

“Doing Well
by Doing Good:
Investor-Owned Hospitals”

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I am greatly honored to have been asked to deliver the twenty-first Michael M. Davis Lecture and to join you in celebrating the fiftieth anniversary of the Program in Hospital Administration. The roster of Davis lecturers is headed in 1963 by one of your founding fathers, Michael Davis himself, and in 1964 by Marion Folson, one of the great architects of social insurance in the United States. The list includes ministers of health of various foreign countries, and leading scholars of the health industry. I have tried to imagine what qualifies me for membership in this distinguished company, and the only thing I can think of is that I may hold some sort of health record: for twenty-five years, I have never spent enough on health services in one year to qualify for tax deductibility.

It is appropriate on this occasion to compliment the company assembled here for their association with a praiseworthy institution. Unfortunately, my own association tends to make the compliment self-serving. Perhaps I can enhance the value of the compliment you all deserve by recalling that my high regard for the Program in Hospital Administration predates my own association with the Graduate School of Business and can even be documented. In 1972–74, I served on the Kellogg Foundation's Commission on Health Administration. In the course of a two-year study, we examined every major health administration program in the United States, and some not so major. One conclusion of our study—one I supported wholeheartedly—was that the Chicago program was by far the best, both because of the intellectual rigor of its approach to

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training health administrators and because of its practical success in training exceptionally effective administrators.

Practically all my adult life, I have lived and worked in the not-for-profit environment of private universities, for the last twenty years as a manager. Recently, I have had the opportunity to broaden my education and experience in management practices through exposure to the inner sanctums of profit-seeking business enterprises. The differences I have observed that distinguish these two realms from one another are best summed up in the remark of a university vice-president, commenting on the operation of the profit motive in a traditionally not-for-profit setting. Here is the background:

About seven or eight years ago, when I was Dean of the Business School, a group of four business students approached me for permission to sell soup and sandwiches in the business students' lounge at lunchtime. An agreement was struck covering responsibility for such considerations as cleanliness, quality, and repair of facilities, and a small business was established. As the year ended and graduation loomed, I was approached again by these young entrepreneurs. They pointed out that they had built a prosperous business and that there were several groups eager to succeed them. They advanced the argument that their successors would have an incentive to improve the business if there was a property right to be enhanced. Naturally, the way to create such a right was to allow the present group to auction off the right to their successors, thus capturing for themselves the value that had been established. After further negotiations having to do with eligibility of bidders and rates of taxation, the auction was held. Chicago, after all, is where Adam Smith would feel most at home if he were alive today.

The first auction brought seven thousand dollars. One year later the menu had been expanded to include yogurt, fresh fruit, extra-large oatmeal cookies, cold pop, and the *Wall Street Journal*. The second auction brought twelve thousand dollars. After seven years of rapid and profitable growth, the concession sold for just under two hundred thousand dollars. About the time the price topped a hundred thousand dollars, a vice-president of the university was heard to remark that the whole thing was a great puzzle to him. "How do they do it?" he wondered. "Their food is the best on campus, their prices are reasonable, and service is excellent. Of course, we couldn't do it the way they do—they're only in it for the money."

His puzzlement reflected a belief, based on his own experience, that quality and profit are in conflict—that one can be obtained only by sacrificing the other. Not-for-profit institutions are frequently in the business of providing services that cost more than their beneficiaries can afford to pay or are willing to pay. The best universities, not-for-profits all, would become far more exclusive than they already are if they tried to charge all their students the

full cost of a first-rate education. Only by sacrificing quality could they bring the cost down to a level affordable to most of their students. In the absence of philanthropy, they would be forced to do what all competitive businesses do to stay alive: select a level of quality their students could afford and charge for it. They might even find a way to attract investors, which brings us to the subject of this lecture.

Whether or not the investor-owned hospital chains are doing good, they are certainly doing well. Hospital Corporation of America, the largest of the IO chains, with operating revenue of just under \$4 billion in 1983, has enjoyed steadily rising earnings per share for fifteen straight years, with a compound annual EPS growth rate of 25 percent. Humana Corporation, a more recent entry in the hospital industry, has averaged 41 percent EPS growth to become the number two contender; and American Medical International, number three, has averaged 26 percent. All three of these companies are currently earning their shareholders an after-tax return in excess of 20 percent; all three trade on the New York Stock Exchange at above-average price-to-earnings ratios of about fourteen. Altogether, IO chains operate 9 percent of all nonfederal hospital beds in the United States and manage another 3.5 percent; they are increasing their market share at about 8 percent per year, and are doing exceptionally well for their investors. Why they do well and whether they do good is just now becoming the subject of serious study by scholars equipped to tackle such difficult questions.

So far, research has focused on comparisons between investor-owned chains and not-for-profit hospitals: what kinds of patients do they handle, how much does care cost, and how profitable are they? The commonly acknowledged first shot was fired in 1980 by Arnold Relman in an article published in the *New England Journal of Medicine* with the inflammatory title, "The New Medical-Industrial Complex." Dr. Relman raised questions best answered by economists, who were quick to discover the profitable opportunities represented by the challenge.

Briefly summarizing the results so far, the IO chains seem to handle essentially the same case mix as the nonteaching NFPs; both charge about the same for basic services but stays are shorter in the IOs; the IOs provide more ancillary services and charge more for them; and both operate in the black. Some progress has been made in measuring quality, and the results suggest that quality and efficiency seem to go hand in hand, but no direct comparison has been made between the IOs and the NFPs with respect to these measures.

What can the customers expect from all this? The theory is that profits can be increased by lowering costs, improving quality, and attracting customers. With profit-hungry professional managers searching tirelessly for ways to achieve these worthy results, will the benefits of the profit motive at work soon become as apparent to

patients as they are now to investors?

The profit motive stimulates the search for profits wherever they lie, but profits do not always lie in directions we commonly think of in terms of improved efficiency or quality. Studies show, for example, that hospitals lose money on the basic services they provide, but make money on certain of the ancillary services. Since most of the ancillary services are provided in the first few days of a hospital stay, increased profits lie in the direction of shortening the stay as much as possible without compromising the quality of care enough to drive away patients. Rate setting combines economics and politics in ways that are not well understood. To understand whether this shift is efficient in the usual sense economists attach to that word, we would need to know something about why basic services are provided at unprofitable rates. In the highly regulated hospital industry, a decision that is profitable for the hospital may not be efficient from the patient's point of view.

Or another example: Hospitals sometimes have trouble obtaining full reimbursement from the state because they are not skillful in demonstrating that their costs are fully justified by the requirements of patient care. Improved profits, but not necessarily lowered costs, may lie in the direction of knowing the regulations in minute detail, keeping excellent records aimed at the necessary documentation, and selecting the optimal risk to run with respect to whether accounts receivable from the state will actually be received. Normally, in a competitive market, each firm strives to lower costs in order to increase profits, and competition among firms squeezes out excessive profits. Customers can rely on these two forces working together for their benefit and have no need to know whether the firm can justify its expenses. I probably do not need to dwell on the many ways in which this model breaks down when the state pays for care provided by hospitals in a market that is not competitive—at least not in the usual sense.

The relentless search for efficiencies and other opportunities for profit does not automatically occur in an IO firm. Profit potential attracts investors, but unless systems of incentives are established within these firms to encourage the search for profitable opportunities, efficiency will not be achieved. The profits earned by the IOs belong to the investors who provide the capital and run the risks; but in a well-managed firm, self-interest leads investors to share their profits with the managers who are charged with responsibility for the day-to-day operation of a hospital and with those who plan and guide its future development.

Of course, even managers of NFP hospitals have some incentive to pay attention to opportunities for profit. Their trustees like black ink better than red. The trustees' satisfaction with their manager's ability to operate in the black is reflected in his or her salary and marketability as a manager. But the NFP manager's incentive is blunted as compared with an IO manager. NFP managers cannot

participate in profit-sharing and stock option programs of the sort that spur their IO counterparts, so they may not try as hard to discover just where the optimal mix lies, and they may focus too strongly on the short run at the expense of the long run. NFPs are profitable, but not nearly as profitable as the IOs. Partly, this is because profitability is not the NFP's only objective, and partly it is because the search for profitable opportunities is not quite so relentlessly pursued.

For scholars who study what we once called labor markets—now human resource markets—the transition from NFP to IO provides a rich source of material for studying the effects of incentive systems on managerial efficiency. Many of the IO hospitals are former NFPs that were transformed through acquisition. It would be interesting to study a sample of pairs of hospitals, both originally NFP, one acquired and one not, and matched according to their NFP characteristics. The study should attempt to discover the exact nature of the internal incentives affecting the decisions of managers.

While evidence of the internal effects of the profit motive is meager, we know, at least, that the IO chains operate hospitals at staffing levels about 20 percent below comparable NFPs. The external evidence is stronger, consisting of the success IOs have in marketing—attracting physicians who bring paying patients into the hospital, even attracting them to previously underserved areas—and their aggressive search for profitable acquisitions. While there are examples of NFP hospitals with effective marketing programs and even of moderate-sized, regional NFP chains, nothing in the NFP experience quite matches the systematic way in which the large IO chains work to improve their market position where they are already entrenched and search for new national and international markets to serve. There can be no question but that these strikingly observable differences are due entirely to the fact that the managers of the IO chains are motivated by far greater incentives than are ever available to managers of NFPs.

These undeniable external signs of the difference between IOs and NFPs strongly suggest to me that important internal differences in operating practices will develop over time—in fact, would probably be visible already if only we knew what to look for. The case against the IOs' claim of efficiency consists mainly of the fact that the IOs charge as much as, or even more than, the NFPs. If there are efficiencies, when will prices fall? The answer, of course, is that efficiencies increase profits, but the mere achievement of efficiencies does not automatically lead to lower prices. A profit-seeking firm will not pass its savings along to its customers in the absence of competition. Few industries are more enmeshed in regulation than the hospital industry, and much of the regulation is anticompetitive.

The rise of the IOs has closely paralleled the extension of hospital insurance to practically every individual American, with

the last piece of the puzzle falling into place during the lavish days of Great Society enthusiasm, when Medicare and Medicaid were enacted in order to provide medical care to the elderly and the poor as close as possible, in terms of quality, to that enjoyed by the more affluent. Hospital insurance, from its very beginning in 1929, was designed to serve twin objectives: to mitigate the financial risks faced by households and to minimize the collection costs of hospitals.

Hospital insurance, both private and government, has contributed in two ways to the rise of the IOs: by providing a dependable source of payment in an industry traditionally plagued with spongy accounts receivable, and by encouraging phenomenal waste and inefficiency. Ordinarily, insurance helps us cope with large risks we cannot cope with ourselves, but leaves us to cope with smaller, more manageable risks, both to keep down administrative costs and to limit moral hazard. Property and casualty insurance policies of all sorts commonly feature deductibility and coinsurance as the principal means of controlling costs. Until recently, hospital insurance eschewed these cost-controlling features in order to serve the hospital objective of minimizing collection costs. The result has been an insurance system that insulates the transaction between the hospital and the patient from the ordinary forces of supply and demand which balance the value of resources to the customer against their value to the rest of society.

The steadily increasing disparity between the value of resources employed and the value patients attach to benefits they receive creates an immense reservoir of potential profit that can be tapped by almost any hospital willing to abandon the advantages of tax exemption and philanthropic support. It is no accident that much of the IO growth has resulted from acquisition of existing, often unprofitable, NFP hospitals.

In the past decade, there have been signs that the forces contributing to IO growth may be abating. The most important private-sector response has been the shift away from the earlier unsound practices of hospital insurers. Deductibles and coinsurance are increasingly important features of private health insurance, popular with cost-conscious employers who foot the bill. Even Blue Cross and Blue Shield have finally been forced to drop their traditional opposition to these practices in order to stem the erosion of their market position. Government programs have adopted these and other measures—unfortunately not all equally well advised—to limit the inflation of hospital costs. The best of these measures are all directed at reestablishing the role of ordinary economic considerations in the market for hospital care. There has been a steady shift away from the Great Society's exclusive concern with equal access for all, toward concern for what things cost.

I will finish by describing a few of the developments worth watching for as the IO sector of the hospital grows and matures:

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1. As the IO chains grow, they may become increasingly competitive in the markets they serve. I suspect they have tended to acquire or build hospitals where they are sheltered from competition, but that will be increasingly difficult as they gain market share and as the most attractive acquisitions are picked off. The extent to which they are forced to compete with one another and with the NFPs for patients has a bearing on whether the internal efficiencies they achieve will be passed on to the customers in the form of higher quality and lower costs.
 2. The IOs may prove effective in devising incentive systems that control the physician's use of hospital resources. New relationships may develop between physicians and hospitals that will give the physician a financial stake in the profitability of the hospital.
 3. While the IOs will probably continue to attract patients primarily by making themselves attractive to practicing physicians, they may find it possible and desirable to appeal directly to their customers. Unaccustomed as we are to advertisements extolling the merits of hospitals, the possibility should not be dismissed.
 4. The performance of the IOs may affect the management of the NFPs both by example and through the forces of competition.
 5. Vertical integration to the level of the insurer may give the IO chains an important cost-cutting advantage. If so, competition may drive them toward it.
 6. Humana Corporation has taken the first step toward providing medical education. Are we on the brink of a revolution: corporate provision of medical education?

These by no means exhaust the list of interesting possibilities likely to emerge as we gain experience with this new phenomenon. I am hopeful that as the future of this important industry unfolds, it will preserve the humanitarian and innovative qualities we all value in the hospitals of our country, but with a greatly improved ability to put our scarce resources to uses fully consistent with their value to society.

Note

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