management environment for hospitals with much less room for errors in judgment. Indeed, the ability to tap into various types of management expertise was one of the major reason cited by hospitals for joining alliances and seeking joint venture partners.

While most hospitals will be able to find the expertise that they need through alliances and joint venture partnerships, the question remains as to what the hospitals which are not invited to join alliances or cannot find venture partners, will do to obtain needed expertise. This problem is significant in that the financially weaker hospitals are often the ones which provide a disproportionate amount of care for indigent patients that are less likely to be asked to join an alliance or to enter into a joint venture arrangement.

Government policy makers could help such hospitals by providing financial and tax based incentives to those who would assist these hospitals. Financial incentives could take the form of adding an amount on the payment that these hospitals receive form Medicare and Medicaid sufficient to allow the hospitals to purchase expertise. Such payment would be tied to a formula similar to the arrangements by which capital expense is factored into Medicare and Medicaid payments. Tax incentives could be

offered to for-profit consultant firms that assist "qualified" hospitals to reduce fees. Tax incentives could also be devised that would encourage hospital alliances to take in poorer hospitals as members of their alliances, perhaps on a less than full voting rights membership basis. Similarly, tax incentives could be used to encourage for- profit providers to enter into joint ventures with hospitals that are in poorer financial condition.

Indigent Care Fund

One of the potentially most significant issues to be dealt with in health care in the coming years in Business Model Hospitals is that of paying for indigent care, i.e. care for those who can not afford to pay. As noted earlier, business minded hospitals are often strategically planning their operations in such a manner as to avoid the patient who can not pay. This trend is likely to continue as major purchasers of health care services attempt to devise payment schemes which reduce the ability of hospitals to shift costs from those patients that cannot pay to those that can. Public policy makers will need to provide incentives for hospitals not to avoid patients that cannot afford to pay for the care they receive. One way of getting profit minded hospitals to care for indigent patients is to establish a fund against which hospitals can draw upon to help meet the expenses that they incur in treating such patients.

Reliance on free market forces to regulate the delivery of health care services brings to the forefront two conficting notions widely held in this nation. These conficting notions are first, that obtaining health care services is primarily a matter of individual responsibility and second, that access to adequate basic medical care should not be restricted by the ability of an individual to pay for services. The establishment of indigent an health care fund is a way of providing a mechanism that allow more people to participate in the health care market.

Indigent health care funds are not a new idea. Some States already have established such pools. Massachusetts, for example, is one of several states that has developed some variation of such an arrangement to pay for indigent care. It is funded primarily by a seven per cent tax levied on each patient's hospital bill. As a result of the indigent care fund strategy, patient dumping is not a major problem in Massachusetts. In fact, Boston City Hospital, which has a large proportion of indigent patients, reported when interviewed for this study, that as a result of the indigent care pool it was enjoying its most profitable years. Other states, including Virginia, have considered such methods for paying for those patients that cannot afford to pay. The proposal in Virginia was turned down by the State Legislature in 1988 as a "tax upon the sick."

In the absence a national health insurance program or something similar to it, there needs to be some way to compensate hospitals for taking care of the medically indigent. Otherwise, those hospitals that are willing to treat these patients will be adversely affected by the drain on resources from non-paying patients. An indigent health care financed fund could be funded through several sources or a combination of sources such as contributions from employers, commercial insurance companies, a tax on physicians services, or general revenue funds. It is unfair to place a heavy financial and administrative burden on hospitals in an effort to provide care for indigent patients by making them the main focal point of policy intervention. The burden should be distributed among all the participants in the health care financing and delivery systems, including providers, purchasers, and users.

The source of funding for an indigent care is a matter that will have to be resolved through the political process. I suggest here that establishing a pool of money to cover the cost of treating the medical indigent is a necessary step if the Business Model approach to hospital care is to be allowed to continued.

It is realized that the complexities of health care economics and who pays for what and how are very important matters when dealing with the issue of paying for indigent patient care. Such complexities are beyond the scope of this research which focuses

on how hospitals are coping with changes in the health care field. What this research has revealed is further evidence of what is already generally known about the problem of paying for indigent care. This is that the new health care environment in which hospitals operate encourages the avoidance of poor patients.

The free market approach to health care in theory assumes that each patient will have to have financial resources from somewhere to pay for his care. The reality is that an estimated 37 million people do not. The call for the establishment of a pool of money to cover the cost of care for indigent patients is a simplistic solution to a complex problem. It is important for public policy makers to realize that the problem of paying for indigent care is a problem of sufficient magnitude to undermine the vitality of many of the nation's hospitals and in some cases, push them over the edge to extinction.

As pointed out earlier, the new health care environment has seen a shift in power from providers (hospitals and others) to those that pay for services (the major third party health insurers, large employers, etc.). Whereas in the past hospitals looked for ways to help cover the cost of indigent care through cost shifting and philanthropy, major health service purchasers are focusing their efforts on limiting the amount of money they must pay to provide health services to their beneficiaries. The

major purchasers, now the more powerful participant, have little incentive to assist in paying for health services for those that can not afford to pay themselves. In fact, major purchasers are actively attempting to limit the cost shifting practices that hospitals have used in the past to help pay for indigent care. The free market approach to health care has generated some businesslike efficiencies on the part of hospitals that are being demanded by major health care purchasers, but these efficiencies are largely at the expense of the medically indigent.

Decentralization of Medical Technology

The ability to keep reasonably up-to-date in medical technology is essential if hospitals are to avoid obsolescence. As discussed earlier, staying abreast of new medical technology is necessary to attract good medical staff and paying patients. Those hospitals that are allowed to deteriorate, in terms of the medical technology they are able to purchase, are likely to be doomed to treating only the financially poor patient who cannot afford to travel to hospitals which have the latest technology. If hospitals suffering from this problem are not forced out of business, such a development is at least a major step toward forming an increasingly differentiated or tiered health care delivery system based on the patient's ability to pay. Hospitals caught in this self-perpetuating downward spiral are

unlikely to ever pull out on their own.

Public policy will need to address the matter of decentralizing and disseminating medical technology. This must allow hospitals that serve thinly populated rural areas and poor inter-city areas to maintain viable medical service delivery capabilities. One recommendation for addressing this issue is to provide financial incentives (e.g.,tax incentives) to firms that manufacture and sell medical equipment in order to persuade them to sell their equipment to hospitals that serve targeted areas. Another recommendation is to create requirements which stipulate that medical technology developed as a result of government sponsored research be made available to selected hospitals on a priority basis. This requirement would make it easier for targeted hospitals and the patients they serve to maintain modern equipment and facilities. The issue of how to develop and disseminate new medical technology are policy issues that must not be left unaddressed if multi-tiered health care systems are to be appropriately constrained.

Use of Paramedicals

Rising health care costs are a fundamental factor behind the emergence of the new business oriented political economy in health care. Health care costs continue greatly toexceed the general inflation rate. One public policy option that could

help hold down future costs in health care delivery is that of promoting the increased use of paramedicals. Paramedicals include persons trained generally in two and four year programs to perform less complicated medical diagnosis and treatment of patients with routine problems. Paramedics include physician assistants, family nurse practitioners, respiratory therapists, and emergency medical technicians.

The use of paramedicals could help hold down rising health care costs through handling many routine diagnosis and treatment with personnel that are less expensive. Paramedical personnel can be trained more quickly and at less expense than physicians and they are more easily persuaded to serve in areas of greater medical need. The use of paramedicals also allows physicians and other more highly trained personnel to apply their unique skills and training to maximum advantage. Use of paramedicals could improve access to health services for patients living in areas where physicians are scarce, such as rural and inter-city urban areas. Increased use of paramedicals could also speed up the delivery of health services by reducing waiting time to get appointments and time spent in the waiting room by patients. Paramedicals are also more likely to have the extra time required to deliver more personalized care to the patients whom they treat.

Social and Economic Review of Major Health Care Providers Activities

Hospitals are in general heavily regulated. Federal, state and local governments take a hand in overseeing the activities of hospitals in both day- to-day operations and in future development plans. Their regulatory efforts include a variety of devices such as certificate of need review for adding new services and expanding old ones, review of charge rates, minimum staffing requirements, building / maintenance standards, operational procedures and so forth.

However, through changes related primarily to Certificate of Need Laws, federal and many state governments are now reducing their efforts to regulate services that hospitals can provide, the expansion of facilities, and the setting of rates. Free market competition largely determines these matters. Some States, for example, have raised the threshold amount of money involved in establishing a new service or building a new facility before a certificate of need review is required. Others have begun to phase out certificate of need review requirements for most activities. The prospective payment systems, competitive bidding for large blocks of "wholesale patients," and general competition among local hospitals are seen as a replacement for rate review by some observers.

## Establishment of a Publicly Owned Hospital Corporation

Some of the preceding recommendations may be difficult to implement effectively because they rely on private entities to meet public interest objectives. In order to help avoid the dilution that often ocurrs when public policy is implemented through non-government organizations, I propose the establishment of a publicly owned hospital corporation. This publicly controlled hospital corporation would be a multi-hospital health care conglomerate similar to the existing large scale multi-hospitals systems that are emerging in the hospital industry. The public hospital corporation would be a hybrid public/private organization, operating as a market competitor in health care but controlled by and assisted directly by government as is necessary to meet public interest and public policy objectives. The organization would be financed by both public and private sources, including the sale of stock to the public and direct funding by the Congress as is necessary.

The idea for a publicly owned hospital corporation is drawn from the idea put forth by Carnoy and Shearer in their book Economic Democracy. It is also based on my own observation that the power of having resources through which to act at an operational level is often more effective in filling policy voids than is imposing statutory regulations on private sector organizations. Carnoy and Shearer suggest that government sponsorship of competitive

public enterprises in key segments of the economy is a way of influencing the behavior of the private sector competitors.[2]

The public hospital corporation would serve as an industry leader in implementing new innovative ideas as well a providing health care services in areas where private sector providers are unwilling or unable to meet identified needs. In addition to providing health care services directly, it could provide an operational platform for launching and refining public policy initiatives. It could also provide a wealth of operational experience data on hospitals and other information on the health care industry that could be very valuable to public policy makers.

The public hospital corporation as envisioned here would own hospitals as well as provide management services for other hospitals on a contract basis. The hospitals that it controlled would need to include a cross section of hospitals, big and small, general care and tertiary care providers, and urban as well as rural. Most importantly, it would need to control some of the financially strongest hospitals that are well positioned in their markets. It could own and manage hospitals that are weak and struggling, but serving a vital interest in their communities. To be an effective force in the health care market however, it could not be composed primarily of weak and poor competitor hospitals. Although it would require a large amount

of start-up funding, the public hospital corporation would need to be able to sustain it self financially. The public hospital would seek direct government subsidies only for operations that are clearly in the public interest, locally or nationally, that are not able to finance themselves.

A major advantage of the public hospital corporation is that it could facilitate the implementation of many of the recommendations that were discussed earlier. The linking of service requests with other identified public needs would carry more weight if private hospital competitors felt that a public hospital corporation facility might be encouraged to enter a particular segment of the health care market. Public reporting of private hospitals could be compared with the experience data generated by public hospital corporation facilities to allow for a better assessment of what is being reported. The managerial expertise that could be generated by a public hospital corporation could be readily shared with hospitals that lack such expertise.

By developing a broad-based, competitively fit, multi-hospital health care provider organization, the public hospital corporation would be able to tap into capital markets just as private hospital corporations do to meet their capital financing needs. This would not be a total solution for meeting capital financing needs of deserving hospitals but it would help

hospitals that are brought into the public hospital corporation system. Public ownership of a large hospital system could help significantly in efforts to deploy new medical technology to hospitals that may not be able to obtain it on a timely basis. Public corporation hospitals could serve as demonstration projects for organizing and utilizing various paramedical personnel to increase health care delivery productivity.

The public hospital corporation envisioned here should not be looked upon as a nationalized hospital system as would be found under a system of socialized medicine. Rather, it would be an economically and politically viable health care provider organization that has the capability of intervening selectively to help alleviate problems that the free market approach to health care either creates or fails to resolve. The public hospital corporation would not replace the need for other types of governmental intervention and assistance for hospitals. But the public hospital corporation could be highly useful in efforts of public policy intervention in the field of health care. Being publicly controlled and with appropriate provisions for local community input, the public hospital corporation could restore ties to local communities that is now drifting away with private sector hospital corporations in many cases.

The discussion here follows along the lines of developing "a"

public hospital corporation. In reality, such an approach would probably be best implemented through several public hospital corporations which operate within logically defined geographic and economic regions. These regional units could be supported by a national umbrella public hospital corporation that served as an overall coordinator. A network of publicly controlled hospitals could help avoid some of the siphoning of profit from providing health care services and could have a significant impact on how health care dollars are invested. Such a network of publicly controlled hospitals could serve as a partial correction mechanism for some of the excesses of the free market system.

As hospitals have dramatically altered their perspective, organizational forms, and those organizations on which they depend to cope with an increasingly complex health care environment, the notion that hospitals are in the hands of "others" has promoted a sense of detatchement of the hospitals from the communities they serve. The establishment of a publicly controlled hospital corporation to operate hospitals could help many communities restore the sense of ownership in their hospitals.

## Conclusion

An up-to-date hospital is a major economic and social asset to

the community that it serves. The availability of quality, up-to-date health care, is an important overall contributor to the quality of life of a community. A good hospital can serve as a major asset in a community's efforts to recruit new businesses and industries. Lack of a good hospital can serve as a detriment to a community's appeal.

A hospital not only provides health care to the community, it is often a a significant employer of local people and significant purchaser of goods and services. Even relatively small hospitals (150 to 200 beds) often have annual operating budgets in the range of $20 million. Larger tertiary care hospitals in metropolitan areas often have annual operating budgets in the $250 million range. Few communities could afford to lose a hospital without suffering significant economic damage.

It appears that performance pressures on the health care system in general and hospitals particularly, will likely continue to increase in the future. Demands will be placed on health care providers to provide more and better services to a rapidly expanding elderly population and a general population that is becoming more health care conscious. At the same time, it is likely that greater efforts will be made to control health care costs by the major purchasers of health services. After a twenty to thirty year period of hospital expansion, fueled by relatively generous third party health insurers, the pendulum is

now swinging in the opposite direction. Today, resources are more limited relative to the demands and expectations being placed on hospitals today. Highly knowledgeable and skilled health care administrators and public policy makers will be needed to guide the nation's health care system, as there will be increasingly less room for errors.

Hospitals that entered the 1980s financially sound, have the benefits of good management, and are well located in terms of paying patients are likely to perform better in the emerging environment. It is the weaker, poorly situated, marginal hospitals that are suffering from less than adequate (past or present) management practices or heavy indigent patient loads that will be most adversely affected. Some hospitals are in a fragile state and are likely to be adversely affected by even relatively small fluctuations in the health care political economy. The large debt burden that many hospitals have or might have to incur to stay competitive will, in some cases, make even a one per cent decrease in payments from Medicare difficult to absorb, which is a likely possibility.

With the introduction of the prospective payment systems, the trend toward reduced federal and state regulation, and a greater reliance on competitive market forces, there is now, in effect, a defacto de-regulation of the hospital industry emerging. Hospital managers are faced simultaneously with greater

challenges and more opportunities than have existed in the past. The interviews conducted for this study indicate that most hospital administrators are moving quickly to seize the new opportunities. Their successes or failures might not be known until they are tested further by the growing competition in health care or by other factors such as a general down turn in the economy.

The emergence of the Business Model Hospital is a logical response to the new forces that are impacting hospitals today. This model has great potential for both positive and negative consequences for individual hospitals and the public interest. The adoption of a business perspective, business techniques and the increased reliance on private capital markets for financing are time honored elements of the American capitalistic system that are now being applied to the hospital industry. As hospitals have changed from charity institutions to capitalistic enterprises, public policy makers must make sure that it does not turn out to be a "no fault" capitalism, where the profits of providing health care services are kept privately while losses are to be paid for out of the public treasury.

The free market approach to health care treats all hospitals on an equal basis - as if they were equal. They, of course, are not. Public policy makers will have to deal with the dual reality that some hospitals are reaping huge profits while other hospitals

cannot afford to continue to provide basic services. As the weaker hospitals, large and small, find it difficult to adapt to the new political economy of health care, public policy makers must to decide when and how these hospitals should be helped and, in some cases, whether they should be helped at all.

The overall conclusion arrived at in this work is that the activities of hospitals and hospital systems should be continuously reviewed in terms of their broader social and economic impact on the communities that they serve as well as on their ability to provide high quality, cost effective health services. Hospitals that serve the vital interest of their communities should be treated as public trusts. As the complexity of the new health care environment grow, it will be the public policy makers that must take the lead as the guardians of this trust.

Public policy makers should address policy making for hospitals with an eye to the broader impact hospitals have on the communities they serve. Business model hospitals are rapidly reorganizing themselves in efforts to serve the demands of new "constituencies" outside the community, including hospital alliances, investment bankers, bond holders, and stockholders. The problems of de-institutionalization of hospitals, the increased potential for destabilization of hospitals and other negative aspects of business model hospital behavior will need

to be addressed on a broader social scale than that of business efficiency.

## Notes

1 The Wall Street Journal, January 29, 1989, p. 1

2 Carnoy, Martin and Derek Shearer, Economic Democracy: The Challenge of the 1980s (Armonk, N.Y., M. E. Sharpe, Inc. 1980) pp. 79-85

## Bibliography

Aaron, Henry J. and William B. Schwartz. The Painful Prescription: Rationing Hospital Care. Washington D.C.: The Brookings Institute, 1984.

American Hospital Association. Hospital Statistics, 1987. Chicago: American Hospital Association, 1987.

Berki, S. E.. "Health Care Policy: Lessons fom the Past and Issues of the Future." The Annals of the American Academy, (vol.468):231-247.

Blyth Eastman Paine Webber Health Care Funding, Inc. "Health Care Policy: The Crisis in Capital Formation."

Brown. J.H.U. The High Cost of Healing: Physicians and the Health Care System. Houston: Human Sciences, Inc., 1985.

Brown, Lawrence D. "Competiton and Health Care Policy: Experiance and Expectations." The Annals of the American Academy, (vol468): 49-59.

Carnoy, Martin and Derek Shearer. Economic Democracy: The Challenge of the 1980s. Armonk,N.Y.: M.E. Sharpe, Inc.,1980.

Chronicle of Higher Education, The, 6 February 1985, pp.20-22.

Coe, Rodney M. Sociology of Medicine. New York: McGraw-Hill Book Company, 1970.

Dowling, Harry F. City Hospitals: The Undercare of the Underprivileged. Cambridge: Harvard University Press, 1982.

Dyer, Thomas R. Models of Politics: Some Help in Thinking about Public Policy. Englewood Cliffs, N.J.: Prentice Hall, 1981.

Fisher, George Ross. The Hospital That Ate Chicago. Philadelphia: W.B. Saunders Company, 1980.

Freidson, Eliot., ed, The Hospital in Modern Society. London: Collier-Macmillan Limited, 1963.

Gray, Bradford H., ed. The New Health Care for Profit. Washington D.C.: National Academy Press, 1983.

Grimaldi, Paul L. Setting Rates For Hospital And Hospital And Nursing Home Care, Washington D.C.: Medical & Scientific Books, 1985.

Hoch, Lewis, J.,ed. "Should nonprofit hospitals consider corporate reorganization?" Topics in Health Care Financing (vol.11, no.1, Fall 1984)

Hoch, Lewis, J.,ed. "Alternative structures" Topics in Health Care Financing (vol.11,no.1,Fall 1984)

Hollingsworth, J. Rogers and Ellen Jane Hollingsworth. Controversy about American Hospitals. Washington D.C.: American Enterprise Institute for Public Policy Research, 1987.

Jaeger, B. Jon; Kaluzny, Arnold D. and Kathryn Magruder-Habib. "A new perspective on multiinstitutional systems management." Health Care Management vol.12 no.4, Fall 1987, pp.9-19

Johnson, Everett A. and Richard L. Johnson. Hospitals In Transition. Rockville, Md.: An Aspen Publication, 1982.

Lave, Judith R. and Lester B. Lave. The Hospital Construction Act: An Evaluation of the Hill-Burton Program, 1948-1973. Washington D.C.: American Enterprise Institute for Public Policy Research, 1974.

Lewis, Irving J. and Cecil G. Sheps. The Sick Citadel: The American Academic Medical Center and the Public Interest. Cambridge: Oelgeschlager, Gunn & Hain, Publishers, Inc., 1983.

Marmor, Theodore R. and Jon B. Christianson. Health Care Policy: A Political Economy Approach. Beverly Hills: Sage Publications, 1982.

McClure, Walter. "The Competition Strategy for Medical Care." The Annals of the American Academy, (vol.468) 31-47.

McKinlay, John B., ed. Issues in the Political Economy of Health Care. New York: Travistock Publications, 1984.

Meyer, Jack A., ed. Market Reforms in Health Care. Washington D.C.: American Enterprise Institute for Public Policy Research, 1983.

Porter, Michael E. Cases in Competitive Strategy. New York: The Free Press, 1983.

Ricardo-Campbell, Rita. The Economics And Politics Of Health. Chapel Hill: The University of North Carolina Press, 1982.

Rosner, David. A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1855-1915. Cambridge: Cambridge University Press, 1982.

Russell, Louise B. and Carol S. Burke. The Political Economy of Federal Health Programs in the United States: An Historical Review. Brookings General Series, 1978; reprint 341, Washington D.C.

Salkever, David S. and Thomas W. Bice. Hospital Certificate Of-Need Controls: Impact on Investment, Cost, and Use. Washington D.C.: American Enterprise Institute for Public Policy Research, 1979.

Snook, I. Donald, Jr. Hospitals: What They Are and How They Work. Philadelphia: An Aspen Publication, 1981.

Standard & Poor's Corporation. "S&P's Approach to Rating Hospital Revenue Bonds." December 1982.

The Bureau of National Affairs, Inc. Controlling Health Care Costs: Crisis In Employee Benefits. Washington D.C.: The Bureau of National Affairs, Inc., 1983.

U.S. Department of Commerce. Statistical Abstracts of the United States, 1987. Washington D.C.: Government Printing Office, 1987.

Vladeck, Bruce C. "Why Non-Profits Go Broke." The Public Interest No.42 Winter 1976:87-101.

Vogel, Morris J. The Invention of the Modern Hospital. Chicago: University of Chicago Press, 1980.

Vraciu, Robert A. "Hospital strategies for the eighties a mid-decade look." Health Care Management vol.10 no.4, Fall 1985, pp.9-19.

Zuckerman, Howard S. "Industrialization of a Cottage Industry: Multi-Institutional Hospital Systems The Annals of the American Academy, (vol468):217-230.

## Appendix

### Hospitals and Other Organizations Included in the Study

Beckley Appalachian Regional Hospital
Beckley, WV.
Non-profit; Hospital System
Licensed beds 221 (operating 100 to 120)

Beckley Hospital
Beckley, WV.
For-profit; Family owned
Licensed beds 126

Bluefield Community Hospital
Bluefield, WV.
Non-profit
Licensed beds 265

Boston City Hospital
Boston, MA.
Non-profit; City Owned Public Hospital
Licensed beds 393

Brighams and Womens Hospital
Boston, MA.
Non-profit; Teaching Hospital (Harvard Medical)
Licensed beds 713

Burbank Hospital
Fitchburg MA.
Non-profit
Licensed beds 226

Charleston Area Medical Center
Charleston, WV.
Non-profit; Hospital System
Licensed beds 934

Community Hospital of Roanoke Valley
Roanoke, VA.
Non-profit
Licensed beds 400
Staffed beds 280

Emerson Memorial Hospital
Concord, MA.
Non-profit
Licensed beds 221

Giles Memorial Hospital
Pearisburg, VA.
Non-Profit
Licensed beds 65

Humana Hospital-St. Lukes
Bluefield, WV.
For-profit; Owned by Humana Hospital Corp.
Licensed beds 79

Leominster Hospital
Leominster, MA.
Non-profit
Licensed beds 150

Lewis-Gale Hospital
Salem, VA.
For-profit; Owned by Hospital Corporation of America
Licensed beds 406

Massachusettes General Hospital Hospital
Boston, MA.
Non-profit
Licensed beds 1082

Montgomery County Hospital
Blacksburg, VA.
For-profit; Owned by Hospital Corp of America
Licensed beds 146

Mt. Aurbun Hospital
Cambrige, MA.
Non-profit; Teaching Hospital (Harvard Medical)
Licensed beds 305

New England Memorial Hospital
Stoneham, MA.
Non-profit; Owned by Seventh Day Adventist Church
Licensed beds 301

Newton - Wellesley Hospital
Newton MA.
Non-profit
Licensed beds 351

Princeton Community Hosptial
Princeton, WV.
Non-profit; Community/City Hospital
Licensed beds 215

Radford Community Hospital
Radford, VA.
Non-Profit
Licensed beds 175

Raleigh General Hospital
Beckley, WV.
For-profit; Owned by Hospital Corporation
Licensed beds 266

Roanoke Memorial Hospital
Roanoke, VA.
Non-profit; Hospital System
Licensed beds 675

St. Francis Hospital
Charleston, WV.
Non-profit;- Owned by the Catholic Church
Licensed beds 206

Summers County Hospital
Hinton, WV.
Non-profit; County owned but under HCA management contract
Licensed beds 95

Non-hospital affiliated interviewees:

Michael J. Doyle, Director of Development
National Medical Enterprises
For-profit Hospital Company

Mike Varadian, Director of U S Health Care Development
American Medical International
For-profit Hospital Company

David R. Kaloupek, Development Director
Hospital Corporation of America
For-profit Hospital Company

Bob DeVore
Nu Med
For-profit Hospital Company

John Quickly
American Hospital Association Represenative for the
Northeast Region

Grant Heggie, President
Mid-Atlantic Region of Volunteer Hospitals of America
National Hospital Alliance (Mid Atlantic Region, 5 states)

Pat Poston, Senior VP Legal Affairs
Sun Health Alliance
Regional Hospital Alliance (15 States)

Larry Brenkus, MD, Health Care Consultant
Arthur D. Little, Inc.

Andrew H. Nighswander, Health Care Consultant
Arthur D. Little, Inc.

The _4__ page vita has been removed from the scanned document

The vita has been removed from the scanned document

The vita has been removed from the scanned document

The vita has been removed from the scanned document