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The Effects of For-Profit Health Care Corporations on American Health Care

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The Effects of For-Profit Hospital Corporations on American Health Care

A Thesis

The Honors Program

College of St. Benedict/St. John's University

In Partial Fulfillment

of the Requirements for the Distinction "All College Honors"

and the Degree Bachelor of Arts

In the Departments of Economics and Political Science

by

Erik Leaver

April, 1997
Project Title: The Effects of For-Profit Hospital Corporations on American Health Care

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The medical system may not be doing too well at fighting disease, but as any broker will testify, it's one of the healthiest businesses around.

--Barbara and John Ehrenreich in *The American Health Empire* (Lindorff 1).

Investor-owned corporations are having an increasing influence on America's healthcare system. This is the topic of heated debate among many drastically dissenting interests. Many people dislike the idea that corporations are allowed to profit from the bad health of American citizens. They feel that healthcare is too sacred to be exploited by greedy, money-hungry entrepreneurs. However, many other people feel that for-profit health corporations will be able to provide better, lower cost care to consumers.

When I began this paper, I was intrigued by the idea that so much money was being made in the health care industry. Medical costs seemed to be soaring out of control, and I wanted to find out what key factors were causing this to happen. I immediately had the suspicion that for-profit corporations were to blame. It seemed obvious that non-profit firms would always act in the best interests of the consumer, and that for-profit firms would only act in the interests of financial gain. I was prepared to attack the for-profit sector for intruding on a market that they had no business operating in.

My original thesis was that the ethical responsibilities of hospitals to care for the sick would be compromised by the profit motives of for-profit health care corporations. However, my research has brought me to some new discoveries
regarding the role of different forms of hospital ownership. I have found that for-profit hospital corporations have been a very positive force in the drive to keep health care costs under control. In this paper, I will show that consumers will benefit from the increased competition brought about by for-profit hospital corporations, as long as the government regulates this competition properly.

In order to provide a foundation for my arguments, I must begin with some background on the current state and the history of American healthcare.

**Current State of American Health Care**

Health care in America has been described by many as overpriced, inefficient, and inequitable. Total health care expenditures as a percentage of GDP have doubled in the past twenty years, and currently account for 14% of America's GDP. In comparison to other industrialized countries, health care expenditures as a percentage of GDP in Canada, Germany, Japan, and the United Kingdom all lie within the 6% to 9% range (Andrews 15). The average annual dollars spent per person on health care in the United States is $2868. Canada is a distant second, spending about $1915 per person, and all other industrialized countries spend even less (Marmor 3). The graph on the next page illustrates the average annual health care expenditures per person in the United States and eight other industrialized countries.
Although America spends far more than any other country on health care, our country lags behind many other developed countries in terms of overall health. Infant mortality in the United States not only lags behind some of the poorer European countries, but also some third world countries like Singapore and Hong Kong. In fact, the infant mortality rates in some of America’s urban ghettos are comparable to those in Bangladesh (Lindorff 2). Healthcare author Charles Andrews writes:

... new technology alone has not and cannot achieve good health care, especially economical, high quality care for large numbers of patients... the U.S. population as a whole ranks below most developed nations in measures of health. Infant mortality is higher than in twenty other countries. A man in the United States can expect to live a year less than a man in the United Kingdom (Andrews 26).
Sixty percent of Americans feel that fundamental changes are needed in America's health care system, and twenty-nine percent feel that the entire system should be rebuilt (Patel 26). These statistics indicate that a large number of Americans are unhappy with the way health care is being delivered in America today.

So what exactly is America's health care "system?" The fact is that America does not have one coherent system. The face of health care is changing very rapidly with increased competition, cost containment, and a myriad of payment methods. Americans receive their health care from a variety of different providers, and they pay for these services in a variety of different ways. Health care providers include hospitals, nursing homes, doctors, clinics, nurses, and pharmacists. Health care payers include private insurance companies; federal, state, and local governments; Health Maintenance Organizations; and individual patients. Professors Kant Patel and Mark E. Rushefsky describe America's health system best when they write: "... health care policy in the United States is in a constant state of fluidity, lacks consistency, and often encompasses a mishmash of programs involving conflicting values (Patel 2)." The factors that contribute to American health care policy are also very diverse. These factors include "constitutional or legal requirements, institutional settings, shared understandings about the rules of the game, cultural values of society, political ideology, economic resources, and technical innovations (Patel 2)." America's health care "system" could be described as fragmented at best.
The U.S. government does not have a system of universal health care coverage for all Americans. In fact, the United States and South Africa are the only industrialized countries who do not have some form of a national health care system (Patel 105). The government does provide comprehensive health insurance for the very poor (under Medicaid) and the elderly (under Medicare). The majority of insured Americans receive coverage through their employers as a fringe benefit. In reality, this employer-provided insurance is subsidized by the government because it is a tax-free, non-wage benefit. Although the majority of Americans have some sort of health insurance, almost 40 million Americans—17% of all working people—have no form of health insurance (Weissman 824).

Most traditional health insurance plans (both public and private) are “third party payers.” This means that they pay for all or part of the medical expenses of the patients that they insure. Traditionally, insurance companies have reimbursed health care providers on a fee-for-service basis. In this relationship, patients (the first party) have incentives to over-consume because they do not directly bear the costs of health care services. They would be more likely to opt for expensive tests “just to be safe.” In addition, because the third party payer reimburses them for each additional service, caregivers have incentives to maximize the amount of health services that they provide (Marmor 268). One alternative to this type of system would be one in which patients paid their medical bills directly out of their
own pockets. Because of the extremely high costs of many medical procedures, it is very difficult for patients to pay for their bills in this way.

Another type of payment, called capitation, departs from the traditional fee-for-service method. Under a system of capitation, the hospital or doctor is paid a fixed amount per patient per year regardless of how many services the patient receives. Thus, providers have incentives to minimize the number of services that they provide. This type of payment has become increasingly popular in Health Maintenance Organizations (HMO’s) during the past twenty years. Many corporations have flocked to HMO’s in an effort to prevent the costs of their health care plans from spiraling out of control. A common title for health plans that utilize capitation is “managed care.” Although it will not be covered in this paper, capitation systems are a very important component in the rapidly changing health care environment (Marmor 257).

One general trend in the health care industry is a move towards larger conglomerations of hospitals in the form of health networks. Hospitals that stand alone are becoming increasingly scarce. In a managed care environment, HMO’s have a great deal of control over where patients will be treated, and large hospital groups have a significant advantage in negotiating contracts with them. In addition, large hospitals networks are able to utilize economies of scale to get better prices on hospital supplies and building contracts. As I will discuss later in this paper, competition in health care is becoming fierce, and both non-profit and
for-profit hospitals are finding strength in numbers by merging into hospital networks.

Now that some of the foundations of American health care have been laid, the remainder of this paper will concentrate on the provision of health care in hospitals. More specifically, it will analyze the impact of the increased influenced of investor-owned hospitals on American health care. Because hospitals are the location for the majority of high technology medical equipment, hospitals have become the primary setting for the delivery of health care services in the United States (Patel 17). In a $1 trillion industry, hospitals receive 40 cents of every health care dollar (Lutz 1). Currently, America has approximately 7000 hospitals made up of three ownership types: proprietary, private nonprofit, and government. In order to understand the influence of investor owned hospitals, it is important to understand the differences between each of these ownership types.

Hospital Ownership Types

For-profit hospitals are similar in structure to most other private corporations. This means that they are typically owned by shareholders, and managed by a board of directors that is elected by these shareholders. They must pay corporate income tax, property taxes, sales taxes, and other taxes that vary from state to state. For-profit hospitals raise capital through the sale of equity (stock) and the issuance of debt. In addition, any net earnings can be either reinvested in the corporation or distributed to the shareholders in the form of
dividends (Marmor, Schlesinger 223). The terms 'for-profit' and 'proprietary' will be used synonymously throughout this paper.

The second type of ownership type is the private non-profit hospital. The term 'non-profit' is somewhat misleading because most non-profit institutions do actually make profits. In fact, most non-profit hospitals must make profits in order to survive. What separates non-profits from proprietary institutions is the non-distribution constraint on profits. This constraint states that non-profits may accumulate net earnings, but all of these net earnings must be reinvested back into the corporation. They are unable to pay out any dividends to individuals, and they may not issue stock. They typically raise capital through donations or the issuance of debt. Non-profit corporations are managed by a board of directors that can be appointed within the organization, by the community, or by donors.

Private non-profits are exempt from paying most corporate income taxes, property taxes, and sales taxes. In exchange for these tax breaks, non-profit institutions are required to fulfill community needs. As I will discuss later, "community needs" are not clearly defined. Almost all non-profit hospitals are classified as charities under section 501(c)(3) of the federal tax law. This means that any person who donates money to a non-profit hospital can deduct this amount from their taxable income. Although they are technically classified as charities, almost all non-profit hospitals are commercial non-profits. This means that they
generate most of their revenue through fees that they charge for their goods and services—not from private donations.

Government operated hospitals are the third ownership type. Cities, counties, states, and the federal government operate various hospitals and health facilities around the country. The primary funding source for these institutions is taxes, and they are managed under the control of their respective level of government. As with private non-profits, government operated hospitals also have non-profit status and are exempt from most taxes. Government operated hospitals are often found in poor communities where the need for health services are great, but the ability to pay is minimal. They serve a disproportionate amount of Medicare, Medicaid, and uninsured patients compared to either private non-profit or for-profit hospitals (Marmor, Schlesinger 223-224).

**Economic Reasons for the Existence of Non-Profit Hospitals**

Non-profit hospitals represent the majority of all hospitals in America today. Why is it that non-profit hospitals have thrived? There are two key theories that help explain the existence of private non-profit firms: The public goods theory, and the theory of contract failure. These theories help describe the existence on non-profit hospitals in some respects, but fall short in others.

The public goods theory suggests that non-profit firms serve as private producers of public goods. Public goods have two main characteristics. First, the good must be non-excludable: Once the good has been provided no one can be
excluded from enjoying the good. Second, the good must be non-rival: One person can enjoy the good without detracting from any other person’s enjoyment of it. Two goods that satisfy both these characteristics are national defense and air pollution control. The theory of public goods states that the government will provide the level of a certain public good that satisfies the demand of the median voter. However, some citizens will demand more of this public good than the median voter. Non-profit organizations arise to meet this additional demand for the public good (Hansmann 29).

The theory of public goods does not seem to adequately explain the need for health care services being provided by the non-profit sector. Although some medical goods and services are public goods to a certain degree (immunizations, health hotlines, public health education, and medical research), the majority of medical services represent private goods. Heart surgeries, standard physicals, and knee surgeries all represent private goods. Only a very small percentage of the goods and services that hospitals provide are public goods.

The second key theory of non-profit institutions, contract failure, definitely gives much stronger support to the existence of non-profit hospitals. Contract failure exists in markets for goods in which there is an asymmetry of information between the consumer and the provider. This means that buyers of the good are relatively ill-informed on how to judge the quality of the good that they are consuming. In these situations, consumers are at risk of exploitation by producers
charging unfair prices for low quality goods. Henry Hansmann elaborates on the theory of contract failures

... owing either to the circumstances under which a service is purchased or consumed or to the nature of the service itself, consumers feel unable to evaluate accurately the quantity or quality of the service a firm produces for them. In such circumstances, a for-profit firm has both the incentive and the opportunity to take advantage of customers by providing less service to them than was promised and paid for (Hansmann 29).

According to the theory of contract failure non-profit firms have relatively little incentive to take advantage of this asymmetry of information, because of the non-distribution constraint. Because of this, consumers put more trust in non-profit institutions when they are faced with an asymmetry of information.

The theory of contract failure is a viable explanation for health care services being provided by the non-profit sector. Most people know very little about how much a brain surgery or a bone marrow transplant ought to cost. In addition, these types of services are often needed in emergency situations where the patient does not have time to shop around to find the best price. Finally, many types of health care services are provided on a continuing long term basis, and the costs associated with switching to a different hospital or doctor might be significant enough to keep the patient “locked in” to a disadvantageous relationship (Hansmann 30).

According to Hansmann, the presence of both non-profit and proprietary hospitals may be due to the fact that certain people are better able to judge the quality of medical services than others. Those who are reasonably confident in their abilities to judge the quality of care would be more apt to patronize for-profit
hospitals, and those who are less confident will seek care from non-profit hospitals (Hansmann 31).

At first glance, the theory of contract failure seems to support the existence of non-profit hospitals. However, under further scrutiny the theory of contract failure may be inadequate to justify non-profit hospitals. Hansmann sites that physicians, not hospitals, provide the patient care that is the most sensitive and difficult to evaluate. Hansmann states:

The hospital itself is largely confined to providing relatively simple services such as room and board, nursing care, and medicines. Second, the patient herself does not order the hospital services she receives; rather, they are ordered and monitored for her by a skilled and knowledgeable purchasing agent, namely, her physician. Consequently, it is not at all obvious that the nondistribution constraint offers the hospital patient any special protection that she would clearly be lacking without it (Hansmann 31).

In addition, the salaries of administrators in non-profit hospitals are often commensurate with the size and the prestige of the institution. This could cause even non-profit administrators to act in their own self-interests.

Hansmann blames the historical lag of the contract theory on the prevalence of non-profit hospitals today. When hospitals first began, they provided a substantial amount of charity care and relied on donations to survive. Because of the non-distribution constraint, people who donated to non-profit hospitals could be relatively certain that their donation would go towards the provision of care. However, today non-profit hospitals are almost entirely commercial institutions,
they receive little income from donations, and they provide relatively little charity care. He argues:

The predominance of nonprofit firms may simply be the consequence of institutional lag and of the various subsidies and exemptions that continue to be available to nonprofit but not for-profit hospitals (Hansmann 31).

The justification for tax exemption in commercial non-profit hospitals will be discussed later in this paper. Historical evidence can explain how non-profit hospitals became the dominant ownership in the hospital industry.

**The History of Hospitals in American Health Care**

During the nineteenth century, American medicine was in its infancy stages. Almost all hospitals were set up by philanthropic or religious organizations to provide care for the very poor. These hospitals were almost entirely set up as non-profits, funded by private donations and government subsidies. For the more affluent, doctors would make private house visits to provide care. Therefore, hospitals were not the primary care setting for most Americans at this time.

This began to change near the end of the nineteenth and beginning of the twentieth century. During this period, the increasing complexity of medical knowledge and the growth in medical technology made hospitals the principle location for medical care in America. For-profit hospitals were typically operated by a small group of physicians who catered to the wealthy. The non-profit hospitals continued to rely on philanthropic support, but also began to rely on patient fees for revenue. As advances in medical technology continued throughout
the beginning of the twentieth century, increasingly larger hospitals were needed so physicians could pool the costs of expensive equipment and resources. In these early hospitals, the physicians were the dominant decision makers.

During this first half of the twentieth century, non-profit hospitals established themselves as the dominant ownership type. This can be attributed to a number of factors. First, non-profit hospitals had a greater access to capital due to their religious and philanthropic support. In addition, the majority of doctors embraced non-profit hospitals because they were able to exhibit a great deal of authority in how the institutions were run. By supporting non-profit hospitals physicians were able to reduce the threat of corporate control. These two main factors led to the proliferation of non-profit hospitals. In addition, health care at this time was not that lucrative because health insurance had not yet been developed and patient fees were paid directly out-of-pocket. Proprietary hospitals were generally able to survive only if they served the very rich or if they were located in areas with a weak philanthropic tradition (i.e. many of the Western states). Supplying health care to the majority of Americans had not become a profitable business—yet.

During the early 1930's, Blue Cross developed the first health insurance plan. This was followed shortly after by Blue Shield. These were non-profit insurance plans that offered health coverage to entire communities of people. This was the first step in the departure from the out-of-pocket system of payment. It
was the beginning of widespread third party payment system that we see today. An attractive feature of the early Blue Cross/Blue Shield plans was that they charged the same premiums to all people within a community--known as "community rating." By doing this, the over-all risk of an individual medical emergency was pooled over a large population. Since they did not discriminate in price, the old and the poor (whose average medical expenses are statistically higher) were subsidized. This was very desirable from a public policy standpoint.

The emergence of Blue Cross and Blue Shield solidified the position of non-profit hospitals in health care. The Blues favored non-profit hospitals by negotiating lower reimbursement rates for proprietary hospitals. By 1946, for-profit hospitals composed less than 10% of the hospital market. Physicians continued to be the dominant decision-makers in the non-profit hospitals. Due to wage freezes during WWII and the Korean War, many unions began pushing for more non-wage benefits. Health insurance became one of the most popular components in these non-wage benefit packages. As a result, the enrollment in private insurance plans rose from 13 million in 1940 to over 100 million in 1955 (Marmor, *Nonprofit* 227). The government subsidized this type of system by making employer-provided health packages tax-free. In addition to Blue Cross/Blue Shield, proprietary health insurance companies expanded rapidly after WWII. Unlike the Blues, the proprietary insurance companies practiced price discrimination on the basis of medical risks among certain groups. This put
competitive pressures on Blue Cross and Blue Shield to the point where they were forced to abandon their practice of community rating—effectively ending the subsidization of the poor and elderly under private insurance.

During the period between 1950 and 1975, several government programs were introduced that intended to increase access to medical care: Hill-Burton, Medicare, and Medicaid. The Hill-Burton program was specifically designed to promote non-profit and public hospitals. It gave them access to federal funds for the purpose of building or upgrading non-profit medical facilities. This program subsidized one third of all hospital construction projects between 1947 and 1972 (Marmor, Nonprofit 226).

Although Hill Burton was intended to promote non-profit hospitals, its subsequent promotion of public hospitals in some ways reduced the power of non-profit hospitals. As the number of government-operated hospitals grew, non-profits began shifting the responsibility of indigent care to the public hospitals. Thus, the need for people to offer charitable contributions to non-profit hospitals was reduced. This signified a shift in the perception that government should be responsible for providing care for those who were unable to pay for health care. Because they were seen as more commercial rather than charitable institutions, private non-profits became less distinguishable from their for-profit counterparts (Marmor, Nonprofit 224-229).
In 1965, the government insurance programs Medicare and Medicaid were created under President Johnson. Medicare sought to guarantee health insurance coverage for elderly Americans over the age of 65. This group typically had a very strong need for health care, but an inability to afford insurance. Medicaid was developed to expand coverage for very poor Americans who fell below the poverty line. The two programs were enacted at similar times, but are actually quite different. Under Medicaid, much more power is delegated to the states to decide on eligibility and benefit standards. Medicare, on the other hand is almost completely administered and financed by the federal government. National health insurance had been at the forefront of public debate in the 1960’s, and these two programs were somewhat of a compromise between those who supported a universal health plan and those who wanted the government to play only a limited role in the financing of health care (Patel 52).

The Medicaid and Medicare programs made it possible for millions of elderly and poor Americans to receive health care. They also pumped billions of tax-payer dollars into the medical industry. In 1993, the government paid out over $263 billion in benefits under these two programs combined (Patel 38).

The Rise of For-Profit Hospitals

The implementation of Medicaid and Medicare planted the seeds for rapid growth in for-profit hospitals. These public health care programs as well as the rapid increase in private insurance greatly expanded the number of Americans who
could pay for health care services. Because more people were able to obtain health care, the demand for hospitals and health services increased dramatically. Since billions of dollars were available in the health care industry, for-profit firms set up shop to get a piece of the action and reap the rewards. Industry analyst Luanne Kennedy describes how these government programs encouraged the rise in proprietary hospitals in their attempt to extend access to more Americans:

In a sense we set up these companies. People on the left, like myself and liberals and others, kept pushing to ‘mainstream’ people, to get them into the health care system, and with the reimbursement system that was created, we encouraged higher [health care] costs (Lindorff 34).

Theodore Marmor states: "Third-party financing, in short, transformed medicine into a virtual gold-mine for commercial non-profit as well as for-profit enterprise (Marmor, Schlesinger 227)."

Basic economic theory of supply and demand can illustrate the effect that Medicaid, Medicare, and private insurance had on the price and quantity of health care services produced. The following supply/demand diagram demonstrates that increases in both private and public insurance programs shifted the demand for generic units of health care from D1 to D2. Because of this, both the equilibrium quantity of units of health care and the equilibrium price of these units increased.
Empirical evidence demonstrates that government financed health care programs and subsidies have induced proprietary agencies to enter the market for health care. The chart on the following page shows five increases in government funded medical coverage, and the effect on the market share of various types of proprietary health care institutions. Notice that each of these five government expenditure programs were followed by an increase in the market share of for-profit institutions within 3-5 years.
<table>
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<tr>
<th>Public Subsidies and the Growth of For-Profit Health Care</th>
<th>Market Share of Proprietary Agencies</th>
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<tr>
<td><strong>Type of facility</strong></td>
<td><strong>Change in Coverage</strong></td>
</tr>
<tr>
<td>Acute hospitals</td>
<td>Medicare enacted 1965</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>Medicaid enacted 1965</td>
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<tr>
<td>Dialysis centers</td>
<td>Medicare covered 1972</td>
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<tr>
<td>Home health agencies</td>
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<tr>
<td>Psychiatric hospitals</td>
<td>States mandate private insurance coverage</td>
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<tr>
<td>Residences for mentally impaired</td>
<td>Title XX enacted 1974</td>
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</tbody>
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Source: (Marmor, *Nonprofit 227*)

After the boom days of prosperity during the 1960's and 1970's, hospitals began to face tougher times in the mid-1980's. Both public and private payers realized that they needed to constrain exploding health care costs. In particular, major changes were implemented in the Medicare reimbursement system. Before the mid-1980's, the government reimbursed hospitals for covering Medicare patients based on a cost-plus pricing approach. Thus, hospitals were virtually guaranteed profits when they treated Medicare patients, because their reimbursement would always be a certain percentage above their costs. In addition to guaranteeing profits, this system did not encourage hospitals to control their costs. Sandy Lutz, writer for Modern Healthcare magazine, described these early stages of Medicare best when she writes:

Essentially, the federal government gave hospitals a blank check: Just add up your costs, fill in the blank and Uncle Sam will reimburse you. The more you spend, the more you get paid (Lutz 9).
This liberal system of Medicare reimbursement ended in 1983 with the introduction of Diagnosis Related Groups (DRG's). DRG's formed a payment system in which hospitals were paid a certain fixed amount of money based on a Medicare patient's diagnosis. The profitable days of cost-plus reimbursement were over. This change in the Medicare reimbursement system forced all types of hospitals to retool themselves in order to survive. In addition, increased enrollments in private HMO's based on capitation further forced hospitals to be able to contain costs.

A second surge in for-profit hospitals began near the end of the 1980's, as for-profit hospitals began to adjust to the changes in the Medicare system. No longer could inefficient hospitals survive under less generous public and private reimbursement systems. In this period, for-profits began to expand largely because they were able to adapt more quickly to the rapidly changing health care environment. The difference in the recent resurgence of for-profits is that the main source of growth has not come through building new hospitals, but rather by taking over or merging with existing non-profit hospitals (Patel 43-44).

This surge in for-profit hospitals is currently gaining momentum all across the country. Wall Street investors have realized that many struggling community hospitals are lucrative investment targets that can be restored to profitability through improved management and cost containment. As a for-profit institution, a hospital's goals are transformed to include profit maximization and accountability.
to the corporation's shareholders. During the four-year period from 1992 to 1996, the number of publicly traded health care corporations jumped by over 430% from 33 to 144. In addition, the market capitalization for publicly traded health care corporations went from $36 billion in 1992 to $140 billion today (Wagner 3).

![Graph showing the number of publicly traded health companies and their market capitalization from 1992 to 1996.](image)

Source: (Wagner 3)

The leader in the for-profit revolution in health care is the Columbia/HCA Healthcare Corporation, based in Nashville, Tennessee. In 1995, this company owned 332 hospitals, controlled 7% of all hospital beds, and netted nearly $1 billion in profits. With 240,000 employees, it is America's tenth largest employer. To demonstrate how much it has grown in the past seven years, in 1988 it only controlled four hospitals and its net profits did not even reach $2 million (Kuttner 362). Forbes magazine refers to Columbia/HCA as "a young corporate
phenomenon with a market value rivaling Eastman Kodak and Dow Chemical (Berman 52)."

Columbia/HCA is steadily buying up more and more non-profit hospitals, and other for-profit corporations, such as the Tenet Corporation and OrNda, are following suit. The revenue growth of these three corporations has been impressive over the past three years. Columbia’s revenue in 1996 was nearly $30 billion, Tenet’s was over $10 billion, and OrNda was almost $8 billion (Wagner 11). The following graph depicts the rapid revenue growth of these three companies in the past few years.

![Revenue Growth Graph (1991-1996)](image)

Source: (Wagner 11)
The hospitals that Columbia/HCA acquires are often struggling survive financially on their own. The concept of restoring ailing community hospitals to profitability not only seems acceptable, but even desirable. In addition, supporters of for-profit hospitals argue that they are more efficient, and will keep the enormous costs of health care under control. Columbia/HCA has demonstrated that it is able to develop successful cost-cutting measures to achieve profitability within its hospitals. The typical hospital operating margin (profits before interest, taxes, depreciation and amortization divided by sales) is barely positive, while Columbia's is around twenty percent (Berman 53). As an industry, the operating profit margin of for-profit hospitals is fifteen percent, while the hospital average is only 3.2 percent (Wagner 12).

Overall, proprietary hospitals have gained considerable market share over the past twenty years. In 1978, there were only 445 investor-owned hospitals. This number had jumped to 955 by 1984, and all the way to 1382 by 1991. This represented 25% of all non-federally owned U.S. hospitals (Lindorff 49). Over this same period, the total number of hospitals in America remained almost constant (Gray 15). The following graph illustrates the rapid increase in corporate owned hospitals.
Implications of For-Profit Ownership

What does this rapid rise in for-profit hospitals mean to us as patients, consumers, and policy makers? Should we be alarmed by the rapid growth of a company like Columbia/HCA? Is it bad for investors to make money off of the health care needs of Americans? In order to answer these questions, we need to examine the differences that separate non-profit and for-profit hospitals. We need to know what advantages and disadvantages each type of institution brings to health care in the areas of cost, quality, and access.

To a large extent, the differences between non-profit and proprietary hospitals have been diminished by the increasingly commercial nature of the health care market. The days when people made widespread donations to non-profit
hospitals are gone, and almost all hospitals (both non-profit and proprietary) receive the majority of their revenues through patient fees. Both non-profit and for-profit hospitals compete in the same markets, and they provide many of the same goods and services. The differences between ownership types are becoming very difficult to recognize. According to Theodore R. Marmor:

Increased competition and lessened professional autonomy have reduced or eliminated some of the goals and practices that once distinguished nonprofit and for-profit providers of health care. Nonprofit institutions increasingly mirror the institutional structure of their investor-owned competitors (Marmor 62).

Even hospitals with religious roots are competing vigorously in the marketplace. New York Times journalist Rhonda L. Rundle describes how competition has affected the nuns of Catholic hospitals when she writes:

With their charitable traditions, Catholic hospitals, which account for about one in six hospital admissions in the country, are often viewed as more caring than investor-owned chains. But as Catholic Healthcare West operations show, Catholic nuns can be just as aggressive as their for-profit rivals when fighting to gain market share. Like their rivals, Catholic hospitals realize that growth may be a matter of survival (Rundle 1).

Many people associate non-profit hospitals with being giving, charitable institutions. They believe that the behaviors of non-profit hospitals are absolutely distinct from the money-hungry for-profits. As I have said, the distinction between the two types of ownership are becoming less and less clear. Doctor Robert H. Harris argues that non-profit hospitals are not the sacred, charitable institutions that many people perceive them to be. He writes:
... where I have been practicing medicine in exclusively not-for-profit hospitals for nearly 30 years, I have yet to see the idealistic attitudes and behavior they describe in their not-for-profit world. The hospitals, regardless of what they or anyone else says, are all busily preoccupied with the problems of survival in a competitive world, and the pennies are pinched and the bottom line is defended just as aggressively as in for-profit hospitals (Harris 438).

On the other side of the coin, a certain degree of differences do exist between the two ownership types. Many non-profit hospitals have missions that focus on fulfilling community needs, and providing charitable care. According to Joel Weissman writer for the Journal of the American Medical Association:

Not-for-profit hospitals provide more uncompensated care in underserved areas where the need is greatest; they tend to provide more varied services, including some that are not profitable, and they are more committed to public goods such as research and education than for-profit institutions (Weissman 825)."

A for-profit hospital, on the other hand, has profit maximization at the core of its mission. Weissman states, "For-profit hospitals are much more likely to have policies that discourage admission of uninsured or Medicaid patients (Weissman 825)." Evidence supports the fact that proprietary hospitals are more likely to screen patients based on their ability to pay. In a survey of physicians, proprietary hospitals were found to be twice as likely to adopt policies that discourage admissions of uninsured or Medicaid patients compared to nonprofit hospitals (Marmor 70).
The Provision of Uncompensated Care and Community Benefits

Will for-profit hospitals provide adequate levels of community benefit programs and care for those who are unable to pay? This is a very legitimate concern. Many people would argue that the community and charitable goals associated with non-profit hospitals might become clouded when they become for-profit entities. The business strategy of a for-profit hospital might include such things as getting rid of unprofitable services and unprofitable patients. A treatment might not be evaluated by how many lives it saved, but by how much money it would make. Also, patients with no health insurance might be seen as costly expenses that should be avoided. Charles M. Ewell writes:

The not-for-profits ask, "What is best for the community?" followed by, "What are the financial requirements?" The for-profits, by necessity, must ask those key questions in reverse. This key difference can never be resolved. Of course, from time to time, what is best for the stockholders may also be best for the community, but the corporation will never commit financial suicide by turning its back to the stockholders. Wall Street must be served (Ewell 82).

America currently has 40 million people who do not have any health insurance. In the past, many hospitals have given away free or uncompensated care to uninsured, indigent patients--especially in cases of medical emergency. In fact, it is against the law to turn away a patient in an emergency situation such as a heart attack or a stroke. The mission statements of many non-profit hospitals explicitly state that they will care for members of the community regardless of their abilities to pay. However, in today's more competitive health care
environment, it is becoming increasingly difficult for even non-profit hospitals to provide uncompensated care. Until our government adopts a health care reform plan that guarantees universal coverage, uncompensated care will be relied upon to provide for those who are unable to pay.

Uncompensated Care is composed of two elements: free care, and bad debts. Together they account for approximately 6% of hospital costs. Free care alone accounts for about 1% to 1.5% of total costs. Uncompensated care is provided by both non-profit and for-profit hospitals. However, greater amounts are provided by the non-profit sector. More than one half of total uncompensated care comes from private non-profit hospitals (58.3%) as opposed to 7.8% in for-profits. The remaining 32.9% of uncompensated care is provided by large urban public hospitals. These hospitals serve a disproportionately large percentage of uninsured patients relative to their overall market share (Weissman 825). The following graph illustrates the percentage of uncompensated care that each hospital ownership type provides.
Uncompensated care can also be measured as a percentage of operating costs minus government subsidies. In 1993, for-profit hospitals provided uncompensated care at a rate of approximately 3.5% of their operating costs. Non-profits, on the other hand, provided uncompensated care at a rate of 4.5% of operating costs (Weisman 824). As suspected, these statistics show that for-profits provide lower levels of uncompensated care than private non-profits. However the difference is not nearly as great as some people might tend to believe. In addition, government operated hospitals provide a significantly higher percentage of uncompensated care than either private non-profit or proprietary hospitals. They provided a uncompensated care at a whopping 7.3% of operating costs. The
following graph shows levels of uncompensated care as a percentage of costs (net of government subsidies) among the three hospital ownership types since 1981.

The provision of uncompensated care became a requirement for many non-profit hospitals who obtained funds under the Hill-Burton Act of 1946. The Hill Burton program provided federal funds for construction and renovation of public and non-profit hospitals (Musser 14). This act required that hospitals receiving federal funds must provide a certain level of uncompensated care for 20 years. This level was set to be the lesser of 3% of annual operating costs or 10% of total
federal assistance received. The twenty-year period has expired, or will expire soon for most hospitals in America. In 1980, 4000 hospitals were still subject; today there are only 900; and in 2005 there will be less than 200. The critical question is whether or not hospitals will continue to administer similar levels of uncompensated care after they are no longer obligated under the Hill-Burton Act (Weissman 824).

Among non-profit hospitals in the state of Wisconsin, Hill-Burton obligations have appeared to be an important stimulus in the provision of uncompensated care. In 1990, there were forty-one Wisconsin hospitals who were subject to Hill Burton Obligations. By 1995, this number had dropped to seventeen. Of the hospitals who were no longer obligated to give a certain amount of uncompensated under the Hill Burton program, approximately two-thirds of them reduced their levels of uncompensated care (Klausner 31-33, Musser 21-26). This shows that non-profit hospitals indicates that non-profit hospitals are less inclined to provide uncompensated care when they are not required to do so. In addition, it shows that government legislation can be used to increase levels of uncompensated care.

Under federal tax revenue codes, the qualifications for what determines a hospital's tax-exempt status has changed over the past fifty years. Between 1956 and 1969, a non-profit hospital was required to provide care for "those not able to pay for the services rendered" in order to be considered a charitable institution.
However, after the implementation of Medicare and Medicaid this charitable requirement was relaxed. In 1969, the IRS determined that the "promotion of health" was enough to qualify for tax-exempt status. They established the "community benefit standard" which stated that non-profit hospitals would qualify for tax exemption if they: 1) Operated an emergency room; 2) Accepted publicly insured patients; and 3) Did not distribute net earnings. Ironically, non-profit hospitals were no longer required to meet any sort of charitable standard to be classified as charities (Buchmueller 462).

Beginning in the late 1980's many legislators and policy analysts began to question the legitimacy of the "community benefit standard." Over thirty states have re-evaluated the tax-exemption requirements placed on private non-profit hospitals. For example, in 1994 the state of California enacted legislation that required non-profit hospitals to work with community leaders to conduct a community needs assessment. Each hospital is required to use the results of their needs assessment to devise a "community benefits plan," which must be submitted to the state and made available to the public.

The community benefit requirements developed in the state of Texas go one step further. Legislation passed in 1993 required Texas non-profit hospitals to conduct a community needs assessment similar to that in California. In addition, the legislation created a set of four other criteria for measuring community benefits. Of the following four criteria, non-profit hospitals were required to meet
at least one of them. The first criteria stated that the value of total uncompensated care (which includes charitable care plus unreimbursed costs of providing care for publicly insured patients) must be “commensurate” with the level of unmet need in the community as determined by the community needs assessment. The second criteria stated that uncompensated care must equal at least four percent of net patient revenues. According to the third criteria, uncompensated care must equal 100 percent of tax-exempt benefits, excluding federal taxes. The fourth criteria stated that the amount of uncompensated care plus other community benefit programs must be at least 5 percent of net patient revenue (Buchmueller 463).

Hospitals provide many other types of services that benefit the community such as health education, health screening and immunizations, free or subsidized outpatient clinics, and the education of health professionals. By some estimates, hospitals spend approximately three times as much on these programs as on uncompensated care. Taking these community benefits into account makes a big difference in determining whether hospitals should qualify for tax-exempt status. According to University of California Irvine Professors Thomas C. Buchmueller and Paul J. Feldstein:

... if tax exemption were linked to the provision of certain level of uncompensated care, only 20 to 40 percent of California hospitals would meet standards recently proposed. In contrast, 75 to 90 percent would qualify for preferential tax treatment based on a "total benefits" standard that includes charity care as well as the provision of other free and subsidized services (Buchmueller 464).
From a public policy standpoint, it is very important to note that the provision of community benefits can differ starkly from the provision of charitable care in terms of the populations who benefit. Many community benefit programs are designed to directly benefit the more affluent people within a community. In addition, these types of community programs are often used as marketing tools for hospitals to attract more business. "Community benefit" programs that are not geared to benefit the poor and uninsured will do little more than subsidize those in the middle and upper class. Buchmueller and Feldstein make the important distinction between true charity and community services that further the interests of the hospital when they write:

The fact that a hospital is not fully reimbursed for a program or service does not in itself indicate a charitable intent. Certain programs that are money-losing in a narrow accounting sense may indirectly increase a hospital's net income. For example, many health screening and educational programs serve the economic interests of the sponsoring hospital (and participating physicians) by increasing the demand for reimbursed services. Similarly, common programs such as the distribution of free bicycle helmets (Tomsho 1994) and subsidized childbirth education classes, serve an advertising function and may be an effective way for hospitals to attract young, healthy families who are desirable patients under a capitated payment system... In particular, many programs targeted mainly at insured populations will do little to meet the most pressing unmet needs of the uninsured (Buchmueller 464).

In a 1990 report, the U.S. General Accounting Office found that similar percentages of non-profit and for-profit hospitals provide many of the most common community benefit programs and services. The report did show that 22 percent of non-profits offer AIDS education as opposed to 11 percent in for-
profits. The conclusions drawn from the study were that "although non-profit hospitals are more likely to target programs to the poor and underserved, this differential arises from the behavior of a minority of nonprofit hospitals (Buchmueller 464-465)."

A 1994 survey of California hospital community benefits found that approximately 66 percent of non-profit hospitals have a formal policy on community benefit statistics, compared with 21 percent in for-profit hospitals. The survey also found that 35.4 percent of private non-profits had performed a community-wide needs assessment, compared to 7.1 percent of for-profit hospitals (Buchmueller 468-469). At face value, these statistics seem to indicate that non-profits are more attentive to community needs than for-profits. However, this may be due to the fact that non-profit hospitals are documenting these community benefit activities out of necessity to protect their tax-exempt status. For-profits on the other hand have relatively little to gain by expending the resources needed to document such activities (Buchmueller 470).

The critical point is that more definite standards need to be developed in order for non-profit hospitals to qualify for tax-exempt status. Higher levels of uncompensated care and community benefit programs should be expected of non-profit hospitals to justify their tax-exempt status.
Increased Competition and Cost Containment

For-profit hospitals are changing the face of health care delivery in this country. They have brought a level of competition to health care that the industry had never seen before. As a percentage of health care costs, the dollars spent on hospital care dropped significantly between 1983 and 1993. In 1983, hospital expenditures accounted for 41.3% of total health care expenditures. By 1993, this percentage had dropped to 37% (California, Facts 1). According to Michael Wagner of the Health Care Advisory Board, "The investor owned companies...are proving to be fundamentally different competitors . . . no matter what we may think of the moral merits of for-profit medicine (Wagner 11)." As opposed to traditional non-profit hospitals, for-profits are much more operations focused and more market driven.

In particular cost/revenue structures are not as aggressively managed by non-profit hospitals. In Wagner's words, non-profits lack the "signal power" of Wall Street. For-profit hospitals are constantly reminded of their need to satisfy shareholders, because hundreds of market analysts hold them under a microscope. Under these conditions, managers of for-profit hospitals are forced to pay close attention to cost containment and profitability. Non-profits, on the other hand lack this "signal power," and may find it more difficult to recognize inefficiencies that cause them to lose money.
Some of the primary areas where for-profit hospitals have been doing a better job of cutting costs are in creating better management structures, reducing labor costs, cutting down on the number of unoccupied beds, minimizing the duplication of expensive equipment, and negotiating for better prices on hospital supplies. The California Healthcare Association has identified six major areas in which California hospitals have made major progress in efficiency and cost effectiveness:

1) The significant shift from inpatient care towards less expensive outpatient services: The percentage of outpatient visits by community hospitals increased by 74.7 percent between 1983 and 1993.

2) Shorter lengths of hospital stay: The average length of stay in hospitals dropped from 6.4 days in 1987 to 5.7 days in 1993.

3) Reducing hospital admissions through better prevention and increased outpatient care: Hospital admissions were reduced from 132 admissions per 1000 people in 1980 to 118.6 admissions per 1000 people in 1992.

4) Sharing expensive technology and services between hospitals.

5) Increased number of hospitals involved in managed care systems.

6) Improved labor utilization: Non-technical health care duties are assigned to less skilled personnel (California, Facts 1-2).

One of the main areas where for-profits have been able to cut costs is in their better utilization of labor. Labor costs as a percentage of revenue in for-profit hospitals is approximately 35%, compared to the U.S. hospital mean of 50% (Wagner 13). For example, for-profits hire more nursing assistants to do many of the tasks that were formerly done by higher skilled (and consequently higher paid) nurses. In addition, for-profits are much more focused on setting aggressive goals for high levels of performance and holding their employees accountable to them. They have regular performance reviews to make sure that employees are meeting...
high standards of excellence. For-profit hospitals are much more likely to terminate employees due to poor performance than non-profits. In this way, they are able to get rid of the "dead weight" employees that make them less efficient (Wagner 98).

Economist Theodore E. Keeler estimates that the annual cost of excess bed capacity in U.S. hospitals was approximately $25 billion in 1993 (Keeler 480). In 1994, the average occupancy for all U.S. hospitals was only 66.1%. This percentage has fallen from a high of 76% in 1981. For-profit hospitals have targeted reducing excess bed capacity as a method of cutting their costs. Much of the excess bed capacity in U.S. hospitals today is a result of the rapid construction of hospitals during the 1960's and 1970's. The availability of federal funds during this time caused hospitals to overbuild during this period. In addition, this reduction in hospital occupancy can also be attributed to the change in medical technology. Keeler writes:

... it appears that medical technology itself has changed so as to favor shorter hospital visits and more outpatient treatment, which further tends to reduce demand for inpatient services (Keeler 470).

One way that for-profits have been able to reduce excess bed capacity is through closing down and merging hospitals. A company like Columbia/HCA has the resources to buy several underutilized hospitals within a geographic region, close one of them, and transfer the patients from that hospital to the other hospitals. In this way, it is able to better utilize their hospital space and resources
in order to be more efficient. Along with this, it is able to reduce the duplication of expensive medical equipment (such as CAT scan, X-ray, and MRI machines). Non-profits often lack the capital necessary to merge and close down hospitals in this way.

Generally, for-profits are able to make the tough decisions that non-profits have historically been reluctant or unable to make (Wagner 94). For-profit hospitals have been the leaders in developing plans for cost-containment and efficiency. However, non-profit hospitals are quickly catching up. The competitive pressures of for-profit hospitals have forced many non-profits to begin to retool themselves to keep pace. Non-profits have begun to reevaluate the ways in which they have done business for so long. They are feeling the pressure to develop more efficient systems. Doctor Edgar J. Schoen writes:

Faced with fierce competition, nonprofits are quickly learning to control costs and improve efficiency while keeping their commitments to members and providers (Schoen 437).

Concerning the arrival of for-profit Salick Health Care in New York, New York Times journalist Elisabeth Rosenthal writes:

... his arrival ... has not put competitors out of business, as hospitals in New York fear, but has prodded rivals to change their ways. Other hospitals and doctors have quickly learned to develop their own practice guidelines and learned to control costs (Rosenthal 22).

Increased competition and cost containment are two of the most positive aspects of for-profit hospitals. Competitive pressures seem to be forcing all hospitals to
become more cost-effective. In a competitive environment, increased cost-containment among hospitals should lead to lower health care prices to patients.

**Economic Theory of Perfectly Competitive Markets**

Economic theory of perfectly competitive markets can shed some light on how cost-containment among for-profit hospitals will lead to a lower cost of health care services to patients. In a perfectly competitive market, all hospitals would seek to maximize profits, while all patients would seek to maximize their medical satisfaction. In addition, there would be a significantly large number of hospitals in the market so that no one hospital could control prices, and there would be no barriers to entry in the market. Patients, on the other hand, would have enough information to make well-informed purchasing decisions. If all of these conditions are present, then the prices will accurately reflect the willingness of hospitals to provide services and patients' willingness to buy. In addition, hospitals will produce just enough goods to satisfy the demand of the patients at the market price (Santerre 163).

No real world industry operates in a perfectly competitive market. However, assuming that a certain degree of competition does exist in hospital markets, the economic model can serve as a vehicle for predicting the type of influence that cost reduction among hospitals will have on price.

A model for a hospital in a perfectly competitive industry is drawn on the following page. The equilibrium point occurs where the lowest point of the
average cost curve (AC) intersects the marginal cost (MC) and average marginal revenue (MR) curves simultaneously. At this point, the hospital is earning zero economic profits. However, if this hospital is able to cut costs, its average cost curve will shift downward to AC'. At this point the hospital is able to earn economic profits because its marginal revenue exceeds average costs. In a perfectly competitive industry, these economic profits can only occur in the short run. In the long run, other hospitals will enter the market and compete away profits. This will drive the MR curve down to MR' where it once again intersects the lowest point on AC'. As the MR curve shifts downward, the price shifts from P to P'. This demonstrates that sustained reductions in cost will lead to long run price reductions in a perfectly competitive industry.
Although competition exists in the hospital market, it is not a perfectly competitive market. The asymmetry of information between provider and patient severely limits the patient’s ability to make informed decisions on the quality of the service they are receiving. In addition, there are not significantly large numbers of hospitals in most markets. Many hospitals are isolated in sparsely populated regions, and patients do not have more than one hospital to choose from. Substantial barriers to entry exist in the hospital industry due to the incredibly large amounts of money that are required to build a hospital. Thus, some hospitals could act as monopolists in areas that can only support one hospital. Finally, the goods and services that different hospitals provide are differentiable from each other as opposed to one homogenous good. With these things in mind, the model for a
perfectly competitive market must be interpreted with caution. Government policies should strive to maximize competition in hospital markets.

Obviously, competition is more prevalent in certain areas than in others. Arguments in favor of for-profit hospitals are directed towards large cities which have several competing hospitals. Many of the positive aspects of for-profit hospitals would not occur without the presence of competition. (Yoder 22-23).

Empirical research investigating the differences between the costs of services among ownership types in the hospital industry have been relatively inconclusive. Studies have shown that only small, inconsistent differences in the reported costs of non-profit and for-profit hospitals. Research has found that the average cost per patient day is typically higher in for-profit hospitals. However, the average cost per admission has been found to be approximately equal due to shorter lengths of stay in for-profit hospitals (Marmor 65).

Quality of Care

It appears that for-profit hospitals have been able to effectively contain costs, and generate profits. However, many question whether for-profits will measure up to non-profits in quality of care. Unfortunately, quality of care is something that is very difficult to measure because no clear definitions of quality exist. Quality could be measured in terms of patient satisfaction, mortality rates, complication rates, or a number of other factors. However, no one can seem to agree on exactly which of these measures are most important. For example, the
level of patient satisfaction might seem to be a very important measure of quality. However, the satisfaction of the patient may be increased by factors that really have nothing to do with improved levels of health care.

Quality defined by added hospital luxuries (like artwork on hospital walls, and Super Nintendos in the children’s waiting room) will likely make patients more comfortable, but will probably do little to improve their health. In an effort to attract patients, for-profit hospitals will likely do everything that they can to make patients comfortable--especially those who can pay. This may appear to be an extravagance to some and an improvement in quality to others. Journalist Dave Lindorff mocks some of the “quality improvements” brought about by for-profit hospitals when he writes:

In urban centers, the introduction of aggressive for-profit hospitals into once cozy relationships among existing public and not-for-profit hospitals has shaken up those facilities, forcing them to address long-ignored consumer concerns like the need for palatable food, attractive delivery rooms, et cetera. Indeed, especially in the area of style and ambience, corporate hospitals are setting new standards (Lindorff 70).

Is it wrong for hospitals to try to make patients more comfortable during their hospital stay? Some may say that a clean, attractive hospital waiting room is an unnecessary luxury while others may think that it is a quality improvement. The point is that many different factors can be used to define “quality” in a hospital, and this makes quality very difficult to measure. Despite these difficulties, studies that measure quality in hospitals have been developed by a number of agencies.
The results of a few of these studies indicate that for-profit hospitals are succeeding in providing high quality health care.

For-profit corporations like Columbia/HCA would argue that their hospitals are every bit as concerned with the quality of patient care as non-profit hospitals. To investigate Columbia’s claim to high quality health care, we can look to the Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission is a non-profit, independent regulatory agency that has established national standards for health care organizations for over forty years. It is governed by representatives from the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, the American Medical Association, an at-large nursing representative, and six public members.

The mission of the Joint Commission is to “improve the quality of health care provided to the public.” Some of the standards that hospitals must meet in order to qualify for accreditation are: rights, responsibilities and ethics; continuum of care; education and communication; leadership; management and human resources; management information; and improving network performance (Columbia, Joint 1-6).

In support of their claim to quality, Columbia/HCA hospitals have received a significantly high percentage of accreditation by the Joint Commission. Nationally, less than 10% of all hospitals qualify for Joint Commission
Accreditation with Commendation. Columbia hospitals on the other hand have qualified for accreditation at a rate of 37% (126 out of 343 hospitals). These numbers indicate that Columbia is committed to providing high quality health care services (Columbia, *Quality* 1-3).

For-profit hospitals also scored well in a second hospital ranking study. In a combined effort, the health care information leader HCIA Inc. (HCIA) and the Health Care Provider Consulting practice of William M. Mercer Incorporated (Mercer HCPC) conduct an annual study titled *100 Top Hospitals: Benchmarks for success*. The study is designed to identify hospital industry standards (known as benchmarks) based on quality care, efficient delivery, and superior financial performance (HCIA, *Top 100* 1-2). The results of the study are based on the following objective, quantitative criteria: Risk-adjusted mortality index, Risk-adjusted complications index, Severity-adjusted average length of stay, Expense per adjusted discharge, Profitability (cash flow margin), Index of outpatient activity, Productivity (total asset turnover ratio), and Long-term growth in equity (Columbia, *Columbia* 1-3).

According to the 1996 study, the performance of America’s *Top 100 Hospitals* improved for the fourth straight year. Mercer Principal Michael D. Blaszyk stated: “This study suggest that performance is improving across the board in health care. The health care consumers and payers appear to be the beneficiaries.” The Chairman and CEO of HCIA, George D. Pillari, added: “It is
also becoming clear that ownership is not a reliable indicator of good or bad performance. The for-profits have succeeded in creating market forces that have driven all hospitals to strive for, and achieve new levels of excellence.” Both non-profit and for-profit hospitals were well represented on the Top 100 list, as 27 were investor-owned compared to 73 non-profit hospitals (HCIA Top 100 1-2). In addition, seventeen of the top 100 hospitals in this study were owned by Columbia/HCA (Columbia, Quality 1-3).

An example of a high quality for-profit health care provider is Salick Health Care, the nation's largest chain of for-profit cancer treatment centers. St. Vincent's hospital of New York was recently taken over by Salick Health Care. The President of St. Vincent's, Dr. Karl P. Adler, speaks of the quality of care at Salick Health Care by saying, "His centers are patient focuses. They're high quality (Rosenthal 22)." Ron Wise, the vice-president of public affairs at Cedars-Sinai Hospital in Los Angeles, says, "Bernard Salick is visionary—patients love his operation." The doctors at one of Salick's breast cancer treatment centers continued to treat Julie Chavez, one of their patients, even after she had lost her insurance. Ms. Chavez said, "The treatment was all-encompassing and everyone was working together. It was a wonderful experience (Rosenthal 21-22)."

Even though quality of care is difficult to measure, it seems reasonable to assume that in an increasingly competitive health care industry, it would be
difficult for either for-profits or non-profits to skimp on care and still attract customers.

**Possible Government Actions**

Competitive market forces have been good for American health care, but the government still needs to play an integral role in regulating the health care industry. Although the costs may be similar, buying a heart surgery is not the same thing as buying a Chevy Blazer. In many ways health care is essential to being able to live a happy, productive life. In addition, when the human life is at stake, patients and their loved ones are put in a very vulnerable position as to what types of economic decisions they are able to make. For these reasons, the government cannot simply leave medicine entirely to free market forces. The government needs to be active in ensuring that competition exists in health care, but also that people are not denied care because they cannot afford it.

In order to make sure that all Americans are able to receive health care, the government needs to address the issue of how to deal with the 40 million uninsured Americans. There is no reason why our government should assume that hospitals will continue to provide for the needs of uninsured Americans. Even non-profit hospitals are becoming less likely to provide charitable care. The government needs to concentrate on finding a way to ensure that all Americans have access to some minimum level of health care. Nearly every other industrialized country has done this, and there is no reason why America should
not be able to do the same. Until our government creates a universal coverage program, we must do the best that we can within the current framework.

Within this framework, the government needs to pass legislation which sets concrete standards for required levels of uncompensated care in non-profit hospitals. Currently, federal law requires that no hospital can turn emergency patients away because of their inability to pay (Lutz 2). Although non-profit hospitals are required to fulfill community needs in order to maintain their tax exempt status, no clear standards currently exist outlining what "fulfilling community needs" requires. Standards need to be developed which require non-profits to justify their tax exempt status. Minimum standards of uncompensated care could also be extended to for-profit hospitals. Alternatively, the government could take the money collected from for-profit hospitals, and ear-mark these dollars towards care for indigent patients.

In order to reduce the asymmetry of information between hospitals and consumers, the government could conduct extensive hospital assessments on the quality of care in our nation's hospitals. This would also include creating clear standards for “quality of care.” In addition, they should make the results of these assessments readily available to Americans. If patients had more information on the quality of care in various hospitals, they would be able to make more informed decisions on which hospital to patronize. In addition, the government could require hospitals to publish all of the prices that they charge for different
procedures. By doing this, patients would be able to "shop around" more in order to find the best and least expensive hospitals.

Barriers to entry will always be present in the hospital market. However, the government needs to regulate for-profit hospital chains to make sure they do not gain too much market power. If a for-profit hospital was able to gain a monopoly in a certain region, consumers in that region would likely suffer. The government needs to prevent a company like Columbia/HCA from becoming so big that it is able to dominate certain markets. It would be almost impossible for most small towns to support more than one hospital. The government might need to prohibit for-profit hospitals from operating in these towns. Alternatively, they could restrict them from raising their prices excessively higher than the overall market charges. Although for-profit hospitals have seemed to increase competition, this competition would disappear if all hospitals were controlled by two or three huge for-profit hospital corporations.

Conclusions

For better or for worse, health care has become a very lucrative business. Next to defense, health care is America's second largest industry. The entire face of medicine has transformed from its charitable roots at the beginning of the century to the commercialized system that it is today. With this shift in the philosophy of private medicine, the differences between the non-profit and proprietary forms of hospital ownership have become blurred. My research has
shown that non-profit hospitals are not necessarily more virtuous than proprietary hospitals.

It appears that for-profit hospitals have shaken up the market for health care and forced other hospitals to improve on efficiency to stay competitive. This will help to keep the exploding costs of health care under control. However, proprietary hospitals are by no means the ticket to market led health care reform. Both non-profit and proprietary firms have a definite place in American medicine. For-profit hospitals have shown that they are doing an excellent job of creating a more competitive environment. Non-profit hospitals, on the other hand, continue to provide higher levels of uncompensated care, and are still the leaders in medical research. Eliminating either of them would do little to solve today’s health care problems.

We should not be alarmed by the increasing influence of for-profit hospital corporations. We should realize that for-profit hospitals will provide quality care, but their focus will be on providing this care for those who can pay for it. With increased competition, non-profits will also be less likely to provide charity care. We need to be prepared to find new ways to provide health care for those who cannot afford it, as it appears that the private sector will be unable to carry the full load. Government policies should not concentrate on the different ownership status of hospitals, but rather on how to better integrate all Americans into a highly privatized and competitive health care system.
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