THE CORPORATIZATION OF THE HEALTHCARE SYSTEM

The Corporatization of the Healthcare System

Marisa Ferris

Professor McLaughlin & Ignagni

Honors Capstone HN-300-D

Sacred Heart University

THE CORPORATIZATION OF THE HEALTHCARE SYSTEM

Abstract

The United States healthcare is the largest United States industry, which spent $3.65 trillion or 17.7% of the U.S. gross domestic product in the year 2018. This number grew in 2020 when healthcare spending was expected to exceed $4 trillion. Within the healthcare system, corporatizations have occurred. The corporatization of private practices and hospitals has led to a monopoly in the healthcare system, resulting in competition between nonprofit and for-profit hospitals, leading to an inflation of all healthcare prices, which leads to disparities in the proper treatment of all individuals.

Keywords: corporatization, integration, non-profit hospitals, Affordable Cares Act

THE CORPORATIZATION OF THE HEALTHCARE SYSTEM

The Corporatization of the Healthcare System

The United States spent $3.65 trillion or 17.7% of the U.S. gross domestic product on healthcare in the year 2018. Despite this, the healthcare system is experiencing significant change, which does not benefit the vast majority of people, due to corporatization. Corporatization is best defined as the restructuring or transformation of a state-owned asset or organization into a corporation. The goal of corporatization is to create enterprises with independent managers to run the company as efficiently as private counterparts (Kenton, 2020, p.1). The corporatization of private practices and hospitals has led to a monopoly in the healthcare system, resulting in competition between nonprofit and for-profit hospitals, leading to an inflation of all healthcare prices, which leads to disparities in the proper treatment of all individuals.

In today's world, the typical United States city has three to four integrated healthcare systems, which are based around large hospitals. For the most part, the number of hospitals in each state has decreased between 1998 to 2010. Throughout all 50 states and the years, "California, Florida, New York, Ohio and Texas are the top five states in terms of the number of hospitals in the sample" (Dong, 2016, 48). The most drastic changes were seen in California, who had 251 hospitals in 1998 and only 131 in 2010, and Pennsylvania, who had 129 hospitals in 1998 and only 20 in 2010. This change in number of hospitals is seen as an attempt to improve the performance of quality healthcare. Under corporatization, the organization becomes legally established as an independent entity, which means the organization is made fully accountable for its own financial performance (Kenton, 2020, p.1). As a result, competition often increases between corporatizations. However, the United States healthcare system has been found to incur

higher costs with lower access, quality and health outcomes, resulting in the number of healthcare institutions to be declining as seen by integration.

Integrated care is defined as a coherent set of methods and models on the funding, administration, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors (Kodner, 2002, p.1). The United States experienced a shift in the type of integration in the mid-1990s. Instead of horizontal integration, which is when organizations acquire or integrate with other organizations that provide the same or similar services such as multihospital systems, the United States began vertical integration. Vertical integration is when organizations acquire or integrate with organizations offering different levels of care, services or functions such as hospital ownership of private practices. Although vertical integration in the United States has been associated with higher performance on certain measures of quality, this does not mean horizontal integration was not effective. For example, The University of Pennsylvania Health System is composed of three hospitals, which "emerged to help hospitals achieve economies of scale and improve access through an expanded delivery network through integration of hospitals in the late 1980s to mid-1990s" (Kodner, 2002, p.3). This example is of a multihospital system that provides similar acute care in multiple locations. On the other hand, an example of a vertically integrated organizational structure are physician-owned hospitals such as the Advocate Health System in Chicago. This system is able to remain aligned, but maintain autonomy as well as work cooperatively while being governed separately. These types of hospitals selectively contract with physicians on the basis of quality and cost performance, while having close relationships with hospitals to coordinate patient care. Evidence of vertical hospital organizational transformation through the 1990s and early 2000s is seen as "Hospitals merged at

record rates, with 176 full asset mergers resulting in consolidated ownership between 1990 and 1997. These latter transformations involved nearly four hundred hospitals or about 7.2 percent of the community hospital industry. In addition, about 65 percent of hospitals were involved in some form of multihospital arrangement by 2001 - either a health system or a network" (Bazzoli, 2004, p. 889). The organizational transformation has a correlation to the total expenditures per patient. According to a study done in California, "In 2012, physician-owned physician organizations had mean expenditures of $3,066 per patient, hospital-owned physician organizations had mean expenditures of $4,312 per patient and physician organizations owned by multihospital systems had mean expenditures of $4,776" (Robinson, 2014, p.1663). These statistics reflect how the hospital-owned physician organizations incurred higher expenditures, which emphasizes how organizational consolidation may increase care coordination, but is also associated with higher costs. The hospital-owned organizations, an example of horizontal integration, were able to directly provide outpatient and inpatient facility services as well as physician services. On the other hand, physician-owned organization, an example of vertical integration, provide only professional services and refer outpatient and inpatient services to other independent facilities, which shows care coordination. However, it may not be worth it as total expenditures for care per patient were significantly higher in organizations owned by local hospitals or multihospital systems. Essentially, the corporatization of the healthcare system was said to be done to improve efficiency, although other factors such as classification of hospitals as nonprofit or for-profit have proven this false.

Hospitals within the healthcare system can be classified as nonprofit or for-profit hospitals. Private nonprofit hospitals are able to achieve higher output, prices and profits than for-profit hospitals. Nonprofit hospital institutions have federal, state and local tax relief and tax-

exempt bond financing, while having not having to justify their business plans to stockholders, since they do not have any. As found in a study published in Health Affairs, seven of the ten most profitable hospitals in the United States are officially nonprofits (Longman, 2020, p.2). Additionally, of the 90 more profitable hospitals, 64% are nonprofit. As Moon (2020) states, "On average, nonprofits have 29% greater profits than for-profits. These findings hold after accounting for investment costs, nonprofit tax benefits and other factors". Despite the hospitals themselves being profitable, the executives of nonprofit hospitals become extremely wealthy as well. In 2018, University of Pittsburgh Medical Center's President and CEO Jeffrey Romoff took a salary of $8.54 million, while 33 other executives each earned more than $1 million. The large margins of revenue are a result of nonprofit hospitals ability to achieve greater profits with higher average prices than for-profit hospitals. According to Moon (2020), "Nonprofits provide 45% more clinical services (e.g. epilepsy, neurosurgery, oncology, neonatal care), achieving greater output on several measures and 54% greater patient revenue than for-profits". These types of services are considered premium specialty medical services, which are more expensive than basic services, such as mental health and primary care. Non-profit hospitals are able to charge monopoly prices for the specialty treatments as they face little competition from rival for-profit hospitals. Therefore, nonprofits invest significantly in high-priced premium specialty medical services, resulting in higher average prices than for-profits. For example, regardless of the type of hospital, the cost of an ordinary room after birth is $1,195 per day, a neonatal intensive care room is $8,935 per day and a pediatric critical room is $10,140. The differing prices between the level of services available echo how adding premium specialist medical services can raise average prices, exemplifying how investments in these services can result in higher average nonprofit prices and profits. The investment in these services increases the

average healthcare costs, which deters patients who struggle financially. Within a seventeen-year period, “the introduction of new treatments and diagnostic tests increased real healthcare spending per capita by $1,327” (Beilfuss, 2016, p.371). The technology significantly contributes to the rising costs in healthcare. Essentially, nonprofits are able to have a greater service mix, which implies higher average prices because the hospitals expand their existing services or have more advanced premium specialty medical services, meaning they are able to offer more complex medical procedures.

Differences between nonprofit and for-profit hospitals can be a result of hospital management practices as well. In other words, the hospital management practices of manipulating financial earnings can occur in both, but the implications and reasonings can have varying explanations. As stated in Earnings Management in the U.S., “Earnings management enables managers to improve their ability to cope with uncertainties in revenue and competition, to control the rising cost of healthcare provision or the windfall of profits. Earnings management occurs when managers use judgement in financial accounting and in structuring transactions to alter financial reports to meet external benchmarks" (Dong, 2016, p.42). Earning management behavior differs between nonprofits and for-profits because for-profit hospitals yearn for higher profit margins due to capital market pressures, which include the need for more capital to survive. As stated in The Keckley Report, “Every hospital is dependent on capital to maintain technologies, facilities and clinical innovations Americans expect” (Keckley, 2018, p.1). For-profit hospitals are subject to profit-maximization pressures by stockholders in order to gain more capital (Dong, 2016, p.43). Additionally, “Large for-profit hospitals are more likely to be targeted for tax-status scrutiny due to high patient revenues and government subsidies” (Dong, 2016, p.46). This results in managers being more likely to use discretionary accruals to lower

their income to maintain their financial feasibility. On the other hand, nonprofits do not have profit-maximization objectives and do not receive government funding, meaning their motivation for earnings management is for tax-avoidance and financial sustainability. Although the motivations may differ, competition increases between nonprofits and for-profit hospitals. Andritsos created a model is created to represent competition between nonprofits and for-profit hospitals. In the model, "Hospital 1is assumed to be a non-profit hospital at which patients can receive free care but may need to wait before being treated. Hospital 2 is now a for-profit hospital at which patients seek care for a fee but with negligible waiting" (Andritos, 2015, p. 1818). The findings from the model were that a price increase by the for-profit hospital will reduce demand for that hospital and increase demand for the non-profit hospital. Regardless of the findings, nonprofits and for-profit hospitals will continue to have little government intervention or legislative policies to ensure that the healthcare system is mandating the best treatment for all individuals.

The Affordable Care Act was created to help make affordable health insurance available to more people and expand the Medicaid program to work to ensure that the healthcare system was providing the best treatment for all individuals. In 2012, the Affordable Care Act was revised and these changes helped to improve health care coverage. The major changes seen were the requirement that private insurers cover children of enrollees until the age of 26, the expansion of Medicaid eligibility, new insurance-market rules that enable people to easily buy plans directly through insurance companies outside the individual marketplaces and marketplaces created for small businesses, known as the Small Business Health Options Program. These changes have made significant impacts on millions of lives as the number of young adults without health insurance has declined by 1 million since the provisions have taken effect.

Additionally, “Insurers selling health plans in these markets can no longer set prices on the basis of health or exclude coverage of preexisting health conditions, and they are limited in what they can charge older adults as compared with younger adults” (Blumenthal, 2014, p.276). As a result, insurers are likely to continue to use narrow networks as a strategy to keep premiums affordable for all, but the growth of premiums will continue as long as healthcare costs rise.

The expansion of Medicaid has ensured that low-income adults gain insurance coverage and access as 12.2 million were enrolled in Medicaid and the Children's Health Insurance Program as of March 2015 in comparison to 2013. Medicaid is a jointly-funded, Federal and State health insurance program, designed to help low-income people. It covers children, the aged, blind, disabled and other people who are eligible to receive federally assisted income payments to ensure low-income individuals are getting the healthcare they need. Specifically, “Changes in insurance and access to medications varied significantly by race/ethnicity, with greater changes among minorities. The reduction in the uninsured rate among Latino adults was greater than the reduction among white adults” (Sommers, 2015, p.369). This reflects how minorities are receiving more access to healthcare as part of a provisional result of the Affordable Care Act. Despite the provisions made within the Affordable Care Act, the turmoil created by today’s hospital mergers and physician practice acquisitions gives hospital systems and insurance companies more leverage to increase the cost of healthcare. However, insurance companies do not care as their profits are increasing. In the first three quarters of 2017, the top-five insurance companies made a record $6 billion in profit, with their executives making seven and eight figure salaries. Additionally, insurance companies are focused on the bottom line. An example of this is seen in “Why Your Health Insurer Doesn’t Care About Your Big Bills” by Marshall Allen, which follows the story of Michael Frank. Michael Frank had a partial hip

replacement surgery at NYU Langone Health in New York, where his insurance company, Aetna, had negotiated an in-network member rate for him. However, "Aetna had agreed to pay NYU Langone $70,000. That's more than three times the Medicare rate for the surgery and more than double the estimate of what other insurance companies would pay" (Allen, 2018, p.1). Aetna agreed to pay a grossly inflated rate that still left Michael Frank to pay over $7,000 for his portion of the bill, while never receiving what his total charges were. The hospital and the insurance company had agreed on a price, which he would have to pay. This becomes a three-party transaction because it involves the patient, the insurance company and the hospital. However, only two of the parties, which are the insurance company and the hospital, have a say in the price as the system is said to be stacked against the consumer. At the same time, health insurance premiums are rising. According to the Department for Professional Employees, "In, 2005, the average annual premiums for employer-sponsored health insurance were $2,713 for single coverage and $8,167 for family coverage. In 2015, premiums more than doubled to $6,251 for employer-sponsored single coverage and $17,545 for employer-sponsored family coverage" (Barrows, 2020, p.1). This inflation increase affects workers wages, as well as small businesses. For example, according to the Pioneer Institute, "forty-three percent of adults with moderate incomes said their deductible was difficult or impossible to afford" (Anthony, 2016, p.1). The cost of healthcare is rising and despite trying to find insurance providers who have the best benefits at the lowest cost, insurance companies will overcharge for healthcare. At the same time, the standard of care in healthcare is negatively changing.

A standard of care refers to the informal and formal guidelines that are generally accepted in the medical community for treatment of a disease or condition. There is no exact formula or definition of standard of care, but it is meant to answer the basic question of what level of care a

doctor is required to provide regardless. Different countries have different standards of care, as well as different policies and legislation regarding healthcare. The United States is the only advanced economy that does not offer universal health-care coverage, which significantly affects all individuals. According to Hsiao (2020), “The amount spent in the United States on administrative expenses related to health care is three times as high as that in other advanced economies. That is because in a multiple-payer system, insurers offer many different policies, each one featuring distinct benefit packages, premium rates and claim procedures. At the same time, insurers negotiate separately with hospitals and clinics, which means they pay different prices for the same services". The United States should follow the lead of countries such as Canada and Taiwan. Both of these countries have opted for a one-tiered system that stems from the idea that coverage should be universal and equal. This has proven to be cost-effective as well. In 2016, Taiwan spent $1430 per person on healthcare in comparison to the United States who spent an average of $10,224. The United States spends more on healthcare per person than any other wealthy countries. The average for wealthy Organization for Economic Co-operation and Development (OECD) countries was only about $5,500 per person. An explanation for the significant healthcare prices in the United States can be due to administrative costs. The United States spends about $940 per person on administrative costs, which is four times more than the average of other wealthy countries. Despite the surging amounts spent on healthcare in the United States, the United States health outcomes are not better than those in other developed countries. For example, according to a study done by The Peter G. Peterson Foundation, on a scale of 30 with 0 being the worst and 30 being the best, the United States received an 8 on the rate of unmanaged diabetes, with Mexico being ranked the worst and Iceland being ranked the best. Additionally, “The United States has the highest chronic disease burden and an obesity rate

that is two times higher than the OECD average and has among the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths" (Tikkanen, 2020, p.1). These statistics reflect the need to transform our healthcare system to be able to increase quality of care at a lower cost. The United States spends more on health care than any other country, but is not achieving a comparable performance in terms of health outcomes.

As a nation, the United States should focus on how to contain costs to improve affordability and access to needed care to alleviate the healthcare problems within the healthcare system. Instead, physicians in the United States are encouraged to promote particular drugs, due to financial benefit instead of the patients benefit, by pharmaceutical companies. One study's finding showed that, "free drug samples might mean that a patient might not always get the best drug prescribed for their needs, because the doctor will be partial to using the pharmaceutical company that has paid him" (Perry, 2014, p. 483). This reflects how patients can be mistreated or misinformed by their doctors who they trust to help them with the most efficient and effective resources. This lack of transparency will infringe upon the patient's autonomy and the trust in the healthcare system.

The corporatization of private practices and hospitals has led to a monopoly of control in the healthcare system, resulting in competition between nonprofit and for-profit hospitals, leading to an inflation of all healthcare prices, which derives in disparities in the proper treatment of all individuals. Therefore, through integration, changes in nonprofits and for-profits, provisions of the Affordable Care Act and a possible transformation system to increase quality care, the United States healthcare system can positively change to ensure a significant impact on all individuals. As of now, the United States healthcare system is a complex system, which needs to transform while recognizing the best interest of all people.

References

Allen, M. (2018). *Why your health insurer doesn't care about your big bills*. Washington: NPR. Retrieved from https://sacredheart.idm.oclc.org/login?url=https://www.proquest.com/blogs-podcasts-websites/why-your-health-insurer-doesnt-care-about-big/docview/2043991140/se-2?accountid=28645

Andritsos, D., & Aflaki, S. (2014). Competition and the Operational Performance of Hospitals: The Role of Hospital Objectives. *SSRN Electronic Journal*. doi:10.2139/ssrn.2446397

Anthony, B. (2016). Healthcare Prices for Common Procedures Are Hard for Consumers to Obtain. Retrieved from https://pioneerinstitute.org/wp-content/uploads/dlm_uploads/MultiCityHealthcareTransparency-PB-1.pdf

Barrows, K. (2020, March 03). The U.S. Health Care System: An International Perspective - Department for Professional Employees, AFL. Retrieved from https://www.dpeaflcio.org/factsheets/the-us-health-care-system-an-international-perspective

Bazzoli, G. J. (2004). The Corporatization of American Hospitals. *Journal of Health Politics, Policy and Law*, *29*(4-5), 885-906. doi:10.1215/03616878-29-4-5-885

Beilfuss, S. (2016). Pathways and hidden benefits of healthcare spending growth in the U.S. Atlantic Economic Jounral, 44(3), 363-375. doi:10.1007/s11293-016-9506-6

Blumenthal, D., & Collins, S. R. (2014). Health Care Coverage under the Affordable Care Act — A Progress Report. *New England Journal of Medicine*, *371*(3), 275-281. doi:10.1056/nejmhpr1405667

Cutler, D. M. (2014). Who Benefits From Health System Change? *Jama*, *312*(16), 1639. doi:10.1001/jama.2014.13491

Dong GN. EARNINGS MANAGEMENT IN U.S. HOSPITALS. J Health Hum Serv Adm. 2016 Summer;39(1):41-71. PMID: 27483974.

Heeringa, J., Mutti, A., Furukawa, M. F., Lechner, A., Maurer, K. A., & Rich, E. (2020). Horizontal and Vertical Integration of Health Care Providers: A Framework for Understanding Various Provider Organizational Structures. *International Journal of Integrated Care*, *20*(1), 2. doi:10.5334/ijic.4635

Hsiao, W. (2020). How to Fix American Health Care: What Other Countries Can - And Can't - Teach the United States. *Foreign Affairs*, *99*(1), 96-106. Retrieved from http://heinonline.org/HOL/Page?handle=hein.jounrals/fora99&div=14

Keckley, Paul. (2018, July 23). Access to Capital for Hospitals: The Realities, The Consequences . Retrieved from https://www.paulkeckley.com/the-keckley-report/2018/7/23/access-to-capital-for-hospitals-the-realities-the-consequences

Kenton, W. (2020, December 05). Corporatization. Retrieved from https://www.investopedia.com/terms/c/coporatization.asp

Kodner, D. L., & Spreeuwenberg, C. (2002, November 14). International Journal of Integrated Care. Retrieved from https://www.ijic.org/articles/10.5334/ijic.67/

Longman, P., & Thakur, U. (2020, July & aug.). Elite Hospitals Have An Epidemic of Greed. *Washington Monthly*. Retrieved from https://washingtonmonthly.com/magazine/july-august-2020/elite-hospitals-have-an-epidemic-of-greed/

Moon, J., & Shugan, S. M. (2020). Nonprofit Versus For-Profit Health Care Competition: How Service Mix Makes Nonprofit Hospitals More Profitable. *Journal of Marketing Research*, *57*(2), 193-210. doi:10.1177/0022243719901169

Perry, J. (2014). Trust and Transparency: Patient perceptions of physicians financial relationships with pharmaceutical companies. Journal of Law, Medicine & Ethics, 42(4), 475-491. Doi:10.1111/jlme.12169

Robinson, J. C., & Miller, K. (2014). Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. *Jama*, *312*(16), 1663. doi:10.1001/jama.2014.14072

Sommers, B. D., Gunja, M. Z., Finegold, K., & Musco, T. (2015). Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act. *Jama*, *314*(4), 366. doi:10.1001/jama.2015.8421

Tikkanen, R. (n.d.). U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes? Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019