Comments on Jack Needleman's "Nonprofit to For-profit Conversion by Hospitals and Health Plans: A Review"

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I would like to thank my colleague, Deborah Socolar, for her valuable insights.

I always enjoy reading Jack Needleman's work. There is much of value in his paper on hospital conversions to for-profit status for the Pioneer Institute.[1] That means that I agree with certain of his findings, such as his conclusion that "for-profits are not more efficient." (p. 20) I think that he is generally right in his descriptions of the *immediate* reasons hospitals sell themselves to for-profit operators.

I won't discuss other areas of agreement, partly for lack of time and partly because this is one of those occasions when I find myself disagreeing with much of Jack Needleman's approach and his core conclusion. Some of this stems from the decision to focus on conversions. More of this stems from my view that much evidence in Jack Needleman's paper challenges his conclusion that "Nothing in the analysis indicates that nonprofit to for-profit conversions should be barred from consideration in Massachusetts." (p. 39) Additional evidence bearing on the value of for-profit hospitals or health plans is not reviewed in the paper because it falls outside the paper's scope.

The paper includes assessments that for-profit hospitals are not more efficient and that they do not offer higher-quality care. It also includes evidence that they are not more adaptable. I think that it is to Jack Needleman's credit that he is so balanced and fair-minded in his work.

But if all these things are so, why should we not oppose further conversions? Any society is naturally conservative. **So the burden of proof should be on those who advocate change. The case has not been made for the change of converting non-profit hospitals to for-profit operation**.

To begin, I have five specific points of disagreement with the paper.

First, Jack Needleman describes (p. 10) the Northeast as least hospitable to expansion of for-profit hospitals. But an examination of the states' shares of for-profit hospitals in 1995 shows fully 20 states—two-fifths of the nation—with six percent or fewer of their beds in for-profit hospitals. These states range in a surprisingly solid belt clear across the top half of the nation from New England and the mid-Atlantic through the Midwest, the upper plains and Rockies, and the Pacific northwest.

Second, Jack Needleman describes the for-profit hospitals as "more efficient in adjusting to rapidly changing reimbursement and market conditions." (p. 13) But shortly thereafter, he acknowledges that the for-profits adapted badly to Medicare's Prospective Payment System, price negotiations, and managed care. (p. 15) Perhaps, then, we should say that for-profits adapt well to some changes and fail to adapt to others.

Third, I disagree with much of the interpretation of the causes or processes by which Metro West and St. Vincent came to appeal for aid from for-profit hospitals. For example, it is worth noting, in the St. Vincent case, that $100 million or more in public subsidy has helped to under-write the construction of the arguably unneeded and financially infeasible Medical City project.

Fourth, I do not understand the comparison between uncompensated care levels at Metro West or St. Vincent and the state-wide average. That average includes care at the former Boston City Hospital, which provided roughly one-quarter of the state's total.

Fifth, even if the non-profit hospitals that convert to for-profit status had been providing relatively low levels of uncompensated care prior to conversion, maybe this was another symptom of their financial distress. Alternatively, some non-profits traditionally have chosen to give little uncompensated care. We need to learn whether either pattern typifies the hospitals that convert. If the former, we should not be sanguine about for-profit take-overs. Instead, we should mourn the loss of uncompensated care prior to the take-over. And we should find ways to pay hospitals that do not force them to choose between their own financial needs and uninsured patients' clinical needs.

More generally, I disagree with Jack Needleman's conclusions that for-profit hospital care is valuable or tolerable enough to allow us to move on and focus on how best to improve the process of conversion, so it is fairer, protects vulnerable patients, and best conserves charitable assets.

Those are the issues that lawyers and advocates raised—legitimately—to try to extract some charitable remainder from mergers or to protect patients by sustaining hospitals' free care. But they are not enormously weighty issues. They should not drive analyses of the propriety of for-profit take-overs of non-profit hospitals. **I think that these are all third-level questions that are best addressed, if at all, after some larger matters are clarified.**

In any case, how much do we need to worry about the conversion process? "By the time a trend is identified, it's half over," Alvin Toeffler has remarked.[2] It appears that the pace of converting hospitals has slowed substantially from that of a few years ago. If for-profits grow again, though, we need to be prepared with much more than tougher regulations or a smoother or regularized conversion process.

The second-level question is whether we should tolerate for-profit hospitals. I don't think we should. For some, this is a matter of ideology. For me, it is one of pragmatism. Only a well-functioning free market could convert private greed into the public good. Health care lacks anything close to such a market. Therefore, we should not tolerate for-profit hospitals.

Why not?

First, please consider how a for-profit hospital could make money.

- Greater efficiency?
- Over-provision of profitable services or under-provision of needed by unprofitable services?
- Higher prices, with or without greater market power?
- Higher prices, with or without systematic fraud exceeding the average level of fraud prevailing in the non-profit sector?
- Less adequate care, relative to patient need?

It is hard to understand how for-profit hospital chains can satisfy their financial objectives without higher prices, less care, or both.

As Jack Needleman summarized, the for-profits are not more efficient. My colleagues and I have found the same, in looking at hospitals in 52 cities since the 1930s.[3]

David W. Johnson has said that the expected return on stockholder equity is 15 percent, after paying income and property taxes.[4] I think that average profit margins in the hospital business will be too low to retain private capital under competitive conditions.

The for-profit hospital sector has been very volatile for decades. For-profits have always been the likeliest to close, my colleagues and I have found.[5]

Second, please consider market realities in health care, not market theory. Discussing Western reactions to the Russian Revolution, Richard Pipes criticizes the intellectuals who "prefer to focus on the declared objectives of the Communists and compare them with the realities of tsarism. This procedure does produce a glaring contrast. The picture, of course, changes substantially as soon as one compares Communist and tsarist realities." [6]

In reality, why do we lack a functioning free market in hospital care?

First, we have too few buyers and sellers. Hospitals close and merge, so geographic oligopolies and even monopolies emerge. Higher prices and unusually high profits would result. Once these happen, competition theory would predict entry of new hospitals in search of a share of the high profits. But, in reality, few—probably no—new hospitals will be built, owing to high financial, physician, and regulatory barriers to entry of new competitors.

Market advocates, who think they are relying on price competition, usually seem to applaud hospital closings. They recognize that price competition is accomplishing

something the planners and regulators could not—reducing the number of hospitals and the acute care bed supply. They are thus semi-conscious agents of either the planners who long demanded fewer beds or of the hospitals that expect to survive. But market advocates are not saving us money. After enough hospitals close, the survivors will happily raise their prices.

Market advocates, relying on competitive theory, say that hospitals that close will be the inefficient and unneeded institutions. But which hospitals have survived in reality?

My colleagues and I have studied this from time to time over several decades and have not yet found an arena in which hospitals' efficiency have had any value in separating the survivors from those that close.[7]

Race of the people residing around the hospital is one of the most powerful predictors of survival in most decades. Consider St. Louis, Missouri, where all of the hospitals on the north (African-American) side of town have closed or relocated.

In the 1990s, hospitals' accumulated financial reserves per adjusted average daily census have become highly predictive of survival.[8]

So we have not survival of the fittest, but—apparently—survival of the fattest.

Under these conditions, trusting a market to select which hospitals should live seems a form of idolatry—something like worshipping a golden calf.

What are some of the likely consequences?

In time, we can expect an inadequate supply of hospital services—of inpatient care and ER care in particular. I am told that when Boston Regional Medical Center in Stoneham announced its closing a few days ago, only one ICU or CCU bed was open in the broad corridor of surrounding communities. And that is widely considered to be an over-bedded region. There was also a shortage of acute beds in the Boston area generally.[9]

Our state is at risk of closing too many hospitals and too many beds. This resembles many cities and towns' closure of too many public schools in the 1970s and 1980s—forcing them to re-acquire land and re-build or buy classroom space at very substantial cost. Cities and towns did so out of a belief that fewer children would need schools in the future, and out of a desire to balance their books in the short-term by selling off public property. Data on the costs of replacing lost public school property are seldom compiled, but I have reason to suspect that the figures are very large. Any failure to learn from the over-closing of public schools would signal that hindsight is often not 20/20.

Predictably, closing too many hospitals will begin to prove dangerous fairly soon. The baby boomers start hitting age 55 in two years. Need for hospital beds will rise substantially.

Need for inpatient hospital capacity would be reinforced by sensible pricing of hospital care. Today, the legacy of average cost pricing, hospitals' difficulty in learning the costs of various sorts of care, and pressure from payors results in bizarre pricing patterns.

One result is that inpatient care is probably used substantially less than it would be under fair and efficient market conditions.[10] Recuperative days, for example, are often priced well above cost, resulting in their under-use. Care may be moved to new sub-acute units whose actual costs exceed those of a hospital's inpatient unit, but whose prices appear lower.[11]

Tomorrow, if hospital services come to be priced in close correlation with their costs, as they would be in a free market, use of inpatient care would probably rise substantially. (Ironically, it may be that only government regulation could oblige hospitals and their payors to adhere to this normal market practice.)

It may be that the types of hospitals that convert to for-profit operation had often been providing relatively little uncompensated care before conversion. This might have been a long-standing preference.[12] Or, it may have been a consequence of years of price competition, which gradually squeezed out the surpluses that had been earned by caring for paying patients, and that were needed to finance free care. In either case, low levels of free care in the years just prior to conversion should not be viewed as a reason for tolerating conversion. The value of for-profits can only be judged by whether they are superior overall—in efficiency, quality, accessibility, and other characteristics—to the alternatives. Providing no less free care than certain non-profit hospitals should not suffice to make Americans comfortable with conversion.

The primary—the most important questions—concern which hospitals, located where, with how many beds, are needed to protect the health of the public—and how should we decide which.

We need better ways to identify which hospitals are needed to keep us healthy, and to assure their survival, than either a failed market or a take-over by a for-profit. After a failed market destabilizes some hospitals, many of which are probably needed, it is unwise to rely on for-profits to pick up the pieces. They may offer immediate relief from financial distress, a quick fix for capital—buildings or equipment, or protection from other large hospital chains, as Jack Needleman says. But all this comes at prices that are much higher than are discussed or imagined at the time of conversion. There is no free lunch. Stockholders will demand returns on all invested dollars. Hospitals lose independence. Forcing small hospitals to put on gang colors as the price of remaining open undermines competition (though not as much as a closing would).

We do not and should not have to rely on markets to decide the shape of our hospital care. We do not and should not have to rely on for-profits to patch up the damage that markets cause to needed hospitals. Any resources they supply must be paid for with interest.

Simple and strategic public intervention is preferable.

What else might be done?

1. State government should require that hospitals price all services in reasonable proportion to cost. In this way, government action would win the prices that would prevail in a free market. Then, prices would clearly signal the real costs of various types of care, leading to substantial increases in efficiency and substantial reductions in spending.

2. State government should annually prepare a list of hospitals facing financial distress.

3. State government should annually prepare a list of hospitals that are needed to protect the health of the public.

4. Hospitals appearing on both lists would qualify for managerial assistance (from competent administrators) or for cash, both financed from a trust fund amassed by placing a one-quarter of one percent assessment on the revenues of all hospitals, state-wide.

5. A receivership statute should authorize the attorney-general, the commissioner, or others with standing to petition for appointment of a receiver to conserve and maintain any hospital appearing on both lists. Legislation proposed by representatives Marzilli and Goguen would accomplish steps 2 through 5.

6. Given the steady stream of hospital closings and mergers in Massachusetts, it seems unlikely that the number of competitors needed for active price competition will be retained or restored. Re-regulation of hospital payments seems inevitable. If it does become necessary, Massachusetts can legislate hospital rate setting and budgeting methods that pay all needed hospitals enough money to remain open, if operated efficiently.

NOTES

[1] Jack Needleman, "Nonprofit to For-profit Conversion by Hospitals and Health Plans: A Review," Boston: Pioneer Institute, 9 February 1999.

[2] "Shock Talk," with Alvin Toeffler, *Hospitals and Health Networks,* Vol. 73, No. 1 (January 1999), p. 28.

[3] Alan Sager, Jasprit Deol, and Deborah Socolar, Causes and Effects of Acute Hospital Closings in Urban America, 1980 – 1997, American Public Health Association, Washington, D.C. , 16 November 1998.

[4] David W. Johnson, panel presentation on Healthy Profit?: Issues and Options in Non-profit and For-profit Health Care," Pioneer Institute, Boston, Massachusetts, 9 February 1999. (Mr. Johnson is managing director of health care finance, Merrill Lynch, Chicago.)

[5] Alan Sager, Jasprit Deol, and Deborah Socolar, Causes and Effects of Acute Hospital Closings in Urban America, 1980 – 1997, American Public Health Association, Washington, D.C. , 16 November 1998.

[6] *A Concise History of the Russian Revolution*, New York: Vintage, 1996, p. 396.

[7] Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Service Research*, Vol. 18, No. 3 (Fall 1983), pp. 45l-48l. Alan Sager, Jasprit Deol, and Deborah Socolar, Causes and Effects of Acute Hospital Closings in Urban America, 1980 – 1997, American Public Health Association, Washington, D.C. , 16 November 1998.

[8] Alan Sager, Jasprit Deol, and Deborah Socolar, Causes and Effects of Acute Hospital Closings in Urban America, 1980 – 1997, American Public Health Association, Washington, D.C. , 16 November 1998. A hospital's adjusted average daily census is adjusted by adding to the actual inpatient census a factor representing ambulatory service. It is a fairer denominator than inpatient census alone.

[9] Larry Tye, "For Flu and Pneumonia, It's Been No Mild Winter," *Boston Globe*, 11 February 1999.

[10] Richard Saltus, "Managed, Yes, but Couple Wonders, Is It Care? Hospital Discharge Puts Patience to Test," *Boston Globe*, 18 February 1999.

[11] See, for example, Uwe E. Reinhardt, "Spending More Through `Cost Control:' Our Obsessive Quest to Gut the Hospital," *Health Affairs*, Vol. 15, No. 2 (Summer 1996), pp. 145-154.

[12] In 52 cities that my colleagues and I have been tracking, for-profit hospitals open in 1997 were significantly more likely to be located in neighborhoods with markedly lower black populations (38.2 percent black for public hospitals; 29.8 percent black for non-profit hospitals; and 20.9 percent black for for-profit hospitals; $p = 0.0018$).