Making our caregivers trustworthy again

Alan Sager talks about reversing the roles of health-care competition and regulation

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By Steven Jones-D'Agostino

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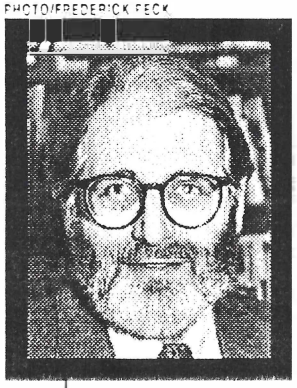

Alan Sager is co-principal of the Access & Affordability Monitoring Project at the Boston University School of Public Health in Boston. As such, he has been a long-time and frequent critic of the proposed $215-million Medical City project in downtown Worcester.

When Sager is not criticizing Medical City, he is working to find ways to contain health-care costs while also protecting the quality of such care. He has proposed a 10-step method for reversing the roles of health-care competition and regulation in Massachusetts, to rely instead on regulation to contain costs and competition to protect quality of care.

He has also gathered some statistics on the hospitals owned by for-profit chains California-based Tenet Healthcare Corp., as well as OrNda Healthcorp and Columbia/HCA Healthcare Corp., both based in Tennessee. And he's compared them to numbers for all for-profit as well as all nonprofit hospitals in the U.S. His findings raise some serious questions about for-profit hospital care.

Starting on page 4 are edited highlights of a recent interview with Sager on these matters.

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Jones-D'Agostino: In a nutshell, what is your method for reversing the roles of health-care competition and regulation in Massachusetts?

Sager: The first is that we need a lot of small HMOs. The second would be that the HMOs would all have to run not-for-profit. That way, we can trust them to [put] patients' interests ahead of the stockholders. The third would be to give each HMO a budget and make sure it spends that entire budget only on providing patient care. There'd be a separate budget for capital cost[s] and other non-patient-care items. In this way, if one patient were denied care, the result would be to free up more money to serve other patients, [and] not to put money into stockholders' or administrators' pockets.

Another step would be to pay each HMO the same price, adjusted only for the age or chronic health problems or other risk factors of the members. In this way, ... there'd be no cutting prices to attract more members.

Another step would be to cover all of the fixed costs of the HMO separately. The State of Maryland happens to pay hospitals that way. It works very well in containing costs and keeping open all of the hospitals that are needed in the state. ... [T]he HMO doesn't make more money when it attracts more [members]. Because it's being paid separately for fixed and variable costs, the HMO gets only enough new revenue to cover the variable cost of its new members, if it gains members. And similarly, if you lose members, you only lose a little revenue ... .

So there isn't an incentive to turn patients away, necessarily.

Right. [There's] no incentive to turn people away, no incentive also to market [in order] to attract more patients. ... One of the results here is that HMOs are not forced to close if they lose members. They're able to stabilize and rebuild. The key here is, we want a lot of competition among HMOs, and competition requires competitors. So we want a lot of small HMOs covering a whole geographic area, [and with the HMOs having] maybe 50,000 or 100,000 members each ... . Worcester County, then, might have eight or 10 HMOs.

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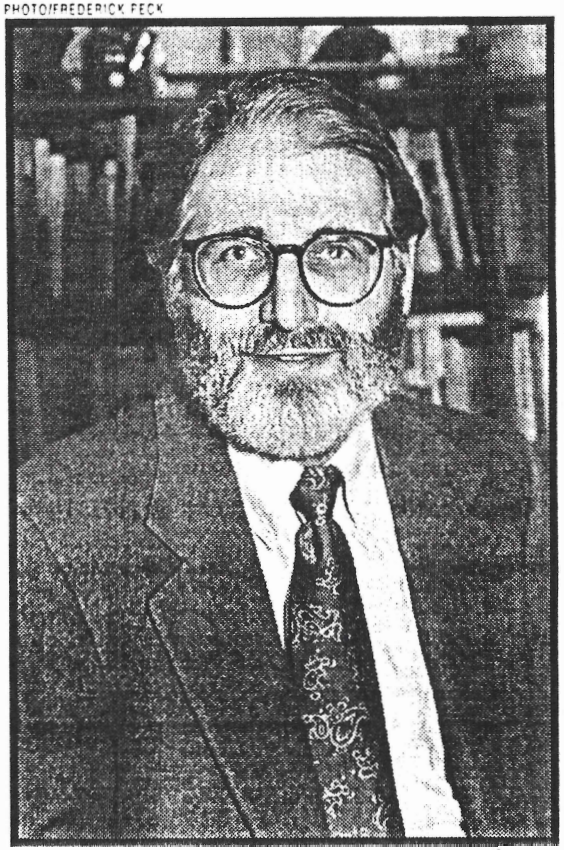

Another step would be that the HMOs would have to pay their doctors and their hospitals in trustworthy methods. Again, [there would be] a flexible budget for hospitals, and maybe fee-for-time or salary or other trustworthy arrangements for doctors. The idea would be that caregivers like doctors and hospitals would not be bribed through fee-for-service to provide more care, or through capitation or fee-for-non-service to provide less care.

So what you have now is no price competition. But still, even though these [HMO] organizations are nonprofit, all organizations compete with one another. ... Because these new HMOs couldn't compete by price, they'd have to compete the way we want them to compete, the way we can trust them to compete: by quality, by competence, by compassion and by the services they offer.

Would your plan prohibit or allow a hospital to do business with just one HMO?

There could be a linkage. Because you'd have a lot of HMOs, the hope would be that this would also help a lot of hospitals to remain open. It's the present arrangement of phony-free-market, crypto-competition-in-health-care that's causing HMOs to merge ... hospitals to merge ... and hospitals to close. We had 142 hospitals in Massachusetts in 1970. Now we have around 80. And our [Access & Affordability Monitoring Project] predicts that in a decade or so we're going to be down to 10 or 15 ... buildings, and they may be grouped in two or three chains.

... [S]ince we'd have eight or 10 HMOs in [Worcester County under this plan], it would be unlikely that any one hospital would want to form, or would need to form, an exclusive relationship with any HMO.

Should a company that also owns an HMO at the same time be allowed to own a hospital that does business with that HMO?

I think the plan is designed to make that arrangement one that we can trust. For example, the [California-based] Kaiser Permanente [HMO] plans in California and elsewhere in the country ... have long owned their own hospitals. But because the entire operation is not-for-profit and because the hospital is part of the HMO network, the hospital, the HMO and

Continued on page 12

Sager

Continued from page 4

the doctors together have to make an honest clinical and financial trade-off: Which is the least expensive site to provide care?

You haven't got the funny, old arrangement that used to prevail in Worcester. [There,] Saint Vincent Hospital, when it was independent [and nonprofit], became so subservient and so dependent on [Worcester-based, nonprofit HMO] Fallon [Community Health Plan] patients that it was forced to grant, I've been told, very deep price concessions. [This] further destabilized the hospital such that ultimately the hospital had to be taken over by Fallon [Healthcare System] if it was to remain open. ...

You've also gathered some statistics on the hospitals owned by for-profit chains Tenet, OrNda and Columbia/HCA, and compared them to numbers for all for-profit as well as all nonprofit hospitals in the U.S. What were your findings, and what conclusions did you draw from them?

... [T]he different for-profit chains devoted much smaller shares of their expenses to paying employees. Nationally across all nonprofit hospitals — and that's two-thirds of all hospitals — about 55 percent of the hospitals' expenditures went to paying people to provide care ... . By contrast, all for-profits devoted only around 47 percent of their revenues to paying people. ... [T]he figure for OrNda was 40 percent; for Tenet, which has now bought OrNda, it's 37.5 percent; and for Columbia/HCA it's around 39 percent. So these are averaging in the range of 15 percentage points of total expenses less going to paying people to provide health care in hospitals than the nonprofits devote.

Is that necessarily a bad thing?

We don't know for sure. I regard this as a potential problem that needs to be investigated more closely. The for-profits would say, "Well, we are just so much more efficient. We have cut out much of the fat and ... waste."

Is it possible that they have fewer employees doing more work, and those people are well-paid by any standard?

That's possible. The other possibility is they have fewer people and they're being paid less. For example, [they may be] more aggressive than the nonprofits in substituting technicians who don't have but a few weeks or months of training for more skilled [licensed practical nurses], registered nurses and other people.

Also, it may be that the for-profits are devoting a smaller share of their money to paying people because they're taking more out of the business, first of all, to pay the debt that they have incurred in buying the different hospitals; and second, in paying property taxes ... . [T]he percentage [of revenues] devoted to paying employees is [also] suppressed because so much money is going to stockholders. ...

Some of these for-profit chains may not be paying dividends to their stockholders. They're highly leveraged, and they're looking to enhance the value of the company in order to sell it.

Honestly, ... what would worry me is that eventually there'll be nobody left to sell out to. And there may not be additional hospitals to buy, and there may be no way of growing the business.

If the underlying fundamentals of the for-profit-hospital world are that shaky, it starts to resemble a Ponzi scheme. I don't mean [this] in any illegal sense, of course. But [it's] like people used to say about sharks: [T]hey have to keep moving through the water to get oxygen passing over their gills. If that is true for for-profit chains, once they can no longer move, they will die.

We know that the for-profit hospital chains have imploded once, in the 1980s. I think that could easily happen again. And many communities that have staked their medical souls and their health-care futures on for-profit hospitals will be very embarrassed. They may find their hospital bankrupt, [and] no state receivership law on the books to take over the hospital and run it for the benefit of the people. And we may have medical meltdown and widespread health-care catastrophe.

... If we imagined that this were a KGB conspiracy — and, of course, I'm not questioning anyone's patriotism or ethics or intentions — you could almost understand this as one of the devices best designed to destabilize U.S. health care [and also] Americans' faith in our doctors and hospitals, which are about one of the last institutions [which] we give widespread credence [to].

... You've said that you're not against capitalism, competition and the free marketplace, except when it comes to health care.

I love the free market, probably as much as anybody in the state of New Hampshire, which is what we call a robust test. But you can't love something that doesn't exist, at least not with any hope of the love being requited. In health care, the free market works great for eyeglasses because we're spending our own money. ... We're making a consumer decision. We know if we have a problem: We keep missing exits on the highway. And then, once the new glasses or contact lenses are put in, we can tell if they work. And if they don't, the lens can be re-ground with no harm. None of those conditions prevails anywhere else in health care.

There are about 20 reasons why all of the major requirements of the free market — lots of small buyers and sellers, no artificial restriction on exit or entry, no artificial influences on supply or demand or price, and good information about price and, particularly, quality — are simply unachievable. I think it's farcical to talk about the existence of a free market in health care.

... Recently, the chairmen of the state Legislature's Joint Committee on Health Care, along with state Attorney General Scott Harshbarger, filed a bill mandating public hearings when for-profit chains seek to buy nonprofit hospitals. It would also require such hospitals to maintain current levels of free care once they are bought by for-profit chains. However, the bill does not require complete disclosure of financial records in such deals. What's your take on this bill?

It's a well-intentioned effort. It won't make much of a difference. Money talks louder than anything else. We have to build a health-care market that we can trust with our lives and with our money. We can absolutely do that if we adopt market principles instead of worshipping them. If we rely on regulation, it's always too little, too late, and we're putting Band-Aids over the gaping wounds.

Would you still like to see complete disclosure?

I prefer to see full disclosure, but even better would be to build a world in which the motives of our caregivers were trustworthy again. And to do that, we need financial neutrality. ... ■