Our Unsystematic Health Care System, 2nd Edition

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Hospitals and Other Health Care Organizations

Press Release: American Hospital Association charged as a defendant in class action lawsuits brought by uninsured patients against nonprofit hospital system and hospitals. . . . Among other things, the AHA encourages its co-defendant nonprofit hospital systems and hospitals to perform "wallet biopsies" on uninsured patients. Through these "wallet biopsies," the AHA's co-defendants' priorities are not necessarily on the appropriate healthcare treatment for the uninsured patient but rather on gouging the uninsured patient with exorbitantly inflated prices, in some cases up to 300 percent more than for insured patients.

Scruggs Law Firm
July 21, 2004

Press Release: Statement from the American Hospital Association on class action lawsuit—America's hospitals are about people taking care of people, often at the most vulnerable times in their life. That is the responsibility hospitals take seriously. Day in and day out. . . . This assault on community hospitals is misdirected and baseless—diverting the focus away from the real issue of how we as a nation are going to extend health care coverage to all Americans.

Dick Davidson
President of the American Hospital Association
July 21, 2004

How hospital performance data are presented is utterly and purposefully confusing. After first proposing a five-star rating system, the JACHO (Joint Commission on Accreditation of Healthcare Organizations) has turned to a grid of overall and separate scores. After tweaking, some stars

> have returned, though what they stand for now is anyone's guess. What payers, let alone hapless consumers, are supposed to do with this jumble is unknown but probably irrelevant.
>
> Todd Sloane
> Assistant managing editor/op-ed of *Modern Healthcare*
> August 2, 2004

Everyone knows what a hospital is. It is where people go in a medical emergency; to have technologically sophisticated tests done to determine if their symptoms are indicative of a serious health problem; to have surgery or other procedures done; and so on. People generally do not think about hospitals unless they need to go to one because of a pressing health problem. When they do go, they are naturally preoccupied with the health problem that is causing them to be there. For purposes of this discussion we will be taking a broader view of hospitals. We will look at hospitals as organizational structures, and we will identify who owns them and who decides how they operate.

The first consideration is that hospitals are not all alike. Some are small community hospitals; some are very large and linked to other large organizations, such as medical schools. There are also highly specialized hospitals—for example, those that treat patients who only need physical rehabilitation. If you cannot quite see a master plan here, you are making the right interpretation. Hospitals have evolved to meet the needs of particular communities. The community they intend to serve is something they themselves decide. To understand how hospitals have evolved, let us begin with the first decade of the twentieth century.

First, it would be good to consider a number of other basic characteristics that distinguish hospitals one from another. The most basic difference stems from how long patients stay in the hospital. There are short-term-stay, "acute care" hospitals, and there are long-term hospitals. The majority of hospitals in this country are short-stay hospitals. Long-term hospitals mostly care for mental patients and rehabilitation patients. There are also long-term care facilities that are not hospitals but nursing homes. We will discuss them later in this chapter. Unless otherwise indicated, the discussion to follow refers to short-term, acute care hospitals.

It might be helpful to look first at some growth trends among hospitals. Counting the number of hospitals tells you something but leaves a lot unsaid about growth. A more precise indicator would also tell us whether individual hospitals are getting larger. There are various ways to measure the size of an organization, including a hospital: the number of employees, the gross annual budget, the number of branches it has established, the size of the geographic region it serves, and so on. The commonly agreed-on measure in this case is

the number of beds. A hospital in a rural area might have fifty to seventy-five beds while a medical center hospital might have five hundred or more beds. As you might imagine, the size of a hospital determines the range of services it can offer, the size and expertise of its staff, the sophistication of the equipment it has available, its budget, and its organizational concerns.

Another basic distinguishing criterion is hospital ownership. It turns out that who owns a particular hospital makes a significant difference and is an issue that has inspired heated debate over the past few of decades. When the government reports hospital statistics, it begins by differentiating between federal government hospitals and nonfederal hospitals. Federally owned and funded hospitals are basically operated by the Veterans Administration for the exclusive use of veterans of the armed forces. All other hospitals fall into the nonfederal category, subdivided into three ownership categories: nonprofit, for profit (previously called proprietary), and state/local government.

Hospitals in the state and local government category are the easiest to recognize. They are usually named to clearly indicate that they are government sponsored—for example, Boston City Hospital, Los Angeles County Hospital, or University of Illinois Hospital. You realize, of course, that the state and local government hospitals are, in the broadest sense, not-for-profit organizations. They are typically referred to as public hospitals—that is, funded by the public through taxes—to distinguish them from hospitals that are privately funded. The same labeling is used to identify the sponsorship of other organizations in the health sector and out. Any organization that is supported by taxes is considered a public organization.

The nonprofit category is not always so easy to distinguish from the for-profit category. Small community hospitals and major teaching hospitals qualify as nonprofit hospitals. University-sponsored teaching hospitals usually, but not always, carry the name of the medical school that owns and operates them. Many other hospitals are loosely affiliated with medical schools, which themselves may be publicly or privately supported nonprofit organizations. Affiliation to a medical school allows a hospital to offer graduate medical education in the form of residency programs, in which persons who have already earned a medical doctor's degree (i.e., medical residents) carry out their postgraduate, practical, on-the-job medical training. Medical schools have more graduates than they can accommodate at the university hospital for residency training, which takes anywhere from three to five years, more if the doctor wishes to subspecialize. For this reason, university/teaching hospitals must develop ties to state, local, and "community" hospitals to provide places for medical students and residents to receive hands-on training.

The term *community hospital* has traditionally served as a catchall label for hospitals that are owned and operated for the benefit of the community as

opposed to that of owners and investors. Such hospitals may have been established by religious orders, residents of a particular geographic community, or leading citizens within a particular community aiming to create a hospital to provide for their own religious or ethnic groups. The government has recently begun to use the *community* label more broadly to refer to all acute care hospitals regardless of ownership (as denoted in table 4.1).

The for-profit category includes hospitals that are privately owned and operated as profit-making enterprises. Historically, this label referred to hospitals that were owned by individuals, usually one or more doctors. As owners, they pocketed what they earned from running the hospital; they made all the decisions regarding general improvements, technological and cosmetic improvements, staff, and so on. They also paid taxes on any profits. This is a major distinction. Nonprofit hospitals are not taxed by the government. Proprietary hospitals of this kind have all but disappeared, although any that still exist would fall into this category. The label is now understood to mean hospitals that are owned by corporations (to make things more confusing, this is sometimes referred to as being "publicly owned" because many people are owners by virtue of investing in it). These hospitals aim to make a profit: they sell shares to stockholders, distribute profits to those who invest in the business, and pay taxes. Table 4.1 indicates growth trends in each of these categories since 1975.

Because counting the number of beds is generally considered to be a more accurate measure of hospital trends, table 4.2 reports the shift in the number of hospital beds between 1975 and 2001. As you can see, the total number of beds has been declining since 1975. However, it is the distribution of beds that policy makers were most interested in, especially the fact that the number of beds in for-profit hospitals continued to increase. We will get back to that observation shortly.

Table 4.1. Hospitals in the United States, 1975–2001

	1975	*1995*	*2001*
All hospitals	7,156	6,291	5,801
Federal	359	299	243
Community			
Nonprofit	3,322	3,09	2,998
For-profit	730	752	754
State/local	1,778	1,350	1,156

Source: "Hospitals, Beds, and Occupancy Rates, according to Type of Ownership and Size of Hospital: United States, Selected Years 1875–2001," *Health United States, 2003* (Washington, D.C.: U.S Department of Health and Human Services, Public Health Service, 2003), table 106.

Table 4.2. Distribution of Hospital Beds, 1975–2001

	1975		*1995*		*2001*	
All	1,465,828	100%	1,080,601	100%	987,440	100%
Federal	131,946	9	77,079	7	51,900	5
Nonfederal	1,333,882	91	1,003,522	93	935,540	95
Community	941,844	100%	872,736	100%	825,966	100%
Nonprofit	658,195	70	609,729	70	585,070	71
For-profit	73,495	8	105,737	12	108,718	13
State/local	210,154	22	157,270	18	132,178	16

Source: "Hospitals, Beds, and Occupancy Rates, according to Type of Ownership and Size of Hospital: United States, Selected Years 1875–2001," *Health United States, 2003* (Washington, D.C.: U.S Department of Health and Human Services, Public Health Service, 2003), table 106.

A BRIEF HISTORY OF HOSPITALS IN THE TWENTIETH CENTURY

Before the twentieth century, people avoided a hospital stay if they had any choice about it. Hospitals were essentially charitable organizations that provided basic care and housing for indigents who had no place else to go. Exactly how many hospitals there were in this country around the turn of the century is difficult to determine. According to one of the few estimates available, as of the mid-1880s, there were only 178.[1] People did not go into a hospital willingly because everyone knew that hospitals were dangerous places. One's chances of dying once you were in the hospital were excellent. Middle-class people certainly would not have paid to go there. Those who could afford it were treated in their own homes or the doctor's office. Many people also sought advice and remedies from the apothecary (pharmacist) and any number of other kinds of health practitioners.

While most people were reluctant to go into the hospital during the first two decades of the twentieth century, surgeons were beginning to find it more difficult to perform surgery outside of the hospital. They had begun to perform more kinds of surgery than they had been able to do even a few decades before, largely due to a range of technological advances. Anesthesia, which was initially developed in the 1840s, had become more effective and reliable. (Imagine what surgery was like before anesthesia! People died from the shock of being cut open even before they had a chance to develop an infection; if they survived, infection was, of course, very likely.) The value of antisepsis (a sterile surgical environment) was discovered in the 1860s and was now fully implemented. X-ray technology came into existence in the 1890s. As surgeons became more dependent on hospitals to perform surgical procedures, they also became more interested in setting standards that would improve the quality of hospital care.

Accordingly, in 1918 the American College of Surgeons began inspecting hospitals in an effort to ensure the public that hospitals were well equipped and that the doctors doing surgery were well qualified. They did so by encouraging doctors to assume greater responsibility for overseeing the work of their colleagues. They were especially concerned about preventing less-qualified or unethical colleagues from performing unnecessary surgery.[2] The medical profession as a whole, led by the most accomplished surgeons, improved the quality of care provided in hospitals by having pathologists perform autopsies on the patients who died in the hospital to determine whether the diagnosis was accurate and whether the surgery was truly necessary and, of course, done well. The public nature of the autopsy meant that surgeons had to be more careful about the surgeries they were performing because all doctors affiliated with the hospital were encouraged to attend autopsies as an excellent method to discuss cases and advance medical knowledge. Having colleagues discover that the surgeon was misdiagnosing patients and performing unnecessary surgery would certainly not be good for the surgeon's reputation.

To ensure that autopsies were in fact being carried out and that the privileges of doctors doing inappropriate surgeries were restricted, the American College of Surgeons encouraged doctors to become active members of the Medical Staff organization in the hospital. In short, doctors were encouraged to establish firm control over the day-to-day work taking place in hospitals.

Administrators of hospitals were well aware of the fact that their interests were not identical to those of surgeons or, for that matter, other physicians and other hospital personnel. They began organizing themselves into an association of their own. In 1899 they established the Association of Hospital Superintendents of the United States and Canada, which became the American Hospital Association (AHA) within the next few years. Over the next decade or so the AHA came around to the view that the surgeons were probably right, that raising hospital standards was important and that inspections were essential. However, the AHA did not have the resources or the power over hospitals to impose such inspections. The American College of Surgeons did have that power.

When hospitals were primarily charitable institutions, doctors contributed their services. They did so because hospitals provided them with interesting "clinical material"—that is, interesting cases. In other words, the patients were more likely to be in an advanced stage of disease because they did not have the money to obtain treatment earlier, often because the disease prevented them from working and thus impoverished them. There were a lot of very sick people who could not afford to see a doctor privately. So doctors volunteered their services in exchange for the opportunity to treat the interesting cases. As hospital care improved, middle-class patients began asking to

be admitted to the hospital, indicating willingness to pay the doctor as well as the hospital for the care they would receive. Here we begin to see a pattern that would lead to hospitals beginning to depend on patients' paying for the hospitals' operating funds. Surgeons were in a position to funnel their paying patients to the hospital of their choice. Hospitals were left with little alternative but to accede to the surgeons' wishes—focusing on making the improvements that surgeons demanded, such as bigger and better surgical suites, more advanced equipment, and more staff.

The AHA first approached the American College of Surgeons around 1950 to explore the possibility of setting up a cooperative inspection program. Four organizations joined together to develop hospital accreditation standards: the AHA, the American College of Surgeons, the American Medical Association, and the American College of Physicians. By 1952 they had worked out standards and established a new organization, the Joint Commission on Hospital Accreditation, to carry out the inspections. The inspections were to be voluntary; hospitals would have to request them and would be charged for the costs of carrying them out. As of 1987, it became the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), generally now referred to as the Joint Commission. The role of JCAHO is very obvious to everyone employed in a hospital, especially when the Joint Commission comes in to do an accreditation visit.

Hospitals continued to grow and expand during the first few decades of the twentieth century, until the end of the 1930s.[3] According to one of the first American Medical Association counts, there were approximately forty-three hundred hospitals in the country in 1928. Then the trend suddenly reversed. By 1935, the number dropped to four thousand. The drop is attributed to the Great Depression. Patients could not afford to go to a hospital; those who were taken there because it was an emergency could not pay for it; and many smaller hospitals did not survive. The hospitals that did survive could absorb such losses only because they were receiving support from especially dedicated and, in many cases, wealthy contributors. Some hospitals survived because of the support they received from religious orders or an entire ethnic community. The only other hospitals that survived the Depression were those operated by local governments.

The next major event that occurred in the twentieth century was World War II, and little changed in the hospital sector between the Depression and the end of the war. Once the war ended, however, the country experienced a period of adjustment that brought with it not only peace but a period of unprecedented prosperity. Because Americans did not, really could not, spend much on consumer goods during the war years, they suddenly found themselves much better off financially than they had been prior to the war. People wasted no

time making up for what they had forgone during the war years. They got married, had babies, built new homes out in the suburbs, bought things for their homes, and purchased cars. With all this expansion, there was a need for new schools, new roads, and of particular relevance to this discussion, new hospitals. The Hill-Burton Act was passed in 1946 to support the construction and expansion of hospitals. The federal government matched the funds raised by the community for the purpose of building a new hospital or adding on to an existing one. The result was that established hospitals expanded and new community hospitals sprang up in rural areas and suburbs all across the country.

At this point we should consider whether there really was a need for so much more hospital construction or whether there could have been some other reason behind the urge to build and expand. Admittedly, the definition of "need" in this case has its own body of literature. For purposes of this discussion, there is something besides objective need involved. Many hospitals came into existence for symbolic reasons. They stood as a major source of pride to the community whether it was an ethnic, religious, or geographical community. The Hill-Burton Act provided the perfect opportunity to act on that sense of pride. It is also true that some urban hospitals were built by people who had good reason to believe that they were not welcome in hospitals operated by other groups, such as Jewish hospitals. Jewish doctors experienced discrimination when seeking privileges in hospitals run by others. Jewish patients felt better being treated by doctors who they felt would understand their cultural values. Similarly, Catholic hospitals offered the assurance that patients could practice their religion and that priests would be readily available to offer solace, hear confession, and offer last rites. Immigrants were concerned about being able to communicate and wanted to be able to speak their own languages in the hospitals. Finally, the newly established suburban communities were interested in proving that they could offer everything that the city could offer, only newer and better. (See the social construction of reality at work here? The people building hospitals were certain there was a need for all those new hospitals and new additions—perhaps not the kind of need that policy analysts were looking for, but as you can see, "need" is in the eyes of the beholder.) It goes without saying that poor people in poor neighborhoods could not and did not take advantage of the Hill-Burton funds. For this reason, new hospitals were not built in the many communities that really needed them.

Aside from community pride in the hospital, there is one other factor that coincidentally came into play just after World War II ended that fostered the expansion of hospitals. Synthesized penicillin came into existence during the late 1940s and became widely available by 1950. (Scientists knew about the value of penicillin in its original state—that is, mold and cobwebs. It took a while to identify the chemical formula so that it could be produced

in volume and under antiseptic conditions.) The availability of penicillin would have a major effect on hospital expansion because this was the first time that hospitals could control infection with certainty. Before that time, drugs to control infection did exist, but none was as powerful as the new series of antibiotics, starting with penicillin.

THE HISTORY OF HOSPITALS OVER THE LAST FIVE DECADES

Starting in the second half of the twentieth century, it seems that people were not only more willing to go into the hospital but were prepared to stay there for days. However, even at that time, staying in the hospital was not a minor expense. So who paid for people to luxuriate in the hospital for days? The answer is health insurance, initially Blue Cross, later commercial insurance, and as of 1965 Medicare and Medicaid (in short, the former is for the elderly, and the latter is for the poor; see chapter 7 for a more comprehensive discussion of health insurance).

The enactment of Medicare and Medicaid turns out to be a really big event for the future of U.S. hospitals and health care in general. The two programs guaranteed payment on behalf of those who had been least likely to be hospitalized because they could not afford it. That brought in a lot of "new business" to hospitals causing hospitals to grow and expand to accommodate increasing demand for health care services. (If talk about the business of health care delivery makes you think that things are finally going to be orderly and efficient, you are going to like what happens over the next few decades; if talk about the health care business makes you uncomfortable, prepare yourself: this is just the beginning. Hospitals and health care organizations are about to become *big business*.) The expenditures on hospital care went from $9 billion in 1960 to over $451 billion in 2001.[4]

From the perspective of hospitals, Medicare (and to a lesser extent Medicaid) would be providing a steady—and, more important, reliable—stream of funding from this time forward. By 1965, the government was already providing around 38 percent of the funding for hospital care (which includes various subsidies, research funds, and so on); by 2002, the government was providing just under 60 percent of the funding.[5] You know the old saying "He who pays the piper calls the tune"? The federal government has very little competition when it decides that it wants to call a particular tune. Here are two of the tunes it called from the beginning using the Medicare program as its vehicle for exclusive request of a song.

The government wanted some assurance that government funds would be going to good, as opposed to fly-by-night, hospitals. Therefore, the government

decreed that Medicare funds could only go to hospitals that were accredited by the JCAHO (remember, this is the voluntary association created to upgrade standards). That not only gave the Joint Commission increased power, but it eliminated hospitals that could not successfully pass a review by the Joint Commission because they could not compete with hospitals that could advertise this stamp of approval.

The second tune was dedicated to Blue Cross–Blue Shield. The government was not about to set up its own bureaucracy to administer the Medicare program. Instead, it agreed to pay an administrative fee to organizations that were already processing health insurance claims. It seemed like a good idea to give that responsibility to an insurance company that was a nonprofit organization rather than one that would make a profit on public funds spent by the government. In time, the for-profit insurance companies convinced the government that they could provide the same services for less. That was an argument that appealed to the government and was popular with the public. Insurance carriers, who bid on providing this service for the lowest fee, now administer Medicare, generally on a state-by-state basis.

After the first two or three years, the government realized that Medicare costs would not drop, as policy analysts had expected. Policy analysts who projected costs had reasoned that a backlog of untreated illness would push up the initial costs of Medicare and Medicaid but that once that backlog was addressed, costs would drop. However, costs showed no sign of falling. The government did not take major steps to reduce costs until 1983, which is when diagnostic-related groups (DRGs) were introduced. The government developed a reimbursement schedule based on the diagnoses with which patients were admitted to the hospital. Hospitals were fully aware that this was coming and knew that the government was using the data that the hospitals themselves were submitting in order to receive Medicare reimbursements to construct the schedule. Amazingly, all possible diagnostic categories were subsumed into 467 categories, plus a few more catchall categories. The system was set up so that the government would pay *X* amount of money per diagnostic category (1 of the 476) per Medicare patient admission. Private insurance companies did not change their reimbursement arrangements in response to the introduction of DRGs, at least not immediately. However, over the decade of the 1990s, private insurance companies adopted the DRG reimbursement schedule, and Medicaid programs in most states did too.

If the hospital could do whatever was necessary for less than the DRG payment for particular procedures or services, it got to keep the extra funds. If the funds were insufficient, the hospital simply had to find a way to deal with that. Hospitals did find ways to deal with it. One was to increase charges to patients covered by private insurance. Another way was to begin cutting back on the number of days (length of stay) a person stayed in the hospital.

A number of factors were coming into play at the same time that had an impact on the length of stay in the hospital. Surgical techniques had been improving all along; more laser surgery was being used (which is less invasive and may be done on an outpatient basis); and everyone agreed that it was better for the patient to go home to more familiar and comforting surroundings (where there was less chance of contracting new strains of infection that are hospital based). The reason for paying attention to length of stay is the impact this has on hospital occupancy rates. If people stayed in the hospital for fewer days, that would leave beds empty. If this trend continued, hospitals would have to take beds out of service permanently, and that is exactly what happened. Some hospitals had such a low "census," or occupancy rate, that they could no longer survive, which explains the decline in hospitals and hospital beds over the last two decades.

The introduction of DRGs marked an important turning point in the operations of hospitals regardless of ownership. Consider the fact that, before DRGs, Medicare paid hospitals on the basis of charges, not costs. In other words, whatever the hospital charged was what Medicare paid. The government created DRGs because many critics repeatedly pointed out that paying on a charge basis, rather than a cost basis, was one of the main reasons behind the escalation of costs. They argued that hospitals could and should become more efficient and accountable for how they were spending public funds. Hospitals had no alternative but to become more efficient.

Hospitals came up with yet another way to make up for the loss they sustained because of tighter Medicare controls in response to DRGs. They were already reducing the length of stay; all they had to do was extend that idea. They simply admitted patients for less than a full day (i.e., less than twenty-four hours). Since DRGs cover inpatient care but not outpatient care, hospitals could charge rates that were not so closely monitored. This practice explains why hospitals began building freestanding, outpatient clinics both near and far from the parent hospital.

The declining length of stay plus the increase in outpatient facilities contributed to the decline in the number of hospital beds during the 1980s. This trend, in turn, explains another closely related phenomenon. By the late 1980s, the patients being admitted to the hospital were too seriously ill to be treated on an outpatient basis. In other words, hospitals were now admitting sicker patients requiring more personal attention and more technologically sophisticated care. This manifested itself in two diametrically opposed trends that actually make perfect sense when you think about it. First, the ratio of staff to patients was steadily increasing; second, personnel costs were steadily

declining compared to other hospital costs, which were skyrocketing. What accounts for rising hospital costs is not so difficult to understand once you start thinking about all the new technology that hospitals have invested in. This includes diagnostic and monitoring equipment, such as CT (computerized axial tomography) scanners, MRI (magnetic resonance imaging) equipment, and the computers that compile and analyze all the information that the diagnostic equipment produces. All those machines are enormously expensive, and they are replaced every other year or so as newer, improved versions are released. Every patient most certainly wants the most recent version of any diagnostic instrument available, and your doctor certainly feels that way, too; that, among other things (such as the threat of malpractice suits for using outdated equipment) convinces the hospital that staying current is a wise investment.

Clearly, hospitals could make stringent efforts to become more cost conscious when buying new equipment. However, since one of the main ways hospitals promote themselves is on the basis of having the latest technology, it is difficult to see why they would be interested in cutting back on all that highly sophisticated technological equipment and the highly paid staff required to operate it. To cover these costs, hospitals increasingly began relying on a traditional funding mechanism—namely, the "sliding scale," meaning the rich paid more than the nonrich. In its more recent incarnation, it became known as "cost-shifting"—that is, charging privately insured patients more than those whose bills were paid by public insurance. More recently, hospitals have been entering into contractual arrangements with some private insurance companies but not others. Anyone who is not included in such arrangements is charged more. Whether they are actually able to pay what they are charged is another matter.

Unfair? Hospital representatives say that they must take care of persons who carry no insurance but run up high costs. Where are they supposed to get the funds to cover that? Laws passed in 1986 prevent hospitals from turning away patients who are uninsured and unable to pay for care.[6] Hospitals are allowed to stabilize such patients and send them off to the nearest government-supported hospital. However, sometimes this involves emergency surgery and days spent in the most expensive part of the hospital, the "intensive care" unit. Surgical patients who are admitted to the hospital for a planned, routine surgery typically only spend a short time there. Patients who are involved in serious accidents or have multiple gun-shot wounds stay much longer. There is no public funding to cover the costs of caring for patients who require this kind of intensive care but are poor and have no insurance to cover it. Over the last couple of decades, additional funds called "disproportionate share hospital payments" have been legislated to help cover the costs incurred by hospitals that care for large numbers of poor and uninsured patients. However, administrators of such hospitals say that they continue to struggle to make ends meet.

HOSPITALS AT THE TURN OF THE TWENTY-FIRST CENTURY

Policy makers who focus on the hospital sector of the health care system have been following a number of developments for the last quarter century. The steady expansion of for-profit hospitals came under increased scrutiny during this period. For-profit hospital corporations had been growing at an unexpectedly fast rate. The representatives of these corporations argued that what they were doing was socially beneficial because it put pressure on nonprofit hospitals to be more efficient, which they said would bring down prices. Critics countered by arguing that the aggressive form of competition introduced by the for-profit hospital corporations went too far, that it made it more difficult for the poor and uninsured to receive care because the nonprofit hospitals could not afford to provide "charity" care and keep their doors open. They said that competition brought downsizing to hospitals, which translated into laying off the most experienced and therefore most expensive nurses and hiring less expensive, easily replaced "technicians" trained to do very specific tasks (e.g., take blood pressure or give shots). The problem, the critics said, is that bringing in less-skilled personnel was increasing the risk of mistakes—medication errors, inability to recognize disease indicators, carelessness about disposal of infectious materials, and so on.

A good indicator of public concern was the pressure it put on legislators to pass laws to prevent patients from being discharged prematurely (i.e., earlier than what the public thought appropriate) or, as policy analysts put it, to prevent their falling victim to the "quicker and sicker" cycle. By the end of 1996, twenty-nine states had passed laws governing "early discharge" to prevent women who had just had a baby from being discharged in less than two days or those who had a mastectomy from being discharged the same day.[7] The laws were actually directed at the insurance companies responsible for restrictions on length of stay. We will get back to this topic in later chapters. For now, let's just say that health policy types see this as a very strange way to deal with the problem of quality of care. Do we expect legislators to pass laws to cover every possible concern about hospital care expressed by the public?

The major problem, according to some observers, has been that the commitment to business practices led to mergers and buyouts of entire hospital corporations. Hospitals began acting more as other businesses, interested in increasing their profits by focusing on cutting expenditures—the old "leaner

and meaner" story. As tables that appeared earlier in this chapter show, the number of for-profit hospitals increased steadily. To survive in this environment, nonprofit hospitals began to adopt aggressive business practices similar to those used by for-profit hospitals. By the end of the twentieth century, it became more difficult to identify the differences between for-profit hospitals and nonprofit hospitals.

Whether the changes that took place in the hospital sector have been good for patients, health sector personnel, and society as a whole has been the subject of controversy for quite some time. We will return in later chapters to the question of whether increased reliance on a business model for running hospitals has been beneficial or detrimental, for now the basic elements of the argument are these. Those in favor of the continued growth of the for-profit hospital sector say it is about time that hospitals learned to apply basic business practices. They say that the growth of the for-profits has introduced better management techniques, reduced costs, improved service, and so forth. Those who are opposed say the for-profits skim off the richest, healthiest patients; do almost no research, no medical education; and have as their primary goal financial gain that benefits hospital executives and shareholders. The critics argue that the health care delivery system should not be making a profit on the members of society who have the misfortune of being sick.

Which side is right? Depends on your perspective. The answer boils down to whether you think recent trends are more beneficial to society as a whole or to that portion of society that is getting rich from investments in the health sector.

OTHER HEALTH CARE ORGANIZATIONS

Applying one of the basic differentiating characteristics used in discussing hospitals, we can differentiate some other health care organizations by whether they care for patients who are ambulatory (to ambulate is to walk) or bedridden. Ambulatory patients may receive care at clinics, now more often called health centers, which can be freestanding or attached to a hospital. Patients can be acutely but temporarily ill or chronically ill; in both cases, they receive health care services on an outpatient basis for whatever time it takes, whether long term or short term. Long-term-care patients, who are no longer able to get to the hospital or clinic on a regular basis without a great deal of assistance, may end up being admitted to a facility to receive care as inpatients. Long-term-care facilities are generally privately owned, often operated as for-profit organizations. While most rely on Medicare and Medicaid funds, the facilities themselves are typically not government owned.

Long-term care, both inpatient and outpatient, has been attracting a considerable amount of attention over the last few decades.[8] The reason is perfectly clear—fear that this will turn into a serious problem. You know that the baby boom generation is moving right along toward their golden years. As the boomers develop health problems associated with aging, they are expected to break the bank. The list of threatened institutions is lengthy: social security, Medicare, nursing home care, and all associated services required by the elderly. The expected increase in the number of aged who require nursing home care plus the increasing number of severely disabled younger people requires serious attention and planning.

Added to the increasing number of people who will need nursing home care because of the problems associated with aging is the devastation caused by chronic illness in younger populations—for example, paralysis due to spinal injury, mental problems, and HIV/AIDS. Finally, the fact that modern medicine can perform miracles in saving people who would not have survived years ago does not necessarily mean that those who are saved can lead normal, healthy lives. Many require extensive care for years.

The over-sixty-five population is, however, of greatest concern to policy makers because of the numbers involved. Only about 4 percent to 5 percent of this population is in a nursing home at any point. The explanation is that they usually do not stay in nursing homes for very long. The average length of stay is approximately 80 days, but for persons over eighty-five it goes up to 145 days. The problem is that even a short stay is expensive, $4,000 to $5,000 per month. Nursing homes are classified as skilled nursing facilities (SNFs), which provide the full range of health services that a convalescent patient might need; and intermediate nursing facilities (INFs), which provide less-extensive health-related services, including rehabilitation, personal care and social services. Medicare, more often Medicaid, reimburses for care provided by the facilities. A growing number of people need custodial care not because they are ill but because they are frail, forgetful, and not fully able to manage on their own. This kind of care is not funded.

Home health care has been supported, in fact promoted, albeit with some trepidation, by the government as a good alternative to nursing home care. The reason that home health care is not likely to be promoted even more enthusiastically is that it poses a potential cost problem that is interesting to reflect upon. Home health care is much less expensive than nursing home care because people stay in their own homes and health workers go in for a few hours at a time. Also, virtually everyone prefers to stay in his or her own home. The problem is the fear that too many people will opt for this form of care. Traditionally, wives, daughters, and other female relatives provided such care out of sense of duty. Now that the majority of women

are not staying home, the government is concerned that it will have to pick up the bill. For now, the costs do not seem to be rising too rapidly, but this cost item is being carefully monitored.

Hospices are another interesting innovation. For years, critics said terminally ill patients did not have to be in the hospital. It was too expensive; it put the patient through unnecessary pain and aggravation; it was a bad idea all around. Hospices promised to provide the patient with comfort and relief from pain, rather than aggressive intervention. The result was expected to be less expensive. As it turns out, the kind of care patients are receiving is pretty much what was anticipated. Most people think it is excellent. The problem is that it has not reduced costs very much.

CONCLUSION

As is obvious, we have encountered many kinds of issues in this chapter. One's conclusions depend on the questions that one wishes to address. Working backward, we can ask, Are alternatives to hospitalization worth developing? The general consensus seems to be yes, they are. However, how we can accomplish that objective is not at all clear, which is where institution building comes in. Since there is no blueprint, anyone who has a plan is trying to institute it. Will that work? No one knows with certainty, but since we do not know how else to do it, we will most likely continue along the same path.

How about the future of hospitals? The questions here largely revolve around who we want to see operating them. Asking who is best suited or who will do the best job for us is, at bottom, a matter of perspective on the benefits of competition and private sector ownership versus dependence on nonprofit organizations plus greater government involvement and oversight. This is not something that people debate without emotion. Those who are most closely involved tend to be believers in one approach or the other. Rarely do you find people sitting on the fence. Even if you have not come to this debate with strong feelings about this question already, by the time you finish this book, you too will likely be taking sides.

Theoretical perspectives are useful in explaining "where people are coming from" when they enter such debates. Theoretical perspectives do not, however, provide clear answers to the questions raised in such discussions, nor are they designed to do so. To begin with, the functionalist and conflict theory perspectives do not match the two sides of the debate, if only because one side is not as well articulated as the other. At the heart of the controversy is the question of whether health care organizations are like other organizations that produce and sell goods and services or whether they are somehow different.

Where the conflict theorists stand on this point is perfectly clear. They say that health care delivery organizations are special, that they should not be operated for profit. They argue that the misfortune of others should not provide an opportunity to further enrich the rich and powerful in society. And they say that health care is too important to treat as just another commodity that can be traded on the market, like pork bellies, or as a product that is purchased as a matter of preference, like a breakfast cereal.

Functionalists are neither seen nor heard discussing these points. This is not to say that the other side of the argument about the nature of health care organizations is not being vigorously represented. It is just that the people who are taking the lead are economists, who do not employ the same labels as sociologists to identify themselves as functionalists or conflict theorists. We will discuss what they have to say when we discuss health care reform in chapter 11. There are, however, many more topics to cover before we do that. Health care occupations is the topic we address next.

NOTES

1. E. H. L. Corwin, *The American Hospital* (New York: Commonwealth Fund, 1946).
2. Rosemary Stevens, *In Sickness and in Wealth* (New York: Basic Books, 1989).
3. "Hospital Service in the United States," *Journal of the American Medical Association* 106 (April 3, 1925): 1009; "Hospital Service in the United States," *Journal of the American Medical Association* 106 (March 7, 1935): 792.
4. "National Health Expenditures, Average Annual Percent Change, and Percent Distribution according to Type of Expenditure: United States, Selected Years 1960–2001," *Health United States, 2003* (Washington D.C.: U.S. Department of Health and Human Services, Public Health Service, 2003), table 115.
5. "National Health Care Expenditures, Hospital Care Expenditures Aggregated and Per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1990–2013" (Baltimore, Md.: Centers for Medicare & Medicaid Services, 2003), table 6.
6. The Combined Budget Reconciliation Act of 1985 (COBRA)—which prohibits hospitals receiving Medicare funds from transferring unstable patients and women in active labor until they are stabilized—went into effect on August 1, 1986.
7. Eugene Declercq and Diana Simmes, "The Politics of 'Drive-Through Deliveries': Putting Early Postpartum Discharge on the Legislative Agenda," *Milbank Quarterly* 75 (1997): 175–202.
8. Alice Rivlin and Joshua Wiener, *Caring for the Disabled Elderly* (Washington D.C.: Brookings Institution, 1988).