CONSUMER HEALTH PERSPECTIVES

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HOSPITAL MANAGEMENT CORPORATIONS

CREEPING PROPRIETARIZATION

The future of America's non-profit hospitals is uncertain, largely because of the emergence of two contradictory trends. On the one hand, increasing public awareness of the lack of accountability in the delivery system has led many groups (the American Public Health Association and the Consumer Commission among them) to endorse public ownership of all health facilities through the creation of a National Health Service. At the same time, there is a growing tendency of voluntary and public hospitals to contract with private, profit-making "hospital management corporations" to take over their administration and fiscal management.

Given the dubious record of privately-owned health institutions in delivering services free from financial scandal, not to speak of questionable patient care practices (witness the recent nursing home investigations), the movement to private management on the part of the non-profit hospitals should be cause for serious concern among the public and its representatives in government.

Although there has been much public pressure on hospitals to cut costs, decisions about how and where economies can be made are not easily identified by service-oriented hospitals. But where economies are made will have far reaching consequences for patient care, and therefore the remedy of employing hospital management corporations must be carefully reviewed.

Quality of care and access to services by all segments of society, regardless of ability to pay, are at stake. Placing voluntary and public hospitals under the auspices of management firms whose prime goal is not service, but the efficiency which leads to profit, subjects vital health care decisions to mixed (if not contradictory) motives. Though there is little dispute that health care can and should be delivered more efficiently, the consumer must carefully examine the ability of the profit-making sector to perform that task without sacrificing quality, accessibility, availability and other equally important components of health care services.

Originally, hospital care in America was regarded as a charitable and public charge. A version of this tradition has continued into the present day, with most hospital care (financed chiefly by government and non-profit insurers) being delivered through non-profit institutions. As recently as 1976, only 12% of general hospitals, nationwide, were operated for profit. In some states, profit-making hospitals are entirely prohibited.

The alacrity with which many voluntaries have moved to private management has lent credence to the charges of many consumer groups that the "non-profit" hospitals were not functioning in the public interest. At a time when the public, through increased recognition of the importance of consumer participation and representation, has begun to gain a foothold in the formulation of health policy, this retreat of hospital administration into the proprietary sector is particularly ironic.

This issue of CONSUMER HEALTH PERSPECTIVES discusses the qualitative, fiscal and legal issues raised by profit-making firms taking over the management of non-profit hospitals. In studying this subject, the Consumer Commission took a look at the proprietarization experience of two major New York City voluntary institutions, Roosevelt and Flower Fifth Avenue hospitals, both of which entered into contracts with a Tennessee-based hospital management corporation, Hospital Affiliates International (HAI). This description of the New York City experience is followed by an overview of Ruth Roemer's recent report to the National Health Law Project on proprietary management firms in California county hospitals. Also included are the results of a report by a group of public-interest accountants on the performance of hospital management firms in the West.

Since most decisions to contract with hospital management corporations are made when hospitals are under financial duress, particular attention is given here to the claim that profit-making management firms can control costs through efficient management techniques. The major concerns, however, in this discussion of proprietarization are its sweeping implications for long-range decision-making in the health care sector and its immediate effects on those who seek care in the newly proprietized sector.

THE LURE OF PROPRIETARY MANAGEMENT

Hospitals of all kinds—large tertiary care complexes, municipals in poor neighborhoods, small hospitals in rural communities—have fiscal problems and are coming under heavy pressure to operate themselves more economically. The major health insurers and federal and state government have drawn the lines of battle with the hospitals' 15% annual inflation rate and soaring *per diem* charges.

Non-profit hospitals, with their obligations to serve the indigent, their teaching requirements, their confused lines of accountability running between medical and administrative staff, have never been known for economic efficiency. Operating as independent fiefdoms, hospitals often find themselves in a struggle for economic survival, competing with one another to attract physicians and to amass an impressive array of equipment and services. Meanwhile, increasing labor costs, along with greater demands from society (perhaps unduly spurred by physicians) for inpa-

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tient services, make strenuous demands on hospital finances. As a result, many institutions find themselves in major financial difficulties, although their services are astronomically expensive.

In terms of solutions, profit-making management firms have rushed in to fill a vacuum in public policy. Boards of directors of public and voluntary hospitals have taken the lure that management firms hold out: that the superior management capabilities of private enterprise will put hospitals on the road to fiscal recovery. Hospital management corporations, usually operating "chains" of hospitals composed of separate institutions located throughout the United States and even abroad, have offered the fiscally troubled hospitals the prospect of saving money through shared purchasing, other economies associated with coordination and cooperation, and generally rigorous expert management techniques.

It is not difficult to see how the small or isolated hospital, with its limited capacity for hiring special administrators or technical consultants or for entering joint purchasing arrangements with other hospitals, may perceive that there is an advantage in affiliating with a commercially operated chain.

What is surprising is the fact that although hospitals could work out cooperative buying services among themselves without paying the consultant fees that go along with proprietarization, they do not. Rather, they wait until their financial condition is critical, and then decide to purchase what they could have had for nothing.

Less innocent are the motivations of boards of directors who look to management corporations to shoulder "distasteful" administrative decisions—the laying off of service personnel, for example, or the closing of an outpatient department—which they see as necessary for institutional survival. A hospital management arrangement allows board members to turn their heads from the medical and/or social consequences of cutbacks made in the name of cost-efficiency.

BURGEONING BUSINESS

Hospital management corporations, portraying themselves as having the practical and technical know-how sorely lacking in the non-profit sector, began to acquire and manage hospitals as early as 1968. In the seventies, the management industry is experiencing remarkable growth.

In 1975, there were 91 privately managed hospitals, with a total of 10,785 beds. In 1976, this increased to 127 hospitals with 16,063 beds. By mid-1977 the Federation of American Hospitals Directory reported 202 managed hospitals with a total of 24,181 beds.

This growth is reported regularly in the financial papers. An E.F. Hutton's *Industry Report* (February 8, 1977) states:

> the common shares of the leading hospital management companies are...recommended as attractive speculative purchases for capital gains...
>
> These companies have acquired excellent growth records over the past five years for outstripping the progress of both the overall health care industry and the community hospital sector, two of the most rapidly expanding segments of the American economy...
>
> Prospects for the next three to five years appear equally favorable, and we project that leaders in the hospital management field will be able to increase profits at annual rates of 15%-20% in 1977 and in succeeding years assisted by large-scale expansion programs recently undertaken by several companies.

Hutton cites several reasons for this optimistic forecast:

1. there is increased coverage under government and private health insurance. Hospitalization is encouraged by these programs.
2. the population is getting older and requiring more hospitalization.
3. it is expected that there will be additions in the number of hospital beds in community hospitals through new facilities and plant expansion. Although it is estimated that 100,000 beds are located in inappropriate geographical areas or are medically nonconforming, the Department of Public Health [sic] estimates that the country needs more than 80,000 new beds.
4. Outpatient services in hospitals are expected to increase.
5. The advances in technology have resulted in greater hospital utilization.
6. Hospitals have proven their ability to be granted rate increases.

A September, 1977 article in the *New York Times* revealed that while brokerage stocks are selling at their lowest levels since early 1976, hospital management companies are among the top performers: "By way of contrast, *Value Line*...rankings for relative performance during the next year are, at the present time, accorded to medical services, or hospital management companies..."

Fortune magazine (December, 1977) was euphoric over hospital profits: "It sounds like a joke, but it happens to be true! In a year when Wall Street has generally been sick, the hospital stocks have done just beautifully."

The *Fortune* article spells out how the financial success of hospital management companies is directly related to favorable decisions made in Congress regarding Medicare and Medicaid cost-plus reimbursement policies. It also explains how the use of part-time help and high-margin, capital-intensive ancillary services—such as laboratories and radiology facilities—leads to the maximization of profits. Nowhere are the qualitative effects of relying on part-time help discussed, nor is the possibility raised that harmful, painful or unnecessary laboratory tests may be a side effect of profits.

ABOUT HAI

How do management firms work and how do they make money? Hospital Affiliates International, Inc. (HAI)—which undertook the management of Roosevelt and Flower-Fifth Avenue Hospitals in New York City—is the fourth largest hospital management company in the country in terms of revenue.

It is the leader in the field, however, when it comes to number of management contracts. As of December, 1976 HAI had 73 hospitals in operation or under development containing more than 9,500 beds. Of these facilities, 48 were managed by HAI and 25 were HAI-owned. By June 1977, the number of HAI-managed hospitals had quickly risen to 56, while the number of company-owned facilities remained stable at 24.

Under its management contracts, HAI becomes responsible for the total, day-to-day management of the hospital. All the employees of the hospital, with the exception of the chief administrator, remain on the payroll of the institution; but the administrator, appointed by the management firm, can be paid either by the hospital or by HAI, depending on the terms of the contract. If on the HAI payroll, the administrator is eligible to participate in HAI's stock option plan and other incentive programs.

According to the HAI Annual Report of 1975, specialists in accounting, auditing, budgeting, community relations, construction, dietary services, emergency room procedures, environment control (housekeeping), equipment planning, food management, laboratory operations, labor relations, maintenance, medical records, nursing, pharmacy operations, physician recruitment, purchasing, radiology, systems and procedures, tax management and third-party reimbursement are all made available to the hospital. After the contract has been signed, these specialists survey the hospital, make recommendations and work with the administrator to implement changes. According to HAI, the trustees of the hospital, though delegating administration to the management corporation, retain all policy-making authority.

The cost of engaging management services varies with each institution. Corporation fees are usually based upon such factors as the hospital's gross revenues, range of services provided and the amount of effort required to make improvements. The method of payment agreed upon may be a flat fee, a flat fee plus an incentive, a per-patient-day rate, a percentage of gross annual revenue, or a straight incentive factor. According to Jack Anderson, Chairman of HAI, the most common form of reimbursement is a flat fee plus an additional bonus calculated on an incentive basis. The total usually amounts to anywhere between four and eight percent of a hospital's gross annual revenues. Durations of contracts vary, but are typically in effect for three to five years.

HEALTH CONGLOMERATION

How well do management corporations do? According to *Business Week*, hospital management firms usually break even the first year they manage a hospital, and their profits range from one-third to two-thirds of the annual fee thereafter. The fees charged by HAI in New York City (per year per hospital) were in the $400,000 to $500,000 range. Assuming the *Business Week* formula to be correct, profits in New York would range upwards from $133,000 per year for each hospital.

Management corporations have other ways of making money. HAI, for instance, has a comprehensive national purchasing program for buying supplies for its hospitals. Group purchasing is one chain management method which purports to save money for hospitals. In the case of HAI, the supply companies from which many of its hospitals purchase their goods are themselves HAI subsidiaries. These companies include PSC Disposables, Inc. (Hospital Room Supplies), Allied Laboratory, Inc. (Laboratory Services), and National Medical Supply Corporation. The precise extent of HAI's profits which are derived from supplying business for its own subsidiaries cannot be inferred from either its annual report or its SEC Form 10-K, but HAI's remarkably tangled web of interests includes the following:

- Hospital Care
- Hospital Supplies
- Laboratory Services
- Hospital Management

In all, HAI has done well. According to its Annual Report for 1975, net annual earnings increased from $3,960,000 in 1974 to $4,118,000 in 1975. Management contracts were spoken of in promising tones, though at the time they amounted to only 10% of HAI's total annual revenues.

The profitability of the health care business in general has been an inducement for private firms to diversify their holdings into an increasing variety of hospital-related fields. This raises the possibility that the health industry will be consolidated into fewer and fewer private hands. In fact, such a trend is already taking place. Insurance Company of North America, the fourth largest commercial health and accident insurer in New York State, acquired both HAI and HMO International (a pre-paid health plan) during the last year as part of its plans to expand its interests in the health field. INA (to which New York residents paid a total of $17,921,068 in premiums in 1975) is a diversified insurance company offering a wide range of life, health and malpractice insurance as well as owning a chain of seventeen hospitals.

HAI is not alone in being assimilated into a larger corporate entity. Humana, Inc. (the sixth largest hospital management corporation a year ago) successfully purchased a majority of American Medicorp's stock in early 1978. Medicorp was the largest hospital management corporation one year ago. Also competing for control of Medicorp was Hilton International, a wholly owned subsidiary of Trans World Airlines.

Having the nation's inpatient care delivered by a few powerful private interests, with minimal ties to the regions served and minimal accountability to the interest of health consumers is not a prospect to be relished by those who see health care as a public service.

ADMINISTRATION OR POLICYMAKING?

In his book on hospital management, *Road to Recovery*, Jack Anderson discusses the many factors which bring about improved fiscal health for hospitals. One of the factors stressed by Anderson is improved fiscal screening of patients. HAI institutions prefer to do a thorough credit and collection check on patients well in advance of the admission date, and negative financial information about patients is passed on to physicians. Anderson suggests that doctors be given a series of lectures on this subject and be shown how good fiscal screening can be translated into equipment improvements for the hospital.

HAI's orientation can also be shown by the fact that, in its annual report to the SEC, the "more profitable" nature of ancillary (laboratory, radiology, pharmacy) services is remarked upon, as it is in the annual report to stockholders.

Anderson's book, HAI's financial reports, the magazine articles on the general subject of management corporations, help us to put together a partial picture of the tactics used by management corporations to generate revenue and to save on expenditures. Among these are: fiscal screening, employment of part-time rather than full-time personnel, the use of ancillary services where profitable, and purchase of costly equipment to draw physician staff (and thereby swell the occupancy rate). Each of these methods can have implications that go beyond efficient administration. In fact, hospital policy is being made.

Fiscal screening may result in the skimming of profitable cases for the proprietary or "managed" institutions, putting an unjust burden on other hospitals to care for the poorer and oftentimes sicker patients. Proprietary hospitals have typically cared for patients with simpler maladies, and have left less profitable services to the other hospitals. This policy, known as "cream skimming," undermines the whole notion of equal access to health care and is especially to be avoided by public or voluntary hospitals created and chartered to care for the whole community, including the medically indigent.

If layoffs are effected to save money by employing part-time and *per diem* staff, quality of care (not to mention labor practices) is at issue. What guarantee exists that layoffs are not made at the expense of services?

If a proprietary management firm recognizes that capital intensive equipment is the most profitable asset in the hospital what checks exist to control over-utilization of dangerous procedures or the ordering of unnecessary tests?

The examples could easily be multiplied, but the implications of administrative decisions for policy—medical and social— are plain. Both the hospital trustees who sign proprietary management contracts and the firms who do the managing persist in endorsing the fiction that "management decisions" and "policymaking" are clearly separable activities and concepts. Policymaking is reserved for the governing board; management and administration are "delegated" to the management corporation, and are portrayed as "derived powers." That this clear line exists is a myth.

Another myth is that corporation-hired administrators can somehow serve two masters. Perhaps through some superior faculty of mind or will, hospital administrators, recruited and selected by a proprietary management firm, retained and remunerated on the basis of their ability to cut costs and maximize profits, can simultaneously express the will of the hospital governing board charged with delivering the best possible health care to its community.

The above-described management methods necessarily have great impact on the quantity and quality of medical care received by the affected community. Consumers have long recognized that over-utilization, skimming and under-staffing already exist in our hospital system. The advent of private hospital management can easily exacerbate these problems and further remove the possibility of publicly arrived-at solutions.

HAI IN NEW YORK

Roosevelt Hospital, a major New York voluntary, contracted with HAI in April, 1977. Apparently the largest contract in hospital management history up to that point, the base fee was $400,000, plus an incentive bonus of $100,000 to be paid at the discretion of the Board of Directors. The contract was undertaken for a period of two years, with an option to extend the agreement for an additional year.

In Article II of the contract, the overall responsibilities of HAI at Roosevelt were stated as follows:

> HMC (a wholly owned subsidiary of HAI) shall manage and operate the hospital on a daily basis and shall provide short and long range planning necessary to the maintenance of high standards of patient care, and effectuation of the efficient utilization of resources, consistent with the policies adopted by the Board, and shall furnish the hospital with HMC employees and HMC staff...

The provisions of the contract include the right of HAI to hire and fire all operating and service personnel. The hospital's Board of Directors has the option of hiring the chief executive officer of the institution, but in fact the management corporation furnished the institution with the Associate Executive Vice President, an Associate Vice President for Administration, and an Associate Vice President for Finance. The hospital covers their salaries. The Board itself hired no executive officer.

Roosevelt entered into the HAI agreement because of its poor fiscal condition. Since 1966 the hospital's net annual loss has ranged from $445,000 to $9,000,000 (with the exception of 1971, when the loss was only $4,000). Because of these heavy losses, Roosevelt's unrestricted endowment had been virtually used up.

It is difficult to assess the impact of HAI management on Roosevelt—both because of the recent date of the HAI takeover and because information and resources are lacking for consumers to undertake a comprehensive study. However, it was possible to test the HAI claim that it was able to purchase hospital supplies more cheaply for Roosevelt. To this end, the prices paid by Roosevelt Hospital and the prices paid by the Health and Hospital Corporation (the quasi-independent public benefit corporation which runs New York's municipal hospitals) under its group purchasing program were compared for nine selected representative items (see Table).

PRICES PAID BY ROOSEVELT HOSPITAL AND THE HEALTH AND HOSPITAL CORPORATION FOR NINE SELECTED ITEMS

	Roosevelt (1977)	**HHC** (1976)
4x4 Plain Sterile gauze sponge-per 1200	$37.13	$33.61
Exam Gloves-latex Sterile-per 100	13.23	8.16
Canes 1"-each	1.85	1.57*
Dimetapp Extentabs-per 500	34.56	20.00
Foam Cups-8 oz.-per 1000	7.62	7.05
Lids for foam cups-per 1000	4.25	4.30
Sitz baths-disposable-per 10	30.82	13.90
Disposable Diaper-Newborn size per 360	17.80	16.50
Disposable Diaper-Daytime size per 180	24.40	11.50

*Not in HHC purchasing program. Price is lowest paid in open market by municipal hospitals.

For all but one item (lids for foam cups) Roosevelt paid a higher purchase price than did the city's municipal hospitals.

In June 1977, two months after HAI's assumption of Roosevelt's management, eighty-six hospital workers were laid off. According to Mr. Michael Canselosi, presently Northeast regional director of HAI and former interim manager of Roosevelt, HAI saved the hospital more than $2 million dollars between April and August of 1977 through tightened management and improved revenue-generating procedures.

The overall effect of HAI management on Roosevelt's policies, quality and morale are not easily ascertained. The fact that the management corporation did not obtain supplies economically, the fact that some of their savings were obtained by lay-offs cast suspicion on the value judgments involved in HAI management. The very difficulty of making a public, open assessment of the state of an important voluntary hospital is illustrative of the problem of having a public service delivered by a privately accountable, profit-making corporation, often based thousands of miles from the community served.

FLOWER AND FIFTH AVENUE HOSPITAL

On March 15, 1976, Flower & Fifth Avenue Hospital entered into a contract with Hospital Affiliates Counselling Corporation of New York (HCC), a subsidiary of HAI.

The agreement between Flower and HAI was termed a consultant contract, although it differed little, in effect, from a management arrangement. In a letter of agreement from Joseph C. Hutts of HAI, the relationship was described as follows:

ARE HOSPITAL MANAGEMENT CONTRACTS LEGAL IN NEW YORK STATE?

There are two major legal questions about hospital management contracts in New York State. The first relates to the legality of a hospital's governing board delegating its authority to a management firm. Section 720.1 of the State Health Code states:

> Governing authority: (a) There shall be an organized governing authority, or designated person(s) so functioning, who shall be responsible for the establishment of policies and for the management and operation of the hospital, in a manner consonant with the hospital's objectives of making available quality health services at a reasonable cost. The governing authority shall not enter into any agreement limiting such responsibility.

When Hospital Affiliates, Inc. was negotiating its contract with Roosevelt Hospital in New York City, there was a great deal of debate as to whether its board of directors would be relinquishing its authority under the contract and therefore acting illegally. Meetings were held in the Health Department, where there was apparent disagreement as to the interpretation of this aspect of the Health Code. Nonetheless, Roosevelt's management contract was ultimately approved.

Recent information indicates that the NYS Office of Health Systems Management is considering a change in the State law to eliminate any legal bar to employing a proprietary management firm to operate a hospital in New York State.

A second legal question exists: whether under federal and state law the costs of proprietary management firms are a legitimate, reasonable and allowed reimbursable expense under Medicaid, Medicare and Blue Cross. Should reimbursement to hospitals be computed to cover HAI management fees which have run up to $400,000 per year? The Cost Control Act of 1969 states regarding state approved hospital reimbursement rates:

> Prior to the approval of such rates, the commissioner shall determine and certify to the Superintendent of Insurance and the State Director of the Budget that the proposed schedule for payments for hospital and health related service are reasonably related to the costs of efficient production of such service.

If no reimbursement can be paid by a third party to a hospital unless proof is given that the cost item is associated with "efficient production of services," and a management contract led to increased cost, or even equal costs, can that management fee be legally reimbursed under NYS law?

In regard to quality of care, it should be noted that if a hospital's cost ceiling has been reached, cutbacks in patient services might be made in order to insure that the management corporation gets paid its fee.

In a letter to the New York State Health Department, the Consumer Commission wrote:

> A management contract with a proprietary firm is an added financial cost without any guarantee that the hospital is acting in accordance with the 1969 Act. The cost of a management contract, in our judgment, should not be a reimbursable cost item.

In response to the Commission's position, Glenn E. Haughie, M.D., Deputy Commissioner of New York's Department of Health, wrote:

> ...the Department has reviewed in depth the contract between Flower & Fifth Avenue Hospital and Hospital Affiliates. Our review confirms the competence of Hospital Affiliates in managing hospitals. Copies of the management contract have been provided to the Department. We have also reviewed the issue of reimbursement costs and have concluded that such cost would be an allowable hospital administrative and fiscal cost, should this cost be found to be reasonable and within the allowable cost ceiling.

and

> Article 28 of the Public Health Law does not prohibit management consultation on contract agreements where it can be shown that the Governing Authority has not delegated its responsibility for managing the hospital operation. A review of Flower and Fifth Avenue Hospital contract did not present a problem on this issue, and it is our opinion that the hospital has acted properly.

It appears that the NYS Health Department preferred to avoid a meaningful review and action regarding the proprietary management firm takeovers of hospitals chartered by New York State as voluntary, non-profit institutions. Blue Cross and Medicare funds will continue to indirectly pay profit-making hospital management fees through the non-profit hospital conduits—all with a minimum of public review and accountability.

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1. **Relationship of NYMC and HCC.** HCC [an HAI-owned consulting firm, Hospital Affiliates Counseling Corporation of New York] shall perform its duties hereunder as a consultant to NYMC through the Executive Director of the Hospital (Executive Director). The decision to accept any recommendation made by HCC shall rest with the Executive Director as Chief Executive Officer of the Hospital. HCC shall submit monthly reports and recommendations to the Executive Director. This Agreement in no way limits, or is intended to limit, or otherwise restrict the authority and responsibility of the Board of Trustees of NYMC for the operation of the hospital.

5.1 **Special Employees.** HCC shall recruit for the Hospital a qualified Hospital Administrator and Associate Administrator both of whom shall be acceptable to the Executive Director. The Hospital Administrator and Associate Administrator shall be employees of and compensated by the Hospital. Costs incurred in the relocation of the Hospital Administrator and Associate Administrator employed by the Hospital after the effective date hereof shall require the prior approval of the Executive Director and shall be paid by the Hospital.

HCC (HAI) was to perform its duties "as a consultant" to the Executive Director; a qualified Hospital Administrator and an Associate Administrator were to be recruited and were to be "acceptable" to the hospital's Executive Director. As it happened, however, the position of Executive Director was itself filled by HAI's Michael Barton. The Hospital Administrator was also from HAI, and two Associate Administrators were recruited and hired by HAI but not from their own ranks. HAI supplied these high level staff, who were compensated by Flower and Fifth Avenue Hospital. In other

words, their salaries were paid in addition to the HAI consulting fee.

Although the Letter of Agreement strongly implies an arms-length distance between Flower's Executive Director and the consulting firm, and between the Executive Director and the other administrative officers, such distance did not in fact obtain. The "decision to accept any recommendations made by HCC" rested with a man from HCC's parent corporation, HAI.

The Executive Director, Barton, was responsible for managing the hospital, theoretically under the direction of the hospital's Board of Trustees. Also referred to in the letter were the other areas of HAI involvement: analysis of services, quality control, maintenance of standards, preparation of annual budget, accounting procedures, purchasing procedures and capital expenditures. For its services, HAI was to receive a fee of $400,000 a year.

Executive Director Barton, in an interview conducted by a CCAHS board member, stated that when HAI came to Flower, its first task was to bring the institution into better financial condition. In pursuit of this aim, a total of 181 employees lost their jobs—100 through lay-offs and another 81 by attrition. In addition, changes were made in data processing, billing, accounting and purchasing. This process took about six months. According to Barton, only after the institution appeared to be financially more stable was quality of care examined.

DID HAI FINISH OFF FLOWER?

Although a thoroughgoing investigation of Flower's finances and quality under HAI's tenure could not be undertaken, interviews with nursing, administrative, technical and medical staff at Flower elicited charges of mismanagement by HAI, including non-payment of crucial bills (leading to shortages in blood, tetanus toxoid and even clean linens), lay-offs of vital service staff, replacement of housestaff medical malpractice insurance with a less comprehensive self-insured plan, high pressure to fill beds, and a decline in teaching quality due to the recruitment of physician staff to whom teaching was not a high priority. Staff nurses who did not wish to be quoted charged that the practice of employing temporary "per diem" staff (apparently undertaken to offset labor shortages caused by lay-offs) led to slowness, inefficiency and a lower quality of care due to the fact that temporary aides and nurses had no familiarity with the units to which they were assigned. HAI's involvement with Flower ended on February 28, 1978.

Assessing HAI's impact on Flower is difficult: Flower had been in financial difficulty for some time prior to HAI involvement. During HAI's tenure, its financial condition worsened until an arrangement was made between the hospital and the New York Archdiocese in which the Archdiocese was granted two-thirds of the seats on the governing board in exchange for assuming responsibility for the hospital's millions of dollars in debts. More recently, plans have been made to convert the hospital into a long-term care facility for retarded children.

Employees at Flower have charged that HAI mismanagement hastened the hospital's decline. Charges that millions of dollars in accounts receivable were lost and that the complexities of the reimbursement system in New York were not understood by HAI's managers have also been leveled at the management corporation. The Consumer Commission believes that New York State health agencies closed their eyes to the law when they permitted consultant fees to be paid HAI despite the stipulation in the Cost Control Act of 1969 that all reimbursed costs be related to "efficient production of service." (See box, "Are Management Contracts Legal in New York State?")

THE CALIFORNIA EXPERIENCE

In a 1977 report to the National Health Law Project (NHeLP) *Administration of County General Hospitals in California by Private Management Firms*, Ruth Roemer was able to bring to light some specific problems raised by proprietary management of publicly-owned health facilities, and to define areas for further investigation.

In recent years, nine counties in California have entered into contractual agreements with management firms, six with the Nevada-based National Medical Enterprises, Inc. (NME). Much of the information in Roemer's report comes out of her examination of the experience of one county—Merced—with NME. Merced County Medical Center was selected both because time constraints forbade a more comprehensive study and because that county hospital's involvement with NME was of the longest duration in the state.

Roemer's report states that one effect of NME management in Merced has been to implement much tighter billing and collection procedures: patients on Medicare are billed for deductible charges which formerly remained uncollected by the county; county departments are now billed for the treatment of county employees (charges formerly uncollected because they represented expenses that stayed within the county); while the county is billed by NME for 85% of all costs of indigent care, a collection agency continues to seek the remainder from the indigent patients themselves. Unreimbursed portions of billings are consigned to the category of "overhead" charges or "administration" and, reports Roemer, become the basis for increased charges the following year. Thus assigned, uncollected charges push up the per-diem reimbursement rate for the hospital—a tactic which may appear to improve the fiscal position of the hospital, but which, in a larger sense, is not a savings, but a pass-along to the consumer.

Under NME's Merced arrangement, contractual arrangements are made with groups of private physicians for the operation of specific departments, such as radiology, pathology, emergency, etc. A proportion of revenues from fees for service in these departments go to the physicians and the rest accrues to the hospital. Roemer reports that, since the inception of NME operations, and the consequent contracting out for emergency services, the costs of a visit to the emergency room at Merced rose from about $20 per visit to around $50. Emergency visits are, thus, highly lucrative and can be relied upon to offset losses in other hospital departments. Since Merced's out-patient department is not organized for "walk-in" visits or for those patients who do not fit into its teaching objectives, the more expensive emergency room has been steadily increasing its share of outpatient encounters. These "cost savings" tactics—besides passing along increased expenses to consumers—present major problems for access and quality which warrant further investigation.

PASSING THE MEDICAL BUCK

In Sonoma County, NME management resulted in higher hospital charges, and ambulatory care began to accept only those patients with a source of payment. This withdrawal of responsibility for ambulatory care for the medically needy apparently resulted in attempts by public health nurses to set up available free clinics in the Sonoma County area. Other suggestive data turned up by Roemer's exploratory report was the indication that the NME-managed hospitals—when compared with non-proprietary county facilities in California—receive a substantially larger proportion of their revenues from private payers than from those with Medicare and Medicaid coverage. This indication of possible "skimming" by privately-managed hospitals, that is, the practice of altering the hospital caseload in favor of those who can

JOINT PURCHASING AND CONFLICT OF INTEREST

Many management firms offer joint purchasing programs to their client hospitals, whereby supplies are purchased from companies which are themselves subsidiaries of the hospital management corporation. A potential for conflict of interest lies in the incentive for the hospital purchasing agent or administrator not to seek competitive bids for needed goods and services or to overbuy such goods and services even when the unit price is competitive.

This question was raised in California, where several county hospitals are under proprietary management. Ruth Roemer, in her report on the relationship between hospital management corporations and county hospitals in California, relates a case in which National Medical Enterprises (NME) managed a hospital and, under contract, purchased hospital goods and supplies from its own wholly owned subsidiaries. The county requested an opinion from the California Attorney General as to whether this practice constituted a prohibited conflict of interest. Since the hospital administrator informs, advises and counsels the county purchasing agent with regard to purchases from concerns paying rebates to the contractor, the Attorney General concluded that the hospital administrator was participating in these decisions as well as influencing government decisions, and ruled that a prohibited conflict of interest existed.

In New York City, it is possible that joint purchasing from a subsidiary is prohibited under Rule 9 of the City's Board of Estimate (Conditions Governing Payments to Charitable Institutions), which forbids Medicaid payments for any business dealings between hospital officers and the facility:

> No money shall be paid to any institution which pays any salary to, gives any consideration for services, (financial and otherwise) by, has any business dealing with or secures goods or merchandise (directly or indirectly) from any officer or trustee or member of its board of Managers, or where any such person otherwise receives any pecuniary profit from the operation of such an institution.

In addition, the less than "arm's length" relationship between administration and "consultants"—in hospitals where management firms play both of these roles—may also be illegal in New York under the same rule.

bring greater revenues to the institution, of course raises serious ethical and legal questions for county or other public hospitals which are chartered to serve the health needs of all those in their area. Again, the point is to be made that if the indigent are to be treated elsewhere in the system (for instance, by public health nurses), the costs will merely have been passed along by the privately managed hospital to another part (probably public) of the health sector. The *total* cost to consumers and government of treating everybody has been increased by the presence of the management firm.

PUBLIC EYE ACCOUNTANTS

In accordance with a request from a Fresno County Group—Community Coalition on Valley Medical Center—a team of accountants associated with Accountants in the Public Interest (API) assessed the financial problems surrounding the operation of Fresno County's tertiary care hospital and analyzed the experience of two proprietary management bidders (NME and Hyatt International).

The API team concluded in a study released on August 26, 1977, that there was insufficient evidence that Fresno County would derive any greater financial benefit from the use of an outside management firm than from the continuation of county management of its hospital.

In its comparative study one of the hospitals investigated by the API team was, in fact, the NME-managed Merced County Medical Center, the same institution studied by Ruth Roemer. Southern Nevada Memorial Hospital, managed by Hyatt, was also studied in an attempt to assess the fiscal consequences of private management of institutions. In the former case, a claim of cost savings was found to be unsupported; in the latter, a surplus in the budget was the result of a 13.5% increase in hospital charges.

In an attempt to assess the comparative merits of the management firms bidding for the operation of Valley Medical Center in Fresno, the accountants requested from NME and Hyatt a description of their respective computation methods and details of their cost components. The accountants were unable to elicit this information from either firm. NME gave "the demands of the competitive market" as the reason for being unable to supply such information. Hyatt did not respond to the request. As the accounting team noted in their report to the Fresno group, since "a substantial expenditure of public funds is involved, the public is entitled to know what it is paying for."

These preliminary looks at the California experience with private management reveal a situation which is doubly grim. Not only do indications suggest that private management decisions can have a negative effect on access, quality and continuity of care—but even the claim that proprietary management is cost-effective has been cast in very serious doubt. The only thing that does come clear in this otherwise murky picture is that management corporations themselves reap a profit from the fees charged to communities, counties, or voluntary hospitals. These fees are ultimately paid for by increased taxes for health costs, increased insurance premiums and increased out-of-pocket payments.

COSTS

On the basis of preliminary evidence, it is not at all clear that hospital management corporations save money for either the hospital or consumer. Until such evidence is presented, and the records of hospital management firms are the subject of routine public audit, the Consumer Commission recommends that the hospital management "fee" be disallowed as a reimbursable cost item by state, federal and other health insurers. Group purchasing arrangements, and other cost saving services which can reasonably be supplied by the public sector, should be established by formation of public consortiums or public-benefit corporations on a city or a statewide basis.

CONSUMER CONCERNS

The fiscal crises of the public and voluntary hospitals reflect many complex social, economic and organizational factors, and consumers should regard any sheerly "managerial" solutions with suspicion. Although the wording of management contracts may satisfy state and local requirements that non-profit hospital trustees not relinquish their responsibilities, such abdication of authority has taken place and will continue to occur. All major management decisions are essentially indistinguishable from policymaking, and management contracts mean that policymaking will—to varying

degrees—emanate from a proprietary frame of reference. Lay-offs, fiscal screening, decisions to purchase costly equipment, to close or to open a particular service—all of these affect the hospital's relationship with the community and reflect social and medical judgments...or, policymaking.

In terms of long-range consumer goals, the move toward proprietarization of hospitals is a harmful detour. Consumers desire public responsiveness and representation on health institutions; proprietarization by its very nature removes hospital administration further from public view. If consumers want community participation and community responsiveness, they must remember that the proprietary administrator is primarily accountable to a management corporation often thousands of miles from the community served. If consumers support regional thinking on the subject of health resources, proprietarization encourages autonomous profit-making businesses, or, at best, thinking that applies only to one corporate "chain." If consumers put quality as their highest priority, the prime motive of a management firm may be a notion of efficiency which is inimical to thorough care. If equality of access is the aim, proprietary firms may have a strong motive to skim for themselves that part of the population with highest insurance coverage and lowest incidence of chronic or serious disease. If consumers are beginning to question the number of unnecessary tests generated by the presence of expensive equipment in hospitals, proprietary management firms may encourage purchase of fee-producing equipment and reliance on lucrative special services.

At a time when consumers want to use their influence to bring health institutions into conformance with broad public health goals, hospitals are far too uncritically capitulating to the "management firm" solution.

Without any external signs, without any explicit change in public policy or law, the non-profit and public hospitals are being deli ered into profit-making hands. If this process of "creeping proprietarization" is to be stopped, consumers must move to have private management of non-profit and public hospitals disallowed under state and federal law and to prohibit the payment of management and consultant fees from the coffers of public health insurance programs.

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