



HOSPITALS



Chapter 9

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Introduction



- Changes in the U.S. hospital industry dramatize the transformation occurring throughout the entire health services system and illustrate the ongoing tensions between conflicting views of health services as a social good to which all should have basic access or a commodity responsive to market forces.



Development of the Hospital in the U.S. System

- U.S. hospitals had their origins in almshouses established as early as the 17th century as domiciliaries for the destitute and sick.
- The provision of medical care, rudimentary at best at that time, was secondary to the provision of the more basic needs of food and shelter.



Development of the Hospital in the U.S. System

- Paul Starr (1982), in his book *The Social Transformation of American Medicine*, identifies three phases of hospital development that shape the current institution.
- Phase I, lasting from approximately 1751 to the mid-1800s, featured the development of voluntary and public hospitals.
- Voluntary hospitals were so designated because voluntary donations rather than taxes supported them.
- Public hospitals were in large part tax-supported.



Development of the Hospital in the U.S. System

- In Phase II, from the mid-1800s to 1890, “particularistic” hospitals to treat special populations such as children or specific diseases such as tuberculosis emerged.
- Near the end of Phase II, 172 hospitals existed in the United States.



Development of the Hospital in the U.S. System

- In Phase III, from 1890 to about 1920, profit-making (proprietary) hospitals appeared on the U.S. health services scene.
- By the end of this phase, more than 4,000 hospitals of all types were available, and an additional 521 mental illness hospitals had been established.



The Hospital in Today's Health Services System

- As of 2000, 5,810 general short-stay, nonfederal hospitals provided a range of medical and surgical services to those requiring inpatient hospitalization.
- Only about 4 percent of all hospitals are federal and more than half of all hospitals are not-for-profit institutions.



The Hospital in Today's Health Services System

- In addition to general short-stay hospitals, other classes of hospitals include federal, long-term, and specialty hospitals such as rehabilitation hospitals, children's hospitals, substance abuse treatment hospitals, and hospitals that treat only burn patients, cancer patients, or those with other specific diseases or conditions.



Hospital Supply and Distribution

- In addition to the financial resources to establish and maintain the physical plant, hospitals require two other kinds of resources: a complement of medical and allied health professionals to provide inpatient care and a large enough population base to utilize the available services.



Supply: The Hill-Burton Program to Build Hospitals

- As the nation turned to rebuilding and strengthening its industrial base following World War II, ***a shortage of hospitals and health services providers was declared.***
- To remedy the hospital shortage, the Hospital Survey and ***Construction Act of 1946, also referred to as the Hill-Burton Act, initially provided funds for hospital construction in rural areas.***



Supply: Hospital Capital Expenditure Review Programs

- The *Hill-Burton program* influenced the distribution of hospitals creating financial incentives to place them in *rural and other underserved areas* where they may not otherwise have been established.



Distribution: Sole Community Hospitals, Essential Access Community Hospitals, and Rural Primary Care Hospitals

- Although the effects of the market are increasingly evident in the hospital industry, hospital distribution has traditionally not been entirely responsive to market forces.
- Hospitals may be situated in areas that have limited populations and provider resources simply because there is no other facility within a reasonable distance.
- Sole community hospitals (SCHs) is a hospital class identified under the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) for special treatment by the Centers for Medicare and Medicaid Services (CMS) under Medicare's Prospective Payment System (PPS).



Distribution: Centers of Excellence

- At the other end of the distribution spectrum, certain medical or surgical functions, because of the costs to maintain adequately trained professionals and provide the necessary equipment or operatories, may be regionalized into centers of excellence.



Hospital Organization

- Three dimensions of hospital organization are important to an understanding of the health services system:
 - how an individual hospital is organized to perform its functions
 - how hospitals may be linked into systems,
 - the hospital's relationship to other health services functions and facilities in its community.



Hospital Organization

Most hospitals have traditionally been organized along three related but separate

lines of authority:

- The medical staff
- Hospital administration
- The governing body



Hospital Medical Staff

- Until recent changes in the U.S. health services system (addressed later in this chapter) most physicians on the hospital's medical staff generally were not employees of the hospitals.
- Some types of physician specialists, such as pathologists and radiologists, may be direct employees of the hospital, providing a support service to all admitted patients.



Hospital Administration

- Hospital administration has been a recognized profession in the United States since the early 1900s and was established to allow experts in facility organization and finance to professionally operate the hospital, leaving physicians free to concentrate on patient care.



Hospital Governance

- The type of governing body serving a hospital depends on the hospital's tax status.
- Even though the for-profit (proprietary) hospital industry has grown significantly in recent years, the majority of nonfederal short-stay hospitals are organized as not-for-profit hospitals.



Freestanding Hospitals

- Freestanding hospitals – discrete organizational entities unaffiliated with other hospitals in a multihospital system
 - are an increasingly rare species in the hospital world.



Hospital Systems

- The majority of nonfederal short-stay hospitals, both proprietary and not-for-profit, are either allied with other hospitals *in their markets through cooperative agreements, joint ventures, or other organizational linkages, and/or they are members of a multihospital organization.*



Management Services Organizations (MSOs)

- MSOs buy the physical assets of their participating physicians, provide administrative services, and negotiate with managed care firms.
- Integrated health services organizations may take many forms: ***formal organizational entities distinct from both physicians and hospitals, contractual or practice ownership linkages between physicians and hospitals, or other organizational configurations that involve risk sharing to varying degrees.***



Provider Sponsored Organizations (PSOs)

- ***Vertical integration*** set the stage for hospitals to sponsor or ***participate in other new organizational forms such as provider-sponsored organizations (PSOs), management service organizations (MSOs), and integrated health services networks.***
 - PSOs take many forms.
 - One of the earliest, the physician hospital organization (PHO), is a ***joint venture*** between a ***hospital and its medical staff to contract with HMOs or self-insuring employers to provide services to an enrolled population.***



Hospital Revenue Sources and Financing

- Revenue streams are common to all types of hospitals, but one aspect of hospital revenue, uncompensated care, is less likely to be an issue in investor-owned facilities.
- Some financing issues are common to all types of hospitals.
- Other financing issues are specifically related to the hospital's tax status – whether it is a public hospital, a not-for-profit hospital, or a for-profit hospital.



Uncompensated Hospital Care

- What about the patient who is uninsured and has no means to pay for inpatient hospital care?
 - A patient who presents at a ***hospital emergency department in need of care must receive treatment if that hospital participates in the Medicare program*** (Potter and Longest 1994), and nearly all ***general short-stay hospitals participate in Medicare.***



Financing of Not-for-Profit Hospitals, Including Public Hospitals

- This review of hospital financing begins with issues that are specific to a hospital's tax structure.
- Not-for-profit hospitals are organized under Section 501(c)(3) of the Internal Revenue Service's tax code, and as such are exempt from federal and state taxes and generally from local property and other taxes.
- Not-for-profit hospitals also have access to tax-exempt bond financing and have tax-deductible status for gifts and contributions.
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The Hospital: Major Focus of Health Services Expenditures

- Even before the passage of Medicare and Medicaid authorization in 1965, which increased access to inpatient hospital and other health services, hospitals accounted for the majority of health services expenditures, nearly 39 percent in 1960.
- In 2000, hospitals accounted for 37 percent of all personal health service expenditures.



Changes in Hospital Reimbursement Lead to Changes in Care Delivery

- Hospitals account for such a significant proportion of total health services expenditures not only because of the volume and intensity of high technology services they provide but also, until recent changes in the Medicare program, because of the ways in which hospital services were reimbursed.



Changes in Hospital Reimbursement Lead to Changes in Care Delivery

- Until Medicare's PPS was established in 1983, hospitals based their charges on their costs, both capital and operating, plus a profit margin.
 - Costs were essentially distributed across payers so that some of the costs of providing care to uninsured and other nonpaying patients were shifted to paying patients.



Hospital Acquisitions, Mergers, and Closures

- Hospital acquisitions, mergers, and closures have changed the configuration of hospitals in the U.S. delivery system.
- Reductions in hospital capacity have occurred through downsizing and reengineering.



Hospital Leveraged Buy Outs

- Industry-wide changes have occurred in hospitals as well.
- ***Hospital acquisition, mergers, and closures became hallmarks of the industry in the 1980s and early 1990s.***
- In the 1980s, hospitals were as susceptible to the leveraged buyout (LBO) frenzy as any other major business.



Hospital Mergers

- Hospital mergers also occurred with increasing regularity during this period.
- Between 1991 and 1993, 60 hospitals were involved in mergers and acquisitions, but by 1994, the number of hospitals involved was 674 (Kassirer 1996).



Hospital Downsizing and Reengineering

- The number of hospitals *continues to decline, although some of the reduction in numbers may be due to mergers and consolidations.*
- Particularly in the mid- to late-1990s, hospitals downsized by way of reengineering and, in some instances, closing.



Hospital Downsizing and Reengineering

- Between 1983 and 1993, 949 hospitals closed (Shortell et al. 1995).
- Downsizing and closures may result from excess capacity and may occur as the result of hospital market consolidation through mergers and acquisitions.
- ***Closures, especially rural hospital closures, have given rise to concerns about access.***



Hospital Downsizing and Reengineering

- Between 1980 and 1988, *200 rural hospitals closed, representing about half of all community hospital closures for this period (USGAO 1991).*
- Closed rural hospitals shared many common characteristics.



The Changing Role of the Hospital

- The role of the hospital is clearly changing.
- Some see this role becoming more narrow and specialized; other see a transition from an institution providing primarily acute inpatient care to a health system offering a continuum of care.



The Changing Role of the Hospital

- To survive, analysts suggest that a hospital must reduce its costs; develop a pricing strategy that loads more of the overhead costs in the early stages of the stay and makes the incremental cost of additional days more competitive; assume a utilization review role based on the use of clinical epidemiology, computers, and continuous quality improvement; and seek other partners in downsizing.



Questions

