Mar 15, 1984 Statement by Robert M. Heyssel before the Institute of Medicine Committee on the Implications of For-Profit Enterprise in Health Care

Fd 11

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Presented by

ROBERT M. HEYSSEL, M.D.
Chairman

Before the

INSTITUTE OF MEDICINE
COMMITTEE ON THE IMPLICATIONS OF FOR-PROFIT ENTERPRISE IN HEALTH CARE

March 15, 1984

COMMITEE ON THE IMPLICATIONS OF FOR-PROFIT
ENTERPRISE IN HEALTH CARE

March 15, 1984

Good morning. I am Robert M. Heyssel, MD, President, The Johns Hopkins Hospital, and Chairman of the Association of American Medical Colleges. The AAMC is pleased to have this opportunity to tesify before the Committee. In addition to representing all of the nation's medical schools, and 76 academic societies, the Association's Council of Teaching Hospitals (COTH) represents 350 state, municipal and not-for-profit hospitals, and 71 Veterans Administration Medical Centers.

Before beginning, I wish to make my views clear on a couple of matters. I'm not here with the view that profits are evil. First, the hospital and physician environment is surrounded by and interwoven with profit-making enterprises. I think it's fair to say the same is true of universities; anyone who isn't aware of that hasn't looked too closely at the financial relationships that have developed between universities, their faculties, and embryonic as well as well-known corporations. Second, profit is necessary even for non-profit hospitals: to launch new programs, maintain a modern and effective physical plant, and to develop new ideas. The Johns Hopkins Hospital generated almost a $6.4 million profit on operations in 1983 and has consistently had profits from operations for 10 years. This return was earned by efficient operations performed within the revenue limits approved by the Maryland Health Services Cost Review Commission. I would call to your attention that this is an operating margin of roughly three percent.

Neither am I here this morning to discuss the pros and cons of all aspects of the impact of the for-profit enterprises on health care, which is your Committee's title. I am here to discuss the issues which worry and concern me as I think about the implications of investor-owned acute care hospitals. I do wish to share with you two brief illustrations which will give you an idea of where my presentation is headed. First, I'd like to refer back to the $6.4 million profit on operations that we earned at The Johns Hopkins Hospital last year. You may not be aware of this, but I'd like for you to know that we had an opportunity to raise our prices during the year, and stay within the Cost Commission's limit on rates. That would have increased our profit margin significantly. We chose not to. Why? Because in our view, based on our mid-year projections, that our operating margin, based on our then current charges, would satisfy a target need we had set based on a variety of assumptions about our future financial requirements. I ask you, "Would that have been a recommendation that management would make, or that the Board would adopt if we were an investor-owned corporation?" I have my own opinion, but I'll leave the question for you to answer.

The second illustration is somewhat more complicated, but suggests some issues to think about in a very compelling way. Last April, Cedars-Sinai Medical Center in Los Angeles failed to win a Medi-Cal inpatient service contract from the State of California under the newly developed "price competitive" bidding arrangements.

Thus the hospital started referring all Medi-Cal inpatients and outpatients to other hospitals that negotiated inpatient contracts. The decision not to serve outpatients was controversial because the state continues to reimburse hospitals that see outpatients regardless of whether the hospital has an inpatient contract. Cedars-Sinai stated it would be unethical for the hospital to continue to see outpatients when it could not guarantee their continuity of care if inpatient services would be required, since most of the physician and resident staff do not have appointments at other hospitals.

I am well acquainted with Stuart Marylander, the chief executive of Cedars-Sinai Medical Center. He is an extremely competent and compassionate man. I understand the pressures the hospital was under, and the reasons for the decision. The response to the decision, however, created considerable controversy. A number of Jewish community organizations and publications expressed views ranging from concern to outrage. Substantial apprehension was expressed over the inability of a hospital which has historically provided services to all patients to continue to do so. It's important to realize that the hospital clinics never closed. Patients without health care coverage of any sort continued to be served. It was only patients covered under the Medi-Cal program that were affected.

The resolution to this controversy is state approval of a subcontract between UCLA Medical Center, a Medi-Cal contracting hospital, and Cedars-Sinai Medical Center which will allow Cedars-Sinai to treat Medi-Cal patients through its ambulatory care center. There are many sides to this story which I'm sure are unknown to me, and in this regard I suggest readers review the open letter to the community on this subject which is attached as Appendix A to this testimony. However, I think there are some central questions to think about.

- If Cedars-Sinai Medical Center were a corporation owned by a group of investors, would this controversy have ever arisen?

  I seriously doubt it.

- If Cedars-Sinai and UCLA Medical Centers were investor-owned corporations (or even if one of them were), would the cooperative arrangement to solve the problem have been possible?

  I seriously doubt it.

- What does this experience tell us about the role of the hospital in the community?

  Cedars-Sinai Medical Center is woven into the very fabric and sociology of the greater Los Angeles community I think this kind of hospital/community relationship is one upon which we should place a very high value. I do question whether such a relationship can be sustained or developed if the hospital is owned by a group of investors.

Along a different dimension, but on the same point, I was interested in the view of one of the physicians who participated in the purchase of Coral Reef Hospital

in South Miami, Florida. According to a report in the February issue of American Medical News, he said, "We were tired of being sold every few years to another corporation." I realize when I make this point that in this case the for-profit status of Coral Reef Hospital didn't change. However, the case does demonstrate the kind of ownership instability that concerns me as I think about the relationship of the hospital to the community and its physicians.

It is fair to say that until recently, the vast majority of hospitals were not built and developed to make a profit. Notwithstanding very recent events, this continues to be the case for teaching hospitals. And teaching hospitals have taken pride in their accomplishments in the development of tertiary care services, provision of educational programs, efforts in clinical research and technology transfer, and their role in providing service to the poor and medically indigent. These are the unique societal contributions that teaching hospitals provide. I'm quite sure these contributions would not be carried out in similar fashion if all our teaching hospitals were owned by investors.

TEACHING HOSPITAL SOCIETAL CONTRIBUTIONS

Tertiary Hospital Services

The teaching hospital's patient care reputation is clear: it is the place for the most severely ill patieints. In a disease staging case mix study of 24 Council of Teaching Hospitals (COTH) members, 12% of the cases in the teaching hospitals studied were in the most severely ill categories and accounted for 20% of total patient days. Half of those patients had either cancer or cardiovascular diseases.

Patients with the most severe medical needs tend to be sent to teaching hospitals for the latest patient care capabilities. In 1980, the 329 non-federal members of the Council of Teaching Hospitals performed:

- 68% of the pediatric open heart surgeries;
- 49% of the computerized (CT) scans;
- 47% of the adult open heart surgeries; and
- 30% of the computerized (CT) body scans

provided by short-term, non-federal hospitals. Teaching hospitals are also the primary source of microsurgery, joint replacement surgery, transplant surgery, specialized laboratory and blood banking services, and specialized neurological and ophthalmology procedures. TABLE I on page 3a rather dramatically demonstrates the volume of special service contributions made by teaching hospitals.

Full Service Clinical Education

Teaching hospitals are major educational institutions. In 1983, COTH short-term, non-federal hospitals provided the training sites for over 45,000 residents and

TABLE I

Percentage of Short-Term, Non-Federal Hospitals Providing Selected Services by Membership in the Council of Teaching Hospitals 1980

Selected Services	Percentage of Hospitals Providing		COTH as a Percentage of All Hospitals
	COTH Members	Non Members	
Social Work Departments	95%	69%	7%
Histopathology Lab	94	57	9
Electroencephalography	93	57	9
Diagnostic Radioisotope Facility	91	57	9
Emergency Service			
24 Hour Physician Coverage	91	48	10
As Organized Department	90	70	7
Blood Bank	88	70	9
Hemodialysis—Inpatient	85	18	22
Cardiac Catheterization Facility	83	11	31
Organized Outpatient Department	82	42	10
Therapeutic Radioisotope Facility	80	20	19
C.T. Scanner	80	17	22
Premature Nursery	78	34	12
Radioactive Inplants	77	20	23
X-Ray Radiation Therapy	75	15	22
Megavolt Radiation Therapy	71	11	27
Open Heart Surgery Facility	67	6	39
Hemodialysis—Outpatient	66	8	32
Genetic Counseling	53	4	45
Organ Bank	28	2	46
Burn Care Unit	23	1	58

Source: 1980 Annual Survey of Hospitals, American Hospital Association.

fellows in graduate medical education programs, over 30,000 students in the last two years of medical school, and large numbers of nurses and allied health students. As major teaching hospitals, non-federal COTH members are active participants in multiple residency training programs; 6% of the hospitals participated in at least 26 residency programs; 41% participated in 16 or more programs. At least 70% of the COTH hospitals provided programs in the basic specialties of internal medicine, general surgery, obstetrics-gynecology, pathology, orthopaedic surgery, and pediatrics.

The clinical education of medical, nursing and allied health students is organized around the daily operations of the hospital. Patients are being treated and students are being trained through the same activities. In effect, both products - patient care and education - are being simultaneously, or jointly, produced. The joint nature of patient services and clinical education does not imply that education is being produced without additional costs - education is not simply a byproduct. The addition of the educational role does involve additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. It is most difficult, however, to identify distinctly many of the educational costs because of the impossibility of a clear separation of clinical care from clinical education. It is also difficult to quantify the service benefits teaching hospitals receive from physicians, nurses, and technicians in training programs.

Residents learn clinical skills through supervised participation in the diagnosis and care of patients. The patient service benefits that accompany this learning reduce, in some part, the costs of graduate medical education programs. The cost reduction varies with the patient's clinical needs and the resident's level of training. Service benefits provided by residents are probably more substantial for tertiary care patients requiring continuous medical supervision than for routine patients and are greater for senior residents than junior residents. While there is no conclusive study comparing the costs added by residency programs with the service benefits provided by residents, hospital executives and medical educators generally believe that the costs of operating a residency program exceed the service benefits obtained by patients. This added cost is the investment necessary to adequately prepare the future generation of professional health personnel.

Clinical Research and Applied Technology

The reputation of teaching hospitals for state-of-the-art medical care is world-renowned but difficult to quantify. Hospital industry questionnaires generally do not inquire about new, rare, or unique services. Occassionally, a national inventory does provide some insight. For example, in 1980, the US Public Health Service published a list of clinical genetic service centers. Of the 223 listed centers, 82 were hospital programs with 57 of these (70%) sponsored by members of the Council of Teaching Hospitals. An additional 36 programs were located in state agencies, private health agencies, and private research institutes. The largest concentration, 105 programs, was located in universities, but in these university programs, the roles of their teaching hospitals were not separately identified.

The clinical genetics data illustrate the problem of identifying the teaching hospital's role in clinical research. In most cases, the university's clinical faculty are also the hospital's medical staff. The specific identification of research program location may reflect more upon the flow of grant funds (e.g., National Institutes of Health to university) than on the actual site of the research (e.g., university or hospital). Data on clinical research derived from funding flow typically understate the teaching hospital's role.

The presence of medical research in the teaching hospital has environmental, managerial, and financial implications. To attract and retain research-oriented faculty physicians, the hospital must create and maintain a climate conducive to research. Research scholarship must be esteemed, research support and supplies must be readily available, and individual hospital departments must be flexible and responsive to the demands accompanying research. Managerially, the inclusion of medical research in a teaching hospital's primary mission requires governing board and senior management commitment to integrating research into the daily operations of the hospital. Specialized supporting staff must be hired and trained, necessary research review and patient protection procedures must be developed and monitored, record-keeping and reporting by the funding organization must be established, and management styles appropriate for personalized and efficient patient care must be balanced with a collegial style appropriate for research productivity. Without an appropriate environment and management, research will not flourish.

Establishing a medical research program increases a teaching hospital's costs. Additional costs are incurred for staff, supplies and equipment, space maintenance and upkeep, and record keeping. Most, but not all, of these added costs are supported by grants, contracts, endowments, and gifts. Regular hospital services provided for research patients are generally paid by the patient or his third party coverage.

There is much to be said and understood about this subject. However, the point I wish to leave with you is that without an appropriate environment and management attitude, research simply will not flourish.

Charity Care

Providing service to low income patients is not a responsibility which is distributed uniformly across all hospitals. Teaching hospitals care for a disproportionate number of the poor. Non-federal members of the Council of Teaching Hospitals have 19% of the nation's short stay beds but 25% of the Medicaid admimissions. In addition, teaching hospitals have a disproportionate share of the patient bad debts and charity care (TABLE II). In 1980, COTH members wrote off 47% of the charity care ($601 million) and 35% of the bad debts ($1,176 billion) incurred by all short-term, non-federal hospitals. As a result, the average COTH member deduction of 9.4% of revenues for charity and bad debts was 84% greater than the hospital average deduction of 5.1% of revenues.

Having made this point on behalf of teaching hospitals, it also needs to be pointed out that this responsibility is not equally shared within the teaching hospital community. There are some institutions, particularly some urban hospitals, which carry an inequitably large share of this responsibility.

TABLE II

Bad Debt and Charity Deductions for Short-Term, Non-Federal Hospitals by Membership in the Council of Teaching Hospitals 1980

	COTH Members	Non-COTH	Total
Number of Hospitals	327	5,503	5,830
Deductions for Bad Debts	$1,176,457,285	$2,147,076,975	$3,323,534,260
Deductions for Charity	600,830,737	673,420,989	1,274,251,726
Total Net Patient Revenue	18,935,681,665	54,883,157,724	73,818,839,389
Percent of Hospitals	5.6%	94.4%	100.0%
Percent of Bad Debts	35.4%	64.6%	100.0%
Percent of Charity	47.2%	52.8%	100.0%
Percent of Net Patient Revenue	25.7%	74.3%	100.0%
Bad Debt and Charity as a Percent of Net Patient Revenue	9.4%	5.1%	6.2%

Source: 1980 Annual Survey of Hospitals, American Hospital Association

DISCUSSION

I have taken much time to describe the societal contributions of teaching hospitals. I have done so to be sure certain questions get proper attention. In the excellent Institute of Medicine publication on the subject before us today, Professor Luft states, "After all, the concerns about for-profit enterprises in medicine stem largely from the notion that care will suffer." At the level of the patient-physician relationship, this is correct; however, in a broader societal context, the question becomes, "Will certain desirable functions be continued?" In the abstract, it's a bit too easy to say, "Sure, clinical research will move ahead, new tertiary services will be available, manpower will be trained and educated, and someone will take care of the poor." Those words roll out so easily, and more recently, with greater and greater frequency. However, the financing arrangements and characteristics of the hospital environment which have enabled us to support these important societal contributions of the teaching hospitals are beginning to shift, and changes are occurring rapidly.

With the exception of research grants and contracts, and state and local government support for a relatively small number of hospitals, patient service revenue in the teaching hospital is the dollar stream that supports these very necessary societal contributions. "Cost-shifting" or "charge-shifting," whatever term you prefer, is in fact taking place, as the Health Insurance Association of America (HIAA) has charged. However, it's not quite as undesirable as the insurance executives allege, and there is some more to it. In the final analysis, it does not come down to need for a profit (all hospitals need a profit), but to the question of what one does with the money. I understand the other side of the HIAA argument, but let's again ask some basic questions:

- "Is it wrong to charge one group of patients higher charges so another group of patients can be served?"
- "Is it wrong to finance education from higher charges to patients, particularly when other sources of financing are not available?
- "Is it wrong to finance some clinical research and development from patient revenue?"

Essentially, what we're doing here is subsidizing several functions with revenue from one function. However, these cross-subsidy choices are less and less available as the environment changes to reflect an attitude where competition is strictly on the basis of price. Suffice it to say that although price competition may stimulate prudent decisions by educated consumers and groups with purchasing power, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet the needs of all our citizens.

More to the point of this hearing, however, is Shortell's distinction between investor-owned and voluntary hospitals:

A basic distinction between investor-owned and voluntary hospitals is the former's need to make a return on stockholders' equity. This return might be viewed as the ultimate goal of the investor-owned hospital with the rendering of patient care serving as an instrumental goal or means of achieving the ultimate goal of return on equity. In contrast, for the voluntary hospital the ultimate goal is the delivery of patient care to the community and generating a surplus (or profit) serves as an instrumental goal or means by which this is achieved. In brief, the means-ends relationships become reversed.

It is important to note that for both investor-owned and voluntary hospitals, financial viability and the delivery of cost-effective patient care are important, whether as instrumental or ultimate goals. Nevertheless, one might hypothesize that this difference will affect the decision-making process and the resulting choices of specific services offered by hospitals. The investor-owned hospital will presumably be particularly interested in adding services that will increase return on investment.

Some observers might suggest that the strategies that not-for-profit hospitals are using to overcome certain disadvantages resulting from their organizational form are blurring the differences between not-for-profit and investor-owned hospitals. Blurred perhaps, but the fundamental difference remains, and that difference is exemplified by the basic purpose and mission of an investor-owned corporation. I would suggest that the investor-owned corporation has a legal obligation to its shareholders. Each decision that a corporation makes with regard to service mix, program selection, and population served will have an impact on earnings per share. I would agree that some of these decisions can be made in the "loss-leader" context. However, the need and responsibility to make a profit for the shareholders must be the overriding factor in these decisions.

Let's take this thought a bit further. It has become almost conventional wisdom to say that hospitals can no longer think of themselves as community service organizations if they hope to compete successfully for the shrinking pool of capital funds. David Winston, Senior Vice-President for Planning, Voluntary Hospitals of America, was recently quoted as saying, "All of us in health care have to abandon forever the idea that health care is not a business. It is a business, and we have to treat it as such." I agree with the intent of that statement with regard to the competition for capital, but I think we need to examine carefully the "business world" before we fully adopt all of its characteristics. HCA Chairman Donald MacNaughton has said, "I hope at some point the myth relating an aura of purity to an IRS tax exemption is dispelled. As a result of the myth, many hospitals are run loosely as social institutions with an economic burden. HCA operates its hospitals as economic institutions with a social responsibility." In my own view, the question is how "businesslike" can we in the teaching hospital community become, and maintain our multiple missions and societal contributions?

I could move now into the allegations concerning overuse of technology, skimping on quality, cream skimming and conflict of interest that may accompany the profit motive. I'm not satisfied that there aren't some problems in these areas.

However, Professor Veatch has outlined the issues that are of greatest interest to me in his paper on "ethical dilemmas." It would be my suggestion that this Committee pursue vigorously the themes outlined under the heading "Differences Between Business and Physician Ethics." A number of subjects are addressed; however, those that most closely parallel the concerns set forth in this paper are as follows:

- exclusion of inefficient customers;
- supplying unprofitable products and services; and,
- the duty to the indigent.

In this regard, Bob Cunningham, a long time observer of the medical and hospital scene has outlined the situation very well. He said, "What got doctors and hospitals to the special place they have always held in society, and still have, was not tidy balance sheets and debt-equity ratios. As long as they can keep on giving the people, the ultimate scorekeepers, what is new, what is best, and what is needed for all of them, doctors and hospitals can keep the public trust...at any price! If they don't, they won't...also at any price." Thus, my basic concern here is that we continue to provide the mix of products unique to the teaching hospital mission: service to all patients, tertiary care services, manpower for the future, and an environment which allows research to flourish. If we are able to do so, we will keep the public trust that has been placed in us.

CEDARS-SINAI MEDICAL CENTER

Reply to
Box 48750
Los Angeles, California 90048

Direct Dial Number

February 17, 1984

LETTER TO THE COMMUNITY

We are writing to clarify some recent public misunderstanding about Cedars-Sinai Medical Center resulting from inaccurate reporting on certain elements of the press. From the opening of Kaspare Cohn Hospital, Cedars' predecessor, in 1902, and Mount Sinai Hospital in 1921, Cedars-Sinai has continuously provided care to the indigent Jews of Los Angeles. The medical center has never deviated from its central theme of compassion and charity. For example, last year, Cedars-Sinai provided $3,546,000 for free care to indigent patients. These indigent patients received 6,500 outpatient visits and procedures and were hospitalized over 1,100 days. With the exception of $995,000 received from the Jewish Federation Council and the United Way, this free care was absorbed out of our own resources.

Our clinics never have closed. Both inpatient and outpatient services to indigent Jews who are without health care coverage of any sort have continued without interruption. Many other poor and aged individuals do have health care coverage from governmental sources, under two programs whose recipients are sometimes confused with those without any coverage. Here is a brief explanation which may help.

In 1965 a Federal law created two programs: (1) Medicare, which provided health care coverage for those aged 65 and over and certain disabled people, and (2) Medicaid (Medi-Cal in California) which did the same for certain categories of the poor. Part of the funding of Medi-Cal was from State sources. Before this legislation all of the indigent aged and the poor were dependent on free clinics, either provided by the County, or a few hospitals such as Cedars-Sinai. Since then, those who are really indigent (without such coverage) continue to be dependent on free care, and have been welcome at Cedars-Sinai.

Certain drastic changes were made recently in the Medi-Cal law. Medi-Cal patients now are allowed to go only to those hospitals which have entered into a new type of

Despite inaccurate reports to the contrary, during this entire difficult period we have continued to furnish outstanding care to both outpatient and inpatient indigent individuals who do not have either Medi-Cal or Medicare coverage. As always Cedars-Sinai recognizes its mission to provide quality health care to those who cannot afford it, and to serve the entire community with the highest standard of excellence in hospital care, medical education, and research.

Sincerely,

Robert L. Spencer
Chairman of the Board

Stuart J. Marylander
President