# THE ANDREW PATTULLO LECTURE

## In Our New Competitive World, Is the Health Field Headed for Investor-Owned Takeover? Is it for Better or Worse?

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*PREFATORY STATEMENT ON ANDREW PATTULLO: Andy graduated from the University of Chicago, Program in Hospital Administration in 1943. Following his residency, he went directly to the W. K. Kellogg Foundation. As director of the hospital division of the foundation, he made more contributions to the fledgling programs in hospital administration than anyone I know. By judicious investments across the country, in education, research, and demonstrations, he carefully nurtured hospital administration to a legitimate academic discipline and laid the early foundation for health services research. Open to differences of opinion, Andy supported programs in public health, business, and medical school settings.*

*As founding director of the program at the University of Michigan, I was one of his beneficiaries. His support made a critical difference in our growth and our impact. More importantly, we became good friends. For me, this lecture is a special privilege.*

In the early 1980s, concerns over growing investor ownership in the health field rose to the point where the Institute of Medicine (IOM), National

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Academy of Sciences, was requested to undertake a study of for-profit enterprise in health care. Professionals and legislators alike feared that investor-owned organizations, in order to satisfy stockholders, would become excessively commercialized at the expense of quality of care, education, research, access to care, and the fiduciary responsibility of physicians. A major study was undertaken by the IOM and the results were published, based on public hearings, case studies, reviews of the published literature, and commissioned research.

For a time, the issue appeared to die down. Investor-owned institutions experienced growing pains; some realized a drop in stock price or a burdensome accumulation of debt, as a result of marginal or poor investments. What seemed to be an inexorable force with inherent advantages over not-for-profit and government institutions lost some momentum in the late 1980s.

In the last few years, investor-owned initiatives have resurged and some of the old concerns voiced are being repeated. A few of the strong investor-owned networks reported significant increases in net income; for example, American Medical International (AMI), on January 10, 1995, reported a 39.6 percent increase for the first quarter over the previous year. More recently, National Medical Enterprises acquired AMI and significantly increased its leverage in the market. The Columbia/HCA Healthcare Corp. (COL) has been on an acquisition binge in the last several months, including an 80 percent purchase of the Tulane Medical Center. Joint ventures have been agreed to by COL with such institutions as the Halifax Medical Center, the Medical University of South Carolina, and Charter Medical Corp. Selective management contracts have been signed, such as the one with the Lee County Health Plan (SW Florida). Hurdles have been put in the way; for example, the University of Nebraska Medical Center successfully challenged COL's right to acquire Bishop Clarkson Memorial Hospital under a forty year old agreement giving them right of first refusal. In Kentucky, the state announced that it would rebid its management contract for the University of Louisville Hospital because COL pulled its headquarters out of the city. In Florida, the city manager of Tarpon Springs raised questions about a joint venture between COL and the city hospital. In April 1995, in announcing a consent agreement with the Federal Trade Commission over the merger with Health Trust, Inc., COL added that it would have to divest itself of seven hospitals, end a joint venture that owns another, and gain FTC approval before acquiring any new hospitals in any of six markets at issue for the next ten years.

Faltering delivery organizations have been strengthened by merger or acquisition. For example, in December, 1994, Standard and Poor's Rating Group revised its rating outlook on CNM to *negative* from *stable*, reflecting continued weakness in the company's contract service business and potential rehabilitation reimbursement risk over the intermediate term. Both, in turn, related to pricing pressure and a highly leveraged financial structure. In April, 1995, Horizon Healthcare Corp. acquired CNM in a stock swap valued at $502.1 million, pairing an acquisitive nursing home operator with a debt-heavy rehabilitation company. The two companies will provide long-term nursing care, contract rehabilitation services, and inpatient rehabilitation programs with combined revenues of about $1.6 billion. Consolidations characterize the scene, as they do in the non-profit field.

## Investor-Owned Activity in Perspective

In examining the issue of investor-owned activity in the health field, we should pause and put the subject in perspective. As pointed out in *For-Profit Enterprise in Health*, "in our highly decentralized and pluralistic health system, health care is provided by a mixture of for-profit, secular and religious not-for-profit, and public institutions, some of which are independent and some of which are a part of multi-institutional systems" (Gray 1986). Concern about the adverse effects of profit motivations in health care per se goes back to Shaw 1911. Over the years since, there have been advocates of publicly controlled health care systems—such as we see in many developed countries, rooted in the feeling that health care is an inherent right—and, at the other extreme, there are advocates of a market system with minimal government intervention. Public preference has favored mostly private health care, reflecting a distrust of big government, and public institutions have been cast in the role of provider of last resort. "The debate about for-profit health care per se is not about private versus public control of medical institutions, but is, instead, largely about the difference between (and relative virtues of) two types of private institutions—not-for-profit and for-profit" (Gray 1986), each surrounded by strong passions as well as historical myths.

Still in perspective, we need to remind ourselves that for-profit hospitals are not new. In the early 1900s more than half of the hospitals in the United States were proprietary. This share shrank over time until in the 1980s, it was 13 percent. From 1975 to 1985, however, the number of investor-owned versus proprietary hospitals doubled, while the indepen-

dents declined at about the same rate. Growth for the investor-owned institutions was fueled by purchase of for-profit institutions, both independents and chain-owned (78 percent), and not-for-profits (20 percent).

Traditionally, approximately half of psychiatric hospitals have been owned by the government. The trend here is toward investor-owned systems. Over 80 percent of nursing homes are proprietary, but a growing percent are investor-owned (the rest, non-profit or government).

With a strong tradition of not-for-profit enterprise (e.g., Kaiser Permanente, Group Health Cooperative of Puget Sound, Health Insurance Plan of Greater New York), we have seen a major growth of investor-owned HMOs. In 1983, the first stock of a publicly traded HMO company was issued—U.S. Health Care Systems. Today such companies are a dominant force, and the number of large HMOs has increased at the expense of smaller HMOs. Several of the large HMOs have multi-state networks; many are very profitable. Employers are increasingly concerned about these profits and, of course, want a greater share in them. In some cases, consumers have raised questions about quality of care, because choices have been limited.

Home care is now populated with investor-owned firms such as Abbott, Baxter Travenol, NME, Beverly Enterprises, and HCA, in addition to independent for-profit operations.

In the 1980s, we saw a growth of ambulatory surgery centers and primary care centers, many started by entrepreneurial physicians competing with not-for-profit hospitals. Several of these have since been absorbed by profit and not-for-profit health systems. For-profit ownership became prominent among free standing dialysis centers and cardiac rehabilitation centers and in a small but significant number of hospice care and birthing centers. The accommodation between these centers and vertically integrated health systems (for-profit and not-for-profit) is still underway.

Although now extending to most areas of the country, initially, investor-owned initiatives tended to focus on areas of the country with minimum regulation, maximum population growth, and high per capita income, such as Texas, California, and Florida.

All the delivery institutions mentioned, profit and non-profit and government alike, have, of course, been served by investor-owned suppliers, device companies, and biotech companies. Add to this not only drug companies and, principally, physicians, but also a growing number of other professionals, involved as independents and partners of institutions.

On the financing side, beyond HMOs the competition among for-profit, mutual, and not-for-profit carriers has also been instructive. Non-profit

Blue Cross/Blue Shield flourished on community rating, minimum underwriting, and portability of benefits. Early HMOs had similar characteristics. Against commercial carriers with experience rating and prescriptive underwriting, the Blues had to yield, as did many HMOs. Today, driven by competition, differences are less. For example, some Blues have become mutual companies or investor-owned, and there have been several consolidations among both Blue Plans and HMOs.

Taking all of the above into account, investor-owned growth has been significant.

## Findings of the IOM Study

The findings of the IOM study raised many questions and sharpened the issues, but they were not conclusive. Briefly:

*Costs of Care.* Investor-owned institutions tended to cost more (3–10 percent) on expenses per day; expenses per case differences were smaller. They were more expensive for cost-based payers (8–15 percent) and for charge-paying payers (17–24 percent).

*Access to Care.* According to two relatively weak measures—percent of patients uninsured and the amount of uncompensated care given—differences were also small, i.e.:

—number of uninsured patients: not-for-profit 7.9 percent; for-profit 6.0 percent

—amount of uncompensated care: about even (differences were significantly greater in states where more than 30 percent of the hospitals were for-profit)

*Quality of Care.* Measured by JCAHO approval, board certification of physicians, and number of registered nurses per bed, there was no overall pattern. Special studies on the outcomes of elective surgery were inconclusive.

*Education and Research.* There was far less involvement by investor-owned institutions in education and research, although many were smaller than teaching institutions and it was protested that the not-for-profit hospitals acquired were never involved in the first place.

*Fiduciary Role of Physicians.* It was pointed out that physicians were involved in an increasing number of private ventures, e.g.:

—making substantial investment in technology and equipment they controlled and used

—owning an interest in organizations to which they refer patients

—receiving bonuses on an individual versus group basis from hospitals for taking actions to enhance revenues
—using commercial labs to trade equipment and free up personnel for referrals

How to interpret these and other less than definitive findings was complicated by two factors: First, in the absence of conclusive data, committee debate was fueled as much by personal values as by evidence. As Gray (1986) pointed out, some looked at health as an economic good, emphasizing the attributes of health shares with other goods and services purchased in the market place. Others saw health care as a social good, a world of caring, compassion and charity, emphasizing the characteristics that distinguish medical care from commercial services, e.g., the ability of consumers to judge quality and the inverse relation of need and ability to pay.

Second, the growth of hybrid institutions blurred the difference between investor-owned and non-profit institutions, e.g.:

—proprietary subsidiaries of non-profit institutions
—non-profit contracting for property management
—joint ventures between profit and non-profit institutions
—for-profit alliances of non-profit institutions (e.g., Voluntary Hospitals of America)
—for-profits setting up non-profit foundations
—incentive compensation in non-profit institutions
—profits access to tax-exempt debt through industrial revenue bonds

As a result, the IOM Committee concluded that "available evidence on differences between not-for-profit and for-profit health care organizations [was] not sufficient to justify a recommendation that investor ownership of health care organizations be either opposed or supported by public policy" (Gray 1986).

This conclusion, though based on the evidence available, left a lot of people in the health field uneasy, if not unhappy. Congress acted mainly on physician conflict of interest observations by defining more precisely in regulation what constituted conflict.

## Recent Developments

Since the late 1980s, we have seen some key developments in this same perspective, e.g.:

—the dynamic growth of not-for-profit health systems, vertically integrated and horizontally linked
—not-for-profit hospitals and systems in some cities expanding their market share by buying for-profit facilities
—the formation of a not-for-profit organization to take over two or more assets for sale by investor-owned networks (IRS has issued stern warning that these and other moves must be inspired by more than a desire for access to less expensive capital)
—a gradual movement by non-profit health systems toward assuming risk in the market either through their own HMOs or in partnership with independent HMOs
—a migration of profit and non-profit carriers into managed care through contract, joint ownership, or purchase of delivery systems (projected to be 90 percent business by the year 2000)
—*both* profits and not-for-profits have been in the news

Despite hyping by the press, the recent surge of investor-owned activity has not assumed major proportions. Up-to-date data are notoriously weak, but regarding *hospital* ownership the trends are as follows:

| | *1980* | *1986* | *1993* |
|---|---|---|---|
| *non-profit* | 3,322 (57%) | 3,323 (59%) | 3,154 (60%) |
| *for-profit* | 730 (13%) | 834 (15%) | 717 (14%) |
| *government* | 1,778 (30%) | 1,521 (27%) | 1,390 (26%) |
| | 5,830 (100%) | 5,678 (100%) | 5,261 (100%) |

Source: *AHA Statistical Guide.*

The most remarkable trend is in HMOs—from almost all non-profit in 1980 to 75 percent for-profit (55 percent enrollees) in 1994. Also we see, as mentioned before, a growing for-profit presence in psychiatric hospitals, home care, and nursing home care. In all of the above, there is consolidation, reflecting a motivating and competitive market.

## Looking Ahead

In looking ahead, what kind of growth trends appear likely? Do the investor-owned institutions have an inherent advantage?

As Gray (1986) has well pointed out, investor-owned institutions did not grow in the first place because they were more efficient. Nor was it true that more beds were needed; capital wasn't always the key. Non-profits had access to tax-exempt bonds, and most purchases were of other existing hospitals.

Growth was stimulated by the fact that Medicare and others paid capital costs of investing in hospitals, including reimbursement for interest costs, allowances for depreciation, and return on equity; thus, hospitals were more valuable to purchasers than to current owners. Another factor was stock price. Stock, a vital source of capital, responded to growth in revenues and earnings. Again, as Gray (1986) pointed out, the best way to increase growth in earnings was to acquire more hospitals. Multiples of thirty to forty times earnings produced magic for a while.

The growth of phase one (1970s to mid-1980s) slowed for several reasons:

—Congress changed Medicare's capital payment rules.
—In the private sector, there is a new, more rigorous payment environment.
—The low-lying fruit was picked in targeted areas of the country and good risks became harder to find. Prestigious institutions were largely not for sale.
—Fraud and abuse statutes limited ability to share hospital profits with doctors.
—The stock market fell out of love with several companies.
—Purchase mistakes were made and purchasers were unable to carry their share of debt.
—Non-profit institutions gradually became better competitors (price and quality).
—Aside from COL and a few others, closures and consolidations among acute hospitals has been greater among profits than non-profits and, as a result, there was a turn toward psychiatric hospitals, rehabilitation institutions, home care and HMOs.

On the other hand, currently investor-owned institutions have advantages (some learned with experience) worth noting:

—Reform (the 1994 debates) favorable to the non-profit institution did not pass; the mood of the country still favors non-government solutions and, to many, this means market solutions.

—Investor-owned health systems:

–can set standards easier across systems by executive order and make them stick

–can institute common information systems quickly to measure financial and clinical effectiveness

–have access to equity, as well as debt, which permits large investor-owned systems to make big deals, e.g., $500 million or more, and thus gain dominance in regulated markets

–can take advantage of the fact that today there is a lot of investment money out there against limits on tax-free debt. In a highly liquid market, stock prices are high, banks are lending again, and there is an increasing number of health care REITS available.

–can control technology easier in their systems (not all institutions in an investor-owned system are likely to have an MRI)

–are developing strong ties with business coalitions (through a common language)

–when necessary, can develop partnerships with non-profit institutions to achieve efficiency

–can more easily and quickly close or sell a weak institution or institutions, or convert them

–prospectively, can become more attractive to M.D. groups by sharing equity and aligning incentives effectively. This could be a significant advantage.

–On this phase, the for-profit systems appear to be better managers than they were earlier. For example:

-they appear to be making fewer bad investments and paying more reasonable prices (relative)

-they are achieving greater diversification by type of service offered and geographic location

-they have better appreciation of the need for regional systems and for trophy properties

Do investor-owned have an inherent advantage? Not *inherent*, but they have enough going for them to warrant the undivided attention of non-profit institutions.

—As more care migrates to ambulatory and home settings, involving fewer expensive buildings, there is less to offer bond agencies in raising critically important capital.

—For the not-for-profit institutions that have tried to keep their community benefit responsibilities, the road is getting rougher. More price-conscious buyers in a world of managed care are making it harder for not-for-profit institutions to compete economically while at the same time subsidizing care for the poor. This is particularly true in old neighborhoods that have large numbers of low income persons (often avoided by for-profit institutions).

—In twenty or more states (e.g., Pennsylvania, Utah), not-for-profit institutions have been challenged regarding taxes.

- –Often local governments or states need money and they are looking for new sources of revenue (universities and others have been targeted); no malice seems intended.
- –In other instances, the state or local government reflects the frustrations of small business complaining about unfair competition, or the public's feeling that non-profit institutions too often lack community orientation.
- –As in universities, compromises have been discussed regarding voluntary payments for fire and police protection and other services.
- –At some point, the state courts usually intervene and specify more clearly what an entity must possess to qualify as a public charity, but the hurdle is generally higher than what most states have enunciated to date.

—Currently, the IRS is looking closely at several multi-organizational health care systems (in addition to colleges and universities, farmer cooperatives, etc.) in such areas as: unrelated business income, pension and profit sharing arrangements, extraordinary fund raising expenses, and submission of knowingly inaccurate information regarding tax-deductible contributions. Breaches could result in loss of exempt status (federal and state).

—Of major concern is the fact that responsible health reform has failed at both the federal and state levels, e.g.:

- –Medicare and Medicaid "cuts" have *not* been balanced by making access reasonably universal. Many key not-for-profit health systems are left exposed (more than their for-profit counterparts).
- –Absent special provisions for teaching and research, many critical

institutions will be badly squeezed by increasing price pressures from both the public and private sectors.

–Without insurance reform, *selection* in an essentially competitive market will create greater distance between the haves and have nots.

–Lacking a more concerted investment in health services research, essential information on quality, appropriate use, and outcomes will be slower in coming and thus, *value* will be harder to measure. We may see more shopping on the basis of price alone.

–Although the scene is rapidly changing, larger and larger not-for-profit networks too often lack the management and governance expertise to cope with dramatic change.

## Conclusions

Overall, we have a health system with many investor-owned institutions among suppliers, carriers, and HMOs, *and* an aggressive minority on the delivery side. The current system is not predominately a voluntary system, particularly in light of the fact that 26 percent of acute hospitals are owned by government (neither investor-owned or not-for-profit).[9]

The somewhat frail evidence we have does not show large efficiency or quality differences between for-profit or not-for-profit health delivery institutions, on the average. There are large differences in involvement in education and research.

Because of location and role, it may be fair to say that not-for-profit institutions, on the average, are more exposed to the relentless selection of a competitive market.

In this context, our largest challenge is to keep the health system focused on doing right by the patient—taking into account factors other than ability to pay—and to reinforce the fiduciary ethic as a fundamental principle orienting the behavior of physicians. The interests of the investor cannot be substituted gratuitously for the interests of the patient or of the community, to the extent they are in conflict.

In this framework, the key issue is *not* for-profit versus not-for-profit delivery institutions. The balance has not changed that much in several years. We should be more concerned about how money flows through our increasingly commercial payers, i.e., HMOs, Blue Cross/Blue Shield and insurance companies, as Larry Lewin has pointed out in a recent speech. Increasingly, it is becoming apparent that it is the context within which

investor-owned versus not-for-profit institutions operate overall that is the essence. For example, in an unregulated, competitive environment, not-for-profit and for-profit institutions will operate differently from in a regulated one (Schlesinger 1994). Certainly, in the current environment neither prototype can solve the access problem created by selection and absence of coverage.

In regard to the commercialization of health services, the real question we face is, have we lost our moral compass as a nation? Possibly we have:

—Faced with loss of real earnings between 1975 and 1995—even with two or three persons per family working—unable to improve on the standard of living set by their parents and seeing upper income persons increasing their share of the national wealth, the middle class appears less willing to help the poor (even with relatively low unemployment).

—In addition, faced with federal and state deficits, crime in the streets, and breakdowns in the family structure, many worry about what government (particularly big government) can do at all or do efficiently.

—In the last election, the swing was to the right and the vision of universal coverage and a better health system was not only rationalized, i.e., it would come through market forces—it was *lost*!

—Granted that the White House handled the issue poorly, and the President's leverage was not what President Johnson had in 1965, *any* bill was a tough sell and would have required careful crafting.

What is sadly lacking now, with the failure of reform, is a public policy framework that directly addresses the access and quality questions, plus those of professional education and research, within which the issue of ownership and other key issues can be fairly tested.

At a minimum, for our pluralistic system to work, whether for our profit or non-profit institutions, we need to accept that the health market *is* unique and that it requires a stronger element of legislative and regulatory support than most other markets to survive, let alone work. Given the shortcomings, it cannot by itself produce adequate access, adequate standards, or efficiency. To feature capitated managed care under Titles 18 and 19 and give states more flexibility and to count on the marginal contributions of non-profit institutions and then rest on our oars is either incredibly naïve or cynical.

At a minimum, we need:

—reasonably universal access to care, even if we have to approach it with increments
—more explicit public accountabilities for *both* profit and non-profit health institutions, holding each accountable for a fair community share of disadvantaged patients
—a stronger flow of quality and cost information, enabling consumers to make sound purchase judgements
—provisions for risk adjustment
—selective insurance reform, e.g.:
  –some form of community rating
  –portability of benefits
  –minimal underwriting
—separate funding, in part, for education and research

For the past thirty or forty years, our health system has been in somewhat precarious balance, holding the middle ground between *laissez faire* on one extreme and a one-payer or one-owner system on the other. The middle ground represented our cultural preference for pluralism and pragmatism in the frame of a public/private partnership.

In this time period, the not-for-profit institution played a key role—inherently professional and often (not always) concerned about community good. Not-for-profit hospitals and members of their medical staffs often gave free care. Religious communities gave free labor. Blue Cross/Blue Shield Plans fostered community rating, minimum underwriting, and portability. Often, there was coordination among hospitals and allied institutions in the same area. Information was less proprietary and more freely shared.

The door opened to commercial competition in health insurance, and experience rating quickly followed, as did aggressive selection against the underprivileged. Under BC/BS rates, large group payers accepted fewer surcharges for more vulnerable small groups and individuals, when Medicare and Medicaid were enacted. A surplus of beds and physicians, driven by cost and charge reimbursements, rising costs, and greater use of buying power resulted in a more competitive market, not unlike other maturing markets. The entry of investor-owned institutions simply served to heighten the competition; they were not a primary cause.

Local initiatives, previously mentioned, are trying (and need to be

strongly supported), but they cannot take up all the slack on a voluntary basis.

If the middle ground of minimum standard and flexibility is our goal, we are in an unstable state. Clearly, it is unlikely we can go back to the 1940s and 1950s. Who will rule out commercial insurance or investor-owned institutions? The only feasible alternative is incremental reform at the federal level that provides the proper setting. Without it, a vacuum will develop, where selection will accelerate as a counterfeit for effectiveness and we will court more drastic reform later.

In the last analysis, the renewed issue of for-profit versus not-for-profit ownership may be a favor in disguise, pointing the way to our real challenge, which is finding the courage to face up to universal access (and the sense of human decency inherent in it) and the need to strengthen the market rather than lean on it.

In closing, it should be acknowledged that there are many educational implications in all of this:

—Students must understand the larger social, political, and economic context of which the health system is a part.
—It is important to make health systems more efficient through better management and alignment of financial incentives.
—But, it is even more important for students to understand that a country that turns its back on the poor is in danger of moral decay and that the greater partnership we need is not between doctors and hospitals in new health systems, but between the public and private sectors, and among voluntary, market, and regulatory forces, in the context of a responsible public policy framework.

I am not concerned about a takeover by investor-owned institutions in the health field. I worry more about the ability of the not-for-profit sector and the government to stay the course and also about our vision for the future: our ends, not just our means.

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