EDITORIAL AND COMMENT

It Is Time to Liberate Hospitals from Profit-Centered Care

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The way we pay hospitals is toxic. It rewards, indeed requires, bad behavior from hospital leaders and stifles the better angels of their nature.

In our market-driven payment system, hospitals' success, and even survival, depends on generating profits. Even non-profit hospitals live or die based on profit margins (often labeled "surpluses" in non-profit facilities). Hospitals that lack profits (or the prospect of future profits that can entice lenders or investors) face a grim future. Unable to renovate or expand their original facilities, purchase new equipment, acquire other hospitals, or grow their provider networks, unprofitable hospitals often spiral downward. As one public hospital CEO admonished two of us, "no margin, no mission."

In this issue of JGIM, Ly and Cutler[1] demonstrate one noxious side effect of making profitability the arbiter of hospital success. Their analysis of changes in hospital profit margins between 2003 and 2013 indicates that hospitals won the profit game by boosting prices, not by improving efficiency, or through exemplary community service (e.g., by increasing their care for Medicaid patients). The losers cared for a disproportionate share of publicly insured patients (and presumably the uninsured, although Ly could not assess that) or had the bad luck to be located in rural America. Public hospitals lagged, while not-for-profits grew their profits even faster than for-profits. (Although not discernible from Ly's analysis, MedPAC data indicates that investor-owned hospitals had much higher profit margins at baseline and retain a big profit lead.[2]) Chaining up was a winning strategy, presumably because it increased hospitals' leverage in negotiations with insurers, allowing them to command higher prices.

Ly's conclusion that upcoding did not drive profitability gains will surprise many clinicians whose hospital managers obsess about capturing every billable diagnosis. While the study found a positive relationship between growth in a hospital's casemix index (CMI) and growth in its profit margin, this finding was not statistically significant. Unfortunately, this analysis was underpowered because it used all-payer CMI data, which was available for only a subsample of 587 hospitals in eight states. Nationwide, increases in the Medicare CMI (available for almost all hospitals) strongly predict total margin growth (Dickman S, Woolhandler S, Himmelstein DU. Unpublished analysis of Medicare Cost Report and Medicare casemix data, 1998–2016). It seems likely that upcoding is an important profit-driver.

Hospitals did not always have to turn a profit in order to survive. In our past (and today in Canada, much of Europe, and our VA system), funds for capital investments came from government grants or charitable donations.

During the first three decades of the twentieth century, private donors funded almost all US hospital construction.[3] The federal government stepped in to provide capital funds to non-profit hospitals during the Great Depression, and its Hill-Burton program was the major funder of hospital construction in the post-war period. The seed of profit-based capital funding was planted by the hospital industry-controlled Blue Cross plans of that era, which paid hospitals a per diem rate that covered operating costs (including interest on loans, i.e., payment for existing capital investments), plus depreciation and a capital add-on to provide hospitals with reserves for future capital investment.[4] But even as late as 1965 (when Congress passed Medicare and Medicaid), hospitals' reserves together with their long-term borrowing accounted for only 31.9% of hospital construction funds.[5]

Two developments in the mid-1960s accelerated the shift from grant-based to profit margin-based funding for not-for-profit hospital capital. First, a 1963 IRS ruling triggered states to start offering tax-exempt bond funding for hospital construction, allowing hospitals to obtain loans with minimal down payments, and pay them off with future profits. Second, Medicare adopted Blue Cross' capital payment model (with an extra profit allowance for investor-owned facilities). For hospitals with a good payer mix, this assured a flow of public dollars to build up reserves for future investments, and to pay off bondholders and investors. By the 1970s, 70% of construction was debt-funded, with much of the rest covered by hospitals' reserves.[6]

Before the mid 1960s, explicit (if often flawed) public decision-making guided the allocation of government funding for hospital construction. Thereafter, the flow of taxpayer dollars surged but public control of decision-making shriveled. Profitability determined which hospitals could afford new projects, and private boards and executives decided how to deploy those funds.

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Medicare's (and private insurers') capital payment policies have undergone many twists and turns over the past half century. But the link between profitability and ability to expand and modernize has been a constant. In effect, all non-federal hospitals have been forced to become quasi-commercial enterprises, and to think of themselves in business rather than social terms[4]. As profitability became mandatory for hospital survival, the distinction between for-profit and non-profit hospitals began to erode—although even decades later, for-profits continued to deliver inferior quality care at higher prices.[7,8]

The price-boosting that Ly identifies as a key profit-driver (among non-profit as well as investor-owned hospitals) is just one of the ill-effects of making profit margin the mission. Hospitals' manipulations of their payer and service mixes, the efforts squandered on financial gaming, and the ethical compromises that have become commonplace in the healthcare milieu are also, like price gauging, antithetical to the public's interests.

Hospitals' efforts to avoid money-losing patients, effectively excluding many of those most in need, have become so routine that many of us have become inured to this disgrace. New York City's private academic medical centers exclude almost all uninsured persons and maintain separate clinic systems for patients with Medicaid, leading to the de facto racial as well as socioeconomic segregation of care,[9] a situation that is not unique to New York. The CEO of the Mayo Clinic—which generated an operating surplus of $707 million last year, while investing $714 million in new capital projects—instructed employees to "prioritize" patients with private insurance over those with Medicaid, and even Medicare.[10,11]

The profit imperative, even among non-profit hospitals, similarly distorts the mix of services that hospitals choose to offer or promote. Money-losing services like mental health and primary care are accorded second-class status, in contrast to the opulent resources devoted to elective cardiac and orthopedic interventions, even those of dubious value.

Selectively recruiting profitable patients and excluding the unprofitably ill require considerable bureaucratic effort and expense. But that is just the beginning. Much more is spent to maximize billings and collect payment. At one non-profit Utah hospital system, 2300 employees, 6% of all employees, work on claims processing and bill collections.[12] Meanwhile, the patient chart has morphed from a clinical diary for facilitating care into a billing document driven by commercial imperatives, padded with redundant (and even misleading) material. Physicians now spend half their time on electronic documentation and other clerical/administrative tasks.[13] Overall, the average US hospital now devotes more than one quarter of its budget to administration, a share that is continuing to increase, and is already twice that in Canada (or Scotland).[14]

Why is hospital administration so much leaner in Canada? Although physician payment in Canada's single-payer system looks a lot like US Medicare's, its hospital payment strategy is dramatically different, more akin to the way we fund the VA. Canadian provinces (and Scotland) pay hospitals' global operating budgets, with separate government grants for capital costs. Even countries like France, Switzerland, and Germany which have more complex universal social insurance schemes, fund much of new hospital investments through government grants rather than hospitals' profits. This dampens US-style entrepreneurial incentives, leading to lower bureaucratic costs, less price-inflating gaming, and greater healthcare equity.

Profit-seeking does not just undermine efficiency and equity, it also fosters corruption. For-profit hospital firms have been most frequently implicated in the most egregious incidents, paying billions to settle fraud and abuse claims. But the faltering moral compass of non-profit and even public hospital leaders has an even greater impact because they control 80% of community hospitals, and almost all academic medical centers. Massachusetts General Hospital received $123 million in royalties and licenses over a four-year period,[15] mostly from orthopedic device-makers whose high prices are borne largely by Medicare. In 2013, 73 leaders of academic medical centers also sat on the boards of 85 publicly traded healthcare firms, receiving median compensation of $209,000 per directorship, and, in addition, held 5,493,946 shares of stock in those firms.[16] It takes extraordinary ethical gymnastics to justify such dual commitments.

Ly implies that a crackdown on hospital prices would lead to salutary change, goading hospitals to seek profit through efficiency. But controlling prices without eliminating profits could amplify current profit-inflating misbehaviors, e.g., prioritizing the care of privately insured patients. As long as profit-centered care remains the key to hospital survival, patient-centered and community-centered care will suffer.

No law of nature requires that hospitals make profits in order to thrive. What is needed is a single-payer reform that:

- Pays hospital lump-sum operating budgets, like those for schools, fire houses, or VA hospitals;
- Claws back any money they do not spend on care; and
- Allocates truly needed capital funding through a region-wide accountable government grant program that directs investments to the highest priority, community responsive projects.

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REFERENCES

1. **Ly DP, Cutler DM.** Factors of U.S. hospitals associated with improved profit margins: An observational study. JGIM 2018; DOI: https://doi.org/10.1007/s11606-018-4347-4.

2. MedPAC. Report to the Congress: Medicare payment policy. Medicare Payment Advisory Commission, Washington: March 15, 2017. Available at: http://www.medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0 (access 2/17/2018).
3. **Stevens R.** In sickness and in wealth: American hospitals in the twentieth century. New York: Basic Books, 1989.
4. **Brown JB** with **Thomas SR** and members of the Harvard University Health Capital Project. Health capital financing. Ann Arbor, MI: Health Administration Press, 1988.
5. **Stambaugh JL** A study of the sources of capital funds for hospital construction in the United States. Inquiry June, 1967;14:3–22.
6. **Wilson G, Sheps CG, Oliver TR.** Effects of hospital revenue bonds on hospital planning and operations. N Engl J Med 1982;307:1426–1430.
7. **Devereaux, P J, Choi P T L., Lacchetti C, et al.**. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. Can Med Assoc J 2002;166:1399–1406.
8. **Devereaux PJ, Heels-Ansdell D, Lacchetti C, et al.** Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. CMAJ. 2004;170(12):1817–1824.
9. **Tikkanen RS, Woolhandler S, Himmelstein DU, Kressin NR, Hanchate A, Lin MY, McCormick D, Lasser KE.** Hospital payer and racial/ethnic mix at private academic medical centers in Boston and New York City. International Journal of Health Services. 2017; 47(3):460–476.
10. **Kacik A.** Mayo Clinic CEO Noseworthy to retire. Modern Healthcare February 26, 2018:6.
11. **Olson J.** Mayo to give preference to privately insured patients over Medicaid patients: Pushback on Medicaid, Medicare part of a trend. Star Tribune March 15, 2017. Available at: http://www.startribune.com/mayo-to-pick-privately-insured-patients-amid-medicaid-pressures/416185134/ (accessed March 4, 2018)
12. **Kacik A.** Intermountain joins outsourcing trend for revenue-cycle management. Modern Healthcare January 29, 2018:8.
13. **Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, Westbrook J, Tutty M, Blike G.** Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. Annals of internal medicine. 2016;165(11):753–60.
14. **Himmelstein DU, Jun M, Busse R, Chevreul K, Geissler A, Jeurissen P, Thomson S, Vinet M-A, Woolhandler S.** A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far. Health Aff. September 2014;33:1586–1594.
15. https://openpaymentsdata.cms.gov/hospital/220071/payment-information (accessed March 6, 2018).
16. **Anderson TS, Good CB, Gellad WF.** Prevalence and compensation of academic leaders, professors,and trustees on publicly traded US healthcare company boards of directors: cross sectional study. BMJ 2015:351:h4826.