COMPARING THE PERFORMANCE OF FOR-PROFIT AND NOT-FOR-PROFIT HOSPITALS IN NORTH CAROLINA

A Report by the N.C. Center for Public Policy Research

N.C. Center for Public Policy Research

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by

Marianne M. Kersey, Lori Ann Harris,
and Ran Coble, with Melissa Jones

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EXECUTIVE SUMMARY

THIS REPORT is the second of two reports by the N.C. Center for Public Policy Research on investor-owned hospitals in North Carolina.

For generations, most hospitals in North Carolina were publicly-owned or not-for-profit hospitals designed to provide health care at modest rates for the citizenry. But since 1980, the ownership and management of North Carolina's hospitals has changed dramatically, and now 47 of the state's 162 non-federal hospitals—more than one in every four—are either owned, leased or managed (at least in part) by for-profit, commercial enterprises. This marks an increase from the 42 hospitals owned, leased, or managed by investor-owned companies in July 1986, when the N.C. Center released its first report, *The Investor-Owned Hospital Movement in North Carolina.* Two years in the making, that first report incorporated original research as well as material from interviews with officials at 39 hospitals throughout the state, and with community leaders in areas where for-profit hospitals had begun to function.

Hospital ownership can be classified into three broadly-defined categories: (1) public; (2) not-for-profit (both secular and religious—also called voluntary); and (3) investor-owned (also called for-profit or proprietary). The majority of North Carolina's hospitals are owned by local governments (counties, cities, hospital districts, or special hospital authorities) or by not-for-profit corporations.

In both reports by the N.C. Center for Public Policy Research, the term *public hospital* refers specifically to those owned by state or local governmental bodies and excludes federal hospitals. *Not-for-profit* hospitals (secular or religious) are privately-owned and operated as charitable community service organizations. Sometimes called "voluntary" hospitals, they are tax-exempt. *Investor-owned* hospitals are also privately owned but are not tax-exempt. The investor-owned hospital seeks to earn a profit for its shareholders in addition to providing health care services in the community. A *multi-hospital system* consists of a group of hospitals with common ownership or management. Like individual hospitals, hospital management companies can be public, not-for-profit, or investor-owned.

The Center's first report represented an overview of the issues raised by for-profit involvement in the hospital industry. It contained individual profiles of the hospitals owned, leased, or managed by the 11 investor-owned, multi-hospital systems then operating in the state. In addition, the report identified some of the possible factors leading to the acceleration of investor-owned involvement in North Carolina. Finally, the report examined several other components of the health care industry which are relatively new to the state and which may affect the viability of any of the state's hospitals.

An earlier report, titled The Investor-Owned Hospital Movement in North Carolina *and published in 1986, focused on the trend toward for-profit hospitals in this state. The report is available from the Center (at P.O. Box 430, Raleigh, NC 27602) for $31.40.*

I. TRENDS FACING HOSPITALS IN NORTH CAROLINA AND THE NATION

Retrenchment in the National Investor-Owned Hospital Movement

SIGNIFICANT CHANGES in both the public and private sectors have combined to slow the American investor-owned hospital movement.

- Federal prospective payment systems and preadmission reviews have significantly lowered hospitals' inpatient occupancy rates, shortened the length of patients' stays, and restricted the potential profits on inpatient hospital care.
- Investor-owned companies' efforts to diversify their business holdings have met with only limited success, and the industry has witnessed widespread divestment of these ventures.
- Many states have intensified their scrutiny and regulation of the health care system which may have helped slow the pace of the investor-owned hospital movement.
- Competition from inside and outside the investor-owned hospital industry has slowed the investor-owned hospital movement nationwide.

Small and Specialized Investor-Owned Companies Emerged During the Investor-Owned Hospital Industry's Retrenchment

ONE PART of the investor-owned hospital industry has weathered the storms in the health care system—specialized facilities such as psychiatric, chemical dependency, and rehabilitation hospitals. Many of the new, small firms in the for-profit hospital industry have used these avenues to move into the business. And these firms are succeeding at a rate which significantly outpaces the industry's giants.

Investor-Owned Hospitals in North Carolina Reflect National Trends

NORTH CAROLINA, where major investor-owned hospital chains rapidly expanded in the early 1980s, now mirrors the national trend of retrenchment in one aspect. Since the North Carolina Center for Public Policy Research published its first report, the overall number of hospitals *owned* by for-profit corporations remains unchanged at 24.* (The first report used, in most cases, data current through 1985.) Three investor-owned hospitals in North Carolina have been sold to private, not-for-profit firms, marking a new trend among hospitals in the state. On the other hand, one investor-owned hospital has been built, and two not-for-profit hospitals have been purchased by investor-owned corporations.

The number of N.C. hospitals which have *management contracts* with investor-owned corporations, however, has grown by six to a total of 21 as of November 1988. Five of these contracts are for psychiatric beds only—a new development in North Carolina. The number of hospitals *leased* by for-profit companies has increased slightly as well, from one to two.

Not-For-Profit Hospitals—Getting Down to Business

NOT-FOR-PROFIT HOSPITALS are getting down to business in North Carolina and across the nation. Changes in the way not-for-profit hospitals operate testify to their growing entrepreneurial bent, as well as to some differences in business strategy between not-for-profit and investor-owned hospitals.

* Blackwelder Memorial Hospital in Lenoir, owned by Futura Health Care Services since 1985, closed in October 1988, when Futura filed for bankruptcy. According to officials of the for-profit corporation, Futura plans to reopen the facility in 1989. Tables and text in this and following chapters do not reflect this closure.

• Not-for-profit hospitals are succeeding with limited diversification.

• Not-for-profit hospitals are buying investor-owned hospitals.

• Not-for-profit hospitals are joining alliances.

• Public hospitals are reorganizing as private, not-for-profit hospitals.

• Public hospitals are seeking a chance to start profit-making ventures.

• County systems of public hospitals are competing for paying patients with private not-for-profit and investor-owned hospitals by opening facilities in affluent suburbs.

Other Trends Affecting Hospitals

OTHER TRENDS affecting hospitals and identified by the N.C. Center in the first chapter of this report include:

• Occupancy rates have fallen for all hospitals during the 1980s, but they have fallen to precariously low levels at small hospitals—which, in North Carolina, are usually rural facilities with a high percentage of Medicare and Medicaid patients. According to James Bernstein, adviser to rural hospitals and section chief of Health Resources Development in the N.C. Department of Human Resources, North Carolina hospitals with fewer than 50 beds "are at the highest risk and are going to have a difficult time operating solely as inpatient institutions. Many will enter a period of transition from inpatient care to multi-service centers, including skilled nursing and outpatient services," he predicts.

• Once patients are admitted to the hospital, they are being discharged sooner than in previous years.

• Long thought to be a problem distant from the Tar Heel state, the national shortage of nurses and other skilled medical personnel has hit North Carolina this year.

• Hospitals have begun to use marketing techniques to attract patients.

The next four chapters contain the results of the N.C. Center's research comparing the performance of for-profit (investor-owned, -managed, or -leased) hospitals and not-for-profit (private and public) hospitals. The research was designed to answer the following four questions:

• Do for-profit hospitals provide more or less indigent care than not-for-profit hospitals? (Chapter 2, pages 37-80.)

• Do for-profit hospitals have higher or lower costs and charges than not-for-profit hospitals? (Chapter 3, pages 81-117.)

• Do for-profit hospitals offer a broader or narrower range of services than not-for-profit hospitals? (Chapter 4, pages 119-153.)

• If for-profit hospitals provide less indigent care, do they (as for-profit corporations) pay taxes which would offset any deficiencies in indigent care? (Chapter 5, pages 155-198.)

II. COMPARISON OF LEVELS OF INDIGENT CARE

CHAPTER 2 contains the Center's findings on indigent care, based on a survey sent to all 127 general, acute care hospitals in North Carolina. Sixty-three percent (80) of the 127 hospitals replied, including both for-profits and not-for-profits. The data were later verified in telephone interviews.

The private not-for-profit and public hospitals responding to the survey provided uncompensated care in an amount equal to 8.4 percent of their gross patient revenue in 1984. This compares with 6.6 percent of gross patient revenue going to uncompensated care at investor-owned and -managed hospitals *—27.3 percent less than that provided by not-for-profit hospitals.* Uncompensated care is defined in the study as the total of a hospital's indigent care, charity care, and bad debt.

A recent study conducted by Lewin and Associates, a Washington-based consulting firm, also found differences in the provision of uncompensated care by investor-owned and not-for-profit hospitals. In four of five states examined (one of which was North Carolina), the study found that not-for-profits commit significantly more of their resources to uncompensated care than do investor-owned hospitals. Harry Nurkin, president of Charlotte Memorial, a public hospital, is not surprised by such findings. "If they are investor-owned, their first obligation is to their investors," says Nurkin. "Providing services to people who are sick and injured is secondary." But Earl Tyndall, administrator of Medical Park Hospital in Winston-Salem, which is managed by a for-profit corporation, contends, "The emphases on patient care and business orientation are identical at for-profit and not-for-profit hospitals." Medical Park Hospital was an independent for-profit hospital until it was purchased by Carolina Medicorp, Inc. in 1986, and is now a private not-for-profit hospital managed by for-profit Hospital Corporation of America.

The increasing number of indigent patients is likely to become a major issue facing the N.C. legislature. For example, a Duke University study estimates that nearly 900,000 individuals in North Carolina have no health insurance at some point during the year.

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Table 1: Investor-Owned Involvement with Hospitals in North Carolina, 1988

Hospital Name	Location	Beds in Use	Hospital Type	Owned/ Leased/ Managed/ & Company	Date I-O Involvement Began	Date of Latest Changeover
A. Owned by Investor-Owned Corporations (24)						
1. Appalachian Hall	Asheville	100	P	O-PIA	1931	1981
2. Blackwelder Memorial Hospital *	Lenoir	35	G	O-FHCS	1985	1987
3. Brynn Marr Neuropsychiatric Hospital	Jacksonville	76	P	O-HSA	1984	1984
4. Central Carolina Hospital	Sanford	142	G	O-AMI	1980	1980
5. Charter Hills Hospital	Greensboro	68	P	O-CMC	1981	1981
6. Charter Mandala Center	Winston-Salem	99	P	O-CMC	1973	1981
7. Charter Northridge Hospital	Raleigh	66	P	O-CMC	1984	1984
8. Charter Pines Hospital	Charlotte	60	P	O-CMC	1985	1985
9. Community Hospital of Rocky Mount	Rocky Mount	50	G	O-BAHC	1913	1986
10. CPC Cedar Spring Hospital	Pineville	50	P	O-CPC	1985	1985
11. Davis Community Hospital	Statesville	149	G	O-HT	1925-37	1987
12. Franklin Regional Medical Center[1]	Louisburg	53	G	O-HMA	1983	1986
13. Frye Regional Medical Center	Hickory	275	G	O-AMI	1912	1972
14. Heritage Hospital[2]	Tarboro	127	G	O-HT	1982	1987
15. Ten Broeck Hospital[3]	Hickory	64	P	O-UMC	1935	1979
16. Highland Hospital	Asheville	98	P	O-PIA	1904	1982
17. Highsmith-Rainey Memorial Hospital	Fayetteville	150	G	O-HCA	1901-63	1983
18. Holly Hill Hospital	Raleigh	106	P	O-HCA	1978	1984
19. HSA Cumberland Hospital	Fayetteville	154	P	O-HSA	1976	1983
20. Life Center of Wilmington	Wilmington	27	S	O-CAPS	1984	1984
21. Lake Norman Regional Medical Center[4]	Mooresville	111	G	O-HMA	1983	1986
22. McPherson Hospital	Durham	24	S	O-Ind	1926	1926
23. Orthopaedic Hospital	Charlotte	120	S	O-HT	1971	1987
24. Raleigh Community Hospital	Raleigh	140	G	O-HCA	1950	1977
B. Managed or Leased by Investor-Owned Corporations (23)						
25. Angel Community Hospital	Franklin	81	G	M-HCA	1926-65	1983
26. Ashe Memorial Hospital	Jefferson	48	G	M-HCA	1981	1981
27. Bertie County Memorial Hospital	Windsor	49	G	M-FHI	1985	1987
28. The Brunswick Hospital	Supply	60	G	L-HT	1981	1987
29. Burnsville Hospital[5]	Burnsville	24	G	M-HCA	1982	1982
30. Chatham Hospital	Siler City	68	G	M-HMP	1987	1987
31. Craven Regional Medical Center[6]	New Bern	24	G	M-HHM	1987	1987
32. District Memorial Hospital[7]	Andrews	61	G	M-HCA	1987	1987

—continued

* See note at bottom of page 5.

Hospital Name	Location	Beds in Use	Hospital Type	Owned/ Leased/ Managed/ & Company	Date I-O Involvement Began	Date of Latest Changeover
33. Duplin General Hospital [8]	Kenansville	20	G	M-PIA	1987	1987
34. Gaston Memorial Hospital [9]	Gastonia	70	G	M-MHM	1987	1987
35. Granville Medical Center	Oxford	66	G	M-HMP	1988	1988
36. Hamlet Hospital	Hamlet	64	G	L-HMA	1987	1987
37. Hoots Memorial Hospital	Yadkinville	54	G	M-HCA	1986	1986
38. Hugh Chatham Memorial Hospital	Elkin	81	G	M-HMP	1985	1985
39. Johnston Memorial Hospital	Smithfield	107	G	M-HCA	1983	1983
40. Margaret R. Pardee Memorial Hospital [9]	Hendersonville	21	G	M-MHM	1987	1987
41. The McDowell Hospital	Marion	65	G	M-Delta	1982	1982
42. Medical Park Hospital	Winston-Salem	120	G	M-HCA	1971	1986
43. Morehead Memorial Hospital	Eden	85	G	M-HMP	1984	1984
44. Person County Hospital	Roxboro	54	G	M-HCA	1981	1981
45. Rutherford Hospital	Rutherfordton	165	G	M-HMP	1983	1983
46. Spruce Pine Community Hospital [5]	Spruce Pine	68	G	M-HCA	1982	1982
47. Wilson Memorial Hospital [9]	Wilson	23	G	M-MHM	1987	1987

G - General hospital (primarily)
P - Psychiatric
S - Specialty

O - Owned
M - Managed
L - Leased

Full names for the 17 for-profit corporations listed above are as follows:

AMI ..... American Medical International, Inc.
BAHC .... Best American Health Care
CAPS ..... Comprehensive Addiction Programs
CMC ..... Charter Medical Corporation
CPC ..... Community Psychiatric Centers
Delta ..... The Delta Group, Inc.
FHCS ..... Futura Health Care Services
FHI. ..... Forum Health Investors
HCA ..... Hospital Corporation of America
HHM ... Horizon Health Management Co.
HMA ... Health Management Associates, Inc.
HMP ... Hospital Management Professionals, Inc.
HSA .... Healthcare Services of America
HT ..... HealthTrust, Inc. — The Hospital Company[10]
MHM .. Mental Health Management Co.
PIA ..... Psychiatric Institutes of America [11]
UMC ... United Medical Corporation
Ind ..... Independently owned, not affiliated with a chain

FOOTNOTES

[1]Formerly named Franklin Memorial Hospital.

[2]Heritage Hospital was built in 1985 as a replacement facility for Edgecombe General.

[3]Formerly named Hickory Memorial Hospital.

[4]Formerly named Lowrance Hospital.

[5]Spruce Pine Community Hospital and Burnsville Hospital are the only hospitals in the Blue Ridge Hospital System, which is managed under contract by Hospital Corporation of America.

[6]Craven Regional Medical Center, formerly Craven County Hospital, is county-owned; Horizon Health Management Co. manages 24 psychiatric beds of the hospital's 276 beds.

[7]Formerly named Mountain Park Medical Center.

[8]Duplin General Hospital has 60 beds and is county-owned; Psychiatric Institutes of America manages 20 psychiatric beds of that total.

[9]Gaston Memorial Hospital is a private, not-for-profit hospital, as is Margaret Pardee Memorial Hospital; Wilson Memorial Hospital is county-owned. Mental Health Management Co. manages 70 psychiatric beds of Gaston Memorial's 354 total beds, 21 psychiatric beds of Margaret Pardee Memorial's 149 total beds, and 23 psychiatric beds of Wilson Memorial's 281 total beds.

[10]HealthTrust is an Employee Stock Ownership Plan formed in September of 1987 by Hospital Corporation of America. HCA divested 104 of its 186 acute care hospitals in the United States that year.

[11]Psychiatric Institutes of America is a subsidiary of National Medical Enterprises, one of the largest national investor-owned hospital companies.

Also, a 1986 report by the University of North Carolina at Chapel Hill Health Services Research Center revealed that nearly one-fourth (23) of the 100 counties in North Carolina had more than 6 percent uninsured poor. The estimate was based on an analysis of data from the annual N.C. Citizens Survey conducted by the N.C. Office of State Budget and Management. Statewide distribution of the uninsured poor ranged from 1.1 percent in Alexander County in western North Carolina to 9.2 percent in Warren County in the northern Piedmont.

III. COMPARISON OF COSTS AND CHARGES

IN CHAPTER 3'S COMPARISON of costs and charges, the Center matches seven investor-owned hospitals with seven not-for-profit hospitals of similar size (number of beds), number of employees and admissions, and occupancy rates. (There were only seven hospitals in North Carolina *owned* by investor-owned corporations during FY 1983, the year of the most

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Table 2: Uncompensated Care Provided By For-Profit and Not-For-Profit Hospitals in North Carolina, 1984

Variables	Eleven Investor-Owned and -Managed Hospitals Responding to Survey	Sixty-Four Not-For-Profit and Public Hospitals Responding to Survey	Percentage Difference
Average uncompensated care[1] as percentage of gross patient revenue[2]	6.6%	8.4%	27.3%
Average uncompensated care per bed	$7,000	$8,593	22.8%
Average uncompensated care per inpatient admission	$ 203	$ 237	16.7%
Average uncompensated care per inpatient and outpatient admission[3]	$ 44	$ 53	20.5%

[1]Uncompensated care is defined as the total of indigent care, charity care, and bad debt.

[2]Gross patient revenue consists of revenue from services rendered to patients, including payments received from or on behalf of individual patients.

[3]Outpatient admissions include outpatient clinic visits, outpatient surgery visits, and emergency room visits.

Sources: N.C. State Center for Health Statistics, *Health Facilities Data Book, 1984*, and surveys of chief executive officers of general acute care hospitals in North Carolina by the N.C. Center for Public Policy Research.

Table 3: Comparisons of Revenues/Charges to Patients Between Investor-Owned and Not-For-Profit Hospitals

Measure	N (Pairs in sample)	Average Percentage Difference Between Investor-Owned and Not-For-Profit Hospitals	P(t), or Level of Significance (*** = highly significant)
A. *Charge Payers* — self-pay, private insurance, Blue Cross (ipf)			
1. **Gross** inpatient revenue per day	7	+ 18.1 %	**
2. Gross inpatient revenue per admission	7	+ 16.0	*
Routine Care Service			
3. Gross inpatient routine revenue per day	7	- 13.7	N/A
4. Gross inpatient routine revenue per admission	7	- 15.7	N/A
5. **General** inpatient routine care service revenue per day	7	- 13.6	N/A
6. General inpatient routine care service revenue per admission	7	- 15.7	N/A
7. **Special** inpatient care service revenue per day	6	- 4.9	N/A
8. Special inpatient care service revenue per admission	6	- 5.8	N/A
Ancillary Services			
9. Gross inpatient ancillary revenue per day	6	+ 29.6	**
10. Gross inpatient ancillary revenue per admission	6	+ 27.6	*
11. Gross inpatient ancillary revenue as percentage of total inpatient revenue	6	+ 7.5	*
B. *Cost Payers* — Medicare and Medicaid (expf)			
12. Inpatient allowable costs (plus return on equity for investor-owned hospitals) per day	7	+ 21.5	***
C. *Net Patient Revenue* (ipf)			
13. Adjusted net patient service revenue per day	7	+ 27.4	***
14. Adjusted net patient service revenue per admission	7	+ 25.3	***

ipf = including professional fees
expf = excluding professional fees
\+ = investor-owned hospitals as a group had higher values on this measure
– = not-for-profit hospitals as a group had higher values on this measure
*** = $p(t) \leq .05$
** = $.05 < p(t) \leq .1$
* = $.1 < p(t) \leq .2$
N/A = percentage difference on this measure was not statistically significant

Table 4: Comparisons of Costs/Expenses Between Investor-Owned and Not-For-Profit Hospitals

Measure	N (Pairs in sample)	Average Percentage Difference Between Investor-Owned and Not-For-Profit Hospitals	P(t), or Level of Significance (*** = highly significant)
A. ***Total Operating Costs***			
1. Total operating costs per adjusted day	7	+ 20.0 %	***
B. ***General Service (Nonpatient) Costs***			
2. General service costs per adjusted day	7	+ 26.9	***
3. Administrative and general costs per adjusted day	7	+ 48.1	***
4. Building and fixture depreciation per adjusted day	7	+ 59.1	**
5. Movable equipment depreciation per adjusted day	6	+ 6.6	N/A
6. Plant operation, laundry service, and housekeeping costs per adjusted day	7	- 1.2	N/A
C. ***Patient Care Costs***			
7. Total patient care costs per adjusted day (ipf)	7	+ 15.9	***
8. Adjusted total patient care costs per admission (ipf)	7	+ 13.8	*
9. Total inpatient care costs per inpatient day (ipf)	7	+ 14.3	**
10. Total inpatient care costs per admission (ipf)	7	+ 12.3	*
11. Total inpatient care costs per inpatient day (expf)	7	+ 16.5	***
12. Total inpatient care costs per admission (expf)	7	+ 14.4	*
13. Routine inpatient service costs per inpatient day (expf)	7	+ 19.5	***
14. Routine inpatient service costs per admission (expf)	7	+ 17.3	*
D. ***Ancillary Department Costs***			
15. Total inpatient ancillary costs per day (expf)	7	+ 13.2	*
16. Operating room inpatient costs per day (expf)	7	+ 38.5	***
17. Drugs charged to patients costs per day (expf)	7	+ 25.2	**
18. Delivery and labor room inpatient costs per day (expf)	3	+123.8	***
19. Electrocardiology inpatient costs per day (expf)	5	- 52.3	*
20. Anesthesiology inpatient costs per day (expf)	7	- 3.5	N/A
21. Radiology inpatient costs per day (expf)	7	- 2.1	N/A
22. Medical supplies costs per day (expf)	7	- 4.5	N/A

ipf = including professional fees
expf = excluding professional fees
\+ = investor-owned hospitals as a group had higher values on this measure
\- = not-for-profit hospitals as a group had higher values on this measure
*** = $p(t) \leq .05$
** = $.05 < p(t) \leq .1$
* = $.1 < p(t) \leq .2$
N/A = percentage difference on this measure was not statistically significant

Table 5: Comparison of Daily Charges for Semi-Private Room for Seven Matched Pairs of Investor-Owned and Not-For-Profit Hospitals in North Carolina

Investor-Owned Hospital	Rates per day 1986	1987	Not-For-Profit Hospital	Rates per day 1986	1987
1. Raleigh Community Hospital (Raleigh)	$155	$155	Grace Hospital* (Morganton)	$175	$175
2. Frye Regional Medical Center (Hickory)	150	156	Margaret R. Pardee Memorial Hospital (Hendersonville)	137	143
3. Medical Park Hospital[a] (Winston-Salem)	124	135	Alamance County Hospital (Burlington)	172	172
4. Humana Hospital Greensboro[b] (Greensboro)	155	155	Cape Fear Memorial Hospital (Wilmington)	124	141
5. Central Carolina Hospital (Sanford)	155	155	Stanly Memorial Hospital* (Albemarle)	139	169
6. Gordon Crowell Memorial Hospital (Lincolnton)	closed		Park Ridge Hospital* (Fletcher)	149	156
7. Community Hospital of Rocky Mount (Rocky Mount)	143	143	J. Arthur Dosher Hospital (Southport)	139	139
Average daily room rate for investor-owned hospitals:	$147	$150	*Average* daily room rate for not-for-profit hospitals:	$148	$156
Median room rate for investor-owned hospitals:	$153	$155	*Median* room rate for not-for-profit hospitals:	$139	$156

* = rates available for private rooms only

[a] Medical Park Hospital was purchased by Carolina Medicorp, Inc. in 1986 and is now a private, not-for-profit hospital.

[b] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

Source: Telephone interviews with hospitals on November 6, 1986 and November 2, 1987 by N.C. Center for Public Policy Research staff.

recent available data when this analysis began.) Using Medicare Cost Reports—financial reports filed annually with the federal Health Care Financing Administration—the Center compared costs (to the hospital) and charges (to the patient) between for-profits and not-for-profits. *For-profits had higher charges generally than comparable not-for-profits, particularly for what are called ancillary services.* Ancillary services are those which are not included in the room charge, such as x-rays, drugs, anesthesiology, and laboratory services. The Center found that gross inpatient revenue per day from ancillary services was almost 30 percent higher at investor-owned hospitals.

The only previous study on hospital charges in North Carolina was done by Blue Cross and Blue Shield of North Carolina in 1983. This study compared the charges to Blue Cross subscribers in 1981-1982 for three commonly performed procedures—hysterectomies, cholecystectomies (gall bladder removals), and normal baby deliveries at investor-owned and not-for-profit hospitals. Blue Cross and Blue Shield found that charges at the six investor-owned chain hospitals in the sample were higher than those at the not-for-profit hospitals with which they were compared, with one exception. Only one investor-owned hospital had lower charges for normal deliveries than the not-for-profit hospitals.

Interestingly, charges for room rates were almost identical in the for-profit and not-for-profit hospitals examined in the Center's study. The average room rate in the for-profit hospitals in 1986 was $147, while the average in not-for-profits was $148. This finding is consistent with that of other studies nationally. For-profit hospitals make money on ancillary services, not room rates. As Dwight Gentry, formerly associate director of the not-for-profit New Hanover Memorial Hospital in Wilmington, puts it, "They [for-profit hospitals] pump up high the I-V [intravenous solution] and all the ancillary charges—sky high."

The Center's research also revealed that investor-owned hospitals had higher *costs* than their not-for-profit counterparts in all areas — general service (nonpatient care) costs, patient care costs, and ancillary department costs. And total operating costs were 20% higher at for-profit hospitals.

Table 6: Comparisons of Services Offered More Frequently by *Medium-Sized* For-Profit and Not-For-Profit N.C. Hospitals in 15 Non-Standard Services†
(Ranked in order of greatest percentage difference)

A. Services offered more frequently by all Medium-Sized Not-For-Profit Hospitals (10)

1. obstetrics
2. newborn nursery
3. cardiac ICU
4. eye, ear, nose, and throat (EEN&T)
5. orthopedics
6. gynecology
7. pediatrics
8. cardiology*
9. psychiatric outpatient*
10. neurosurgery*

B. Services offered more frequently by all Medium-Sized For-Profit Hospitals (5)

1. outpatient clinic
2. psychiatry
3. medical/surgical ICU*
4. neonatal ICU*
5. thoracic surgery*

† Non-standard services are those *not* offered by *all* medium-sized hospitals.
* Percentage difference between hospital types was 10% or less.

IV. COMPARISON OF RANGE OF SERVICES

CHAPTER 4 compares 22 service offerings at for-profit and not-for-profit hospitals in North Carolina. Over the years, critics have charged that for-profit hospitals "skim the cream" in providing services. That is, detractors allege that for-profits offer only services that make money and do not offer other less lucrative services. The Center's findings on this issue were mixed.

First, the Center found that there are four services that can be considered standard at all N.C. hospitals regardless of size or ownership—general medicine,

Table 7: Comparisons of Services Offered More Frequently by *Small* For-Profit and Not-For-Profit N.C. Hospitals in 18 Non-Standard Services†

(Ranked in order of greatest percentage difference)

A. Services offered more frequently by all Small For-Profit Hospitals (11)

1. outpatient clinic
2. thoracic surgery
3. outpatient surgery
4. cardiac ICU
5. obstetrics*
6. psychiatric outpatient*
7. psychiatry*
8. neurosurgery*
9. orthopedics*
10. newborn nursery*
11. physical therapy*

B. Services offered more frequently by all Small Not-For-Profit Hospitals (3)

1. gynecology
2. medical/surgical ICU*
3. eye, ear, nose, and throat (EEN&T)*

C. Services offered by same percentage of Small For-Profit and Not-for-Profit Hospitals (4)

1. urology (80%)
2. pediatrics (60%)
3. cardiology (10%)
4. neonatal ICU (0%)

† Non-standard services are those *not* offered by *all* small hospitals.
* Percentage difference between hospital types was 10% or less.

general surgery, pharmacy, and emergency room services. And medium-sized and large hospitals also had three additional standard services—physical therapy, outpatient surgery, and urology—regardless of ownership type.

In hospitals of medium size (101-399 beds) — the category with the largest number of hospitals (62) — for-profit hospitals offered a narrower range of services. Ten of the 15 non-standard services at medium-sized hospitals were offered more frequently by not-for-profits, including obstetrics and newborn nursery services, generally regarded as less profitable services or revenue losers. By contrast, investor-owned hospitals were more likely to offer only five services more frequently than not-for-profits.

Among small (100 beds or fewer) hospitals, however, for-profits offered 11 of the 18 non-standard services more often than not-for-profit hospitals, particularly in the outpatient area. Small investor-owned and -managed hospitals offered outpatient clinic, outpatient surgery, and psychiatric outpatient services more frequently than not-for-profit hospitals. Three services—gynecology, medical/surgical intensive care units, and eye, ear, nose, and throat (EEN&T)—were offered more frequently by small not-for-profit hospitals than by for-profit hospitals. Four services were offered by the same percentage of for-profit and not-for-profit hospitals.

Chapter 4 also examines whether investor-owned multi-hospital systems, in order to ensure profitability, take into account the population and wealth of an area when deciding whether to purchase a hospital or pursue a management contract. *Fortune* magazine suggests that at least one for-profit chain does. "Humana prefers to own facilities in suburbs where young working families are having lots of babies," the magazine reported in its Nov. 17, 1980 issue. "Though young people use hospitals less than the elderly, they are more likely to be privately insured and in need of surgery, which makes the most money. The babies provide a second generation of customers."

Research by the N.C. Center shows that the answer appears to be yes in North Carolina as well. When the three groups of for-profit hospitals—owned, managed, and leased—were combined, the indicators were strong that investor-owned corporations do take area wealth and population size into consideration. Twenty-three of the 44 hospitals owned, managed, or leased by a for-profit chain as of June 1987 were located in the 25 wealthiest of North Carolina's 100 counties, and 20 of these 23 hospitals were also in the top 25 counties in terms of urbanization.

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Table 8: 1984 Taxes Paid By For-Profit Hospitals (Investor-owned, -managed, and -leased)

Hospitals Paying Taxes in N.C.	County	Local Property Tax Paid	State & Local Sales Tax Paid	State Income Tax Paid	Federal Income Tax Paid
1. Frye Regional Medical Center (IO)	Catawba	$ 177,349	NA	$ 290,709	$ 2,095,042
2. Raleigh Community Hospital (IO)	Wake	161,571	$ 164,564	258,294	1,701,943
3. Highsmith-Rainey Memorial Hospital (IO)	Cumber-land	203,203	50,195	146,525	1,055,961
4. Central Carolina Hospital (IO)	Lee	123,468	14,636	95,344	491,637
5. Davis Community Hospital (IO)	Iredell	61,056	70,985	9,129	62,195
6. Humana Hospital Greensboro (IO)[a]	Guilford	119,652	NA	NA	NA
7. Medical Park Hospital (IO)	Forsyth	73,286	16,773	0 [c]	0 [c]
8. Heritage Hospital (IO) [d]	Edgecombe	61,323	NA	NA	NA
9. Community Hospital of Rocky Mount (IO)	Nash	29,704	NA	NA	NA
10. Cape Fear Valley Medical Center (IM)	Cumber-land	3,800 [e]	0	0	0
11. Angel Community Hospital (IM)	Macon	2,939	NA	NA	NA
TOTAL:		$1,017,351	$ 317,153	$ 800,001	$ 5,406,778

I O = Investor-Owned

I M = Investor-Managed

NA = Not Available

FOOTNOTES

[a] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

[b] Denotes hospitals which did not respond to the North Carolina Center for Public Policy Research survey. Property tax information was supplied instead by the county tax supervisors. Thus, this figure may not accurately depict the total taxes paid by the hospital to other levels of government.

[c] Because Medical Park was a limited partnership in 1984, the hospital itself did not pay any state and federal income taxes. The holding corporation (Maplewood Corp. and Casstevens Co.) made all tax payments. Medical Park Hospital was sold to Carolina Medicorp, Inc. in 1986.

[d] Formerly Edgecombe General Hospital.

[e] Taxes were paid on property leased by the hospital. Cape Fear Vally Medical Center ended its

Other Taxes Paid	Total Taxes Paid	County Appropriations for Hospital Services
$ 535	$ 2,563,635	$ 0
0	2,286,372	3,846,000
33,819	1,489,703	0
11,163	736,248	0
0	203,365	0
NA	119,652 [b]	205,000
0	90,059	0
NA	61,323 [b]	0
NA	29,704 [b]	0
0	3,800	0
NA	2,939 [b]	0
$ 45,517	$7,586,800 [f]	

management contract with National Medical Enterprises, Inc. in 1985, and is currently managed by SunHealth Enterprises.

[f] 94% of the federal, state, and local taxes $7,779,397) paid by the for-profit and not-for-profit hospitals responding to the Center's survey came from five investor-*owned* hospitals (7% of the total sample of 75 hospitals). These five investor-owned hospitals which provided complete tax information paid $7, 279,323.

V. TAXES PAID BY FOR-PROFITS

CHAPTER 5 examines the issue of taxes paid by for-profit hospitals. The chief explanation offered by for-profit hospital officials for their lower levels of indigent care (discussed in Chapter 2) is that for-profits pay taxes to state and local governments. Again through use of surveys of all general acute care hospitals in North Carolina, the Center found that *for-profit hospitals pay substantial amounts in taxes—more than $7.5 million in 1984.* More than $2.1 million was paid in local and state taxes. The vast majority of the taxes, however—$5.4 million—went to the federal government.

Among survey respondents, the highest contributor in *total* taxes was Frye Regional Medical Center in Hickory, which paid almost $2.6 million in total taxes in 1984. Highsmith-Rainey Memorial Hospital in Fayetteville paid the most in *local* property taxes ($203,203), while Frye Regional Medical Center and Raleigh Community Hospital paid the most in *state* income taxes ($290,709 by Frye Regional Medical Center and $258,294 by Raleigh Community Hospital).

For-profit hospital officials point to a number of advantages enjoyed by their tax-exempt counterparts. Exemption from taxes under Section 501(c)(3) of the Internal Revenue Code allows not-for-profits to devote more of their gross revenues to internal operations and expansion and to secure tax-exempt bond financing. Also working to the advantage of not-for-profits are lower postal rates, access to state appropriations, and tax-deductible charitable contributions from foundations, corporations, and individuals.

The Center's research on charitable contributions to hospitals confirms that philanthropic giving can be a considerable source of income for not-for-profit hospitals. *In 1982, North Carolina's not-for-profit hospitals and health care institutions received $25.3 million in charitable gifts from foundations and corporations.* The Duke Endowment alone gave more than $10 million in grants to hospitals for construction, equipment, and free bed days for indigent patients that year, and Cabarrus Memorial Hospital in Concord received grants totaling $1,755,000 from four different Cannon foundations in 1983.

To survive in an increasingly competitive health care environment, not-for-profit hospitals are diversifying into money-making outpatient services such as wellness and stress management programs, sleep disorder centers, home health care, and long-term rehabilitation. Such revenue-boosting efforts are fueling the debate over whether not-for-profit hospitals should retain their tax-exempt status. Current law stipulates that a not-for-profit hospital must pay taxes

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Table 9: The 10 Largest Grants Made in 1982 by Foundations in North Carolina to North Carolina Hospitals

	Amount	Recipient	Foundation
1.	$1,950,000	Duke University Medical Center Durham, NC	The Duke Endowment Charlotte
2.	986,500	Cabarrus Memorial Hospital Concord, NC	Charles A. Cannon Charitable Trust Number One Concord
3.	480,000	Cabarrus Memorial Hospital Concord, NC	The Cannon Foundation Concord
4.	250,000	Durham County Hospital Corporation Durham, NC	The Duke Endowment Charlotte
5.	250,000	Lenoir Memorial Hospital Kinston, NC	The Duke Endowment Charlotte
6.	250,000	Memorial Hospital of Alamance County Burlington, NC	The Duke Endowment Charlotte
7.	250,000	Mercy Hospital Charlotte, NC	The Duke Endowment Charlotte
8.	250,000	Northern Hospital of Surry County Mount Airy, NC	The Duke Endowment Charlotte
9.	250,000	Presbyterian Hospital of Charlotte Charlotte, NC	The Duke Endowment Charlotte
10.	250,000	Scotland Memorial Hospital Laurinburg, NC	The Duke Endowment Charlotte

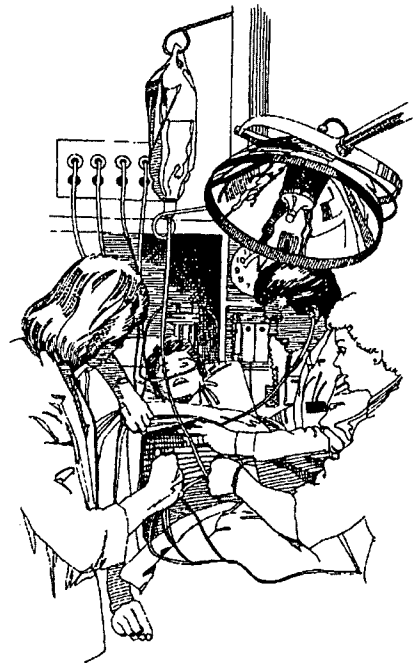
Source: Anita Gunn Shirley, *Grantseeking in North Carolina: A Guide to Foundation and Corporate Giving*, North Carolina Center for Public Policy Research, p. 11.

on any net business income not "substantially related" to its charitable purpose, but Congress is considering greater restrictions on the types of activities that are tax-exempt. Some lawmakers, such as U.S. Rep. Fortney "Pete" Stark (D-California), chairman of the House Ways and Means Subcommittee on Health, argue against tax exemptions for not-for-profit hospitals, saying they do not provide enough charity care to justify continued exemptions. Robert Taylor, an associate professor of health administration at Duke University, says there is less difference between the social benefit provided by not-for-profit hospitals and for-profit hospitals than people think. "Why shouldn't hospitals pay taxes?" asks Taylor. "What do not-for-profit hospitals do that makes them unique? Why do we tax an HCA hospital making $8 million a year and not tax the not-for-profit hospital with the same bottom line?"

Not-for-profit hospital executives defend their tax-exempt status, saying that not-for-profit hospitals not only provide a large amount of uncompensated care to indigent patients, but also a majority of the community health care. Not-for-profit hospitals also provide many specialty programs such as burn units and neonatal intensive care units, which unlike for-profit institutions, produce little if any revenue, according to Merlin K. Duval, former president of American Healthcare Institute.

The tax-exempt status of hospitals is drawing attention not only at the national level, but at the state level as well. In 1987, at least 13 states considered changes in the tax-exempt status of not-for-profit hospitals. Local governments, feeling the crunch of decreasing revenue and increasing demand for city services, also are reviewing the tax-exempt status of not-for-profit hospitals. In Pennsylvania, the city of Pittsburgh balked at allowing property tax exemptions for three hospitals on grounds they no longer carry out their part of the tax bargain by providing large amounts of free care to the poor. Dan Pellegrini, city solicitor, says with the advent of Medicare, Medicaid, and other third-party payers, hospitals do less free care and therefore no longer earn their property tax exemptions. Eventually, an agreement was worked out under which the hospitals would pay $11.1 million in service fees over 10 years to retain the property tax exemption.

The Institute of Medicine of the National Academy of Sciences attempted to answer the question of whether for-profit hospitals make as great a social commitment in taxes paid and charity care given as do not-for-profit hospitals in charity care alone. To do so, the Institute created a social commitment index by adding (a) expenditures within the hospital for indigent care and (b) taxes paid to the county, which



theoretically could then also be spent for indigent care. The total was compared to the amount spent on indigent care by not-for-profit hospitals. For-profit hospitals were found to have the greater social commitment. Using the same concept, the Center's research showed a similar finding within two North Carolina counties (Iredell and Wake), but in three other counties (Catawba, Cumberland, and Forsyth), not-for-profit hospitals were found to have the greater social commitment.

CONCLUSIONS AND RECOMMENDATIONS

THE CENTER'S RESEARCH FINDINGS lead to four major policy conclusions—(1) the state should develop a policy of allocating the burden of indigent care among hospitals; (2) the state needs to make available to the public more information about costs and charges of health care services; (3) the public should be notified if a hospital plans to eliminate or decrease the level of a service; and (4) all not-for-profit hospitals should be monitored by the state to see if they are providing sufficient benefits to their communities to merit their tax-exempt status, and counties should earmark tax revenues received from investor-owned hospitals for indigent care for county residents. The Center does *not* recommend a moratorium or prohibition on further expansion by for-profit hospital chains in the state. Such a moratorium was enacted by the N.C. legislature for six months in 1984. Other states

such as Nevada have placed limits on the amount of profits hospitals can make.

The Center recommends that the N.C. General Assembly enact a program to support care for indigent patients. The Center suggests the state choose one of four options: (a) to require all hospitals to provide a minimum amount of indigent care as measured by a percentage of gross patient revenues; (b) mandate that counties develop and fund their own indigent care programs; (c) assess all hospitals an amount based on each hospital's gross patient revenues and use those assessments for a statewide fund for indigent care; or (d) appropriate state funds for indigent care to hospitals with high levels of indigent care.

The Center also recommends that the General Assembly adopt legislation enabling the N.C. Medical Database Commission to collect data on costs, as well as charges, at all hospitals in North Carolina. The Commission should be authorized to publish this data in order to help the public make more informed choices in the health care marketplace.

The Center's third main recommendation is that a new article be added to Chapter 131E of the N.C. General Statutes requiring *any* hospital—public or private not-for-profit or investor-owned—to give notice and hold a public hearing if (a) the hospital plans to *eliminate permanently or indefinitely* any health care service; (b) if the hospital plans to *reduce permanently* the volume of a service to the extent that the hospital deliberately plans to limit its treatment to fewer patients than used the same service the year before; or (c) if a hospital has *temporarily eliminated or reduced* a service for more than 30 days.

The Center's last major recommendation is that all private not-for-profit and public hospitals should be required to meet a "social benefit = tax exemptions" test. Not-for-profit hospitals should be required by the legislature to submit a "community benefit report" to the N.C. Medical Database Commission documenting services to the poor, educational services for all income levels, and other community services. The Commission should submit this data to the N.C. Department of Revenue, which would then determine if the community benefit provided justifies each not-for-profit hospital's tax exemption. Currently, under the state's revenue laws, any organization that is exempt from federal income tax under the Internal Revenue Code is also exempt from state income tax. The Center proposes that the linkage between the state and federal exemption policies be severed. If state policymakers do not adopt this recommendation, then the Center recommends that (a) the state consider removal of the tax exemption for investor-*managed* hospitals; (b) the state allow public and private not-for-profit hospitals to retain their tax exemptions; and (c) that counties receiving tax payments from investor-owned hospitals earmark the revenues to provide indigent care for county residents.

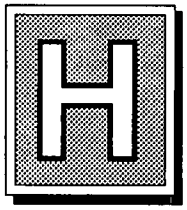
The Center's report served as the research base for a joint production with the University of North Carolina Center for Public Television which aired on the North Carolina Public Television Network on May 25, 1988. James Bernstein, chief of the state's Office of Health Resources Development, led a discussion by a panel comprised of: Earl Tyndall, administrator of Medical Park Hospital in Winston-Salem; Glenn Wilson of the UNC-CH School of Social and Administrative Medicine; Chris Fitzsimon and Jill McSweeney of UNC-TV; and Lori Ann Harris of the Center for Public Policy Research. Copies of the videotape are available for $87 by contacting Ted Harrison at WUNC Television at 919-737-2853.

CHAPTER 1

CHANGES IN THE INVESTOR-OWNED HOSPITAL MOVEMENT

by Melissa Jones

A SUMMARY OF THE CENTER'S FIRST REPORT ON THE INVESTOR-OWNED HOSPITAL MOVEMENT IN NORTH CAROLINA*



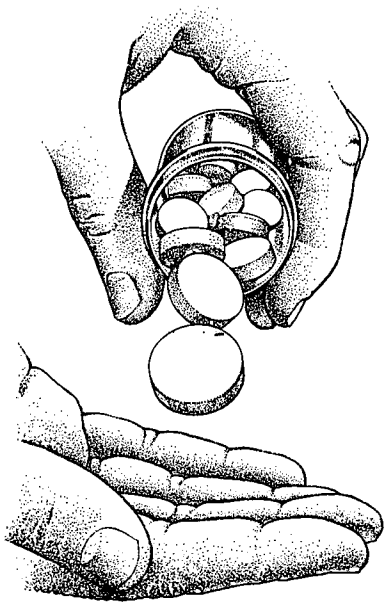
FOR GENERATIONS, most hospitals in North Carolina were publicly-owned or not-for-profit hospitals designed to provide health care at modest rates for the citizenry—and not designed to bring stockholders a return on investment. But since 1980, the ownership and management of North Carolina's hospitals has changed dramatically, and now 47 of the state's 162 non-federal hospitals—more than one in every four—are either owned, leased or managed (at least in part) by for-profit, commercial enterprises, the N.C. Center for Public Policy Research has found. This marks an increase from the 42 hospitals owned, leased, or managed by investor-owned companies in July 1986, when the N.C. Center released its first report on the state's investor-owned hospital movement.

The Center examined this trend in the first of two reports on the for-profit hospital movement in North Carolina. The first report, published in 1986, was called *The Investor-Owned Hospital Movement in North Carolina.* Two years in the making, the report incorporated original research as well as material from interviews with officials at 39 hospitals throughout the state, as well as community leaders in areas where for-profit hospitals had begun to function. "The for-profit trend is one of the most significant health care issues that North Carolina citizens will face," said Ran Coble, executive director of the N.C. Center. "Sooner or later, each of us may require the services of a hospital, and how that hospital is operated and managed may be vital—literally."

Hospital ownership can be classified into three broadly-defined categories: (1) public; (2) not-for-profit (both secular and religious—also called voluntary); and (3) investor-owned (also called private for-profit or proprietary). The majority of North Carolina's hospitals are owned by local governments (counties, cities, hospital districts, or special hospital authorities) or by not-for-profit corporations.

In both reports by the N.C. Center for Public Policy Research, the term *public hospital* refers specifically to those owned by state or local governmental bodies and excludes federal hospitals. *Not-for-profit hospitals* (secular or religious) are privately-owned and operated as charitable, community service organizations. Sometimes called "voluntary" hospitals, they are tax-exempt. *Investor-owned* hospitals are also privately owned but are not tax-exempt. The investor-owned hospital seeks to earn a profit for its shareholders in addition to providing health care services in the community. A *multi-hospital system* con-

*This introductory section, pages 1-5, is primarily comprised of excerpts from the Executive Summary of the N.C. Center's previous report, *The Investor-Owned Hospital Movement in North Carolina,* published in 1986 and edited by Elizabeth M. "Lacy" Maddox, as well as from the news release accompanying that report.



sists of a group of hospitals with common ownership or management. Like individual hospitals, hospital management companies can be public, not-for-profit, or investor-owned.

The Center's first report represented an overview of the issues raised by for-profit involvement in the hospital industry. It contained individual profiles of the hospitals then owned, leased, or managed by the 11 investor-owned, multi-hospital systems operating in the state. In addition, the report identified some of the possible factors leading to the acceleration of investor-owned involvement in North Carolina. Finally, the report examined several other components of the health care industry which are relatively new to the state and which may affect the viability of the state's hospitals.

Advantages and Disadvantages of For-Profit Hospitals

THE FIRST REPORT assessed opinions of hospital administrators and health care experts about the advantages and disadvantages of for-profit hospitals. Among the *possible advantages* are the following:

1. Access to private capital. The major advantage investor ownership or management may offer is access to private capital that can be used to repair, replace, or expand hospital buildings. Hospitals also use these funds to purchase increasingly expensive and sophisticated medical equipment.

2. Access to a national personnel pool. Investor-owned corporations may use their national systems to develop a pool of qualified personnel, particularly hospital administrators.

3. Management expertise. Such a personnel pool may contribute to management expertise. The skills required to be a good county commissioner or a good doctor are not necessarily the same skills that would guarantee a well-run hospital. While a hospital seeks to provide quality health care, it must also manage to stay out of debt.

4. Volume purchasing. Any multi-institutional system has the advantage of saving money through large-volume purchases of basic medical necessities such as intravenous solutions. A single hospital usually lacks the buying power of an investor-owned corporation.

5. Promoting competition in the hospital sector. The presence of investor-owned hospitals in a community may increase competition in the health care sector generally. Competition between hospitals might lower prices and provide more health care options for consumers.

6. Tax advantages for the community. If a hospital changes from a county-owned or other public facility to an investor-owned facility, it will also change from being tax-supported to being a taxpayer, because investor-owned hospitals are subject to local property taxes and corporate income tax levies.

7. Taking the county out of the hospital business. The final potential advantage applies when the hospital has been previously owned by a county or city. County commissioners who have turned over a county-owned facility that was losing money to a private company frequently say a burden has been lifted from their shoulders.

Possible disadvantages also accompany the growth of the investor-owned hospital movement in North Carolina. These potential drawbacks include the following:

1. Higher charges. A chief possible disadvantage of investor-owned hospitals is that they may have higher charges.

2. Indigent care. Another major concern expressed about hospitals affiliated with investor-owned corporations is whether they provide less indigent care than do not-for-profit hospitals.

3. Skimming the cream. Hospitals affiliated with investor-owned corporations may narrow the range of services or alter the patient mix to the extent that investor-owned hospitals provide more of the profitable services and get more of the paying patients—leaving fewer revenue-producing patients or services for not-for-profit hospitals.

4. Changing the nature of health care. Just as

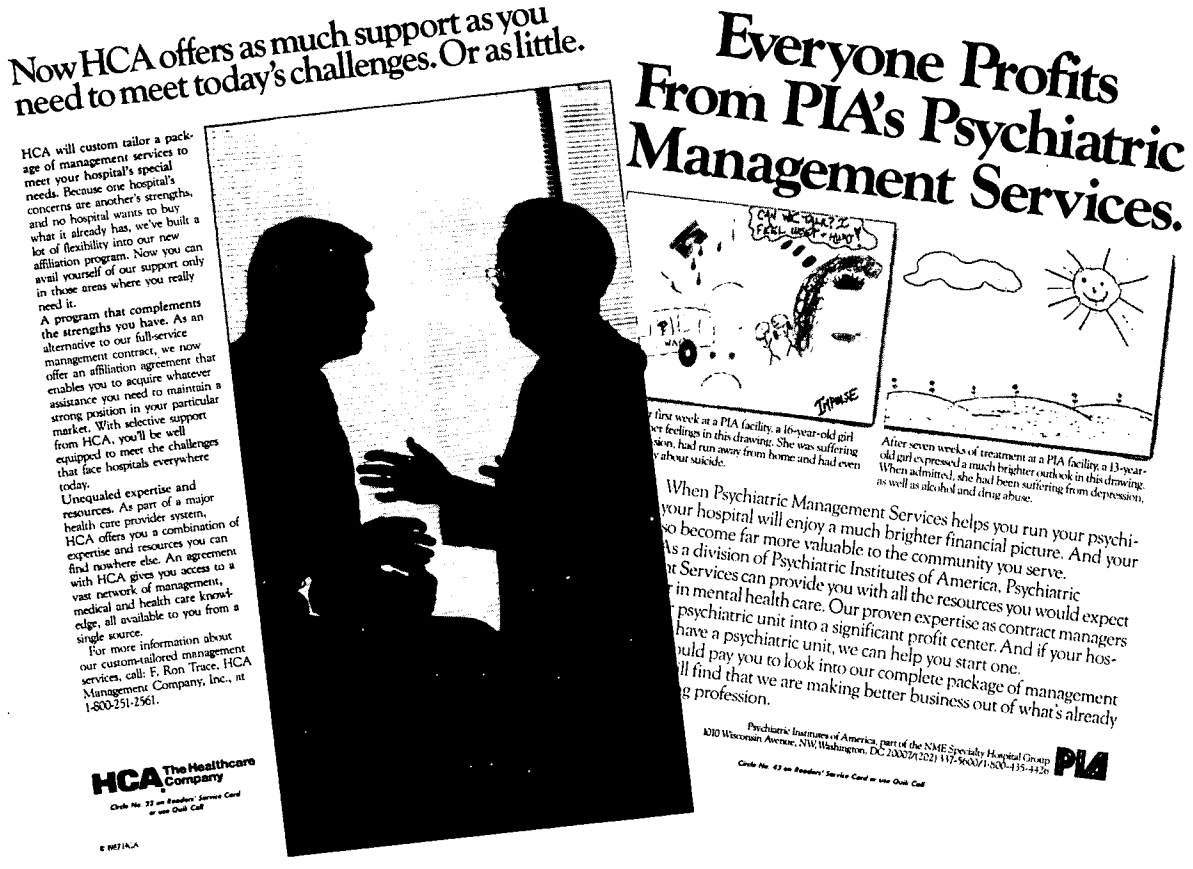
there is a political and financial factor that may be an advantage of investor-owned corporations—namely, increased tax revenue—there is also a philosophical question of whether profit considerations properly belong in the delivery of hospital care. This question is not a problem for research but rather a debate about who has the responsibility for delivery of health care in a democratic society.

Investor-Owned Hospital Companies in North Carolina in 1985

FOLLOWING THIS ANALYSIS, the first report provided extensive summary data on the location, ownership, services, and size of North Carolina's non-federal hospitals. The Center's research also looked at multi-hospital systems in the state. Only one of the 11 for-profit hospital companies operating in North Carolina in 1985—Hospital Corporation of America (HCA)—both owned and managed hospitals in the state at that time. Seven systems then operated in the state only as hospital owners. Three investor-owned systems were engaged exclusively as hospital managers.

Common Assumptions Found to be Wrong

AS PART OF ITS RESEARCH for both the first and second reports, the Center disproved two hypotheses concerning changeovers to for-profit hospitals. The first hypothesis was that *public* hospitals would be more likely to join investor-owned hospital systems than would not-for-profit or independent proprietary hospitals. But the Center found that thus far, this has not been true in North Carolina. Of the 24 hospitals which are *owned* by investor-owned corporations, only five were once public hospitals—Central Caro-



lina Hospital in Sanford, Heritage Hospital in Tarboro, Highsmith-Rainey Memorial in Fayetteville, Franklin Memorial in Louisburg, and Lowrance Hospital in Mooresville, now called Lake Norman Regional Medical Center. However, future sales to investor-owned firms would have to come from not-for-profit and public hospitals because there is only one remaining independent, for-profit hospital left in North Carolina—McPherson Hospital in Durham.

The second hypothesis was that a decision by public or not-for-profit hospitals to join an investor-owned system would be likely to follow the defeat of a local hospital bond referendum. Again, the Center's research has found that this is not true. Based on the available evidence from the N.C. Local Government Commission and from the Department of the State Treasurer, no significant relationship appears to exist between these two events. First of all, hospital bond referenda usually pass. Since November 1970, counties and towns have presented 45 hospital bond referenda to the voters, and only nine have failed. And second, in only three (Lee, Iredell, and Franklin) of those nine counties has the county subsequently affiliated with an investor-owned hospital corporation.

Alternative Health Care Facilities Compete with Hospitals

THE FIRST REPORT examined several new, growing components of the health care industry which affect the viability of the state's community hospitals. Health maintenance organizations (HMOs) and pre-

ferred provider organizations (PPOs), both alternatives to traditional insurance plans, seek to limit patients' use of medical specialists and of inpatient hospital care. Ambulatory surgery clinics and urgent care centers—the so-called "Doc-in-a-Box" health clinics that have popped up in many communities—compete directly with hospitals. "These new service providers can weaken a hospital's economic stability and perhaps make it more likely to be a candidate for sale to an investor-owned company," said Coble.

Some health care experts believe that the very existence of many hospitals will be threatened as these new competitors peel away one hospital profit center after another and turn the hospital into a money loser. "If you pull out all the parts of the hospital that are profitable, the hospital system as we know it will fly apart," said John Young, a staff researcher with the N.C. General Assembly. Three hospitals in North Carolina (Warren General in Warrenton, Gordon Crowell Memorial in Lincolnton, and Huntersville Hospital in Huntersville) have already closed in the past few years.* In this initial report, the Center looked closely at those North Carolina hospitals which have opted for affiliation with an investor-owned corporation. The report also discussed major problems facing hospitals in the next decade.

HOSPITALS FACE CHANGE: AN OVERVIEW OF TRENDS IN NORTH CAROLINA AND THE NATION

PART OF AN INCREASINGLY DIVERSE health care industry, modern American hospitals have begun to shift with the winds of government policies and the market economy. And because those winds change in strong, sudden gusts, hospital administrators can have a tough time keeping their institutions on a steady flight.

The remainder of this introductory chapter traces the various recent trends buffeting hospitals—investor-owned and not-for-profit, public and private, rural and urban—across North Carolina and the nation. While this summary is not exhaustive, it provides a backdrop for the research which follows.

Retrenchment in the Investor-Owned Hospital Movement

RETRENCHMENT, today's buzzword among analysts of the nation's investor-owned hospital industry, seems a far cry from the predictions heard during most of the last decade. In the late 1970s and early 1980s, the "megasystem"—a handful of national investor-owned conglomerates running hospitals, providing insurance, and establishing new sorts of health care entities from health maintenance organizations to urgent care centers—seemed certain to appear on the horizon. Paul Starr charted the "Coming of the Corporation" in his Pulitzer Prize-winning book *The Social Transformation of American Medicine,* and *New England Journal of Medicine* editor Arnold S. Relman wrote an article on "The New Medical-Industrial Complex" which shaped much subsequent debate. Starr and Relman viewed the impending changes as an ominous trend, harmful to the traditional ethos of service to patients in American hospitals.[1] Other analysts, including former Reagan administration budget director David A. Stockman, considered the changes a welcome and necessary addition of rational business expertise to hospitals which, amid mounting costs, could no longer afford less-than-efficient management.[2] Critics of increasingly entrepreneurial hospitals described patients who, under the duress of illness, had little control of their treatment and placed a vital trust in their physician and in their hospital. However, proponents of what *Greensboro News & Record* columnist Giles Lambertson called "the customer theory of running hospitals" hailed the competition among emerging alternatives to traditional insurance, hospitals and physicians' offices as effective at both cutting costs and pleasing the consumer.[3]

What happened to this predicted megasystem? Although the investor-owned movement's influence has significantly changed the way Americans receive medical care and how they pay for it, the prospect of a few large corporate chains providing all facets of health care from cradle to grave now seems unlikely. Although the number of investor-owned hospitals continues to grow, and although fewer investor-owned hospitals remain independent of chains, the major for-profit hospital corporations are either slowing the pace of their purchases or are divesting hospitals, insurance plans, urgent care centers, and other enterprises. From early in the summer of 1986 until just recently, the major investor-owned corporations once known as the "Golden Boys of the 'buy, build and grow' era of the hospital business"[4]—American Medical International, Hospital Corporation of America, Humana, and Na-

* Blackwelder Memorial Hospital in Lenoir, owned by Futura Health Care Services since 1985, closed in October 1988, when Futura filed for bankruptcy. According to officials of the for-profit hospital corporation, Futura plans to reopen the facility in 1989. Tables and text in this and following chapters do not reflect this closure. For more details on hospital closures in North Carolina, see *The Investor-Owned Hospital Movement in North Carolina,* pp. 50-52.

tional Medical Enterprises—posted major financial losses. A feature story in *The Wall Street Journal* recounted the woes of one investor-owned hospital conglomerate—Humana. *The Journal* noted that Humana's profits, although relatively high for the investor-owned hospital industry, had "eroded somewhat," and observed that "Humana stock has lost its glamour."[5]

Significant changes in both the public and private sectors have combined to slow the American investor-owned hospital movement:

1. Prospective payment systems and pre-admission reviews have significantly lowered hospitals' inpatient occupancy rates, shortened the length of patients' stays, and restricted the potential profits on inpatient hospital care. Since 1983, the federal government's prospective payment system for Medicare has used diagnosis related groups (commonly known as DRGs) to reimburse hospitals at a flat rate set before hospitals provide a given service. This *prospective* payment system (PPS) differs from the *retrospective* method once used by Medicare officials to reimburse hospitals for the costs which the hospital had already incurred. (For a quick view of DRGs—what they are and why the government uses them—see the sidebar on pages 10-11.) Even before this watershed in the history of the nation's health care system, private insurance companies, along with groups of physicians and public health officials, had begun to review hospital admissions with an eye toward encouraging outpatient services in place of expensive inpatient care whenever possible. These *pre-admission reviews* also sought to trim any unnecessary time spent in the hospital or the intensive care unit. Private insurers instituted these reviews at the urging of employers, who were feeling the pinch of rising health insurance premiums for their employees.

Such changes in the way government and insurance companies pay for health care has affected hospital bills and budgets. Making less money from fewer patients, "hospitals are having to pass extremely high [price] increases to those of us who pay full price," says Daniel Butler, senior vice president for health affairs at Blue Cross and Blue Shield of North Carolina. While most hospitals are managing to stay in the black, Butler says that doing so is "becoming very difficult." Although Medicare officials assert that hospitals have healthy profit margins, another analyst paints a grimmer picture. All hospitals, says Stephen Morrisette, senior vice president of the North Carolina Hospital Association, "have found out that you cannot make money in general, acute care services alone. It's a no-win situation."

2. Investor-owned companies' efforts to diversify their business holdings have met with only lim-

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A goal is to provide the
specific area to reduce
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provider industry which has the most critical need for sound communities of the country . . . ."

HMA is the best health management company to meet these desirable goals for a number of reasons:

MANAGEMENT STRENGTH. HMA has strong and successful management experience within its officers and employees who have managed hospitals and hospital companies on a national and international level.

FINANCIAL STRENGTH. HMA is a profitable company with financial resources and banking lines of credit to handle bond defeasements, capital improvements, short term operating capital, and facility purchases.

"The role of the community hospital is to anticipate and prepare to meet the health care needs of the people it serves."

The role of the community hospital is to anticipate and prepare to meet the health care needs of the people it serves. The bottom line is the ability to provide quality care for the patients and the diagnostic and treatment capabilities for the physician within fiscally sound operational procedures.

HMA has the capability to apply our staff experience to bring the needs of the patient, the physician and the financial requirements of the hospital into balance. Quality health care for the people, however, is our first and foremost objective, and we never lose sight of this in the application of our management systems for our clients.

HMA Hospitals ha
latest medical t
physician specialt

Our nursing professionals care about the people they serve.

Courtesy Franklin Regional Medical Center

Courtesy McDowell Hospital

The Wellness Center at The McDowell Hospital

ited success, and the industry has witnessed widespread divestment of these ventures. Although diversification—spreading risks over and gathering income from a number of different enterprises—is a common corporate practice, it has not proven as simple or successful as the chief executive officers (CEOs) of investor-owned hospital chains first anticipated. For example, insurance businesses owned and operated by the four major investor-owned chains—American Medical International (AMI), Hospital Corporation of America (HCA), Humana, and National Medical Enterprises (NME)—have lost large amounts of money in recent years, in part by paying insurance benefits to competing hospitals. Also, competition from their networks of doctors' offices and ambulatory surgery centers has irked local physicians. Said former AMI president and CEO Walter L. Weisman, "We and many others lost sight of the importance of the individual physician"—the physician who admits patients and thus controls the hospital's viability.[6] The investor-owned hospital corporations have divested most of their insurance businesses and other subsidiaries.

In another kind of divestment, investor-owned hospital chains have not merely sold subordinate businesses like their urgent care centers but have actually created a new company and sold to it a significant number of their hospitals. Hospital Corporation of America started its spinoff, called HealthTrust, in September 1987. American Medical International completed its spinoff of 36 hospitals to Epic Healthcare Group in September 1988. Each of these sales includes nearly half of the parent company's acute care hospitals, but AMI and HCA are holding on to their psychiatric facilities. Both AMI and HCA own substantial shares of stock in their spinoffs. And both HealthTrust and the AMI spinoff are using their employees' pension funds to finance loans used to purchase hospitals from their parent company. If the spinoffs make money, employees will receive their retirement benefits as shares of company stock. These employee stock ownership plans (ESOPs) bring tax breaks and low interest rates to the corporations but place employees' retirement benefits at risk in the stock market.[7]

Of course, all industries have experienced times of boom and bust. Reacting to this business cycle, CEOs

of investor-owned hospital chains knew when to shift gears in their business ventures. If they failed to make such changes, they could not pay dividends to stockholders or keep their hospitals open.

In the wake of this rush to divest, the big investor-owned firms are making different predictions about the hospital business. While none are predicting a megasystem, their decisions about diversification differ. AMI, for example, "will not diversify again" according to Weisman,[8] but Humana plans to get rid of the bugs in its strategy and make diversification work. Taking a middle course is HCA, which now has a joint insurance venture and will maintain its outpatient and psychiatric clinics. All the big firms, however, seem to have weathered the October 1987 stock market crash, and their earnings are up, as of September 1988. Stock market analysts say the companies got a boost from a drop in corporate income tax rates.[9]

3. Many states have intensified their scrutiny and regulation of the health care system which may have helped slow the pace of the investor-owned hospital movement. According to a study by the National Conference of State Legislatures, in 1984 there were 800 state government programs designed to limit health care costs; in 1986, there were 2,972.[10] A few state commissions even regulate hospital rates.

Like many industries, the investor-owned hospital chains have gravitated to the Sunbelt, where state governments are less likely to have imposed strict regulations. But in Nevada, where hospitals owned and managed by for-profit chains predominate, and where health care costs are some of the highest in the nation, Gov. Richard Bryan has led a fight to cap hospitals' profit margins. (See the sidebar in Chapter 3, page 111, for a more detailed account of state government regulation of the price of health care.)

4. Competition from inside and outside the investor-owned hospital industry has slowed the investor-owned hospital movement nationwide. New, smaller investor-owned firms, many of which concentrate on a particular region, population, or clinical service, have emerged as the major corporations began to divest; but on the other hand, competition from some of these relatively small investor-owned chains may have contributed to the divestitures in the first place.

Major investor-owned hospital companies also compete with their own record of growth and profits. Ironically, a hospital or service yielding early high returns which then level off, or one taking time to turn a profit, can hurt an investor-owned firm's corporate image. David G. Warren, professor of health administration at Duke University, explains that even if such a facility or service keeps a steady profit margin, it may be viewed as a handicap by a corporation watching the bottom line over the short term.

Competition has also come from outside the investor-owned hospital industry. Independent ambulatory surgery centers have pulled patients away from hospitals, which are, after all, the core of investor-owned chains. And not-for-profit hospitals, which have been banding together in an array of corporate and voluntary networks, have also learned to compete for patients and have become more adept at guarding their market share. (For a discussion of the trends among not-for-profit hospitals, see pages 18-25.)

Small and Specialized Investor-Owned Companies Emerge During Industry's Retrenchment

ONE PART of the investor-owned hospital industry has weathered the storms in the health care system—specialized facilities such as psychiatric, chemical dependency, and rehabilitation hospitals.[11] Many of the new, small firms in the for-profit hospital industry have used these avenues to move into the business. And these firms are succeeding at a rate which significantly outpaces the industry's giants. In 1986, according to the Federation of American Health Systems' (FAHS) annual directory, the number of investor-owned specialty hospitals grew by more than 15 percent, with psychiatric hospitals comprising a major part of the increase. Investor-owned psychiatric hospitals grew by a whopping 23 percent that year. These figures outshone the overall investor-owned hospital industry's 1986 performance—a 5 percent increase in the number of hospitals. This 5 percent overall rate of increase matched the pace of growth in the investor-owned hospital industry during the previous five years.[12]

The next year's survey by FAHS, posting the industry's marks for 1987, revealed an overall growth rate of only 1 percent in the number of investor-owned hospitals, to a total of 1,375. Again, the number of specialty hospitals—up 6 percent to a high of 498—grew faster than the whole industry, but that marked a significant slowdown from the previous year. Specialty hospitals comprise more than one third of the investor-owned hospital industry. Psychiatric hospitals, which make up almost 60 percent of the investor-owned specialty hospital market, still led the industry but slowed their rate of growth. Nonetheless, psychiatric hospitals added 9 percent more facilities to reach a total of 297, over 20 percent of the entire investor-owned hospital market.[13]

The fact that Medicare uses neither DRGs nor prospective payment systems for psychiatric services

—continued on page 12

HOW DO HOSPITALS FARE UNDER MEDICARE?

by Melissa Jones

IN THE FIRST REPORT on investor-owned hospitals by the N.C. Center for Public Policy Research, Robert Conn explained how Medicare pays for a patient's hospital stay:

> On October 1, 1983, the way in which the federal government pays for Medicare in-hospital services changed dramatically. Until that time, the amount of the payment for Medicare patients was not determined until all the hospital's services had been provided and the costs of providing those services had been determined. Then—retrospectively—the hospital would tell Medicare how much the services cost and learn how much of the bill Medicare would pay.
>
> Beginning with the new 1984 fiscal year on October 1, 1983, the federal government began to try to get control of rising costs in the Medicare program by changing its payment system so that a hospital would know at the beginning of treatment how much the program would pay for inpatient hospital care. This new Prospective Payment System (PPS) was designed so that hospitals will be paid on the basis of pre-determined—or prospectively determined—rates for the operating costs of inpatient services. The PPS pays an amount that has been calculated by multiplying a weighting factor assigned to a particular Diagnosis Related Group (DRG) by an amount called the appropriate federal rate. DRG is a classification approach using major medical diagnostic categories.[1]

This reimbursement system was supposed to encourage efficient hospital management and reduce the rate of growth in the federal Medicare program. Under the system's first four years, the appropriate federal rate was blended with a regional rate in an attempt to allow hospitals to adjust gradually to a uniform national rate. But congressional budget compromises delayed the uniform national rate, which was scheduled to take effect in 1988. Congress especially tried to help hospitals in the northeast handle the region's higher labor costs, which have been aggravated by a severe nursing shortage. Those hospitals can choose payments under a blended rate, as can hospitals in states along the Atlantic coast. Medicare's reimbursement rates rose in April 1988 for all hospitals, and inner city and rural hospitals received slightly bigger boosts in their rates.[2]

Do hospitals profit from these adjustments—or, for that matter, from PPS? That question sparks quite a debate. According to Brown Gardner, the senior director of benefits administration for Blue Cross and Blue Shield of North Carolina, hospitals in the state did receive a boost in Medicare funds when the reimbursement system changed. And even after inflation in health care costs and growth in the number of claims are considered, PPS and DRGs accounted for about 10 to 13 percent of the increase in federal reimbursements to hospitals from fiscal year 1983 to fiscal 1984—an increase of between $72 and $95 million.[3] More recently, the U.S. Department of Health and Human Services reported that American hospitals still earned, on average, a 9.6 percent profit during the 1986 fiscal year, though this is less than the 14.4 percent average for fiscal 1985.[4]

But hospital administrators assert that the federal government's accounting method fails to consider the full costs of caring for Medicare patients when measuring profits. Surveys and studies by private research firms and trade associations, these administrators point out, contradict the federal government's findings and report that under Medicare hospitals either have minimal profit margins or are losing money.[5] Increases in Medicare reimbursement rates, about 1 percent annually according to the Federation of American Health Systems (an organization of investor-owned hospitals), have not kept up with inflation in health care costs.[6] (For more information on inflation and the cost of health care, see the sidebar in Chapter 3, pp. 93-95.)

—continued

Medicare rules and reviews continue to be complex under the prospective payment system, which was originally designed to simplify the hospital claims process and thus save both the government and the hospitals money. Furthermore, those hospitals which do make money under PPS are, their administrators say, doing what the federal government wants them to do—running a tight ship. Michael D. Bromberg, executive director of the Federation of American Health Systems, explained why the amount Medicare pays is so important to all hospitals:

> About one-half the income received by most hospitals comes from the Medicare and Medicaid programs. For health care managers, that means that the federal government is their largest customer. Given the Medicare DRG payment system, that also means that this largest customer is also setting the price for services rendered by hospitals.[7]

While all hospitals complain that Medicare rates treat them unfairly, rural hospitals in particular fare poorly under PPS. Federal Medicare officials agree that rural hospitals are losing money. These hospitals have received lower reimbursement rates because it was assumed that the cost of living was lower in rural areas than in cities. But any such differences between urban and rural areas are "not significant" compared to other costs faced by rural hospitals, says Stephen Morrisette, senior vice president of the North Carolina Hospital Association. "Rural hospitals must compete for skilled medical staff," says Morrisette, and to persuade medical professionals to forgo the conveniences of cities and major medical centers "can cost more, not less."

The recent congressional changes in reimbursement rates have "taken a little pressure off" North Carolina's rural hospitals, says the state Hospital Association's finance director, Harold Bennington.[8] But the debate continues about how much to raise payments to rural hospitals. The N.C. Hospital Association says that all hospitals should be paid at the same basic rate but get discounts when they offer certain types of community service, such as physician residency programs. Advocates for rural hospitals claim that neither the government nor state and federal hospital associations recognize the full extent of the rate's discrepancy. In Missouri, a group of rural hospitals is taking the U.S. Department of Health and Human Services to court. The hospitals are contending that the government's use of metropolitan statistical areas (MSAs) in differentiating between rural and urban hospitals discriminates against rural hospitals and, they assert, violates the U.S. Constitution's equal protection and due process clauses.[9]

In future years, Medicare's prospective payment program will play an increasingly significant role in this country's health care system. As the American population ages, more people will depend upon Medicare to pay their hospital bills, and Medicare reimbursement will comprise a growing percentage of hospital revenue. Congress is now considering proposals to use prospective payments for the part of Medicare which covers outpatient and physician services. (These types of health care are now reimbursed on the basis of costs incurred, as all Medicare claims once were funded.) If these reforms take place in 1991 as scheduled, Medicare's prospective payment system will not only influence hospitals but will affect how much doctors, home health nurses, and other medical professionals earn. And as the scope of prospective payment plans expands, the debate surrounding them will undoubtedly continue.

FOOTNOTES

[1]Robert Conn, "DRGs—How Medicare Pays for Hospital Care," Elizabeth M. "Lacy" Maddox, ed., *The Investor-Owned Hospital Movement in North Carolina* (Raleigh, NC: The North Carolina Center for Public Policy Research, 1986), p. 93.

[2]See Cathy Tokarski, "PPS to get more complicated April 1," *Modern Healthcare*, February 19, 1988, p. 24.

[3]Robert Conn, "Diagnosis Related Groups and Changes in Physician Practice," Elizabeth M. "Lacy" Maddox, ed., *The Investor-Owned Hospital Movement in North Carolina*, p. 92.

[4]Donna Alvarado, "Hospitals decry report of Medicare profits," *The News and Observer* (Raleigh), February 4, 1988, p. 14C and Office of Inspector General, U.S. Department of Health and Human Services, *Profit Margins for the Third Year of the Prospective Payment System (PPS)* (Washington, DC: February 10, 1988), pp. 1-20.

[5]Maria R. Traska, "Medicare losses lower margins: HMFA study," *Hospitals*, April 20, 1988, p. 28.

[6]Michael D. Bromberg, "Executive Director's Report," *1988 Annual Report* (Little Rock, AR: Federation of American Health Systems, 1988), p. 6.

[7]*Ibid.*

[8]Cathy Tokarski, "PPS to get more complicated April 1," p. 24.

[9]David Holthaus, "Rural-urban distinction challenged in Missouri," *Hospitals*, February 20, 1988, p. 70.

may attract investor-owned corporations to this market. Investor-owned hospital administrators also note that a large percentage of psychiatric patients can pay their bills out of their own pockets or with the help of private insurance, unlike acute-care patients, half of whom rely on Medicare or Medicaid.[14]

It is important to note that this deceleration in the investor-owned industry has come at a time when the number of American hospitals in general has been falling. The past two years have marked a record number of closings of American acute care hospitals: 71 closed in 1986 and 79 in 1987, according to the American Hospital Association. Thirty-five of the hospitals closing in 1987 were investor-owned. While investor-owned hospitals comprise about 15 percent of the nation's hospitals, they accounted for 44 percent of hospital closures in 1987.[15]

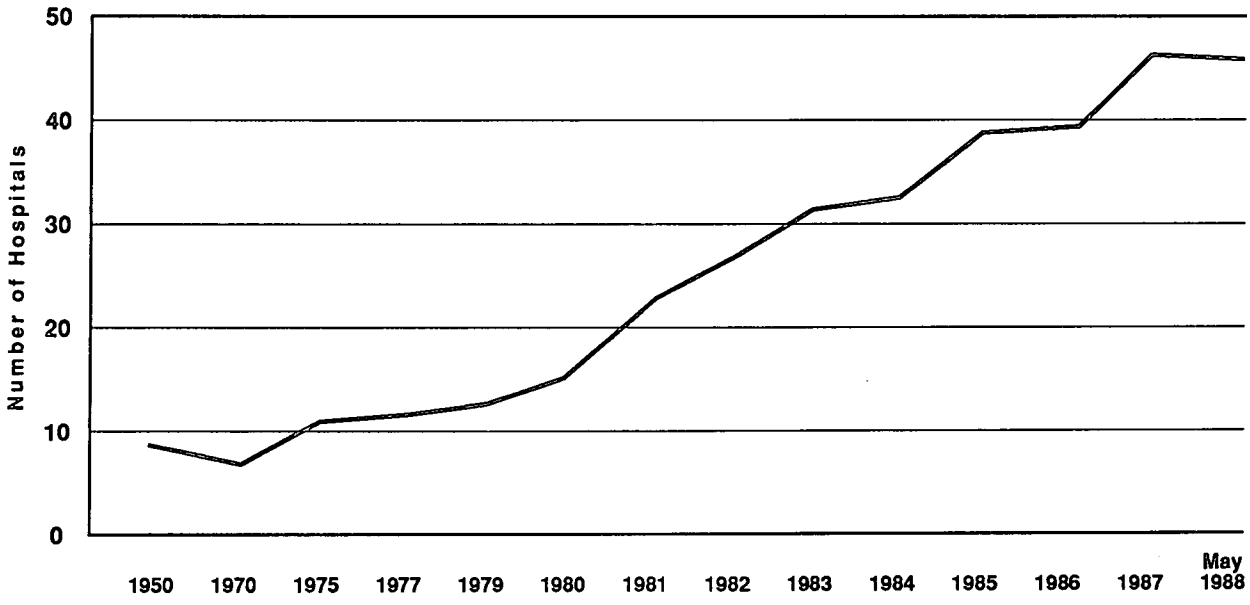
Investor-Owned Hospitals in North Carolina Reflect National Trends

NORTH CAROLINA, where major investor-owned hospital chains rapidly expanded in the early 1980s, now mirrors the national trend of retrenchment in one aspect. Since the North Carolina Center for Public Policy Research published its first report the overall number of hospitals *owned* by for-profit corporations remains unchanged at 24. (The first report used, in most cases, data current through 1985.) Three investor-owned hospitals in North Carolina have been sold to private, not-for-profit firms, marking a new trend among hospitals in the state. On the other hand, one investor-owned hospital has been built, and two not-for-profit hospitals have been purchased by investor-owned corporations.

The number of hospitals which have *management contracts* with investor-owned corporations, however, has grown by six to a total of 21 as of November 1988. The number of hospitals *leased* by for-profit companies has increased slightly as well, from one to a total of two. These management contracts and leases between chains and not-for-profit hospitals demonstrate that the investor-owned hospital movement continues to expand in the state, despite a standstill in the number of hospitals owned by for-profit corporations.

Tables 1.1 and 1.2, as well as Figure 1.1, illustrate specific changes in the state's investor-owned hospi-

Figure 1.1: The Growth of Investor-Owned Hospital Involvement in North Carolina (Total — Owned, Leased and Managed) 1950-1988



tal movement. Table 1.1 lists the 47 hospitals affiliated with investor-owned corporations in the state. Figure 1.1 traces the growth of the investor-owned hospital industry in North Carolina since 1950. Table 1.2 describes the specific changes in the investor-owned hospital movement since the Center's first report in 1986. Significant developments in the industry since the beginning of 1986 include the following:

1. Management contracts between five not-for-profit hospitals and three investor-owned chains—Horizon Health Management Company, Psychiatric Institutes of America, and Mental Health Management Company—mark a new development in the state. (Table 1.3 lists the hospitals which have entered contracts with these companies). These investor-owned firms do not manage entire hospitals but specialize in running only psychiatric units.

Such contracts with national investor-owned firms enable not-for-profit hospitals to recruit psychiatrists, clinical social workers, and other qualified personnel from across the country. Managers from the investor-owned company can also put their expertise to use for not-for-profit hospitals by quickly putting in place comprehensive, workable psychiatric treatment programs. These advantages help not-for-profit hospitals attract patients in the highly competitive and lucrative market for psychiatric care.

While management contracts with investor-owned firms may offer not-for-profit hospitals these kinds of benefits, the contracts sometimes come with strings attached. Because the investor-owned firm's profit motive may conflict with a hospital's mission of community service, the hospital must be careful to stay in control of its psychiatric services, says one North Carolina hospital official whose not-for-profit hospital's psychiatric unit is managed by an investor-owned company. "You don't want to sell them the farm," the official commented, adding that a not-for-profit hospital should, if at all possible, take the time to develop its own psychiatric program without the help or hindrance of a contract with an investor-owned company.

2. Seventeen investor-owned firms are currently affiliated in some way with 46 North Carolina hospitals. (McPherson Hospital in Durham is North Carolina's only independently owned for-profit hospital.) Table 1.4 shows these companies and their hospitals in the state. Several of the nine investor-owned companies which have entered the North Carolina market since 1985 epitomize the expanding presence of relatively small, emerging corporations in the investor-owned hospital industry. These investor-owned hospital firms are described in Table 1.5. Table 1.5 also notes which firms have left the state since the N.C. Center's last report.

One investor-owned company new to North Carolina, Comprehensive Addiction Programs, specializes in managing chemical dependency centers like the Life Center of Wilmington, which Healthcare Services of America divested in late 1987.

Not all of the new companies are small, however. HealthTrust, which now owns three and leases one hospital in North Carolina, is one of the largest hospital chains, investor-owned or not-for-profit, in America. (See below and the sidebars on pages 27-31 for more about HealthTrust's unusual origin.)

3. While some North Carolina communities are witnessing a new investor-owned involvement in their not-for-profit hospitals, others have felt first-hand the consequences of the industry's retrenchment.

• Bertie County Memorial Hospital in Windsor has come full circle since it closed for two months in the summer of 1985. Once county-owned but operated by SunHealth (a not-for-profit hospital management firm and alliance headquartered in Charlotte), the hospital closed in July 1985 only to open again in September under the management of Forum Health Investors (FHI), a for-profit firm. In February of 1986, the investor-owned Westworld Community Healthcare Inc. leased the hospital from the county.

Westworld had entered the investor-owned hospital industry in the early 1980s and grew into a network of rural health care systems including hospitals, a health maintenance organization (HMO), alcohol dependency and pain treatment centers, and even an air ambulance service. But in communities with Westworld hospitals, patients said prices were too high. Some insurance companies agreed and refused to pay the bills; eventually banks refused Westworld credit. On Wall Street, the company's stock fell flat.[16] Despite divesting all of its businesses except for a few rural hospitals and changing executive officers, Westworld failed to turn a profit. In fact, it lost millions.

When Westworld finally declared bankruptcy in July 1987, its hospitals got two days' notice to close their doors. Bertie Memorial reverted to the county's ownership and, once again, entered a management contract with Forum Health Investors.

• In September 1987, Hospital Corporation of America (HCA) divested 104 of its 186 acute care general hospitals in the United States. HCA also created a new company, named HealthTrust, to buy the hospitals. That move made HealthTrust the largest single owner of acute care general hospitals in the country according to *Modern Healthcare* magazine.[17] It also sparked a controversy about the financial

—continued on page 16

Table 1.1: Investor-Owned Involvement with Hospitals in North Carolina, 1988

	Hospital Name	Location	Beds in Use	Hospital Type	Owned/ Leased/ Managed/ & Company	Date I-O Involvement Began	Date of Latest Changeover
A. Owned by Investor-Owned Corporations (24)							
1.	Appalachian Hall	Asheville	100	P	O-PIA	1931	1981
2.	Blackwelder Memorial Hospital *	Lenoir	35	G	O-FHCS	1985	1987
3.	Brynn Marr Neuropsychiatric Hospital	Jacksonville	76	P	O-HSA	1984	1984
4.	Central Carolina Hospital	Sanford	142	G	O-AMI	1980	1980
5.	Charter Hills Hospital	Greensboro	68	P	O-CMC	1981	1981
6.	Charter Mandala Center	Winston-Salem	99	P	O-CMC	1973	1981
7.	Charter Northridge Hospital	Raleigh	66	P	O-CMC	1984	1984
8.	Charter Pines Hospital	Charlotte	60	P	O-CMC	1985	1985
9.	Community Hospital of Rocky Mount	Rocky Mount	50	G	O-BAHC	1913	1986
10.	CPC Cedar Spring Hospital	Pineville	50	P	O-CPC	1985	1985
11.	Davis Community Hospital	Statesville	149	G	O-HT	1925-37	1987
12.	Franklin Regional Medical Center [1]	Louisburg	53	G	O-HMA	1983	1986
13.	Frye Regional Medical Center	Hickory	275	G	O-AMI	1912	1972
14.	Heritage Hospital [2]	Tarboro	127	G	O-HT	1982	1987
15.	Ten Broeck Hospital [3]	Hickory	64	P	O-UMC	1935	1979
16.	Highland Hospital	Asheville	98	P	O-PIA	1904	1982
17.	Highsmith-Rainey Memorial Hospital	Fayetteville	150	G	O-HCA	1901-63	1983
18.	Holly Hill Hospital	Raleigh	106	P	O-HCA	1978	1984
19.	HSA Cumberland Hospital	Fayetteville	154	P	O-HSA	1976	1983
20.	Life Center of Wilmington	Wilmington	27	S	O-CAPS	1984	1984
21.	Lake Norman Regional Medical Center [4]	Mooresville	111	G	O-HMA	1983	1986
22.	McPherson Hospital	Durham	24	S	O-Ind	1926	1926
23.	Orthopaedic Hospital	Charlotte	120	S	O-HT	1971	1987
24.	Raleigh Community Hospital	Raleigh	140	G	O-HCA	1950	1977
B. Managed or Leased by Investor-Owned Corporations (23)							
25.	Angel Community Hospital	Franklin	81	G	M-HCA	1926-65	1983
26.	Ashe Memorial Hospital	Jefferson	48	G	M-HCA	1981	1981
27.	Bertie County Memorial Hospital	Windsor	49	G	M-FHI	1985	1987
28.	The Brunswick Hospital	Supply	60	G	L-HT	1981	1987
29.	Burnsville Hospital [5]	Burnsville	24	G	M-HCA	1982	1982
30.	Chatham Hospital	Siler City	68	G	M-HMP	1987	1987
31.	Craven Regional Medical Center [6]	New Bern	24	G	M-HHM	1987	1987
32.	District Memorial Hospital [7]	Andrews	50	G	M-HCA	1987	1987
33.	Duplin General Hospital [8]	Kenansville	20	G	M-PIA	1987	1987
34.	Gaston Memorial Hospital [9]	Gastonia	70	G	M-MHM	1987	1987
35.	Granville Medical Center	Oxford	66	G	M-HMP	1988	1988
36.	Hamlet Hospital	Hamlet	64	G	L-HMA	1987	1987
37.	Hoots Memorial Hospital	Yadkinville	54	G	M-HCA	1986	1986

* See note at bottom of page 5.

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Table 1.1: Investor-Owned Involvement with Hospitals in North Carolina, 1988, *continued*

	Hospital Name	Location	Beds in Use	Hospital Type	Owned/ Leased/ Managed/ & Company	Date I-O Involvement Began	Date of Latest Changeover
38.	Hugh Chatham Memorial Hospital	Elkin	81	G	M-HMP	1985	1985
39.	Johnston Memorial Hospital	Smithfield	107	G	M-HCA	1983	1983
40.	Margaret R. Pardee Memorial Hospital[9]	Hendersonville	21	G	M-MHM	1987	1987
41.	The McDowell Hospital	Marion	65	G	M-Delta	1982	1982
42.	Medical Park Hospital	Winston-Salem	120	G	M-HCA	1971	1986
43.	Morehead Memorial Hospital	Eden	85	G	M-HMP	1984	1984
44.	Person County Hospital	Roxboro	54	G	M-HCA	1981	1981
45.	Rutherford Hospital	Rutherfordton	165	G	M-HMP	1983	1983
46.	Spruce Pine Community Hospital[5]	Spruce Pine	68	G	M-HCA	1982	1982
47.	Wilson Memorial Hospital[9]	Wilson	23	G	M-MHM	1987	1987

G - General hospital (primarily)	O - Owned
P - Psychiatric	M - Managed
S - Specialty	L - Leased

Full names for the 17 corporations listed above are as follows:

AMI .....American Medical International, Inc.
BAHC.....Best American Health Care
CAPS.....Comprehensive Addiction Programs
CMC.....Charter Medical Corporation
CPC .....Community Psychiatric Centers
Delta .....The Delta Group, Inc.
FHCS .....Futura Health Care Services
FHI .....Forum Health Investors
HCA .....Hospital Corporation of America
HHM .....Horizon Health Management Co.
HMA .....Health Management Associates, Inc.
HMP .....Hospital Management Professionals, Inc.
HSA .....Healthcare Services of America
HT .....HealthTrust, Inc. — The Hospital Company[10]
MHM .....Mental Health Management Co.
PIA .....Psychiatric Institutes of America[11]
UMC .....United Medical Corporation
Ind .....Independently owned, not affiliated with a chain

FOOTNOTES

[1] Formerly named Franklin Memorial Hospital.

[2] Heritage Hospital was built in 1985 as a replacement facility for Edgecombe General.

[3] Formerly named Hickory Memorial Hospital.

[4] Formerly named Lowrance Hospital.

[5] Spruce Pine Community Hospital and Burnsville Hospital are the only hospitals in the Blue Ridge Hospital System, which is managed under contract by Hospital Corporation of America.

[6] Craven Regional Medical Center, formerly Craven County Hospital, is county-owned; Horizon Health Management Co. manages 24 psychiatric beds of the hospital's 276 beds.

[7] Formerly named Mountain Park Medical Center.

[8] Duplin General Hospital has 60 beds and is county-owned; Psychiatric Institutes of America manages 20 psychiatric beds of that total.

[9] Gaston Memorial Hospital is a private, not-for-profit hospital, as is Margaret Pardee Memorial Hospital; Wilson Memorial Hospital is county-owned. Mental Health Management Co. manages 70 psychiatric beds of Gaston Memorial's 354 total beds, 21 psychiatric beds of Margaret Pardee Memorial's 149 total beds, and 23 psychiatric beds of Wilson Memorial's 281 total beds.

[10] HealthTrust was formed in September of 1987 by Hospital Corporation of America. HCA divested 104 of its 186 acute care hospitals in the United States.

[11] Psychiatric Institutes of America is a subsidiary of National Medical Enterprises, one of the largest national investor-owned hospital companies.

health of HealthTrust and of employee pensions which HCA used to fund the deal. (The sidebars on pages 27-31 explain this controversy.) Four North Carolina hospitals—The Brunswick Hospital in Supply, Davis Community Hospital in Statesville, Heritage Hospital in Tarboro, and Orthopaedic Hospital in Charlotte—are now owned by HealthTrust, while three hospitals—both Holly Hill and Raleigh Community in the capital city and Highsmith-Rainey Hospital in Fayetteville—remain with HCA.

One update to the HealthTrust story is in order. The company announced its plans to trade some bonds publicly in February 1988. This move, according to analysts of the investor-owned hospital industry, signals some financial success for the company and is the market's first chance to assess HealthTrust's value.[18] Although its future over the long haul remains uncertain, HealthTrust has paid, well ahead of schedule, $320 million of its $1.7 billion dollar debt as of August 31, 1988, according to Mark Kimbrough, investor relations manager for HCA.

- After a decade of skirmishes with local physicians and low occupancy rates, Humana, Inc. sold its Greensboro hospital to the city's largest hospital—the private, not-for-profit Moses H. Cone Memorial. Even before Humana opened its Greensboro facility in 1977, it had spent five turbulent years of court battles with state health planners and eventually settled for a scaled-down version of the proposed hospital. (Humana faced similar difficulties in an unsuccessful attempt to open a hospital in Cary.) And when the investor-owned corporation opened two MedFirst urgent care clinics in Greensboro, local doctors, facing this new competition, cried foul. Some resigned from Humana Hospital's board of trustees, and many refused to send patients there.

  Ironically, it was Greensboro physicians who had first urged Humana to open a hospital in the city as an alternative to the not-for-profit facilities in the area. Just before Humana, Inc. struck the deal with Moses Cone in 1988, several Greensboro doctors—worried about Cone possibly having too great a market share in the city—offered to buy the hospital from Humana.

  Moses Cone officials are making major changes in the hospital. Maternity care—the one major clinical service not previously offered at Humana Hospital—is exactly what Cone plans for its new sister facility.

—continued

Table 1.2: Changes in North Carolina's Investor-Owned Hospital Movement, 1986-1988

A. Hospitals *newly owned* by investor-owned corporations

1. **CPC Cedar Spring Hospital**, in the Mecklenburg County town of Pineville, is a new facility built by Charter Medical Corporation in 1985.
2. **Franklin Regional Medical Center** in Louisburg, previously named Franklin Memorial Hospital, was owned by the county and was managed by Health Management Associates (HMA). HMA purchased the hospital in 1986.
3. **Lake Norman Regional Medical Center**, formerly named Lowrance Hospital, was owned by Iredell County and managed by Hospital Corporation of America. Health Management Associates bought the hospital, located in Mooresville, in 1986 and renamed it the following year.

B. Hospitals *no longer owned* by investor-owned corporations

1. **Charlotte Eye, Ear and Throat Hospital** in Mecklenburg County, formerly owned by Humana, was purchased by Presbyterian Hospital in 1987. The hospital is now legally named Presbyterian Specialty Hospital.
2. **Humana Hospital Greensboro** in Guilford County was purchased in 1988 by Moses Cone Hospital, a private, not-for-profit facility in the same city.
3. **Medical Park Hospital**, previously an independent for-profit hospital, was purchased in December 1986 by Carolina Medicorp, a private holding company in Winston-Salem. Medical Park has been managed by Hospital Corporation of America since 1984. Carolina Medicorp was formed in 1984 and serves as the holding company owning the not-for-profit Forsyth Memorial Hospital, as well as for-profit subsidiaries.

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Table 1.2: Changes in North Carolina's Investor-Owned Hospital Movement, 1986-1988, *continued*

C. Not-for-profit hospitals *newly managed* by investor-owned corporations

1. **Chatham Hospital** in Siler City has been managed by Hospital Management Professionals since 1987.
2. **Craven Regional Medical Center** in New Bern has a psychiatric unit which has been managed by Horizon Health Management since 1987. The facility was named Craven County Hospital until 1988.
3. **Duplin General Hospital** in Kenansville has a psychiatric unit which has been managed by Psychiatric Institutes of America since 1987.
4. **Gaston Memorial Hospital** in Gastonia has a psychiatric unit which has been managed by Mental Health Management since 1987.
5. **Granville Medical Center** signed a management contract with Hospital Management Professionals in April 1988.
6. **Hoots Memorial Hospital** in Yadkinville has been managed by Hospital Corporation of America since 1986.
7. **Margaret Pardee Memorial Hospital** in Hendersonville has a psychiatric unit which has been managed by Mental Health Management since 1987.
8. **District Memorial Hospital** in the Cherokee County town of Andrews has been managed by Hospital Corporation of America since 1987. In October of that year, its name changed from Mountain Park Medical Center.
9. **Wilson Memorial Hospital** in Wilson has a psychiatric unit which has been managed by Mental Health Management since 1987.

D. Not-for-profit hospitals *no longer managed* by investor-owned corporations

1. **Cape Fear Valley Medical Center** in Fayetteville ended its management contract with National Medical Enterprises in 1985. It is now managed by SunHealth Enterprises, a for-profit subsidiary of The Sun Alliance, a partnership of not-for-profit hospitals.
2. **Franklin Regional Medical Center** in Louisburg ended its management contract with Hospital Corporation of America in 1986. See A2 above.
3. **Lake Norman Regional Medical Center** ended its management contract with Hospital Corporation of America in 1986. See A3 above.

E. Not-for-profit hospitals *newly leased* by investor-owned corporations

1. **The Brunswick Hospital** in Supply is now leased from Brunswick County by Hospital Corporation of North Carolina, a wholly-owned holding subsidiary of HealthTrust. Hospital Corporation of America leased the hospital from 1981 until it created HealthTrust in 1987.
2. **Hamlet Hospital** in Richmond County has been leased by Health Management Associates since 1987.

F. Not-for-profit hospitals *no longer leased* by investor-owned corporations

1. **Bertie County Memorial Hospital** in Windsor was leased by Westworld Community Healthcare Inc. from February 1986 until the investor-owned chain went bankrupt in July 1987. The hospital then reverted to the county and is now managed by Forum Health Investors, as it was prior to the lease with Westworld.

One final note is needed to update the list of investor-owned facilities published on page x in the North Carolina Center's 1986 report on *The Investor-Owned Hospital Movement in North Carolina*. The Life Centers of Fayetteville and Jacksonville are now considered part of the HSA hospitals in those cities — HSA Cumberland Hospital and Brynn Marr Neuropsychiatric Hospital, respectively.

Table 1.3: Not-For-Profit Hospitals in North Carolina with Psychiatric Units Managed by Investor-Owned Corporations, 1988

Hospital	Total beds in use	Psychiatric beds in use	Investor-owned corporation
1. Craven Regional Medical Center	276	24	HHM
2. Duplin General Hospital	60	20	PIA
3. Gaston Memorial Hospital	354	70	MHM
4. Margaret Pardee Memorial Hospital	149	21	MHM
5. Wilson Memorial Hospital	281	23	MHM

Full names for the corporations above are as follows:

HHM .... Horizon Health Management Co.
MHM ... Mental Health Management Co.
PIA ..... Psychiatric Institutes of America, a subsidiary of National Medical Enterprises.

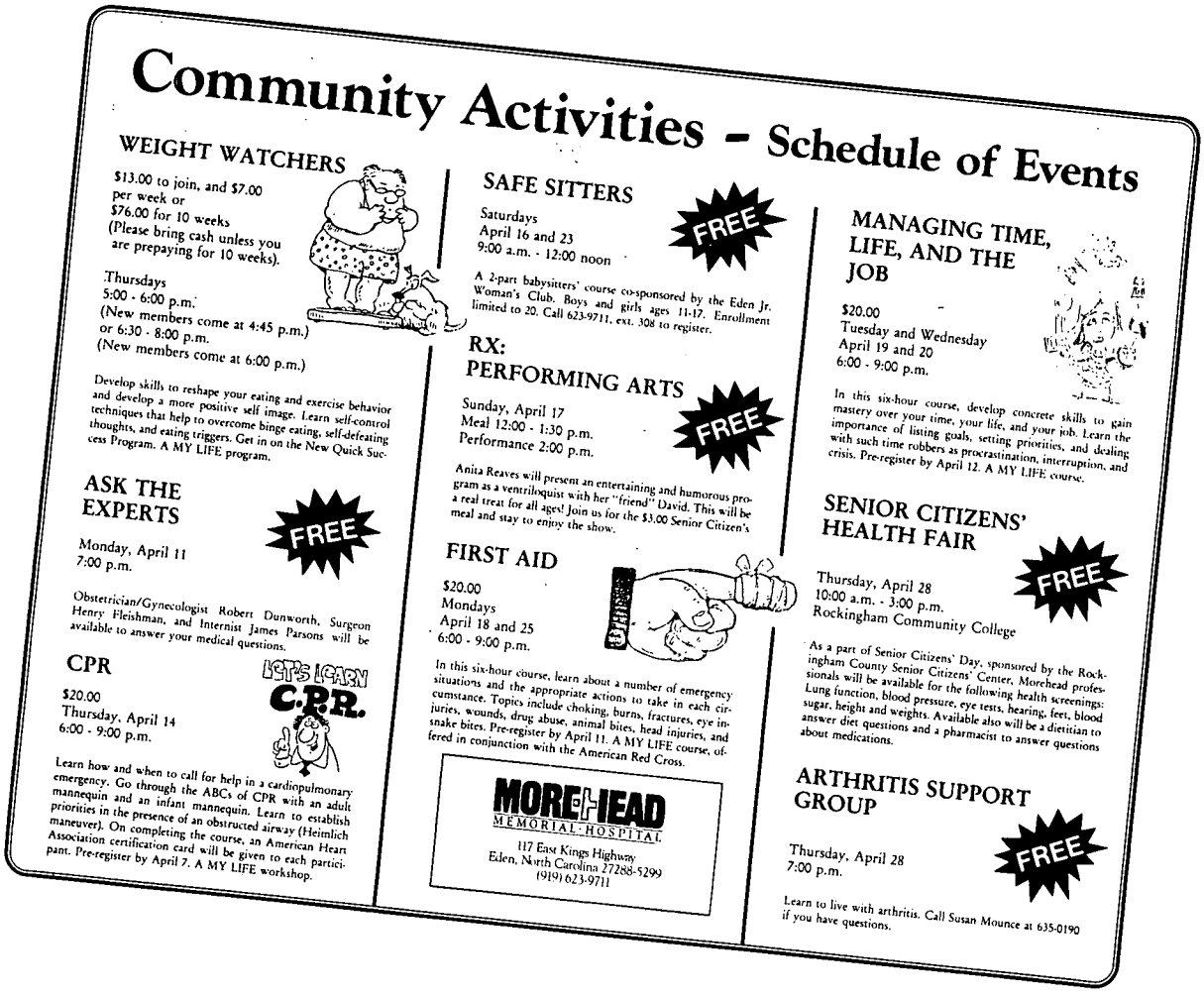
Although it is too early to predict how much of the Greensboro market the planned 115-bed women's hospital will capture, Moses Cone Memorial Hospital already holds a major share of the hospital business in Guilford County. (In 1986, more than 40 percent of Guilford County residents who sought hospital care went to Moses Cone.[19]) This move by Moses Cone administrators to transform their second hospital into a women's health center not only illustrates the trend towards specialty facilities extending to the not-for-profit sector but also underscores the increasing business savvy of not-for-profit hospitals.

Not-For-Profit Hospitals—Getting Down to Business

NOT-FOR-PROFIT HOSPITALS are getting down to business in North Carolina and across the nation. A seasoned hospital administrator in both investor-owned and not-for-profit facilities and currently executive director of Medical Park Hospital in Winston-Salem, Earl H. Tyndall Jr. says, "Those administrators who do not run their hospitals like businesses will find that they have no hospitals to run. It is not possible to run a hospital today as it was 20 years ago." Changes in the way not-for-profit hospitals operate testify to their growing entrepreneurial bent, as well as to some differences in business strategy between not-for-profit and investor-owned hospitals.

1. Not-for-profit hospitals are succeeding with limited diversification.

Some not-for-profit facilities, out of the glare of shareholder scrutiny and *Wall Street Journal* publicity, are absorbing preliminary losses on new ventures and are coping successfully with federal Medicare reimbursement limits and other prospective payment systems, says health care industry analyst Donald E. L. Johnson. (For more about how hospitals fare under Medicare, see the sidebar on pages 10-11.) Because of their traditionally "cautious boards and conservative medical staffs," as well as "insufficient access to capital," not-for-profit hospitals took considerably smaller steps to diversify their holdings than did the investor-owned chains, says Johnson.[20] And while a recent survey for *Hospitals* magazine showed that most hospitals have usually made money or at least broken even on nearly all diversification efforts from outpatient surgery to retirement communities, not-for-profit hospitals may have to scale back their diversification plans if ambulatory services become



Community Activities - Schedule of Events

WEIGHT WATCHERS

$13.00 to join, and $7.00 per week or
$76.00 for 10 weeks
(Please bring cash unless you are prepaying for 10 weeks).

Thursdays
5:00 - 6:00 p.m.
(New members come at 4:45 p.m.)
or 6:30 - 8:00 p.m.
(New members come at 6:00 p.m.)

Develop skills to reshape your eating and exercise behavior and develop a more positive self image. Learn self-control techniques that help to overcome binge eating, self-defeating thoughts, and eating triggers. Get in on the New Quick Success Program. A MY LIFE program.

ASK THE EXPERTS

FREE

Monday, April 11
7:00 p.m.

Obstetrician/Gynecologist Robert Dunworth, Surgeon Henry Fleishman, and Internist James Parsons will be available to answer your medical questions.

CPR

LET'S LEARN C.P.R.

$20.00
Thursday, April 14
6:00 - 9:00 p.m.

Learn how and when to call for help in a cardiopulmonary emergency. Go through the ABCs of CPR with an adult mannequin and an infant mannequin. Learn to establish priorities in the presence of an obstructed airway (Heimlich maneuver). On completing the course, an American Heart Association certification card will be given to each participant. Pre-register by April 7. A MY LIFE workshop.

SAFE SITTERS

FREE

Saturdays
April 16 and 23
9:00 a.m. - 12:00 noon

A 2-part babysitters' course co-sponsored by the Eden Jr. Woman's Club. Boys and girls ages 11-17. Enrollment limited to 20. Call 623-9711, ext. 308 to register.

RX: PERFORMING ARTS

FREE

Sunday, April 17
Meal 12:00 - 1:30 p.m.
Performance 2:00 p.m.

Anita Reaves will present an entertaining and humorous program as a ventriloquist with her "friend" David. This will be a real treat for all ages! Join us for the $3.00 Senior Citizen's meal and stay to enjoy the show.

FIRST AID

$20.00
Mondays
April 18 and 25
6:00 - 9:00 p.m.

In this six-hour course, learn about a number of emergency situations and the appropriate actions to take in each circumstance. Topics include choking, burns, fractures, eye injuries, wounds, drug abuse, animal bites, head injuries, and snake bites. Pre-register by April 11. A MY LIFE course, offered in conjunction with the American Red Cross.

MOREHEAD MEMORIAL HOSPITAL
117 East Kings Highway
Eden, North Carolina 27288-5299
(919) 623-9711

MANAGING TIME, LIFE, AND THE JOB

$20.00
Tuesday and Wednesday
April 19 and 20
6:00 - 9:00 p.m.

In this six-hour course, develop concrete skills to gain mastery over your time, your life, and your job. Learn the importance of listing goals, setting priorities, and dealing with such time robbers as procrastination, interruption, and crisis. Pre-register by April 12. A MY LIFE course.

SENIOR CITIZENS' HEALTH FAIR

FREE

Thursday, April 28
10:00 a.m. - 3:00 p.m.
Rockingham Community College

As a part of Senior Citizens' Day, sponsored by the Rockingham County Senior Citizens' Center, Morehead professionals will be available for the following health screenings: Lung function, blood pressure, eye tests, hearing, feet, blood sugar, height and weights. Available also will be a dietitian to answer diet questions and a pharmacist to answer questions about medications.

ARTHRITIS SUPPORT GROUP

FREE

Thursday, April 28
7:00 p.m.

Learn to live with arthritis. Call Susan Mounce at 635-0190 if you have questions.

Courtesy Morehead Memorial Hospital

"overbuilt," says Diane Howard, director of the American Hospital Association's Division for Ambulatory Care, Women's and Children's Health.[21]

2. Not-for-profit hospitals are buying investor-owned hospitals.

In North Carolina alone, three investor-owned hospitals have been sold to not-for-profit firms since late 1986. Since Presbyterian Health Services, owner of Presbyterian Hospital, bought Charlotte Eye, Ear and Throat Hospital from Humana in 1987 and Moses Cone Memorial purchased Humana Hospital Greensboro in 1988, Humana no longer has any holdings in the state. Carolina Medicorp, a holding company which owns the not-for-profit Forsyth Memorial Hospital, purchased Medical Park Hospital, once an independent, for-profit facility, in December 1986. One analyst sees the trend as a "complete role reversal" for investor-owned and not-for-profit hospitals. Lawrence Gerber, an attorney with a Chicago law firm which often handles hospital purchases, says, "Proprietary systems tried to build an empire on the financial desperation of not-for-profits. Now, not-for-profits are trying to capitalize on the financial desperation of the proprietaries."[22]

3. Not-for-profit hospitals are joining alliances.

While investor-owned hospital chains have purchased independent proprietary hospitals in North Carolina, many of the state's not-for-profit hospitals have been seeking safety in numbers from strict government reimbursement policies and adverse market forces. Many have joined alliances, as have not-for-profit hospitals nationwide. Participation in these multi-institutional arrangements is voluntary, and member hospitals—often concentrated in one region of the country—generally own shares in a central corporation. Recently, small hospitals which could not afford full membership on their own have begun to affiliate with alliances through a complex mix of organizational plans.

These alliances are actually partnerships of not-for-profit hospitals, but they generally oversee a tangled web of for-profit subsidiaries and holding companies. These subsidiaries, collectively called a health system, are owned by the partnership of not-for-profit hospitals but may undertake joint and independent for-profit ventures, such as hospital management, health insurance, and laundry services.

The nation's largest hospital alliance and health system, Voluntary Hospitals of America (VHA), is

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Table 1.4: Investor-Owned Hospital Companies Active in North Carolina (17), 1988 *

Name of Hospital Company and Hospitals in North Carolina Affiliated with the Company	Hospital Location	General (G), Psychiatric (P), or Specialty (S) Hospital	Company Owns (O), Leases (L), or Manages (M) hospital or Manages the Psychiatric Unit (MPU) only
American Medical International (2)			
1. Central Carolina Hospital	Sanford	G	O
2. Frye Regional Medical Center	Hickory	G	O
Best American Health Care (1)			
3. Community Hospital of Rocky Mount	Rocky Mount	G	O
Comprehensive Addiction Programs (1)			
4. Life Center of Wilmington	Wilmington	S	O
Charter Medical Corporation (4)			
5. Charter Hills Hospital	Greensboro	P	O
6. Charter Mandala Center	Winston-Salem	P	O
7. Charter Northridge Hospital	Raleigh	P	O
8. Charter Pines Hospital	Charlotte	P	O
Community Psychiatric Centers (1)			
9. CPC Cedar Spring Hospital	Pineville	P	O
The Delta Group, Inc. (1)			
10. The McDowell Hospital	Marion	G	M
Futura Health Care Services (1)			
11. Blackwelder Memorial Hospital	Lenoir	G	O
Forum Health Investors (1)			
12. Bertie County Memorial Hospital	Windsor	G	M
Hospital Corporation of America (12)			
13. Angel Community Hospital	Franklin	G	M
14. Ashe Memorial Hospital	Jefferson	G	M
15. Burnsville Hospital	Burnsville	G	M
16. District Memorial Hospital	Andrews	G	M
17. Highsmith-Rainey Memorial Hospital	Fayetteville	G	O
18. Holly Hill Hospital	Raleigh	P	O
19. Hoots Memorial Hospital	Yadkinville	G	M
20. Johnston Memorial Hospital	Smithfield	G	M
21. Medical Park Hospital	Winston-Salem	G	M
22. Person County Hospital	Roxboro	G	M
23. Raleigh Community Hospital	Raleigh	G	O
24. Spruce Pine Community Hospital	Spruce Pine	G	M

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Table 1.4: Investor-Owned Hospital Companies Active in North Carolina (17), 1988, * *continued*

Name of Hospital Company and Hospitals in North Carolina Affiliated with the Company	Hospital Location	General (G), Psychiatric (P), or Specialty (S) Hospital	Company Owns (O), Leases (L), or Manages (M) hospital or Manages the Psychiatric Unit (MPU) only
Horizon Health Management Co. (1)			
25. Craven Regional Medical Center	New Bern	G	MPU only
Health Management Associates, Inc. (3)			
26. Franklin Regional Medical Center	Louisburg	G	O
27. Hamlet Hospital	Hamlet	G	L
28. Lake Norman Regional Medical Center	Mooresville	G	O
Hospital Management Professionals, Inc. (5)			
29. Chatham Hospital	Siler City	G	M
30. Granville Medical Center	Oxford	G	M
31. Hugh Chatham Memorial Hospital	Elkin	G	M
32. Morehead Memorial Hospital	Eden	G	M
33. Rutherford Hospital	Rutherfordton	G	M
Healthcare Services of America (2)			
34. Brynn Marrr Neuropsychiatric Hospital	Jacksonville	P	O
35. HSA Cumberland Hospital	Fayetteville	P	O
*HealthTrust, Inc.—The Hospital Company (4)***			
36. The Brunswick Hospital	Supply	G	L
37. Davis Community Hospital	Statesville	G	O
38. Heritage Hospital	Tarboro	G	O
39. Orthopaedic Hospital	Charlotte	S	O
Mental Health Management Co. (3)			
40. Gaston Memorial Hospital	Gastonia	G	MPU only
41. Margaret R. Pardee Memorial Hospital	Hendersonville	G	MPU only
42. Wilson Memorial Hospital	Wilson	G	MPU only
Psychiatric Institutes of America (3)			
43. Appalachian Hall	Asheville	P	O
44. Duplin General Hospital	Kenansville	G	MPU only
45. Highland Hospital	Asheville	P	O
United Medical Corporation (1)			
46. Ten Broeck Hospital	Hickory	P	O

* McPherson Hospital in Durham is North Carolina's only *independently owned* for-profit hospital; it is not included in this table.

** Hospital Corporation of America formed HealthTrust in September 1987 and sold the new company 104 acute-care hospitals. For more information about HealthTrust, see page 13 and the sidebars on pages 27-31.

Table 1.5: Investor-Owned Companies Entering and Leaving North Carolina, 1986-1988

Corporation	N.C. Hospitals Owned	N.C. Hospitals Leased	N.C. Hospitals Managed
A. Investor-owned corporations *new* to North Carolina			
1. Best American Health Care	1	0	0
2. Comprehensive Addiction Programs	1	0	0
3. Community Psychiatric Centers	1	0	0
4. Futura Health Care Services	1	0	0
5. Forum Health Investors	0	0	1
6. Horizon Health Management Co.	0	0	1
7. Health Management Associates	2	1	0
8. HealthTrust, Inc.	3	1	0
9. Mental Health Management Co.	0	0	3
B. Investor-owned corporations *no longer* in North Carolina			
1. Health Care Management Corp.*	1	0	0
2. Humana, Inc.**	2	0	0
3. National Medical Enterprises, Inc.***	0	0	1

* Health Care Management Corp. owned Blackwelder Memorial Hospital in Lenoir from 1985 until 1987, when Futura Health Care Services purchased it.

** Humana owned Charlotte Eye, Ear and Throat Hospital from 1981 until 1987 as well as Humana Hospital Greensboro from 1977 until 1988. Presbyterian Health Services Inc., owner of the private, not-for-profit Presbyterian Hospital, purchased Charlotte Eye, Ear and Throat Hospital. Another private not-for-profit hospital, Moses Cone Memorial, bought Humana Hospital Greensboro. Since Humana, Inc. sold those two hospitals, it is no longer active in North Carolina.

*** National Medical Enterprises managed Cape Fear Valley Medical Center from 1982 until 1985. The hospital is now managed by SunHealth Enterprises of Charlotte, a for-profit subsidiary of The Sun Alliance, a partnership of not-for-profit hospitals. Although NME does not directly own, lease or manage any hospitals in the state, its subsidiary, Psychiatric Institutes of America, owns two psychiatric hospitals in the state—Appalachian Hall and Highland Hospital, both in Asheville. PIA also manages the psychiatric unit at Duplin General Hospital, a county-owned hospital in Kenansville. Another NME subsidiary, The Hillhaven Corporation, owns or manages several North Carolina nursing homes.

active in North Carolina. Through its shareholders and regional health care systems, VHA is affiliated in some fashion with 10 North Carolina hospitals, as well as with several nursing homes and an ambulatory surgery center. VHA shareholders include Carolina Medicorp Inc. (the private holding company in Forsyth County which owns Forsyth Memorial and Medical Park Hospitals) and Charlotte Memorial Hospital and Medical Center, Inc. (owned by the Charlotte-Mecklenburg Hospital Authority, a public entity which also owns Charlotte Rehabilitation Hospital and University Memorial Hospital).

SunHealth Corporation is based in Charlotte and is the holding company for a partnership of not-for-profit hospitals known as the Sun Alliance. SunHealth's holdings make it the third largest health system and alliance in the United States,[23] but its market share in North Carolina is more than twice the size of VHA's. While VHA has affiliated with the state's two major public medical centers in Mecklenburg and Wake counties, those two hospitals' primary competitors—the private, not-for-profit Presbyterian Hospital in Charlotte and Rex Hospital in Raleigh—are SunHealth shareholders or "partners"

in the Sun Alliance. The Sun Alliance has 26 partner hospitals in North Carolina. SunHealth Enterprises, Inc., a for-profit subsidiary of SunHealth Corporation, manages two outpatient clinics and nine hospitals in the state. Hospitals managed under contract with SunHealth Enterprises include Alamance County Hospital and Alamance Memorial Hospital, both in Burlington, as well as Chowan Hospital in Edenton. All hospitals affiliated with SunHealth, whether partners or managed facilities, are members of the SunHealth Network.

Like most recent developments in the American health care system, alliances have generated controversy. Hospital administrators are taking a closer look at the costs and benefits of alliances before they join.[24] Some observers criticize alliances for quietly generating profits for not-for-profit hospitals. Officials like VHA's former president Don Arwine contend, however, that alliances "bring entrepreneurship to the not-for-profit sector. . . to perpetuate and enhance that sector."[25] Alliances, these executives maintain, help to preserve those not-for-profit hospitals which value their voluntary mission.

4. Public hospitals are reorganizing as private, not-for-profit hospitals.

In North Carolina, some counties are getting out of the hospital business. Since 1983, when the General Assembly first passed a law permitting counties to convert their public hospitals to private, not-for-profit facilities, five county boards of commissioners—Alamance, Forsyth, Gaston, Wayne, and Wilson—have decided to do just that.[26] Once a hospital's assets are transferred to a private, not-for-profit holding company, the hospital can establish both for-profit and not-for-profit subsidiaries, like joint ownership of a medical office building with a group of local physicians. For instance, Carolina Medicorp in Forsyth County has launched Foundation Healthsystems Inc., which has opened a medical mall with doctors' offices, a pharmacy, and centers for outpatient surgery, X-rays, and other high-tech medical services. Salem Health Services, also part of Carolina Medicorp, runs a for-profit laundry service. And the holding company has won state approval to build a nursing home.

Again, the introduction of profit-seeking ventures into traditionally not-for-profit hospitals has aroused controversy. The North Carolina statute does require the newly-created private, not-for-profit hospital to continue to serve as a nondiscriminatory "community general hospital" and to provide indigent care if the county so requires. It also permits county commissioners to retain control of the hospital's board of trustees.[27] But some of the state's newspapers have voiced concern that the hospital trustees will not open their meetings to public scrutiny, even though the boards make decisions for the community hospital. *The News and Observer* of Raleigh worried in an editorial that "over time in counties that approve conversions, the public may notice its hospital increasingly run on the basis of financial considerations and more aloof from the community."[28]

Hospital corporation officials, however, contend that financial problems besetting public hospitals make the change a must. Although all the hospitals which changed to a private, not-for-profit status were financially stable at the time, David C. Knesel, spokesman for Carolina Medicorp Inc., maintains that Forsyth Memorial faced a dilemma common to public hospitals:

> It was that [a 19 percent property tax increase for Forsyth County] or go broke. We needed millions of dollars and did not want to seek a tax increase. Reorganization allows us to compete in many areas to make the money we need while responding to what the community wants.[29]

5. Public hospitals are seeking a chance to start profit-making ventures.

Public hospitals also are seeking authority to undertake business ventures for profit *without* reorganizing as private, not-for-profit corporations. Public hospital administrators want to enter joint ventures with physicians to develop medical office buildings and to undertake other profit-making enterprises which do not directly provide medical services. These administrators and their attorneys, along with the N.C. Hospital Association, have urged a state legislative study commission to support an amendment to North Carolina's Constitution, which, they assert, is the only feasible way to put public hospitals on what they term a "level playing field" with competing hospitals.

North Carolina's Constitution currently states that the "power of taxation shall be exercised in a just and equitable manner, *for public purposes only*, and shall never be surrendered, suspended, or contracted away" [emphasis added].[30] The state Supreme Court takes a broad view of this public purpose doctrine, and "it would surely apply to revenues at a county hospital," says J. Phil Carlton, formerly a state Supreme Court justice and now an attorney for one of the state's largest public hospitals—Wake Medical Center in Raleigh. Just what activities public hospitals are barred from undertaking remain uncertain, says Carlton, for "it would take the wisdom of Solomon for anyone to predict whether a court would deem a new hospital endeavor as being for a public purpose."[31] Public hospital administrators express frustration that they cannot undertake joint profitable ventures with

physicians without treading on legal thin ice. Such uncertainties place public hospitals—especially those in rural areas—at a significant disadvantage in attracting physicians and their patients, the administrators say.

While legislators on the Study Commission on Survival of Public Hospitals acknowledge that public hospitals are facing financial hard times, they say that the proposed constitutional amendment flies in the face of political reality. In North Carolina, constitutional amendments must pass each chamber of the General Assembly by a three-fifths majority and must be approved in a statewide referendum. This particular "overkill provision" on "an esoteric point of law" stands little chance of success, says former Sen. Charles Hipps of Haywood County. Hipps recognizes that "public hospitals have one hand tied behind them" when they try to compete with investor-owned and private not-for-profit hospitals, which can launch for-profit subsidiaries. But he and other legislators on the study commission doubt that the proposed amendment can solve what Hipps calls rural public hospitals' "demographic dilemma"—the fact that people in rural areas are bypassing their local public hospital for high-tech medical centers in the city. Legislators say they are searching for some sort of statute to aid the smaller public hospitals in rural communities. These hospitals may have less to gain from the proposed amendment allowing for-profit ventures than the large county medical centers, and they may eventually have to specialize in skilled nursing care or basic emergency service to survive, Hipps notes.

6. County systems of public hospitals are competing for paying patients with private not-for-profit and investor-owned hospitals by opening facilities in affluent suburbs.

Public hospitals often bear a disproportionate burden of Medicare and Medicaid patients. In an attempt to fill hospital beds and attract paying patients, two North Carolina counties are putting their hospitals where their people are.

After converting Huntersville Hospital to a nursing home, the Charlotte-Mecklenburg Hospital Authority opened its new hospital, University Memorial, in the booming area near the University of North Carolina at Charlotte. The hospital lost more than $5

million between early September of 1985 and late October 1986, and by the start of 1987, the hospital's patient count remained under a third of capacity.[32]

University Memorial's struggles have not dissuaded Wake County Hospital System administrators from planning to close Western Wake hospital in Apex to make room for a new hospital scheduled to open in 1992 in the sprawling suburb of Cary.

An Overview of Other Trends Affecting Hospitals

OBVIOUSLY, THE INTRODUCTION of prospective payment systems and pre-admission reviews have changed the health care system across North Carolina and the nation, as has the investor-owned hospital movement itself. Other trends, intertwined with those significant changes, also challenge hospitals today.

1. During the 1980s, occupancy rates have fallen for all hospitals, but they have fallen to precariously low levels at small hospitals — which, in North Carolina, are usually rural facilities with a high percentage of Medicare and Medicaid patients. The decline in occupancy rates began in 1981, as insurance companies and other groups of health care professionals stepped up their screening of hospital admissions. The advent of Medicare's prospective payment system in October of 1983 accounts for the sharp drop between 1983 and 1984. Today, North Carolina hospitals with fewer than 100 beds are struggling to fill even half of their rooms. (Table 1.6 illustrates the decline in occupancy rates at North Carolina hospitals.)

According to James Bernstein, advisor to rural hospitals and section chief of Health Resources Development in the N.C. Department of Human Resources, North Carolina hospitals with fewer than 50 beds "are at the highest risk and are going to have a difficult time operating solely as inpatient institutions. Many will enter a period of transition from inpatient care to multi-service centers, including skilled nursing and outpatient services," he predicts. Faced with competition from large urban medical centers, small hospitals—those with fewer than 100 beds—are trying to develop quality services which respond to their communities' needs. In turn, people

Table 1.6: Declining Occupancy Rates in North Carolina's General Acute Care Hospitals, 1981-1986

	Occupancy Rate (%) By Year					
Hospital Size	**1981**	**1982**	**1983**	**1984**	**1985**	**1986**
6-24 beds	58.3%	57.1%	53.6%	38.0%	33.3%	26.8%
25-49	55.8	54.7	52.9	45.3	43.5	35.9
50-99	67.3	64.7	61.4	52.9	50.8	50.3
100-199	73.1	72.1	68.4	60.8	55.1	57.1
200-299	80.6	79.2	76.5	71.0	66.2	64.6
300-399	81.1	80.4	79.8	69.4	66.7	70.2
400-499	84.7	82.0	76.6	75.7	69.8	75.5
500 or more	86.2	84.9	83.5	81.8	79.7	80.4
All sizes	78.5%	77.0%	74.4%	68.9%	64.8%	65.0%

Source: Data for North Carolina from *Hospital Statistics, 1987 Edition.* Chicago: American Hospital Association, 1987.

in rural communities will have to use those services if the local hospitals are to survive.

Some observers of health care in North Carolina, such as Glenn Wilson, chairman of the department of social and administrative medicine at the University of North Carolina—Chapel Hill School of Medicine, believe that major medical centers and large hospitals should reach out to people who need care in the state's small towns and farmlands. Hospitals such as Duke University Medical Center and Charlotte Memorial have little trouble filling rooms. "I think the worst thing we can do is let the smaller hospitals swing in the wind, which is what we are doing," he told a legislative study commission on public hospitals.[33] Small, struggling hospitals, he said, may need to close or provide only minimal care on an outpatient basis.

2. Once patients are admitted to the hospital, they are being discharged sooner than in previous years. Unlike the decline in occupancy rates, which began before Medicare's introduction of DRGs in late 1983, the major decline in the length of patients' hospital stays came in 1984, in the first year of the prospective payment system. (Table 1.7 shows the length of patient stays in the state's hospitals from 1981-1986.) Although patients' average length of stay rose slightly in 1986 in North Carolina, this change reflects the fact that only the sickest patients are now admitted to hospitals in the first place.

Again, pre-admission reviews and prospective payment systems account for this trend. The sooner a patient leaves the hospital, the less the patient costs the hospital. Most private insurers reimburse hospitals for only a percentage of hospitals' charges to patients. And because Medicare reimburses hospitals at a fixed rate based on the diagnosis, hospitals, in effect, have a limit on the length of time a patient can stay before the hospital begins to lose money—unless the patient can pay the balance, which is not always the case. Although some observers of the American health care scene worry that patients are leaving the hospital "quicker and sicker" under the system with such incentives, physicians usually hesitate to dis-

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Table 1.7: Length of Stay in North Carolina's General Acute Care Hospitals (Average Stay in Days), 1981-1986

	Days Per Year					
Hospital Size	**1981**	**1982**	**1983**	**1984**	**1985**	**1986**
6-24 beds	7.4	7.8	7.8	6.6	4.7	4.9
25-49	6.4	6.4	6.0	5.5	6.1	5.6
50-99	7.2	7.3	7.1	6.5	6.8	6.6
100-199	6.9	6.8	6.8	6.4	6.2	6.6
200-299	7.5	7.5	7.5	6.8	6.8	6.8
300-399	7.9	8.2	8.3	6.8	6.5	6.6
400-499	7.3	7.3	7.1	6.9	6.8	7.0
500 or more	8.5	8.4	8.5	8.1	7.8	7.6
All sizes	7.5	7.5	7.5	7.0	6.8	6.9

Source: Data for North Carolina from *Hospital Statistics, 1987 Edition.* Chicago: American Hospital Association, 1987.

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PENSIONS USED IN HOSPITAL PURCHASES

by Donna Alvarado

TARBORO—A. Thomas Outlaw was surprised to learn last summer that he had been made part owner of a $2.1 billion hospital empire.

Nobody had asked him whether he wanted it. He hadn't paid a penny for it. He scarcely could have afforded it with the modest wages he has earned for the last 18 years as a nurse anesthetist at Heritage Hospital in Tarboro.

But he came to understand that he was one of about 23,000 hospital employees nationwide, and hundreds in North Carolina, who had bought their community hospitals from their employer, Hospital Corp. of America.

HCA had made them members of an employee stock ownership plan in a new company formed to buy 104 of HCA's worst-performing hospitals, including Heritage Hospital, The Brunswick Hospital in Supply, Davis Community Hospital in Statesville and Orthopaedic Hospital in Charlotte.

HCA used its employees' pension fund as collateral to borrow $1.6 billion through a company it set up, HealthTrust. HealthTrust then bought the 104 hospitals from HCA, using the $1.6 billion. The sale was completed Sept. 17.

Some analysts of the for-profit hospital industry are calling the transaction a "brilliant strategic stroke" and a model for other hospitals. They say the company offers hope to hospital chains searching for ways to wring profits from hospitals gone flat financially.

Critics have a different view.

"The model is that the slimy owners have kept the profitable hospitals for themselves and gotten rid of the losers," said Robert J. Brand of the National Union of Hospital and Health Care Employees in Philadelphia.

Brand called the HealthTrust employee stock ownership plan "absolutely unethical" and said the message to employees was: "We have a gun to your head. You can risk your pension and wages to save your jobs."

Critics say that by mortgaging the workers' retirement benefits, HCA has put them in jeopardy.

"I think it's an outrage," said I. Glenn Wilson, chairman of social and administrative medicine at the University of North Carolina at Chapel Hill. "These employees are going to wake up one day and find their pension fund is gone."

HealthTrust officials acknowledge that there are risks for the workers but say they have a stake in improving their hospitals.

"No company can sit there and guarantee wages, pensions and jobs to anyone," said C. Richard Gaston, former HCA executive and a vice president of HealthTrust. "It's up to these employees to make sure that this enterprise is well-received by their community. Their efforts are directly proportional to whether they keep their jobs."

Past contributions to the pension fund are probably secure. They are no longer used as collateral, and they are covered by federal pension insurance.

But employees of the new company will have money added to their pensions only if the HealthTrust makes money. If it doesn't, employees won't get any pension for the years they work with HealthTrust.

"From HCA's point of view, this makes excellent sense," said Joseph R. Blasi, a business professor at

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California Polytechnic State University at San Luis Obispo. Blasi wrote "Employee Ownership: Revolution or Rip-Off?"

"They have taken a part of the company that they could not have sold easily, and they have sold it at a good price," he said. "It could turn out to be the pioneering case in the health-care industry. If HealthTrust can use the commitment of employees to cut costs, it could become a model for the industry."

But he said that employees, rather than playing a substantial part in improving their hospitals, had become pawns in a convenient financial shuffle.

"It just pains me to think that so much potential could be lost because all they're doing is a financial restructuring," Blasi said.

Outlaw, 40, the Heritage Hospital worker, said he didn't understand how his retirement plan would work under HealthTrust but was willing to give the new company a try.

"We're still receiving our paychecks," he said. But he added, "We feel like the community hospitals are in big trouble all over the country. It bothers us to think we might not have a retirement. This is our home. We've raised our children here."

Outlaw said he understood even less about HealthTrust's employee stock ownership plan.

"I'm real fuzzy about how it's employee-owned," he said. What he suspects it means, he said, is that "we'll make it run or we'll have to go somewhere else to work."

The HealthTrust hospitals had occupancy rates 23 percentage points lower than the national average for U.S. hospitals in 1987, and they face futures ranging from uncertain to grim.

Even more revealing is a profile of the HealthTrust hospitals' financial decline in the past few years, while they were owned by HCA. Their net income fell 35.8 percent in 1984-1985; 83.5 percent in 1985-86, and 67.8 percent in 1986-87.

HCA kept 82 other hospitals, many of them larger hospitals in urban areas, that have occupancy rates an average 15 percentage points higher than their HealthTrust counterparts and 8 percentage points lower than the national average. Raleigh Community Hospital and Highsmith-Rainey Hospital in Fayetteville are two such institutions.

Gaston, the HealthTrust vice president, defended the transaction as fair to the rural hospitals. HealthTrust will be better able to concentrate on turning the hospitals' rural character into an asset, he said.

He dismissed criticism that the sale of the rural hospitals had shifted a financial burden from HCA onto 23,000 hospital employees.

"The financial destiny of all of us in the company is in their own hands," Gaston said. "To me, it's like saying these people aren't smart enough to hold their destiny in their own hands."

But Gaston acknowledged that HealthTrust hospitals faced big challenges.

"There's no doubt about it, they are somewhat risky because health care is in a downslide," he said.

Rural hospitals throughout the nation have been fighting for financial survival for several years. Like all hospitals, they are tightening their belts to adjust to lower occupancy rates brought on by pressure to reduce the cost of medical care. But rural hospitals also have been fighting a second battle: loss of patients to urban competitors.

"On the surface of things, I don't know how they could make it profitable," said James D. Bernstein, adviser to rural hospitals and head of the N.C. Office of Health Resources Development, when asked about the prospects for HealthTrust.

Heritage Hospital, where Outlaw works, is perhaps in better shape than most of HealthTrust's hospitals. Built in 1985 at a cost of $18 million, the hospital boasts a staff of doctors providing a full range of medical care plus some frills, such as labor rooms decorated with flowered wallpaper, ruffled curtains and matching bedspreads.

Heritage also has a steady stream of patients coming from a loyal community in Tarboro, the seat of Edgecombe County. Its 1987 occupancy rate was just shy of 50 percent, well above the average 40.3 percent for HealthTrust hospitals.

But Heritage also has a heavy construction debt and a lot of unpaid medical bills from poor patients.

James E. Raynor, administrator at Heritage, is optimistic that it will be able to weather the turbulent times facing hospitals in general, and HealthTrust hospitals in particular.

"I know there are some other hospitals in the [HealthTrust] system that aren't doing well," Raynor said

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in an interview at his office. But he added, "I think we're doing well."

Raynor acknowledged, however, that Heritage employees were subdued when they were told last summer of the impending sale to HealthTrust.

"You take 104 losers and put them all in one company and tell the employees it's going to be their pension fund," Raynor said. "People weren't too excited."

Some of HealthTrust's hospitals face longer odds of turning a profit. The Brunswick Hospital, in the town of Supply in Brunswick County, filled only about one-quarter of its 60 beds on average during 1987.

Brunswick's administrator, John A. Marshall, said he had been devising strategies to turn the hospital around.

"Smaller facilities in the rural areas need to be creative...so the community does not need to leave to get basic medical care," he said.

One priority will be to target services to the hospital's Medicare patients, who are over 65 years old and make up about 57 percent of its patients. Among new services planned are:

• A nursing home unit that accommodates people who otherwise would be discharged from the hospital into a nursing home.

"It's something that people would otherwise have to leave the county for," Marshall said. Brunswick County has no skilled care nursing home.

• Cataract and lens-implant surgery to be provided through an agreement with a Southern Pines cataract center, Carolina Eye Associates.

The nursing home services could pay off. The hospital's occupancy has been boosted to nearly 40 percent since the nursing beds became available in August, and Marshall calls the service "a key stabilizing factor."

Lots of people will be watching nationwide to see whether hospitals like Heritage and Brunswick survive under HealthTrust. But local communities and hospital employees have the most riding on the gamble.

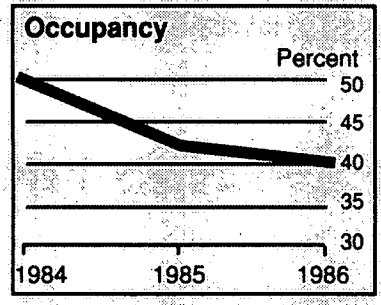
"I need to work, no matter what the company is," said Frances Daughtry, a laboratory technician who has worked at Heritage for 22 years. "No matter what the company."

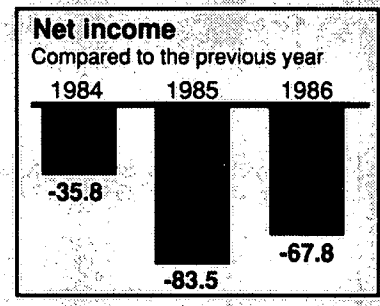
Hospital Corp. gets the best; HealthTrust gets the rest

Hospital Corp. of America	HealthTrust
82 general hospitals	104 general hospitals
Average size — 224 beds	Average size — 134 beds
Occupancy average — 55%	Occupancy average — 40.3%
Mostly urban	Mostly rural
More sophisticated subspecialties	Fewer sophisticated subspecialties
EXAMPLE:	EXAMPLE:
Raleigh Community Hospital	The Brunswick Hospital
Number of beds — 140	Number of beds — 60
1987 Occupancy — 55.7%	1987 Occupancy — 25%

Average U.S. occupancy for for-profit hospitals is 50%, for all hospitals is 63%

HealthTrust feels the pinch





Sources: N.C. Division of Facility Services, Securities and Exchange Commission, Federation of American Health Systems, American Hospital Association, Modern Healthcare magazine

HOSPITAL EMPLOYEES GAINED LITTLE SAY-SO WITH THEIR OWNERSHIP

by Donna Alvarado

THE 23,000 nurses, orderlies and other employees who "bought" their own HealthTrust hospitals have virtually none of the privileges that ownership usually brings.

They had no say in approving the deal and have no say in management of the hospitals. They will have almost no stock voting rights for years and will own no stock if the hospitals don't reverse the steep decline in their profits.

And the workers stand to lose future pensions if the hospitals can't reverse the decline.

The 1974 federal laws that gave tax incentives to companies forming employee stock ownership plans contained no guarantees that employees would have the privileges of ownership.

The tax breaks were intended to foster employee stock ownership plans, giving workers a stake in their company's productivity and allowing companies to obtain loans with tax breaks, according to a report issued by the U.S. General Accounting Office.

Critics say employee stock ownership plans have functioned largely as a corporate tool for reshuffling assets and raising capital without giving employees any opportunity for management.

HealthTrust is managed by a group of executives formerly with HCA. High-level representatives of the employees are the members of three-member committee appointed by former HCA executives now at HealthTrust. The committee reports to a board of directors dominated by former HCA executives.

"The management structure is the same," said James E. Raynor, administrator at Heritage Hospital in Tarboro. "I think the employees have input only to the point that the administration is willing to listen."

Under the HealthTrust plan, if the company makes enough money to pay off the $1.6 billion debt, employees will be rewarded with a retirement plan made up of gradually accumulating shares of company stock. If not, they have no augmented retirement plan.

Hospital industry analysts have been skeptical that HealthTrust would be able to meet its debt payments since nearly half the debt was obtained through "junk bonds," high-risk bonds that carry high interest rates and demand quick returns.

HealthTrust employees have protection from losing previously accumulated pension funds. The terms are under review by the U.S. Department of Labor, said C. Richard Gaston, HealthTrust vice president for administration.

The Labor Department could require HCA to pay HealthTrust employees a lump sum for the entire amount they accumulated under HCA, Gaston said.

Another option, which HealthTrust is pushing, would "roll over" the HCA pension funds to Health-Trust. Under that plan, HealthTrust would not be allowed to translate any of the HCA-derived retirement funds into company stock, and would be required to maintain it as a traditional pension plan payable upon retirement.

Gaston said he did not know when the Labor Department would rule on the question. A spokesman for the Labor Department said there would be no comment while the case was under review.

No one knows whether employees will have pension benefits from the employee stock ownership plan under HealthTrust.

Company executives say they expect HealthTrust employees to earn stock shares on an annual basis that could far outstrip their previous pension plan under HCA.

But Raynor, the Heritage administrator, said that HealthTrust faced a formidable challenge. He said that tying employee pension benefits to the company performance was a gamble.

"You stand to lose a lot of good people if you don't have a pension fund," he said.

This letter is reprinted by permission of the author and of The News and Observer *of Raleigh, North Carolina. The letter to the editor originally appeared in* The News and Observer *on February 7, 1988.*

HCA RESPONDS

AS A NORTH CAROLINA NATIVE and senior officer responsible for the Carolinas, I was disappointed at the tone of *The News and Observer*'s articles, "Pensions used in hospital purchases" and "Hospital employees gained little say-so with their ownership." By its apparent measurement of hospitals' value in profits and ownership rather than the quality of medical care delivered, your newspaper does a gross disservice to the hospitals, their employees, physicians and to the residents who rely upon them.

Your sensational story neglected to consider some relevant facts involved in our corporate restructuring. The 104 hospitals divested to HealthTrust have more than $1.5 billion in revenues and approximately $250 million in cash flow, hardly "losers."

During the past five years, HCA has invested more than $600 million in these facilities for the maintenance of their physical plants and the addition of modern equipment. While HealthTrust's employees will have the new ESOP as their primary retirement plan, their existing HCA retirement benefits will be completely protected.

HCA retains a significant interest in HealthTrust and in these communities. In addition to guaranteeing $240 million in debt for HealthTrust, we own $460 million of preferred stock of the new company. This is obviously a substantial commitment, demonstrating our interest in the long-term success of HealthTrust.

In forming HealthTrust, our overriding concern was to assure that both HCA and the new company remained viable operations providing quality care in each of their communities. After looking at a variety of restructuring options, we determined that this innovative ESOP plan offered the best vehicle to ensure quality medical care and continued success for these facilities and their employees.

Jack O. Bovender Jr.
Senior Vice President
Hospital Corporation of America
Raleigh

charge patients who cannot cope with home care. A study by the Rand Corp. found that while Medicare patients are leaving the hospital sooner since the introduction of the prospective payment system, they do not seem to be sicker when discharged.[34] Prospective pricing has affected when patients are admitted to American hospitals, however. The days of patients entering the hospital for some simple tests the night before routine surgery are definitely over, and outpatient surgery has become a common practice.

3. Long thought to be a problem distant from the Tar Heel state, the national shortage of nurses and other skilled medical personnel has hit North Carolina. According to Clare L. LaBar, executive director of the N.C. Nurses Association, a 1987 survey revealed an 11 percent vacancy rate in registered nursing jobs at hospitals across the state. That figure places North Carolina just behind the 1986 national average of 13.6 percent, a rate which doubled from 6.3 percent in 1985.[35] Compounding the crisis, an even more severe lack of medical technologists, physical therapists, respiratory therapists, and radiologic technologists "is slipping up on us," warns W. E. "Pete" Roye, director of management services for the N.C. Hospital Association.[36]

Shortages of nurses and skilled medical technicians can quickly cripple a hospital's services and finances. Without enough nurses, Chowan Hospital in Edenton recently shut down its recovery unit for intensive care patients, while Wake Medical Center temporarily lost the use of its pediatric intensive care beds—the only ones in the city. And Durham County General Hospital "turns away as many as 30 non-acute patients a week," said president Richard L. Myers, because of its lack of nurses.[37] If hospitals lose too many of their medical technologists and must close a cardiac catheterization laboratory, they could lose hundreds of thousands of dollars in revenue, according to Stuart S. Walden, director of personnel for Pitt County Memorial Hospital in Greenville.[38]

4. Hospitals have begun to use marketing — a tool common to the board room, not the operating

room—to recruit nurses, technicians and physicians, as well as to find their way to financial stability. "All of North Carolina's hospitals are scrambling to maintain their market share," explains the N.C. Hospital Association's Steve Morrisette. Although sometimes leery of the cost, hospital administrators are putting marketing tactics—from research about potential services or patients' needs to newspaper and radio advertising—to the task. "Five years ago," notes Morrisette, "most hospitals did not have a marketing person on staff. Now just about all of the medium-size and large hospitals have several people that do nothing but marketing."

A recent survey of 100 general hospitals in the state revealed that more than half had developed marketing plans, nearly half had tried direct mail, and 60 percent had launched advertising campaigns.[39] While some hospital marketing tactics, like physician referral services and special weekend nursing shifts, are designed primarily to recruit staff, a host of promotional tactics focus on what *paying* patients, considered *consumers* of health care, shop for in a

Courtesy Durham County Hospital Corporation

hospital.

Hospitals are spending big amounts—often six-figure sums—on marketing.[40] A hefty portion of hospitals' advertising budgets target pregnant women, in the hope that if they woo mom—who is thought to make the household health care decisions—they can win a whole "family of customers."[41] Hospital ads do more than tout their innovations in maternity care or expertise in cardiac surgery; some, like High Point Regional, also hail their low cost and personal touch.

The major medical centers, however, are not the only ones marketing. Once called "No Hope Hospital," Harnett County's Good Hope Hospital uses radio and billboard ads to promote a variety of new services, including outpatient clinics, an urgent care center, and inpatient psychiatric treatment. Since a new administrator launched these marketing tactics in 1977, the rural hospital has added 25 beds, pushed its occupancy rate to 75 percent, and boosted its outpatient service by a whopping 600 percent.[42] And a financially troubled urban hospital, Greensboro's L. Richardson Memorial, is also relying on marketing strategies, from open houses promoting its services to contracts with local businesses for employee physicals, wellness programs, and emergency care.[43] For hospitals trying to turn financial losses around and still serve a community in need of health care, finding their place—or niche, in business jargon—in the market proves essential. "It's their salvation," says Morrisette.

Governments, Markets, and Hospitals

NORTH CAROLINA'S HOSPITALS operate under market forces as well as government regulation. Alamance Memorial Hospital administrator John Currin, expressed his "frustration in trying to maintain a viable and accountable hospital in turbulent economic times and in this hybrid [government] regulated/economic theory environment." "The truth is," he said, "it's damned hard to do." Currin notes that "true competition works its wonders by forcing weaker competitors out of the market" and wonders if some North Carolinians could effectively lose access to hospitals or health care if such a harsh shakedown occurs. On the other hand, he asserts that total regulation "provides no better answer than total market competition."

North Carolina's hospitals are not what Currin calls "regulated public utilities," nor are they wholly "competitive creatures of free enterprise."[42] Based upon careful research and thorough discussion, the N.C. Center for Public Policy Research intends, with this volume, to recommend measures best suited to balance the traditional duties and responsibilities of hospitals with the new opportunities in North Carolina's health care market.

Current Research by the N.C. Center for Public Policy Research

IT IS CLEAR that hospitals in North Carolina have witnessed significant changes in recent years. Because many of the changes have involved the investor-owned hospital industry, this report by the N.C. Center for Public Policy Research focuses on hospital ownership and how it affects health care in the state.

The following chapters compare the performance of for-profit (investor-owned, -managed, or -leased) hospitals and not-for-profit hospitals in four important areas:

- Do for-profit hospitals provide more or less indigent care than not-for-profit hospitals? (Chapter 2, pages 37-80.)
- Do for-profit hospitals have higher or lower costs and charges than not-for-profit hospitals? (Chapter 3, pages 81-117.)
- Do for-profit hospitals offer a broader or narrower range of services? (Chapter 4, pages 119-153.)
- If for-profit hospitals provide less indigent care, do they (as for-profit corporations) pay taxes which would offset any deficiency in indigent care? (Chapter 5, pages 155-198.)

FOOTNOTES

[1]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), pp. 420-449; and Arnold S. Relman, "The New Medical-Industrial Complex," *New England Journal of Medicine,* Vol. 303 (October 1980), pp. 963-970.

[2]David A. Stockman, "Premises for a Medical Market Place: A Neoconservative's Vision of How To Transform the Health Care System," *Health Affairs,* Vol. 1 (Winter 1981), pp. 5-18.

[3]Giles Lambertson, "The customer theory of running hospitals," *Greensboro News & Record,* June 26, 1987, p. A13.

[4]Donald E. L. Johnson, "Many not-for-profit hospitals thrive under prospective pricing system," *Modern Healthcare,* November 7, 1986, p. 122.

[5]Richard Koenig, "Guarded Condition: Hospital Chains Curb Ambitions in the Wake of Setback at Humana," *The Wall Street Journal,* October 9, 1987, p. 20.

[6]Cynthia Wallace, "Investor-owned hospital chains streamlining existing operations," *Modern Healthcare,* January 2, 1987, p. 47.

[7]For more information on HCA and HealthTrust, see page 13 and the sidebars on pages 27-31. AMI's plans are described by Howard Kim, "Analysts support AMI spinoff," *Modern Healthcare,* May 20, 1988, p. 4.

[8]Judith Graham, "Diversified hospitals review plans after some bumpy rides," *Modern Healthcare,* August 14, 1987, p. 36.

[9]Fred Bazzoli and Howard Kim, "Chains report improved earnings," *Modern Healthcare,* April 1, 1988, p. 4, and Deborah Denaro Dine, "Nation avoids recession, but the market is still depressed," *Modern Healthcare,* October 14, 1988, p. 6.

[10]Teri Shahoda, "States create 2,972 programs to ratchet costs," *Hospitals,* March 20, 1987, p. 122; and Michelle Polchow, *State Efforts at Health Care Cost Containment: 1986 Update* (Denver, CO: National Conference of State Legislatures, 1986), pp. 2-54.

[11]Some hospitals specialize in chronic diseases or orthopedics. Others are eye, ear, nose and throat facilities; and still others specialize in treating women or children. This trend toward specialization is not confined to investor-owned hospitals: see page 16 for a brief description of a private, not-for-profit women's health center in Greensboro. See also Russ Robinson, "Specialty hospitals growing," *Triad Business Weekly,* December 7, 1987, p. 11. The *Triad Business Weekly* is published each week by the *Greensboro News & Record.*

[12]"1987 Directory shows continued growth for investor-owned hospital companies," *Federation of American Health Systems Review,* January/February 1986, pp. 59-60. These statistics include investor-owned hospitals in the United States and Puerto Rico but do not include not-for-profit hospitals *managed* by investor-owned companies. The FAHS surveys are some of the most extensive in the industry.

[13]"Directory reflects specialty hospital growth in the investor-owned industry," *Federation of American Health Systems Review,* November/December 1987, pp. 54-55.

[14]Administrators from National Medical Enterprises (NME) and Hospital Corporation of America (HCA) quoted by David Burda, "Investor-owned healthcare systems plan to continue expansion in psychiatric care," *Modern Healthcare,* June 3, 1988, p. 63.

[15]David Burda, "Hospital closures top record at 79—AHA," *Modern Healthcare,* March 25, 1988, p. 4.

[16]Cynthia Wallace, "Agreement boosts Westworld credit line," *Modern Healthcare,* January 16, 1987, p. 10.

[17]Clark W. Bell, "HCA, HealthTrust get back to work," *Modern Healthcare,* October 19, 1987, p. 38.

[18]Sandy Lutz, "HealthTrust plans to issue series of bonds," *Modern Healthcare,* February 26, 1988, p. 5.

[19]"Where the sick go," *Greensboro News & Record,* February 23, 1988, p. A1.

[20]Donald E. L. Johnson, "Many not-for-profit hospitals thrive under prospective pricing system," p. 122.

[21]Frank G. Sabatino and Mary A. Grayson, "Diversification: more black ink than red ink," *Hospitals,* January 5, 1988, pp. 36-42. Hamilton/KSA conducts an annual survey for *Hospitals* magazine.

[22]David Burda, "Changing Ownership: Not-for-profit hospitals become major players in hospital takeovers," *Modern Healthcare,* May 6, 1988, p. 24.

[23]Alden T. Solovy, "Business plan key to selecting an alliance," *Hospitals,* April 5, 1988, pp. 78-80.

[24]*Ibid.* See also Jay Greene, "Alliances soon may face their day of reckoning," *Modern Healthcare,* December 18, 1987, pp. 24-37.

[25]Emily Friedman, "Alliances: Linkages to walk tightrope between autonomy and efficiency," *Trustee,* October 1983, pp. 15-25.

[26]Chapter 775 of the 1983 Session Laws, now codified as N.C.G.S. 131E-8. For an outline of the law's key provisions, see the sidebar in Chapter 4, pages 149-153. See also Sally Jacobs, "Public hospitals shed limitations against making profit," *The News and Observer* (Raleigh), September 24, 1985, p. 3D. This article, pp. 1D and 3D, served as a major source for much of this section on hospital reorganization.

[27]N.C.G.S 131E-8(a). Of the five counties which have created private holding companies under this law, only the Alamance County Board of Commissioners has waived its appointment authority over the new corporation's Board of Trustees.

[28]"Hospital trend upsetting," *The News and Observer* (Raleigh), August 22, 1985, p. 16A.

[29]Sally Jacobs, "Public hospitals shed limitations against making profit," p. 3D.

[30]Article V, Section 2(1), Constitution of North Carolina.

[31]J. Phil Carlton, Remarks to the North Carolina Legislative Study Commission on Public Hospitals, December 15, 1987, p. 4. The following disclaimer appears at the end of the remarks: "These remarks were prepared for presentation to the Public Hospital Study Commission at the request of the North Carolina Hospital Association. Nothing contained herein should be considered the official legal opinion of Poyner and Spruill or the official legal opinion of the writer with respect to any particular set of facts."

[32]Carl Graziano, "Mecklenburg hospital authority demonstrates pitfalls confronting Wake," *The News and Observer* (Raleigh), January 11, 1987, p. 27A.

[33]Paul Gaffney, "Large hospitals must come to aid of declining small ones, panel told," *The News and Observer* (Raleigh), March 25, 1988, p. 3C. See also Health Resources Development Section, Division of Facility Services, N.C. Department of Human Resources, *The North Carolina Hospital Trend Report, 1981-1986,* 1988. This report includes selected utilization data for 124 general acute care hospitals.

[34]C. Richard Neu and Scott C. Harrison, *Posthospital Care Before and After a Medicare Prospective Payment System* (Santa Monica, CA: Rand Corp., March 1988). See also Michele L. Robinson, "Rand: Patients discharged quicker but not sicker," *Hospitals,* June 5, 1988, p. 28.

[35]Karla Jennings, "Nurse shortage burdens N.C. hospitals," *The News and Observer* (Raleigh), March 13, 1988, p.1A. This article gives a thorough account of the crisis in the state and serves as the primary source for this section of the chapter.

[36]Karla Jennings, "Shortages felt in many areas of medi-

cine," *The News and Observer* (Raleigh), April 3, 1988, p. 29A.

[37]Karla Jennings, "Nurse shortage burdens N.C. hospitals," p. 1A.

[38]Karla Jennings, "Shortages felt in many areas of medicine," p. 30A.

[39]Dennis R. Joyner, master's thesis in public health, University of North Carolina at Chapel Hill, cited by Steve Adams, "The Selling of Health Care," *Business North Carolina,* October 1986, p. 26. This article contains a wealth of information about hospital advertising and marketing activities in the state.

[40]Steven Steiber, "Hospital advertising budgets grow by 45%," *Hospitals,* March 20, 1988, p. 38.

[41]Karla Jennings, "Hospitals go all out for maternity business," *The News and Observer* (Raleigh), April 11, 1988, p. 16C.

[42]Steve Adams, "The Selling of Health Care," p. 32.

[43]Ed Williams, "L. Richardson re-marketing itself," *Greensboro News & Record,* October 16, 1987, pp. D1 and D5.

[44]This tension between government regulation and the market economy is discussed by Stuart Altman and Marc Rodwin in an article which is part of a new series of reports analyzing the U.S. health care system. The series appears in the summer 1988 issue of the *Journal of Health Politics, Policy and Law* and is entitled "Competition in the Health Care Sector: Ten Years Later." For an overview of all the articles by various experts in the field, see Alden T. Solovy, "Economists revisit competition in the health care market," *Hospitals,* May 20, 1988, pp. 38-41.

CHAPTER 2

THE PERFORMANCE OF FOR-PROFIT AND NOT-FOR-PROFIT HOSPITALS IN PROVIDING HEALTH CARE FOR THE MEDICALLY INDIGENT

by Lori Ann Harris

Introduction

ACCESS TO HEALTH CARE for the medically indigent—individuals unable to pay—continues to be a problem in search of a solution. The challenge of providing health care to the medically indigent is nearing crisis proportions, with analysts estimating the number of Americans who lack adequate private health insur-ance coverage at more than 35 million.[1] In North Carolina, nearly one-third of the population—1.9 million people—is at risk of becoming medically indigent.[2] These individuals have no health insurance coverage, inadequate coverage, or are not eligible for government "social safety net" programs such as Medicare and Medicaid.

A combination of factors has sparked increases in uncompensated care levels at hospitals, including cutbacks in private health insurance coverage by many businesses and reductions in Medicaid coverage due to tight budget conditions in various states. Historically, health care institutions have accepted what they viewed as a social and moral obligation to provide health care services to those who cannot pay. In this chapter, the N.C. Center for Public Policy Research will examine the question of whether for-profit and not-for-profit institutions act differently in their efforts or willingness to provide hospital services to indigent patients.

Problems with Defining Indigent Care

PROVIDING HEALTH CARE to the indigent has always been of serious concern and debate in the United States. The indigent are a vulnerable population, particularly with respect to health care. In colonial America, poor and sick people without a home went to hospitals for care. The early hospitals, called "almshouses," were actually infirmaries, and the original function of the hospitals was to provide the poor with a place to die. Private voluntary hospitals financed by charitable donations soon evolved, emphasizing medical care for the poor.[3]

Through the years, the federal government has constantly redefined its "safety net" role. Federal amendments implemented under the Omnibus Budget Reconciliation Act of 1981 (OBRA) resulted in significant cutbacks in Medicaid assistance and tightened eligibility requirements in many states.[4] State and local governments, in response to these federal cutbacks, have also begun to reduce financial support for public hospitals. Such hospitals in turn have been forced to curtail the amount of free care they provide.

The issue of medical indigence requires some knowledge of the definition of indigent care. Medical indigency is a function of level of poverty, health insurance coverage, and need for medical services. The American Hospital Association defines medical indigence as "the condition of having insufficient income to pay for adequate medical care without depriv-

ing oneself or dependents of food, clothing, shelter, and other essentials of living."[5] The following list encompasses the most frequently used definitions of "indigent care."

1. **charity care:** care provided to patients who upon admission are determined to be unable to pay. Some hospitals are still required to provide charity care as repayment of Hill-Burton obligations. (See sidebar on page xx.)
2. **bad debt:** the difference between hospital charges and reimbursements (payments) from patients. Nonpayment of hospital bills. Bad debt may result from poor collection procedures by the hospital.
3. **free care:** see charity care.
4. **unsponsored care:** care provided to patients who are uninsured or who do not qualify for Medicare and Medicaid.
5. **uncompensated care:** those services provided by a hospital or by a physician or other health care professional for which no charge is made or for which no payment is expected. This definition does not include contractual adjustments obtained by public and private insurers using a cost-based reimbursement method.
6. **total uncompensated care:** the sum of charity care and bad debts absorbed by a hospital in providing medical care for patients who are uninsured or are unable to pay.
7. **uncollectible charges:** see bad debt.
8. **accounts outstanding:** unpaid hospital bills as a result of bad debt.

The American Hospital Association defines indigent care to include: ". . . bad debt, charity care, service discounts, contractual adjustments, and Medicaid program recipients."[6] More recently, a study by the American Hospital Association's Section for Multihospital Systems and the national accounting firm of Arthur Andersen & Co. surveyed representatives from the multihospital systems across the country for their opinion on indigent care issues. These representatives reached a consensus on a definition of who is indigent. The majority of the respondents felt that persons who are eligible for general public assistance programs, the chronically unemployed, and Medicaid recipients who are unable to pay for non-covered charges should be considered indigent. Conversely, seventy-five percent of those surveyed felt that employed persons (or those with the ability to work), regardless of whether they have limited or no employer health benefits, should *not* be considered indigent.[7]

The hospitals and physicians who deliver care to the indigent often perceive it to be "uncompensated" care, although it is more commonly referred to as "free" or "charity" care. "Bad debt" differs from charity care in that it refers to people who are *unwilling* to pay their share of the bill, as well as those *unable* to pay. Some of the bad debt cases have some insurance and are not necessarily poor. Those who prefer the term "unsponsored" care believe that it should relate solely to the medically indigent population and have nothing to do with uncollected debts. Hospital experts agree that although these two concepts are quite different, they are not used consistently by hospitals. Uncompensated care that might be written off as charity care at one institution may be accounted for as bad debt at another. The only institutions that have any reason to account separately for charity care are not-for-profit and public hospitals that have an undischarged Hill-Burton "free care obligation."

The Catholic Health Association (CHA), of St. Louis calls for uniform definitions of charity care that would adequately measure the charitable activities of not-for-profit hospitals. CHA recommends that the new definition of charity care, once developed, be adopted by all not-for-profit hospitals, state data commissions, and hospital associations.[8]

Lewin and Associates have proposed a definition of unsponsored charity costs as a replacement for the traditional definition of uncompensated care. "Unsponsored charity costs (UCC) are defined broadly as those incurred on behalf of patients who cannot afford to pay, and that are recoverable only by obtaining cross-subsidies from paying patients or non-patient revenues (e.g., philanthropy), or by reducing net income. This new definition provides a clear distinction between charity care and bad debt with the intent "to include unreimbursed costs incurred primarily for charitable purposes, and to exclude costs more directly related to commercial purposes. . . .[as well as] to count only for those costs for which there is no sponsorship. . ."[9]

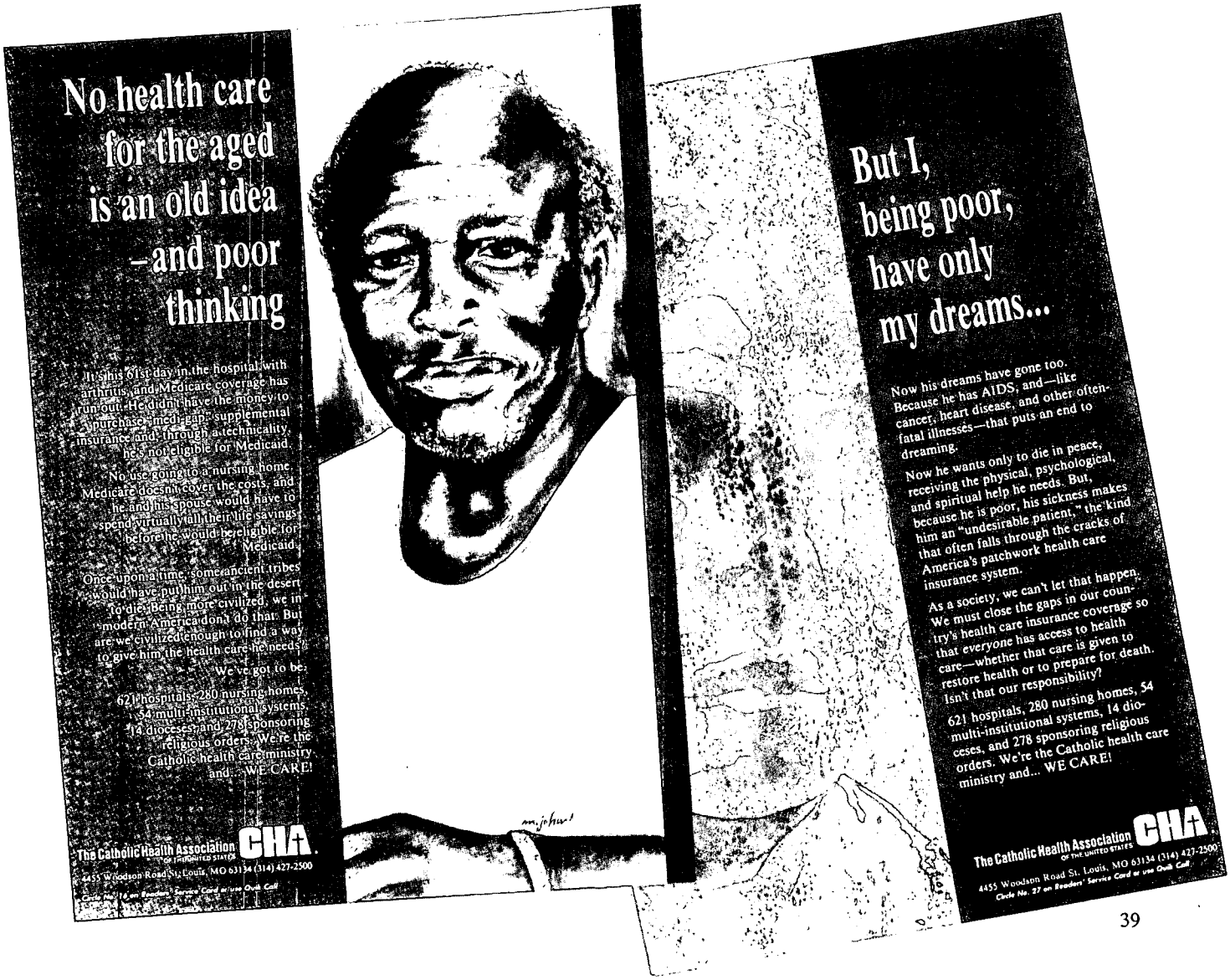
The definition of indigent care, as evidenced from the list above, is subject to various interpretations. Government providers of indigent care through such programs as Medicaid and Hill-Burton regulations often operate under different assumptions about indigent care. Medicaid, a federal/state funded program for the poor, covered only 38% of the poor in 1984, down from 65% in 1976.[10] According to a General Accounting Office (GAO) report, severe inequities exist among state Medicaid programs. States have the flexibility to define mandatory and optional benefits and determine the income and asset limits for eligibility. The eligibility and benefit levels of state programs

vary greatly. In FY 1985, Medicaid spending averaged $1,721 per recipient but ranged from $821 in West Virginia to $3,384 in New York.[11] In order to receive Medicaid benefits in North Carolina, the annual income for a family of four may not exceed $6,984. The change in percentages of the poor covered by Medicaid bears some relation to the fact that *Medicaid* is only extended to the "needy" as defined in each state. Only those meeting *state*-specified income levels—which in 23 states are at or below 55% of the federal poverty level—and who are also aged, blind, disabled or part of a single-parent family with dependent children, are categorically eligible for Medicaid. The difficulties in establishing a uniform definition of indigent care make it hard to quantify how such care is being financed through federal as well as hospital budgets.

There are two other aspects of indigent care which exacerbate this problem of definition. Because hospitals have different markup prices, not all bad debt and charity care is equal. Uncompensated care costs are usually expressed in terms of *charges*, not *costs*. (See Chapter 3 for an explanation of this difference in terms.) In 1986, hospitals nationwide absorbed $7 billion worth of indigent care.[12] This figure may significantly *overstate* the actual cost of care which hospitals must recover. Another aspect of the problem may suggest that the magnitude of the indigent care problem is *understated*. Uncompensated care costs relate only to care provided by hospitals, thus excluding other providers of indigent care, such as physicians in private practice. Many physicians continue to provide free care to patients who are unable to pay, however, much less is known about the total volume and dollar amount of these voluntary contributions of health services.

Financing Uncompensated Care

THE COSTS OF PROVIDING uncompensated care continue to grow. Who is responsible for picking up the bill? Those who ask this question think it should be answered in a way that spreads the burden of indigent care as equitably among hospitals and other



providers as possible, because the reality is that there is no free care; someone must pay.

Uncompensated care is paid for in one of three ways: health care providers accept lower incomes and profit margins; state and local government tax revenues (to which for-profit corporations contribute in the form of income and property taxes); or higher charges to insured patients in the form of cost-shifting. Cost-shifting is a widespread practice among hospitals. It is one way hospitals can cover the expense of uncompensated care. A hospital shifts costs to third-party payers, particularly insurance companies, to make up what it loses in inadequate Medicare and Medicaid reimbursements or uncompensated care. Chris Conover, a Duke University researcher, says:

> Among economists, the most widely accepted theory is that hospitals set prices to maximize revenues, so that most hospitals have enough left over to cover any uncompensated costs. But in some cases, charging what the market will bear does *not* produce enough income to cover losses on some patients, so a deficit results. If hospitals had unlimited ability to cost-shift, no one would ever run a deficit."[13]

Health insurance companies have estimated that $8.8 billion was shifted from Medicare and Medicaid patients to commercially insured patients in 1984.[14] The N.C. Hospital Association reports that the national average of the cost shift is $29.96 per patient day. In North Carolina, the cost shift is $38.92 per patient day—30 percent more than the national average.[15] However, third-party payers (e.g. insurance companies) are increasingly reluctant to finance a disproportionate share of hospital charges not incurred by their subscribers. In some cases, insurers have refused to pay what they viewed as unreasonable hospital charges incurred through cost-shifting. As health care costs have risen, the federal and state governments have enacted regulatory measures which make cost-shifting more difficult. And as the number of medically indigent patients rises, health care providers are becoming less willing to pay for indigent care.

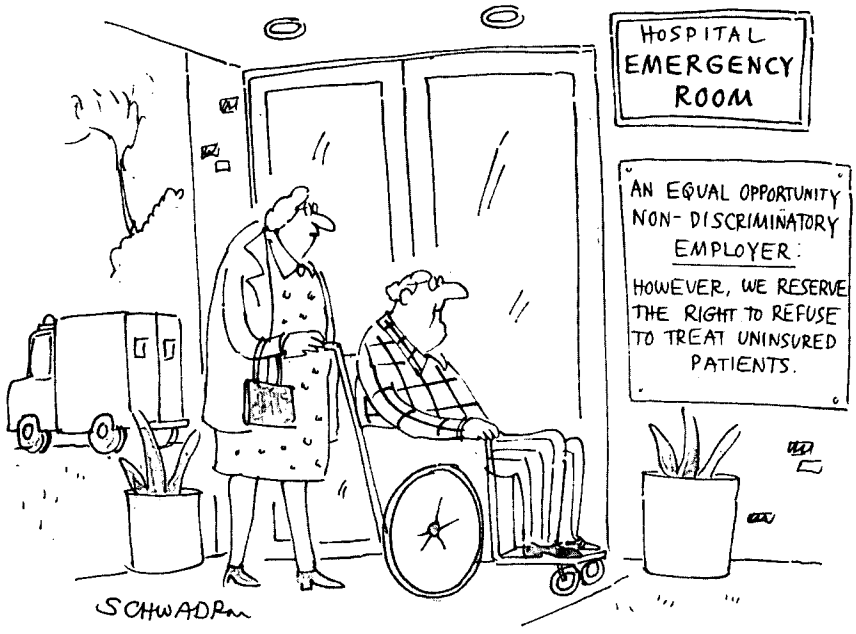
Furthermore, the burden of financing indigent care is often unevenly distributed. Public hospitals, urban hospitals, and teaching hospitals often carry a disproportionate burden of bad debt and charity care because they are more likely to be located near large indigent populations. Results of a survey by the National Association of Public Hospitals shows that of 43 not-for-profit hospitals responding, 51,788 (29%) of their 180,052 inpatient days were uncompensated in 1987. This compared with 42,877 (26%) uncompensated days of 167,184 days for the same not-for-profit hospitals in 1985. In 1985 and 1987, 48% of the hospitals reported a negative profit margin, with an average loss of $6.3 million in 1987.[16]

Hospital location and a well-insured patient base are important considerations of investor-owned hospital companies. (See sidebar on page 122 for more on where investor-owned hospitals locate.) While investor-owned hospitals are required to treat all emergency cases (and usually do), non-emergency uninsured patients are sometimes transferred to public hospitals in the area. For example, in 1984 officials at the state-run N.C. Memorial Hospital testified at a legislative study commission meeting that they were receiving patient referrals from Central Carolina, the for-profit American Medical International hospital in Sanford (Lee County). Ben Gilbert of N.C. Memorial's legal department says that uncompensated care referrals from Lee County for 1987 and 1988, however, have decreased by 32 percent from the preceding year (1986-1987).[17] N.C. Memorial plays a special role in serving the needs of the poor, who in turn play a necessary role in the teaching hospital's educational system. In some cases, even financially strapped not-for-profit hospitals have dumped indigent patients on state-, county-, or city-owned institutions.

Who Are the Medically Uninsured and Underinsured?

THE NUMBER OF MEDICALLY INDIGENT persons in the United States varies widely, depending on the study and the calculation methods used to derive the figures. According to the Institute of Medicine of the National Academy of Sciences, there are an estimated 35 million Americans who are medically indigent.[18] An American Hospital Association Council Report estimates that the national population at risk of medical indigency was approximately 45.3 million people in 1982. This estimate includes the uninsured and underinsured populations. The AHA also noted that 22.4 percent of the population under age 65 is at risk. Of the total at-risk population, about 25.4 million (56.1%) were poor or near-poor in 1982.[19] These estimates, although based on somewhat different definitions and counting methods, indicate the seriousness of the indigent care problem. While a significant portion of the medically indigent have incomes below the federal poverty level, not all are poor or unemployed. Today, increasing numbers of persons simply cannot afford health care or fall outside the boundaries of existing public programs.

Another group of indigents consists of those who *can* afford health insurance but are unable to obtain it. This portion of the indigent population is unable to get insurance because of age, illness, or poor health. A



Harvey L. Schwadron

1985 study by researchers at Duke University's Center for Health Policy Research examined the problems of the medically indigent.[20] According to Chris Conover, one of the Duke researchers, the number of uninsured persons in North Carolina who have no health insurance at some point during the year has been estimated at nearly 1.2 million individuals. There are more than six million people living in North Carolina. Of this total, 624,000 persons are *always* uninsured, and another 532,000 are *sometimes* uninsured during the course of a year. These startling statistics translate to nearly 900,000 persons in North Carolina without health insurance coverage on a typical day. About 400,000 of the estimated 900,000 state residents without health insurance had incomes below the federal poverty level. Moreover, another 750,000 people are underinsured and are unable to pay their medical bills fully. Persons were categorized as underinsured if they had a 5% chance of having health expenses exceeding 10% of their income, or if they only had Medicare coverage.[21]

While the poor in North Carolina are likely to be uninsured, not all the uninsured are poor. The poor are three times as likely to be uninsured compared to those of other income levels. However, nearly 75% of the uninsured population are full- or part-time workers or are dependents of workers, and half of the people working who do not have insurance are employed at small firms that are not required by law to provide health insurance coverage.[22] About 14.3% of North Carolina's people have incomes below the poverty level as determined by the federal poverty guidelines.

The uninsured poor tend to be children or young adults. They have relatively less education than those who are insured and are less likely to have completed high school. The uninsured poor also tend to be female and non-white. They are unlikely to be employed. The North Carolina data reveal that the uninsured poor are disproportionately concentrated in the far eastern and western regions of the state.[23]

According to the Duke University study, the uninsured population on average has 45% fewer ambulatory visits and hospital stays than the general population.[24] They are likely to make greater use of public clinics and emergency room care. Lack of access to care is a contributing factor to the poor health status of the uninsured. Barriers to access for the uninsured poor include lack of transportation to the health care provider, lack of health care facilities within certain geographic areas, inability to pay pre-admission deposits which may be required by hospitals for non-emergency care, difficulty in finding physicians who are willing to treat them, and inability to pay for necessary medical prescriptions.[25]

Because the uninsured are more likely to have a disability or a serious health condition that limits employment opportunities, they are placed in a "Catch-22" situation. In other words, poor health reduces the probability of steady employment, which in turn increases the chance of becoming uninsured, and de-

—*continued on page 46*

THE HILL-BURTON ACT

by Lori Ann Harris

THE HOSPITAL SURVEY AND CONSTRUCTION ACT passed in 1946 was the first attempt by the federal government to enact a health planning concept.[1] Better known as the Hill-Burton Act, it was written by Senators Lister C. Hill, (D-Alabama) and Harold H. Burton, (R-Ohio). The act was passed in response to a perceived shortage of hospital beds following World War II. Hill-Burton funds were available for construction or modernization of public or private not-for-profit hospitals and other medical facilities. Investor-owned hospitals and medical facilities were not eligible for Hill-Burton funds. More than 4,500 hospitals accepted Hill-Burton construction grants and loans from the federal government.[2] Under the Hill-Burton program, health care facility construction in North Carolina totaled more than 500 million dollars. Of this total, 40 percent of the funds was provided by the federal government, 5 percent by the state, and 55 percent by local sponsors. More than 500 Hill-Burton projects were approved in North Carolina between 1946 and 1976, of which 241 were general hospital projects, including 80 completely new facilities.[3] In 1974, Congress ended all Hill-Burton appropriations.

Under the Hill-Burton Act, health care facilities were required to assure that indigent patients would have access to a "reasonable volume" of uncompensated care, a provision known as the "uncompensated care" obligation.[4] A second provision known as the "community service obligation" required facilities receiving Hill-Burton funds to provide patient services to all persons living in the general service area of the facility, without discrimination on the basis of race, color, or creed.[5] The health facilities were required to abide by the reasonable volume regulation for a period of 20 years. If a facility incurred a deficit or provided an excess amount of services, the obligation period could be extended or shortened.[6]

Over the years, the Hill-Burton legislation underwent several modifications. In 1972, the community service obligation was spelled out more clearly. Prior to these changes, the Hill-Burton Act was little more than legislation on the books. The Hill-Burton regulations failed to define what constituted a "reasonable volume" of uncompensated care, and essentially rendered the act unenforceable. Facilities receiving Hill-Burton funding were required to provide charity care each year in an amount equal to 10 percent of the original grant or three percent of operating costs, minus Medicaid and Medicare — whichever was less. Additionally, hospitals had the option of choosing an "open door" policy, thereby certifying that no person would be turned away from the facility because of inability to pay.[7]

In 1974, new federal regulations required that all facilities receiving Hill-Burton funds participate in Medicaid and Medicare.[8] Prior to that time, a Hill-Burton facility, like any other hospital, was free to choose not to participate in the Medicaid program. In 1979, further statutory changes limited the open door option. Each health facility was required to publish a notice of its uncompensated services obligation as well as the eligibility criteria. In 1986, the Department of Health and Human Services issued a regulation requiring that hospitals that had received federal construction funds under the Hill-Burton Act continue to provide free care to indigent patients.[9]

Under the current rule, health facilities which undergo a change in ownership, control, or use may establish trust funds to ensure continued free care for the poor. If the facility has an approved trust fund, it would not be required to repay Hill-Burton funds; however, it would be required to comply with existing Hill-Burton rules for provision of free care. The waiver would be granted if the facility established an "irrevocable trust" for the indigent in an amount equal to "the greater of twice the amount that would have been due under recovery." The new regulation also requires the new owner to notify the U.S. Department of Health and Human Services in writing within 10 days of sale, transfer, or change in the facility's use.[10] In January 1987, the Hospital Corporation of America in Nashville, Tennessee established the first irrevocable trust under the new rule. Benton County Hospital in Camden, Tennessee set up a $1.2 million trust to care for indigent patients, thereby meeting the Hill-Burton requirement. Also in early 1987, American Medical International (AMI) of Beverly Hills, California created a $591,000 trust and AMI's Central Carolina Hospital established an irrevocable trust at the 142-bed hospital in Sanford. Under the old law, these facilities

—continued

were required to repay the government a portion of the assistance they received, ending their obligation to provide free care.[11]

Franklin Memorial Hospital in Louisburg, North Carolina has repaid nearly $120,000 to the Department of Health and Human Services as a result of a recovery action begun by HHS when Health Management Associates of Naples, Florida acquired Franklin Memorial in 1986. Franklin Memorial, a 76-bed general acute-care hospital had received Hill-Burton funds for a construction project completed in 1967.[12]

The Brunswick Hospital (newly leased by HealthTrust, Inc.) in Supply, North Carolina elected to settle its Hill-Burton obligation when it was purchased by Hospital Corporation of America. The Brunswick County Hospital Authority paid $1.06 million to the federal government in 1986 to end its obligation under the new Hill-Burton requirements.[13]

The overall effectiveness of The Hill-Burton Act in meeting the need for hospital-based charity care has long been questioned. Varying interpretations of the law and non-compliance with the record-keeping requirements under the program have made evaluation of the program difficult. According to statistics of the U.S. Department of Health and Human Services, by the end of 1990, only 37 of the 127 general acute-care hospitals in North Carolina will be obligated to provide uncompensated services as required under the Hill-Burton Act.[14]

FOOTNOTES

[1]42 U.S.C. 291, et seq.

[2]Robert Pear, "U.S. to eliminate rule requiring percentage of free hospital care," *The News and Observer* (Raleigh, N.C.), November 4, 1985, p. 5A.

[3]N.C. Medical Care Commission Annual Report, June 30, 1988.

[4]42 U.S.C. 291c(1)(e).

[5]*Ibid.*

[6]42 C.F.R. 124.503 (1977).

[7]42 C.F.R. 53.111(d) (1972).

[8]42 C.F.R. 124.601(c)(ii).

[9]42 C.F.R. 124 (1986).

[10]Donna L. Heller, "Sale of Hill-Burton Facility can pose difficulties for both buyer and seller," *Modern Healthcare*, March 13, 1987, pp. 74-75.

[11]"AMI, HCA create trusts to fulfill Hill-Burton debt," *Modern Healthcare*, February 27, 1987, p. 19.

[12]"Hospital repays $120,000 to HHS for Hill-Burton loan," *Modern Healthcare*, June 19, 1987, p. 26.

[13]Personal communication from David J. Hansen, Legal Counsel for HealthTrust, Inc. - The Hospital Company, May 24, 1988.

[14]U.S. Department of Health and Human Services, *1987 Directory of Facilities Obligated to Provide Uncompensated Services By State and City*, pp. 112-115. For an excellent article evaluating the Hill-Burton program, see Michael A. Dowell, "Hill-Burton: The Unfulfilled Promise," *Journal of Health Politics, Policy and Law*, Vol. 12, No. 1 (Spring 1987), pp. 153-175.

GENERAL ACUTE-CARE HOSPITALS IN NORTH CAROLINA STILL OBLIGATED TO PROVIDE UNCOMPENSATED SERVICES UNDER THE FEDERAL HILL-BURTON ACT

as of March 1, 1988

	HOSPITAL	CITY	COUNTY	TYPE OF OWNER	EXPIRATION DATE OF UNCOMPENSATED SERVICES OBLIGATION: MONTH/YEAR
1.	Albemarle Hospital	Elizabeth City	Pasquotank	County	10/1998
2.	Alleghany County Memorial Hospital	Sparta	Alleghany	PNFP	3/1999
3.	Angel Community Hospital	Franklin	Macon	PNFP	11/1999
4.	Anson County Hospital	Wadesboro	Anson	County	7/1989
5.	Ashe Memorial Hospital	Jefferson	Ashe	PNFP	6/1992

—continued

Hill-Burton Act, *continued*

HOSPITAL	CITY	COUNTY	TYPE OF OWNER	EXPIRATION DATE OF UNCOMPENSATED SERVICES OBLIGATION: MONTH/YEAR
6. Beaufort County Hospital	Washington	Beaufort	County	1/1989
7. Blowing Rock Hospital	Blowing Rock	Watauga	PNFP	1/1988
8. Blue Ridge Hospital System Spruce Pine	Spruce Pine	Mitchell	PNFP	8/1999
9. C. J. Harris Community Hospital	Sylva	Jackson	PNFP	8/1992
10. Caldwell Memorial Hospital	Lenoir	Caldwell	PNFP	9/2002
11. Carteret General Hospital	Morehead City	Carteret	County	7/1987
12. Chatham Hospital	Siler City	Chatham	PNFP	7/1989
13. Chowan Hospital, Inc.	Edenton	Chowan	County	1/1991
14. Columbus County Hospital	Whiteville	Columbus	County	11/1998
15. Community General Hospital	Thomasville	Davidson	PNFP	5/1992
16. District Memorial Hospital [a]	Andrews	Cherokee	PNFP	8/1990
17. Duplin General Hospital	Kenansville	Duplin	County	8/1992
18. Durham County General Hospital	Durham	Durham	County	7/1999
19. Fletcher Hospital Medical Center	Fletcher	Henderson	PNFP	8/1990
20. Forsyth Memorial Hospital	Winston-Salem	Forsyth	PNFP	4/1993
21. Gaston Memorial Hospital	Gastonia	Gaston	PNFP	8/1994
22. Grace Hospital	Morganton	Burke	PNFP	6/1993
23. Halifax Memorial Hospital	Roanoke Rapids	Halifax	Special District	7/1993
24. Highlands Cashiers Hospital	Highlands	Macon	PNFP	8/1986
25. High Point Memorial Hospital	High Point	Guilford	PNFP	11/1992
26. Hugh Chatham Memorial Hospital	Elkin	Surry	PNFP	11/1993
27. Iredell Memorial Hospital	Statesville	Iredell	County	11/1994
28. Johnston Memorial Hospital	Smithfield	Johnston	County	1/1986
29. Lenoir Memorial Hospital	Kinston	Lenoir	County	10/1993
30. Lincoln County Hospital	Lincolnton	Lincoln	County	11/1989
31. Margaret R. Pardee Memorial	Hendersonville	Henderson	County	4/1993
32. Martin County Hospital	Williamston	Martin	County	7/1993

[a] formerly Mountain Park Medical Center.

—continued

Hill-Burton Act, *continued*

	HOSPITAL	CITY	COUNTY	TYPE OF OWNER	EXPIRATION DATE OF UNCOMPENSATED SERVICES OBLIGATION: MONTH/YEAR
33.	Montgomery Memorial Hospital	Troy	Montgomery	PNFP	6/1992
34.	Moore Regional Hospital, Inc.	Pinehurst	Moore	PNFP	12/1999
35.	Moses H. Cone Memorial Hospital	Greensboro	Guilford	PNFP	3/2001
36.	Northern Hospital	Mount Airy	Surry	County	10/1994
37.	Onslow Memorial Hospital	Jacksonville	Onslow	County	8/1994
38.	Pender Memorial Hospital	Burgaw	Pender	County	6/1986
39.	Pitt County Memorial Hospital	Greenville	Pitt	County	7/1998
40.	Randolph Hospital	Asheboro	Randolph	PNFP	8/1996
41.	Roanoke Chowan Hospital	Ahoskie	Hertford	PNFP	11/1999
42.	Rowan Memorial Hospital	Salisbury	Rowan	PNFP	2/1989
43.	Sampson County Memorial Hospital	Clinton	Sampson	County	1/1989
44.	St. Joseph's Hospital	Asheville	Buncombe	PNFP	11/1999
45.	St. Luke's Hospital [b]	Columbus	Polk	PNFP	8/1992
46.	Swain County Hospital	Bryson City	Swain	PNFP	6/1989
47.	Transylvania Community Hospital	Brevard	Transylvania	PNFP	10/1993
48.	Union Memorial Hospital	Monroe	Union	County	6/1985
49.	Washington County Hospital	Plymouth	Washington	County	1/1994
50.	Watauga County Hospital	Boone	Watauga	County	12/2001
51.	Wayne County Memorial Hospital	Goldsboro	Wayne	County	2/1990
52.	Wesley Long Community Hospital	Greensboro	Guilford	PNFP	6/1999
53.	Wilkes General Hospital	North Wilkesboro	Wilkes	City	6/1989
54.	Wilson Memorial Hospital	Wilson	Wilson	County	2/1992

PNFP = Private, not-for-profit

[b] A private not-for -profit corporation leases the hospital from the county.

Source: 1988 Directory of Facilities Obligated to Provide Uncompensated Services By State and City, *U. S. Department of Health and Human Services.*

creasing access to care, which leads to poor health. Data are unavailable to determine the extent to which the lack of insurance is the cause of poor health, and conversely the extent to which poor health affects the inability to obtain insurance coverage.[26]

A report by the UNC-CH Health Services Research Center analyzed data from the annual N.C. Citizens Survey conducted by the N.C. Office of State Budget and Management. They estimate that nearly one-fourth (23) of the 100 counties in North Carolina had more than 6% uninsured poor. The estimated distribution of uninsured poor ranges from 1.1% in Alexander County in the western part of the state to 9.2% in Warren County in the northern Piedmont. (See Table 2.1 and Map 2.1.)[27] There are more than 35 publicly funded programs in North Carolina that provide health care to the medically indigent.[28] During the 1984 fiscal year, $480 million was spent on subsidized care through publicly-funded programs (i.e., excluding third party payments and patient fees), and of that total, $106 million was spent on health care for the uninsured poor.[29]

Findings of Other Studies Comparing For-Profit and Not-for-Profit Hospitals' Performance in Providing Indigent Care

ON THE NATIONAL LEVEL, several studies have attempted to measure the differences in the amount of uncompensated care provided by investor-owned and not-for-profit hospitals. There have been five studies of this question at the state level. A review of the best of these studies follows.

1. **Studies on the National Level**

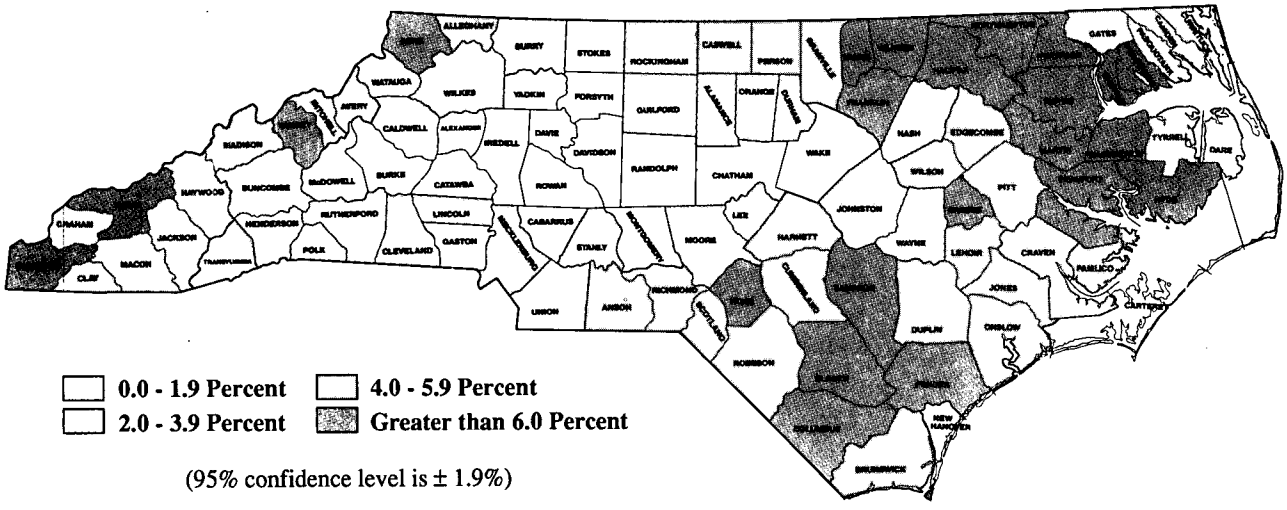
a. **Office of Civil Rights** — In a 1981 study, the Office of Civil Rights in the U. S. Department of Health and Human Services surveyed 5,800 hospitals

—continued on page 48

Table 2.1: North Carolina Counties: Estimated Distribution of Uninsured Poor

County	Percentage of Uninsured Poor	Number of Uninsured Poor
Alamance	2.0%	1965
Alexander	1.1	278
Alleghany	5.9	561
Anson	4.6	1170
Ashe	6.9	1530
Avery	5.4	735
Beaufort	6.0	2410
Bertie	6.3	1333
Bladen	7.7	2326
Brunswick	5.7	2009
Buncombe	2.5	3936
Burke	1.6	1090
Cabarrus	1.6	1361
Caldwell	1.6	1084
Camden	4.9	283
Carteret	3.3	1330
Caswell	5.9	1192
Catawba	1.5	1559
Chatham	1.2	388
Cherokee	6.7	1260
Chowan	7.2	897
Clay	5.4	358
Cleveland	2.5	2009
Columbus	6.2	3140
Craven	3.5	2300
Cumberland	4.3	9482
Currituck	4.3	473
Dare	2.7	355
Davidson	1.9	2171
Davie	1.4	339
Duplin	5.4	2202
Durham	2.3	3299
Edgecombe	4.4	2411
Forsyth	1.2	2881
Franklin	6.1	1776
Gaston	1.9	3083
Gates	4.3	372
Graham	5.9	427
Granville	5.0	1549
Greene	7.6	1212
Guilford	2.0	6205
Halifax	6.9	3742
Harnett	4.5	2587
Haywood	4.5	2048
Henderson	2.9	1691
Hertford	7.0	1550
Hoke	6.3	1243
Hyde	8.6	501
Iredell	1.6	1289
Jackson	5.5	1256
Johnston	3.3	2343
Jones	4.7	454

Map 2.1 North Carolina Counties with Estimated Percentages of Uninsured Poor



County	Percentage of Uninsured Poor	Number of Uninsured Poor
Lee	3.9	1402
Lenoir	5.7	3289
Lincoln	2.0	835
McDowell	1.5	523
Macon	4.1	821
Madison	5.5	883
Martin	6.9	1766
Mecklenburg	2.2	8616
Mitchell	5.1	733
Montgomery	1.8	403
Moore	3.2	1607
Nash	3.7	2466
New Hanover	2.9	2890
Northampton	6.0	1298
Onslow	4.2	3781
Orange	2.5	1654
Pamlico	4.4	461
Pasquotank	5.1	1494
Pender	6.4	1405
Perquimans	7.4	688
Person	4.7	1369
Pitt	4.4	3692
Polk	3.2	415
Randolph	1.6	1494
Richmond	4.3	1942
Robeson	5.9	5849
Rockingham	2.2	1838
Rowan	1.8	1716
Rutherford	3.9	2077
Sampson	6.1	2978
Scotland	4.9	1541
Stanly	2.2	1032
Stokes	1.6	531
Surry	2.8	1656
Swain	7.8	788
Transylvania	1.7	375
Tyrrell	5.4	216
Union	1.8	1225
Vance	6.0	2163
Wake	1.4	3878
Warren	9.2	1473
Washington	6.5	956
Watauga	2.9	801
Wayne	3.4	3133
Wilkes	2.8	1650
Wilson	5.7	3493
Yadkin	1.8	513
Yancey	7.1	1039

Presentation by Kit N. Simpson and Thomas C. Ricketts, UNC-CH Health Services Research Center, to the Indigent Health Care Study Commission, April 22, 1986.

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and gathered data on admissions of uninsured patients during a two-week period. Analysis of the data revealed that *public* hospitals admitted the most uninsured patients—16.8 percent of their admissions. Private *not-for-profit* hospitals (including teaching hospitals) admitted 7.9 percent uninsured, and *for-profit* hospitals admitted 6 percent uninsured patients.[30]

Further analysis by the Office of Civil Rights revealed a smaller percentage of for-profit hospitals (3.1 percent) reported that more than 25 percent of their total admissions were uninsured, compared to 4.1 percent of total admissions for not-for-profit hospitals, and 10.7 percent for public hospitals. For-profit hospitals were also more likely to have fewer than 5 percent uninsured patient admissions (58.6 percent for the for-profit hospitals versus 44.5 percent for the not-for-profit hospitals). For-profit and private not-for-profit hospitals reported that 22 percent of emergency room patients were uninsured patients. The comparable figure for public hospitals was 34 percent.[31]

b. **American Hospital Association**—The American Hospital Association conducts yearly surveys of hospitals. The survey contains information on bad debt and charity care as a percentage of hospital charges. Between 1979 and 1982, state and local government hospitals consistently had the highest percentage of debt and charity care as a percentage of gross patient revenue. By comparison, private not-

Table 2.2: Bad Debt and Charity Care in Registered Community Hospitals, 1979-1982

		Number	Gross Patient Revenue*	Bad Debt*	Charity Care*	Debt and Charity as Percentage of Gross Patient Revenue
1979	Nongovernment, not-for-profit	$ 3,330	$ 55,866	$ 1,521	$ 508	3.63%
	Investor-owned	727	6,120	175	6	2.96
	State and local government	1,785	14,089	1,110	585	12.03
	Total	5,842	76,074	2,806	1,098	5.13
1980	Nongovernment, not-for-profit	3,322	65,700	1,849	656	3.81
	Investor-owned	730	7,496	226	12	3.18
	State and local government	1,778	16,292	1,249	606	11.39
	Total	5,830	89,488	3,324	1,274	5.14
1981	Nongovernment, not-for-profit	3,340	78,282	2,221	793	3.85
	Investor-owned	729	8,942	270	7	3.10
	State and local government	1,744	19,055	1,299	967	11.89
	Total	5,813	106,281	3,790	1,767	5.23
1982	Nongovernment, not-for-profit	3,338	92,856	2,761	1,037	4.09
	Investor-owned	748	10,933	313	9	2.95
	State and local government	1,715	22,172	1,471	943	10.89
	Total	5,801	125,961	4,544	1,989	5.19

**In millions of dollars*

Source: American Hospital Association, Hospital Data Center. Annual Survey of Hospitals *(various years)*

Table 2.3: Uncompensated Care as a Percentage of Charges, by Ownership and Location, United States, 1982 and 1983

Type of Hospital	Metropolitan Areas,[a] 1982	Non-Metropolitan Areas,[a] 1982	U.S.,[b] 1983
For-profit	3.0%	4.2%	3.1%c
Not-for-profit	3.7	4.0	4.2
Teaching	(4.6)		
Nonteaching	(3.6)		
Government	8.6	5.3	11.5
Teaching	(15.0)		
Nonteaching	(7.2)		
TOTAL	4.4	4.5	

[a] Sloan et al. (1986).
[b] American Hospital Association, News Release, February 6, 1985.
[c] The Federation of American Hospitals, the association of for-profit hospitals, reported on the basis of its own survey that its members' deductions from gross revenue for charity and bad debt averaged 4.4 percent in 1983 (Federation of American Hospitals, no date).

for-profit hospitals consistently provided more bad debt and charity care than investor-owned hospitals.[32] (See Table 2.2) In 1983, AHA found that:

—Government hospitals provided 11.5 percent uncompensated care as a percentage of total hospital charges;

—Not-for-profit hospitals provided 4.2 percent uncompensated care; and

—For-profit hospitals provided 3.1 percent uncompensated care.[33] Table 2.3 summarizes the data.

2. **Studies on the State Level**—Significant differences in the provision of uncompensated care showed up in four out of five studies conducted at the state level. The Institute of Medicine obtained data from five states — California, Florida, Tennessee, Texas, and Virginia.[34] Table 2.4 summarizes the findings. In four states—Florida, Tennessee, Texas, and Virginia—for-profit hospitals provided substantially less uncompensated care than not-for-profit hospitals, when uncompensated care was measured as a percentage of gross patient revenues. Not-for-profit hospitals provided 50% to 150% more uncompensated care than their for-profit counterparts. In Tennessee and California, the data indicated that hospitals associated with investor-owned hospital chains had lower uncompensated care rates than did independent proprietary hospitals. Only in California was there no difference between investor-owned chain and not-for-profit chain hospitals. (See Table 2.4)

A study performed by Lewin and Associates, a Washington-based consulting firm, also found real differences in the provision of uncompensated care by investor-owned and not-for-profit hospitals. The study was commissioned by the Volunteer Trustees of Not-for-Profit Hospitals Foundation for Research and Education. The study compared uncompensated care at investor-owned and not-for-profit hospitals in California, Florida, North Carolina, Tennessee, and Virginia. In four of the five states examined (FL, NC, TN, VA) not-for-profit hospitals commit significantly more of their resources to uncompensated care than do investor-owned hospitals. In 1984, North Carolina's

Table 2.4: Hospital Uncompensated Care as a Percentage of Gross Patient Revenues, Various States, 1981-1983

Type of Ownership	California[a] 1981-1982	Florida[b] 1982	Tennessee[c] 1983	Texas[d] 1983	Virginia[e] 1982
Public	7.0%	12.1%	18.7%	32.4%	21.5%
Not-for-profit chain	2.0	6.6	9.0	6.5	5.5
Not-for-profit independent			8.7		
Investor-owned chain	2.0	3.8	3.4	3.5	3.5
Proprietary (independent)	3.0		4.6		

[a]Robert V. Pattison (1986) Response to Financial Incentives Among Investor-Owned and Not-for-profit Hospitals: An Analysis Based on California Data, 1978-1982.

[b]State of Florida (1984) Hospital Cost Containment Board, 1983-1984 Annual Report. Tallahassee, Fla.

[c]State of Tennessee, Department of Health and Environment, Nashville, Tenn. Unpublished data.

[d]Texas Hospital Association, Survey of Uncompensated Care in Hospitals, published in "THA Statement of Fair Share Formula for Financing Care for the Medically Indigent, 1985."

[e]Virginia Health Services Cost Review Commission, Richmond, Va. Unpublished data.

investor-owned hospitals absorbed 4.2 percent of the charity load while not-for-profit hospitals carried 6.7 percent. The Lewin study also found that not-for-profit hospitals are more likely than investor-owned hospitals to have high uncompensated care loads. In Florida, about half of all investor-owned hospitals devote less than 4 percent of their total expenses to uncompensated care, when compared to the statewide average of 6.4 percent for all nongovernment hospitals. In contrast, more than 80 percent of not-for-profit hospitals are above the 4 percent level of uncompensated care.[35]

Methodology

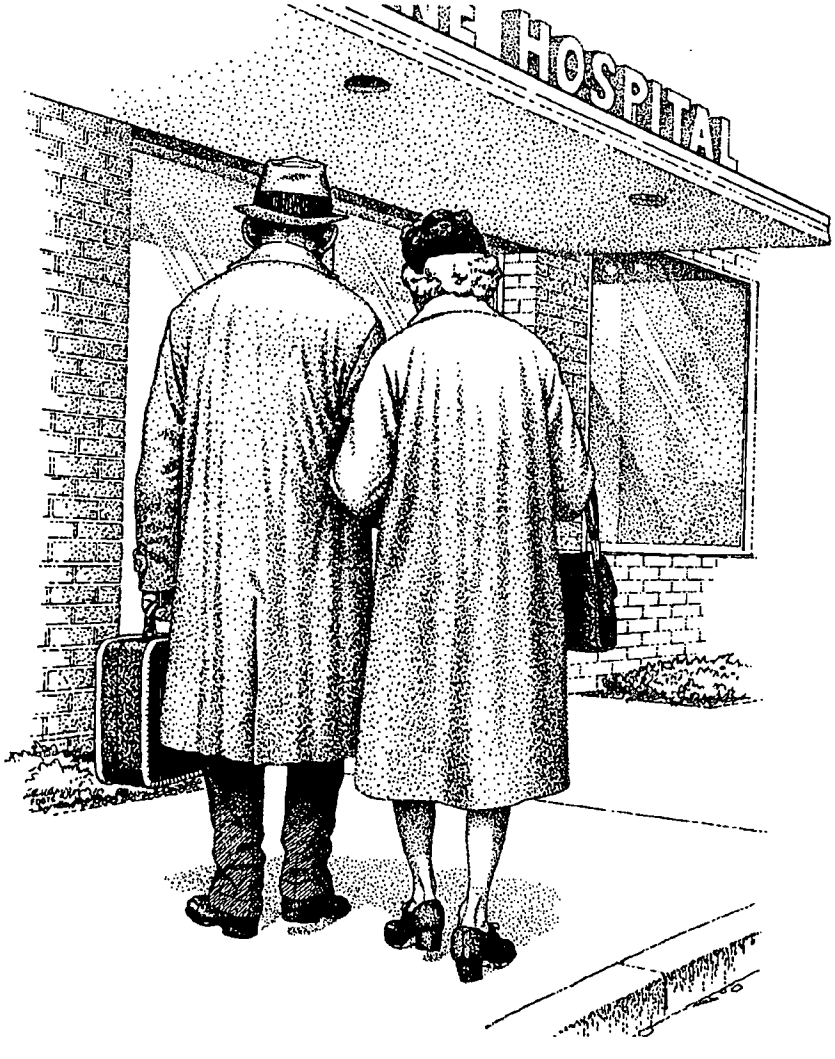
IN AN EFFORT TO DETERMINE the amount of indigent care provided by investor-owned and not-for-profit hospitals in North Carolina, the N.C. Center for Public Policy Research surveyed all 127 general acute care hospitals in the state asking for data on indigent care provided in fiscal year 1984. Eighty (63 percent) hospitals responded to the survey. Of the 80 responses, 75 surveys were complete enough to use in our data analysis, for an actual response rate of 60 percent. Those hospitals included 11 hospitals owned or managed by for-profit corporations, and 64 private not-for-profit and public hospitals. The response rate among the for-profit hospitals (52 percent) was only slightly lower than the not-for-profits (60 percent). Of the four major teaching hospitals in North Carolina, N.C. Baptist Hospital (Bowman Gray School of Medicine of Wake Forest), and Pitt County Memorial Hospital (East Carolina University School of Medicine) are included in this analysis. N.C. Memorial Hospital

(University of North Carolina School of Medicine) returned the survey; however, the data were not included in the analysis because the hospital is a state-owned teaching facility. Duke University Medical Center (Duke University School of Medicine) chose not to participate. The major strength of this methodology is that the Center attempted to look at the entire market of hospital care in North Carolina. Also, the data collected were later verified again by telephone. For the purpose of this analysis, the Center lumped together for-profit *owned* and for-profit *managed* hospitals on the hypothesis that those groups would probably not act differently with respect to providing indigent care.

The Lewin study and the N.C. Center's study both examined uncompensated care provided by hospitals in the same year—1984. The outcome of the studies was the same: not-for-profit hospitals provide more uncompensated care than do investor-owned hospitals. However, the percentages differ both because the source of the data was different and because the Center analyzed a larger group. The Lewin study used data from the 1984 American Hospital Association Annual Survey which includes estimates for data elements not reported by hospitals. The Center's study, however, used actual figures provided by hospital administrators for the data elements during the 1984 fiscal year. Lewin and Associates examined for-profit *owned* hospitals only, but the Center examined for-profit *owned* and for-profit *managed* hospitals. Lewin and Associates looked at not-for-profit hospitals, while the Center looked at not-for-profit *and* public hospitals.

The Center's Findings

IN THIS ANALYSIS, The Center defined uncompensated care as the total amount of indigent care, charity care, and bad debt. Medicaid and Medicare contractual adjustments are not included in the analysis. Contractual adjustments reflect uncollectible differences between established charges for services rendered to insured persons and rates payable for those services under contracts with third-party payers.



Results of the survey show that for-profit hospitals provide 27.3 percent less uncompensated care than not-for-profit and public hospitals, when bad debt and charity care are measured as a percentage of gross patient revenue. As a percentage of a hospital's gross patient revenues, not-for-profit hospitals spent 8.4 percent on uncompensated care, while for-profit hospitals spent 6.6 percent on uncompensated care. In terms of uncompensated care spent per hospital bed, not-for-profit hospitals spent $8,593 per bed and for-profits spent $7,000, for a difference of 22.8 percent. When considering uncompensated care per inpatient admissions, not-for-profits spent $237 per such admission and for-profits spent $203, a difference of 16.7 percent. And finally, if outpatient admissions are added to inpatient admissions, not-for-profits spent $53 per total admission and for-profits spent $44, for a difference of 20.5 percent. These findings are summarized in Table 2.5.

Duke University's Chris Conover surmises that all of these differences probably would be even greater if they were measured as a percentage of private patient admissions, number of beds, etc., since for-profits

Table 2.5: Uncompensated Care Provided By For-Profit and Not-For-Profit Hospitals in North Carolina, 1984

Variables	Eleven (11) Investor-Owned and -Managed Hospitals Responding to Survey	Sixty-Four (64) Not-For-Profit and Public Hospitals Responding to Survey	Percentage Difference
Average uncompensated care[1] as percentage of gross patient revenue[2]	6.6%	8.4%	27.3%
Average uncompensated care per bed	$7,000	$8,593	22.8%
Average uncompensated care per inpatient admission	$ 203	$ 237	16.7%
Average uncompensated care per inpatient and outpatient admission[3]	$ 44	$ 53	20.5%

[1] Uncompensated care is defined as the total of indigent care, charity care, and bad debt.

[2] Gross patient revenue consists of revenue from services rendered to patients including payments received from or on behalf of individual patients.

[3] Outpatient admissions include outpatient clinic visits, outpatient surgery visits, and emergency room visits.

Source: N.C. State Center for Health Statistics, Health Facilities Data Book, 1984, and Surveys of Chief Executive Officers of general acute care hospitals in North Carolina by the N.C. Center for Public Policy Research.

have a higher percentage of private patients than not-for-profits.[36] On the other hand, for-profit hospital executive John C. Bedrosian believes that for-profit hospitals are not the source of the uncompensated care problem. According to Bedrosian, private not-for-profit and for-profit hospitals are both reluctant to accept high numbers of non-paying patients because there is no source of funding for these patients, either through direct subsidy or cost-shifting.[37]

The Center also asked North Carolina hospitals for information on pre-admission deposits. Of the 75 hospitals in the Center's data base, 39 hospitals (52 percent) reported that they request pre-admission deposits. Sixty-seven percent of the investor-owned hospitals responding to the survey require pre-admission deposits; 60 percent of the investor-managed require deposits, and 48 percent of the private not-for-profit and public hospitals reported that they require pre-admission deposits. Most of the hospitals require pre-admission deposits *only* for elective (non-emergency) procedures. The pre-admission deposit varies, however. Many hospitals reported that they request a flat rate (e.g., $500 if the patient is uninsured) or a percentage of the patient's total estimated bill. Other hospitals require 80% of the estimated bill. Some hospitals reported that they were willing to work with patients to arrange monthly payment schedules for patients unable to pay the pre-admission deposit fully.

Table 2.6: Percentage of Respondents Reporting That Their Primary Hospital Discouraged Admission of Uninsured or Medicaid Patients

	Type of Patient	
Hospital ownership	**Uninsured**	**Medicaid**
Independent Hospitals		
For-profit	43 %	15 %
Private nonprofit	20	5
Public	14	3
Multihospital Systems		
For-profit	52	16
Private nonprofit	19	6
Public	9	3

Source: 1984 Core Survey of the AMA's Socioeconomic Monitoring System. Mark Schlesinger, Judy Bentkover, David Blumenthal, Robert Musacchio, and Janet Willer. "The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services," The Milbank Quarterly, *Vol. 65, No. 1; 1987, p. 33.*

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North Carolina Legal Services offices contacted approximately 75 hospitals in 1985 to ask about their pre-admission deposit requirements. Nearly 85 percent of the hospitals contacted requested a pre-admission deposit. Approximately 47 percent of the hospitals stated that they would refuse to admit or would reschedule an admission for a patient who was unable to pay a pre-admission deposit or who had outstanding debts—unless the patient needed emergency care.[38]

In a 1984 survey conducted by the American Medical Association, physicians were asked to provide information about the admitting practices of their primary hospital, as they related to uninsured patients and Medicaid patients. When averages were calculated for all hospitals, twenty-one percent of the physicians reported that their primary hospital discouraged admission of uninsured patients; and six percent of the physicians reported that their primary hospital discouraged admission of Medicaid patients.[39] (See Table 2.6)

Based on the data in Tables 2.7-2.9, one can conclude that any hospital (whether for-profit or not-for-profit) which is the sole provider of hospital services in the community tends to provide a higher level of uncompensated care than would be provided if there were other hospitals in the community. Of the twenty not-for-profit North Carolina hospitals that rank high in terms of providing uncompensated care, six hospitals—Chatham, Duplin General, Lenoir Memorial, Montgomery Memorial, Scotland Memorial, and Wilkes General—are the sole provider of hospital services in the community.

An examination of particular *for-profit* hospitals responding to the Center's survey (investor-owned and investor-managed) reveals that there is wide variation of uncompensated care provided when measured as a percentage of gross patient revenue. Johnston Memorial Hospital, an HCA-managed hospital in Smithfield, provided 14.2 percent uncompensated care. Medical Park Hospital, formerly a physician-owned hospital in Winston-Salem and now owned by Carolina Medicorp, Inc., provided the least uncompensated care (1.2 percent). Johnston Memorial is the only acute-care hospital in Johnston county. The 1984 data shows that Cape Fear Valley Medical Center,

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NORTH CAROLINA CONSIDERS PROPOSALS TO ASSIST PUBLIC HOSPITALS

by Lori Ann Harris

MANY NORTH CAROLINA HOSPITALS are struggling to exist in an environment characterized by decreasing patient revenues and increasing costs for taking care of indigent patients. Since 1985, three North Carolina hospitals have shut down—Gordon Crowell Hospital in Lincolnton, an investor-owned hospital, Huntersville Hospital in Mecklenburg County and Warren General Hospital in Warrenton, both county-owned hospitals.[1] In 1988, legislation was passed that would permit any public hospital[2] to garnish patients' wages in order to collect debts on unpaid hospital bills.[3] The garnishment bill, effective June 3, 1988, will assist hospitals unable to collect outstanding debts from people who are able to pay but refuse to do so. According to Stephen Morrisette, senior vice president of the N.C. Hospital Association, North Carolina hospitals lost $242 million in 1985 due to patients who refused to pay their bills.[4]

In the past, there has been strong opposition to laws permitting wage garnishment for ordinary debts. Under the bill, strict procedural guidelines and conditions must be met before an order of garnishment can be entered. Under the new legislation, an order of garnishment cannot be entered if the debtor's income is at or below 200% of the federal poverty guidelines, less the costs of the family's ongoing medical needs. The garnishment also may not exceed 10% of the debtor's monthly disposable earnings. In addition, a garnishment order cannot be entered if the debtor is making a good faith effort to obtain payment from a third-party payer.

Other legislative action included the establishment of a commission to study the survival of public hospitals. The Public Hospital Study Commission will examine a request by public hospitals for a constitutional amendment to allow them to pursue innovative delivery and financial arrangements in order to compete in the changing health care environment. The issues to be examined by the Commission include:

—How the growth of a more competitive health care environment has affected public hospitals in North Carolina;

—How the operations and capital expenditures of public hospitals owned and controlled by local governments are currently financed;

—What constitutional, statutory, and case law restrictions prevent public hospitals from making the fullest use of their resources in competing with nonpublic providers of health care; and

—What constitutional, statutory, and case law restrictions prevent public hospitals or the local governmental units that own and control them from participating in or financing innovative arrangements for the provision of health care.[5]

For more on this proposed amendment, see pages 161-162 in the text of chapter 5.

FOOTNOTES

[1]For more information on hospital closures, see Jack Betts, "North Carolina Hospitals Succumb to Ills of Health Care Industry," Lacy Maddox, editor, *The Investor-Owned Hospital Movement in North Carolina, N.C. Center for Public Policy Research,* 1986, p. 50.

[2]"Public hospital" as defined by N.C.G.S. 159-39 means a hospital operated on a nonprofit basis, or a hospital owned or operated by a county, city, hospital district, or hospital authority.

[3]Chapter 880 (SB 661) of the 1988 Session Laws.

[4]Stephen Morrisette, Presentation to the N.C. House of Representatives Judiciary II Committee during the 1987 General Assembly.

[5]Chapter 873 (HB 1) of the 1987 Session Laws, Section 16.1.

Table 2.7: Rankings of *For-Profit* Hospitals in Terms of Providing Uncompensated Care: Most to Least (1984)

	For-Profit Hospital	Uncompensated Care as % of Gross Patient Revenue
1.	Johnston Memorial Hospital (IM)	14.2%
2.	Cape Fear Valley Medical Center (IM)	10.3
	Not-For-Profit Hospital Average	*8.4*
3.	Spruce Pine Community Hospital (IM)	8.2
4.	The McDowell Hospital (IM)	7.7
5.	Central Carolina Hospital (IO)	6.7
	For-Profit Hospital Average	*6.6*
6.	Frye Regional Medical Center (IO)	6.0
7.	Davis Community Hospital (IO)	5.4
8.	Highsmith-Rainey Memorial (IO)	4.6
	Ashe Memorial Hospital (IM)	4.6
10.	Raleigh Community Hospital (IO)	4.1
11.	Medical Park Hospital (IO)	1.2

	For-Profit Hospital	Uncompensated Care Per Bed
1.	Cape Fear Valley	$14,361
2.	Johnston	10,481
3.	Central Carolina	8,607
	Not-For-Profit Hospital Average	*8,593*
4.	McDowell	8,151
5.	Frye Regional	7,585
	For-Profit Hospital Average	*7,000*
6.	Raleigh Community	6,631
7.	Spruce Pine	6,261
8.	Highsmith-Rainey	5,387
9.	Davis	5,011
10.	Ashe	3,430
11.	Medical Park	1,095

	For-Profit Hospital	Uncompensated Care Per Inpatient Admissions
1.	Johnston	$386
2.	Cape Fear Valley	362
3.	Frye Regional	248
	Not-For-Profit Hospital Average	*237*
4.	Central Carolina	231
5.	Spruce Pine	220
	For-Profit Hospital Average	*203*
6.	Highsmith-Rainey	197
7.	McDowell	164
8.	Raleigh Community	141
9.	Davis	135
10.	Ashe	130
11.	Medical Park	21

	For-Profit Hospital	Uncompensated Care Per Total Admissions
1.	Johnston	$93
2.	Cape Fear Valley	69
	Not-For-Profit Hospital Average	*53*
3.	Spruce Pine	51
4.	Highsmith-Rainey	50
5.	Central Carolina	46
	For-Profit Hospital Average	*44*
6.	Frye Regional	42
7.	Davis	38
8.	McDowell	35
9.	Ashe	28
10.	Raleigh Community	25
11.	Medical Park	9

IO = *owned* by investor-owned corporation
IM = *managed* by investor-owned corporation

Note: Does *not* include Medicare and Medicaid contractual adjustments.

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

Table 2.8: Rankings of Twenty Highest *Not-For-Profit* Hospitals in Terms of Providing Uncompensated Care (1984)

	Not-For-Profit Hospital	Uncompensated Care as % of Gross Patient Revenue		Not-For-Profit Hospital	Uncompensated Care Per Bed
1.	Martin General	15.6%	1.	Wake Medical Center	$16,533
2.	Lincoln County	13.0	2.	Lexington Memorial	16,018
3.	Wilkes General	12.9	3.	Memorial Mission	14,791
4.	Duplin General	12.0	4.	Moses Cone Memorial	14,761
5.	Montgomery Memorial	11.9	5.	Carteret General	14,557
6.	J. Arthur Dosher Memorial	11.7	6.	Wilkes General	14,500
(tie)	Carteret General	11.7	7.	J. Arthur Dosher	14,241
8.	Charles A. Cannon Memorial	11.6	8.	Caldwell Memorial	13,408
(tie)	Lexington Memorial	11.6	9.	New Hanover Memorial	13,192
10.	Good Hope	11.3	10.	Montgomery Memorial	13,128
11.	Annie Penn Memorial	10.7	11.	Pitt County Memorial	13,027
(tie)	High Point Regional	10.7	12.	High Point Regional	12,971
(tie)	Sloop Memorial	10.7	13.	Craven County	11,864
14.	Cleveland Memorial	10.6	14.	Good Hope	11,399
15.	Chatham	10.5	15.	Martin General	11,205
16.	Catawba Memorial	10.3	16.	Grace	11,073
(tie)	Lenoir Memorial	10.3	17.	Sloop Memorial	10,949
(tie)	Richmond Memorial	10.3	18.	Lenoir Memorial	10,751
19.	Caldwell Memorial	10.2	19.	Catawba Memorial	10,348
20.	Scotland Memorial	9.8	20.	Richmond Memorial	9,908
	Not-For-Profit Hospital Average	*8.4*		*Not-for-Profit Hospital Average*	*$8,593*
	For-Profit Hospital Average	*6.6*		*For-Profit Hospital Average*	*$7,000*

	Not-For-Profit Hospital	Uncompensated Care Per Inpatient Admission
1.	Wake Medical Center	$431
2.	Martin General	371
3.	Moses Cone Memorial	370
4.	Pitt County	366
5.	J. Arthur Dosher	355
6.	Carteret General	340
7.	Memorial Mission	335
8.	Good Hope	331
9.	Anson County	328
10.	Lexington Memorial	322
11.	Richmond Memorial	321
12.	Chowan	316
13.	Caldwell Memorial	315
14.	Annie Penn Memorial	308
15.	Catawba Memorial	307
16.	Southeastern General	299
17.	New Hanover Memorial	298
18.	Scotland Memorial	290
19.	Wilkes General	287
20.	Duplin General	283
	Not-For-Profit Hospital Average	*$237*
	For-Profit Hospital Average	*$203*

	Not-For-Profit Hospital	Uncompensated Care Per Total Admissions
1.	Pitt County Memorial	$100
2.	Memorial Mission	99
3.	J. Arthur Dosher	82
(tie)	Wake Medical Center	82
5.	Sloop Memorial	81
(tie)	Wayne Memorial	81
7.	Southeastern General	79
8.	Caldwell Memorial	78
(tie)	Martin General	78
10.	Moses Cone Memorial	77
11.	High Point Regional	76
(tie)	Lenoir Memorial	76
13.	N. C. Baptist	75
14.	Durham County General	73
15.	Catawba Memorial	69
(tie)	Roanoke-Chowan	69
17.	New Hanover Memorial	68
18.	Charles A. Cannon	67
19.	Albemarle	65
20.	Duplin General	63
	Not-for-Profit Hospital Average	*$53*
	For-Profit Hospital Average	*$44*

Note: Does *not* include Medicare and Medicaid contractual adjustments.

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

Table 2.9: Rankings of Twenty Lowest *Not-For-Profit* Hospitals in Terms of Providing Uncompensated Care (1984)

	Not-For-Profit Hospital	Uncompensated Care as % of Gross Patient Revenue		Not-For-Profit Hospital	Uncompensated Care Per Bed
1.	Sea Level	2.2%	1.	Sea Level	$1,125
2.	Charlotte Memorial	2.4	2.	Alleghany County	2,825
(tie)	Presbyterian	2.4	3.	St. Luke's	3,188
4.	Cape Fear Memorial	3.8	4.	Stokes-Reynolds	3,308
5.	Rex Hospital	4.0	5.	Presbyterian	3,331
6.	Surry County	4.8	6.	Cape Fear Memorial	3,710
7.	Valdese General	5.2	7.	Charlotte Memorial	4,028
8.	N.C. Baptist	5.4	8.	Mountain Park Medical Center	4,108
(tie)	St. Luke's	5.4	9.	Valdese General	4,161
10.	Durham County Gen.	5.7	10.	Memorial of Alamance	4,284
(tie)	Forsyth Memorial	5.7	11.	Davie County	5,465
(tie)	Iredell Memorial	5.7	12.	Charles A. Cannon	5,539
13.	Stokes-Reynolds	5.8	13.	Park Ridge	5,561
14.	Alleghany County	6.1	14.	Stanly Memorial	5,841
15.	Memorial Hospital of Alamance	6.2	15.	Rowan Memorial	5,918
16.	Community General of Thomasville	6.4	16.	Surry County	6,111
17.	C. J. Harris	7.0	17.	Haywood County	6,214
18.	Davie County	7.3	18.	Rex	6,410
(tie)	Stanly Memorial	7.3	19.	Forsyth Memorial	6,429
20.	Haywood County	7.4	20.	Granville	6,580
(tie)	Rowan Memorial	7.4			
	Not-For-Profit Hospital Average	*8.4%*		*Not-For-Profit Hospital Average*	*$8,593*
	For-Profit Hospital Average	*6.6%*		*For-Profit Hospital Average*	*$7,000*

	Not-For-Profit Hospital	Uncompensated Care Per Inpatient Admission
1.	Presbyterian	$ 65
2.	Alleghany County	98
3.	Sea Level	108
4.	Charlotte Memorial	121
5.	Surry County	126
6.	Cape Fear Memorial	130
7.	St. Luke's	133
8.	Rex	140
9.	Iredell	149
(tie)	Valdese General	149
11.	Forsyth Memorial	156
12.	Rowan Memorial	160
13.	Columbus County	161
(tie)	Davie County	161
15.	C. J. Harris	166
16.	Community General of Thomasville	172
17.	Stokes-Reynolds	173
18.	Stanly Memorial	176
19.	Halifax Memorial	177
20.	Haywood County	180
(tie)	Memorial Hospital of Alamance	180
	Not-For-Profit Hospital Average	*$237*
	For-Profit Hospital Average	*$203*

	Not-For-Profit Hospital	Uncompensated Care Per Total Admissions
1.	Charlotte Memorial	$17
2.	Surry County	19
3.	Presbyterian	21
4.	Alleghany County	27
5.	Cape Fear Memorial	30
(tie)	Granville	30
(tie)	Haywood County	30
8.	Cabarrus Memorial	34
(tie)	St. Luke's	34
10.	Iredell Memorial	36
11.	Cleveland Memorial	37
12.	Columbus County	39
(tie)	Forsyth Memorial	39
(tie)	Montgomery Memorial	39
15.	Gaston Memorial	40
(tie)	Sea Level	40
17.	Pender Memorial	41
18.	Memorial Hospital of Alamance	42
(tie)	Richmond Memorial	42
20.	Annie Penn	43
(tie)	Community General-Thomasville	43
(tie)	Stokes-Reynolds	43
(tie)	Wilkes General	43
	Not-For-Profit Hospital Average	*$53*
	For-Profit Hospital Average	*$44*

Note: Does *not* include Medicare and Medicaid contractual adjustments.

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

Table 2.10: Uncompensated Care Provided By Large Hospitals with 400+ Beds (1984)

Hospital	Number of Beds	Uncompensated Care	Uncompensated Care as % of Gross Patient Revenue	Uncompensated Care Per Bed	Uncompensated Care Per Inpatient Admission	Uncompensated Care Per Total Admissions
1. Charlotte Memorial	853	$3,436,157	2.4%	$ 4,028	$121	$17
2. Forsyth Memorial	762	4,898,893	5.7	6,429	156	39
3. N.C. Baptist	701	6,636,000	5.4	9,466	264	75
4. Presbyterian	543	1,808,520	2.4	3,331	65	21
5. Pitt County	538	7,008,296	8.7	13,027	366	100
6. Wake Medical	524	8,663,271	8.9	16,533	431	82
7. Cape Fear Valley (IM)	492	7,065,563	10.3	14,361	362	69
8. Durham County	476	3,471,424	5.7	7,293	218	73
9. Moses Cone	468	6,908,010	9.0	14,761	370	77
10. Cabarrus Memorial	457	3,346,479	8.8	7,323	181	34
11. New Hanover	454	5,989,195	9.4	13,192	298	68
12. Memorial Mission	435	6,433,940	9.1	14,791	335	99
13. Gaston Memorial	431	3,933,973	8.4	9,123	227	40
Not-For-Profit Hospital Average	*220*	*$1,956,917*	*8.4%*	*$ 8,632*	*$238*	*$53*
For-Profit Hospital Average	*172*	*$1,478,060*	*6.6%*	*$ 7,000*	*$203*	*$44*

IM = managed by investor-owned corporation

Note: Does *not* include Medicare and Medicaid contractual adjustments.

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

then managed by National Medical Enterprises, provided the most in uncompensated care per bed among for-profits ($14,361), nearly $6,000 more than the average ($8,593) for not-for-profit hospitals. Cape Fear Valley, the state's largest investor-managed hospital in 1984 has 492 beds. All of the investor-*managed* hospitals, except for HCA's Ashe Memorial Hospital, provided more uncompensated care as a percentage of gross patient revenue than the investor-*owned* hospitals. (See Table 2.7)

Martin General Hospital, a county-owned facility, provided the most uncompensated care as a percentage of gross patient revenue (15.6 percent) of any *not-for-profit*, indeed of any, hospital in this data base during 1984. During the same year, the private not-for-profit Sea Level Hospital in Carteret County provided the least uncompensated care (2.2 percent) among not-for-profit hospitals. The inclusion of data on the amount of indigent/charity care provided (only the amount for bad debt was available) would have

Table 2.11: Uncompensated Care Provided by Hospitals With 250-400 Beds (1984)

	Hospital	Number of Beds	Uncompensated Care	Uncompensated Care as % of Gross Patient Revenue	Uncompensated Care Per Bed	Uncompensated Care Per Inpatient Admission	Uncompensated Care Per Total Admissions
1.	Rex	394	$2,525,555	4.0%	$ 6,410	$140	$46
2.	Southeastern General	355	3,354,000	8.9	9,448	299	77
3.	Wayne Memorial	341	2,652,962	8.8	7,780	234	81
4.	Rowan Memorial	324	1,917,299	7.4	5,918	160	45
5.	Cleveland Memorial	300	2,813,478	10.6	9,378	250	37
6.	High Point	282	3,657,757	10.7	12,971	272	76
7.	Lenoir Memorial	281	3,021,148	10.3	10,751	269	76
8.	Frye Regional Medical Center (IO)	275	2,086,000	6.0	7,585	248	42
9.	Catawba Memorial	260	2,690,526	10.3	10,348	307	69
10.	Craven County	254	3,013,348	8.0	11,864	278	60
	Not-For-Profit Hospital Average	*220*	*$1,956,917*	*8.4%*	*$8,632*	*$238*	*$53*
	For-Profit Hospital Average	*172*	*$1,478,060*	*6.6%*	*$7,000*	*$203*	*$44*

IO = owned by investor-owned corporation

Note: Does *not* include Medicare and Medicaid contractual adjustments.

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

increased Sea Level's percentages for uncompensated care. (See Tables 2.8 and 2.9)

The Center also analyzed the amount of uncompensated care among hospitals of various bed sizes. Investor-managed Cape Fear Valley Medical Center provided the most uncompensated care among large hospitals (400+ beds). High Point Memorial Hospital provided the highest level of uncompensated care in the 250-400 bed category. In the 100-250 bed category, HCA-managed Johnston Memorial Hospital provided the most (14.2 percent) uncompensated care. Two other hospitals, Murphy Medical Center and Kings Mountain also provided a significant amount of uncompensated care. The hospitals' responses included Medicare and Medicaid contractual adjustments, however, and thus overstates the actual percentage of uncompensated care provided when standardized against other responses. The Center did not include Medicare and Medicaid contractual adjust-

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Table 2.12: Uncompensated Care Provided by Hospitals With 100-250 Beds (1984)

	Hospital	Number of Beds	Uncompensated Care	Uncompensated Care as % of Gross Patient Revenue	Uncompensated Care Per Bed	Uncompensated Care Per Inpatient Admission	Uncompensated Care Per Total Admissions
1.	Memorial Hospital of Alamance	222	$ 951,151	6.2%	$4,284	$180	$42
	Not-For-Profit Hospital Average	*220*	*1,956,917*	*8.4*	*8,632*	*238*	*53*
2.	Albemarle	206	1,595,092	8.2	7,743	269	65
3.	Haywood County	200	1,242,728	7.4	6,214	180	30
4.	Halifax Memorial	190	1,398,212	8.0	7,359	177	49
5.	Iredell Memorial	182	1,216,866	5.7	6,686	149	36
6.	Johnston Memorial (IM)	180	1,886,638	14.2	10,481	386	93
	For-Profit Hospital Average	*172*	*1,478,060*	*6.6*	*7,000*	*203*	*44*
7.	Murphy Medical Center	170	1,057,066 *	18.7 *	6,218 *	546 *	115 *
8.	Columbus County	166	1,391,455	7.5	8,382	161	39
9.	Scotland Memorial	165	1,632,803	9.8	9,896	290	48
10.	Grace	161	1,782,807	9.3	11,073	240	46
11.	Annie Penn	152	1,448,415	10.7	9,529	308	43
12.	Highsmith-Rainey (IO)	150	808,081	4.6	5,387	197	50
13.	Davis Community (IO)	149	746,604	5.4	5,011	135	38
14.	Cape Fear Memorial	142	526,840	3.8	3,710	130	30
15.	Central Carolina (IO)	142	1,222,133 *	6.7 *	8,607 *	231 *	46 *
16.	Community General-Thomasville	140	923,012	6.4	6,593	172	43
17.	Raleigh Community (IO)	140	928,288	4.1	6,631	141	25
18.	Medical Park (IO)	136	148,889	1.2	1,095	21	9
19.	Valdese General	134	557,508	5.2	4,161	149	51
20.	Wilkes General	133	1,928,518	12.9	14,500	287	43
21.	Caldwell Memorial	130	1,743,007	10.2	13,408	315	78
22.	Stanly Memorial	130	759,312	7.3	5,841	176	46
23.	Richmond Memorial	122	1,208,729	10.3	9,908	321	42
24.	Roanoke-Chowan	120	1,069,608	9.2	8,913	215	69
25.	Carteret General	119	1,732,326	11.7	14,557	340	51
26.	Lincoln County	110	851,899	13.0	7,745	239	50
27.	Chowan	109	739,691	8.6	6,786	316	62
28.	Surry County	108	660,000	4.8	6,111	126	19
29.	Park Ridge	103	572,739	8.2	5,561	215	62
30.	Kings Mountain	102	1,326,138 *	22.7 *	13,001 *	495 *	103 *
31.	Stokes-Reynolds	100	330,808	5.8	3,308	173	43

IO = owned by investor-owned corporation
IM = managed by investor-owned corporation
* = Medicare and Medicaid contractual adjustments included.

Note: Except for three respondents, does *not* include Medicare and Medicaid contractual adjustments.

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

Table 2.13: Uncompensated Care Provided by Hospitals With 0-99 Beds (1984)

	Hospital	Number of Beds	Uncompensated Care	Uncompensated Care as % of Gross Patient Revenue	Uncompensated Care Per Bed	Uncompensated Care Per Inpatient Admission	Uncompensated Care Per Total Admissions
1.	Anson County	96	$ 678,759	7.9%	$ 7,070	$328	$52
2.	Lexington Memorial	94	1,505,700	11.6	16,018	322	48
3.	Spruce Pine (IM)	92	575,996	8.2	6,261	220	51
4.	C. J. Harris	80	653,080	7.0	8,164	166	56
5.	Duplin General	80	749,747	12.0	9,372	283	63
6.	Charles Cannon	79	437,616	11.6	5,539	260	67
7.	Ashe Memorial (IM)	76	260,684	4.6	3,430	130	28
8.	St. Luke's	74	235,944	5.4	3,188	133	34
9.	Davie County	72	393,515	7.3	5,465	161	47
10.	Good Hope	72	820,780	11.3	11,399	331	47
11.	Sea Level	72	1,595,092	8.2	7,743	269	65
12.	Chatham	68	649,933	10.5	9,558	277	51
13.	Granville	68	447,463	8.2	6,580	259	30
14.	McDowell (IM)	65	529,784	7.7	8,151	164	35
15.	Bladen Cunty	62	494,463	7.9	7,975	210	57
16.	Mountain Park	61	250,573	8.1	4,108	187	49
17.	Hamlet	60	452,262	8.5	7,538	269	51
18.	Montgomery Memorial	57	748,314	11.9	13,128	259	39
19.	Alleghany County	46	129,964	6.1	2,825	98	27
20.	Pender Memorial	44	355,731	8.8	8,085	233	41
	Not-For-Profit Hospital Average	*220*	*$1,956,917*	*8.4%*	*$8,632*	*$238*	*$53*
	For-Profit Hospital Average	*172*	*$1,478,060*	*6.6%*	*$7,000*	*$203*	*$44*

IM = managed by investor-owned corporation

Source: Surveys of Chief Executive Officers of general acute care hospitals in North Carolina, and original research by N.C. Center for Public Policy Research.

Table 2.14: Charity Care and Net Bad Debts as a Percentage of Gross Patient Revenue by Hospital Size * (1983 Averages)

Hospital Size	Charity Care As A Percentage of Gross Patient Revenue	Net Bad Debts As A Percentage of Gross Patient Revenue
0 - 49 beds	.68%	5.46%
50 - 69 beds	1.11	6.51
70 - 99 beds	.83	7.19
100 - 149 beds	.73	6.55
150 - 199 beds	1.40	6.36
200 - 299 beds	1.42	5.96
300 - 399 beds	1.17	5.14
400 + beds	1.40	5.73
Teaching Hospitals	4.48	5.14
All Hospitals	1.80	5.79

* All teaching hospitals are included in the category "Teaching Hospitals" — This category includes general, short-term, acute teaching hospitals.

Source : Provider Payment Section, Blue Cross Blue Shield of North Carolina; Jeanne Johnson Chamberlin, *Indigent Health Care: Ensuring Access, Equity and Cost Effectiveness,* State Health Planning, paper prepared for SHCC Task Force on Uncompensated Care, December 1, 1984.

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ments in the analysis. Finally, in the small hospital category (0-99 beds), Duplin General Hospital was the leader in providing 12.0 percent uncompensated care. See Tables 2.10-2.13 for a complete listing. N.C. Memorial Hospital, a state-owned teaching facility provided 16.9 percent uncompensated care in 1984. N.C. Memorial was not included in the analysis of hospitals in North Carolina.

In 1983, Blue Cross and Blue Shield of North Carolina also collected data on charity care and bad debt by hospital size. When compared to large facilities, small hospitals had a heavier burden of bad debt, but a smaller charity care burden.[40] (See Table 2.14) A table listing the amounts of uncompensated care provided by all North Carolina hospitals responding

—continued on page 71

Table 2.15: County Appropriations to Hospitals, 1986-87 Fiscal Year

	County	County Appropriations to a County-Owned Hospital	County Appropriations to a Privately-Owned Hospital	Total County Appropriations to Local Hospital(s)
1.	Bertie	$ 151,069	$ 0	$ 51,069
2.	Buncombe	0	772,850	772,850
3.	Cabarrus	229,167	0	229,167
4.	Carteret	25,000	0	25,000
5.	Davie	25,004	0	25,004
6.	Duplin	150,000	0	150,000
7.	Durham	2,862,213	0	2,862,213
8.	Granville	0	229,401	229,401
9.	Henderson	100,900	24,270	125,170
10.	Jackson	0	15,000	15,000
11.	Lincoln	1,800	0	1,800
12.	Martin	368,038	0	368,038
13.	Mecklenburg	0	9,269,199	9,269,199
14.	Nash	150,000	0	150,000
15.	Pender	152,774	0	152,774
16.	Person	0	788,308	788,308
17.	Sampson	70,000	0	70,000
18.	Stokes	298,075	0	298,075
19.	Wake	5,059,421	0	5,059,421
20.	Warren	47,664	0	47,664
21.	Washington	12,000	0	12,000
22.	Yadkin	46,000	0	46,000
23.	Yancey	104,708	0	104,708
	TOTAL	$9,807,833	$11,099,028	$20,906,861

Source: N.C. Local Government Commission in the N.C. Department of the State Treasurer.

THE SEARCH FOR SOLUTIONS TO MEDICAL INDIGENCY AT THE FEDERAL AND STATE LEVEL

by Lori Ann Harris

MANY FEDERAL PROPOSALS AND INITIATIVES to address the poor's need for health care have been discussed. A National Health Insurance Plan that would provide broad health coverage for all Americans was first proposed by President Harry S. Truman and has been debated for decades. The government may be forced to increase its role in providing health care as the population ages, as the increasing number of medical indigents rise, and as the AIDS (acquired immune deficiency syndrome) crisis worsens. More recently, federal action has included proposals for national health insurance covering only catastrophic health events.

Many states are taking separate steps to solve the uncompensated care dilemma. The problem of financing indigent care is often viewed as a state matter, and hospitals are beginning to work with state legislators to find solutions. A 1986 survey by the National Conference of State Legislatures revealed that indigent care was a top priority on state legislative agendas.[1] And, according to the Annual State-by-State Survey of Health Legislative Activities conducted by the Federation of American Health Systems, indigent care and Medicaid funding were among the leading health issues in state legislatures in 1987 and 1988. Currently, some 35 states and the District of Columbia have programs to provide health care for the medically indigent. Another 25 states are expected either to start new programs or institute changes that would improve existing programs. In 1988, 38 states and the District of Columbia passed legislation that expanded the Medicaid program to include pregnant women and children.[2] Other proposals include assessments on hospitals and other providers to fund indigent care, increases in state sales taxes, and creation of state insurance pools to provide coverage for those not able to buy private insurance. Many states have developed programs to aid *individuals* rather than hospitals. Programs aimed at hospitals are considered to be less cost-effective, because they encourage patients to seek their care in the more expensive hospital setting.

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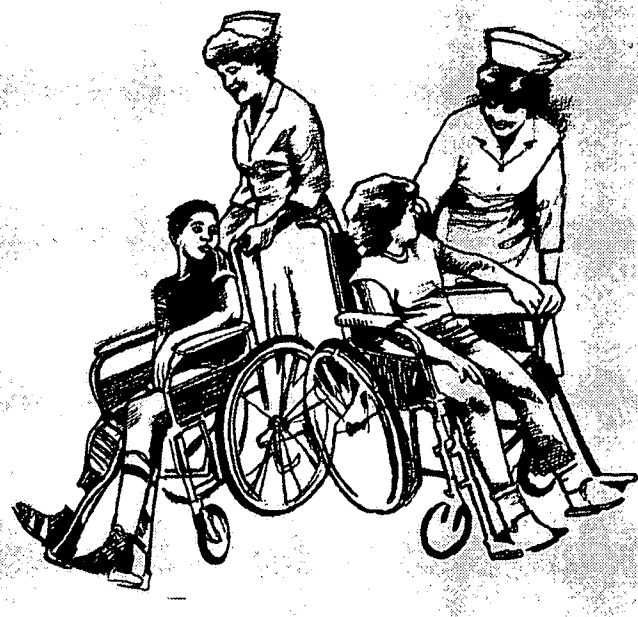

Mandated Employer-Based Insurance Coverage

ONE OPTION used by states to cope with the dilemma of indigent care is to require employers to provide a basic health insurance plan to all employees and dependents. The Employee Retirement Income Security Act of 1974 (ERISA), a federal law, prohibits states from requiring that employers provide health benefits. Hawaii, exempt from the federal law, has required employers to provide health coverage since the early 1970s.

In Massachusetts, a universal health insurance plan was enacted in April 1988. The law proposed by Governor Michael Dukakis is the nation's first system designed to assure health insurance for everyone. The law, which will not be fully phased in until 1992, guarantees medical coverage for an estimated 600,000 (10 percent of the population) uninsured state residents. The plan requires employers with six or more workers to provide health insurance for all employees or pay an unemployment tax surcharge to the state, while the state would provide insurance for the unemployed through a trust fund. Revenues generated by the surcharge would provide a pool of funds to be used for free care and for hospitals' uncollected bills. The legislation also restructures the state's hospital financing system, allowing hospitals to raise fees by $1 billion over the next four years. In addition, new hospital reimbursement methods will be partially based on patient volume.[3]

Other states considered mandated benefit programs similar to that of Massachusetts during the 1988 session. Legislation introduced in Kentucky and Tennessee was defeated; however, both state legislatures are expected to consider the proposals in the next session. Legislation still pending in Michigan would establish an insurance pool to provide medical coverage on a county-by-county basis. Vermont, California, and Missouri also examined ways to mandate insurance benefits.[4]

Of the uninsured workers in the United States, about 90% do not have coverage because their employer does not offer it, while the remaining 10% choose not to pay for it. Some employers impose a waiting period before new employees are eligible for health insurance. Additionally, employees with pre-existing health conditions are often not eligible for health coverage. Furthermore, part-time workers are usually not eligible for insurance benefits. Finally, health coverage is out of financial reach for a number of small firms (firms with fewer than 25 employees). Premiums for small employers tend to be as high as 30 to 40 percent above the going rate for larger employers. A survey conducted by A. Foster Higgins & Company, a New York-based benefits consultant group, showed that corporate and government employers paid an average of $1,985 per worker in 1987 for health care benefits. The cost of providing health care benefits to employees rose 7.9 percent, or an average $128 per employee over 1986 figures. Health care benefit costs were projected to increase to $2,100 per employee in 1988.[5]

Employer-based health coverage has been criticized as a burden on small businesses, essentially creating an additional tax on employment and entrepreneurship. Christine Soloman, Director of State Legislation for the Federation of American Health Systems says, ". . .[T]hose businesses which cannot afford the expense of health insurance will either cease to exist, or will be forced to let employees go, thereby adding to the number of medically indigent the program was developed to reduce."[6] On the other hand, advocates for employer-based health coverage argue that if every business has to pay for insurance, none would have a cost advantage over competitors. Individuals might have less money in their paychecks, but they would have health insurance coverage. It has been speculated, however, that unemployment among minimum wage workers might increase if employers are mandated to provide health benefits.

A more limited proposal would exempt part-time workers, as is done in many states. However, this approach could possibly speed up the trend to replace full-time employees with part-timers who do not qualify for health insurance or other benefits. The most notable advantage of any statutory mandate of employer-based coverage is that it is a way of extensively expanding health care coverage at no cost to the states' budgets.

On the national front, Sen. Edward Kennedy (D-Mass.) has sponsored a "minimum health" bill that would require employers to provide minimum health benefits package to employees working 17.5 hours a week or more, and their dependents. The Congressional Budget Office estimates the bill would cover up to 23 million uninsured people if enacted.[7]

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Rep. Fortney "Pete" Stark (D-CA) sponsored a bill that would authorize fines for businesses that do not offer employees health benefits. Self-employed individuals and unincorporated businesses would receive a higher tax deduction for health insurance plans purchased. The bill would also establish an income tax credit for health insurance premium contributions for low-income workers.[8]

Catastrophic Illness Insurance Program

CATASTROPHIC INSURANCE programs are available in seven states. Catastrophic health insurance is designed to help pay the medical bills of persons with high health care costs due to illness or injury. Among the states with the insurance program are Maine, Maryland, Minnesota, New Hampshire, Rhode Island, and South Carolina. A catastrophic illness program was passed in Alaska in 1986 but the program was never funded. Many states have had difficulties in administering and implementing catastrophic insurance coverage because of its high cost. The programs also proved to be very expensive because states tended to underestimate the demand for such programs. Those states found they had to keep on raising the deductibles and co-payments that had to be paid before any type of state assistance could be given. The result was that fewer individuals actually were served.

A catastrophic insurance bill was passed by Congress in June 1988.[9] The new law addresses long-term care for the elderly and represents a new commitment to the country's aging population. Major changes in Medicare coverage include: (1) unlimited inpatient hospital care after Medicaid beneficiaries pay an annual deductible of $564; (2) an increase in the number of days per year (150 days) for which beneficiaries may receive care in a skilled nursing facility (SNF); (3) elimination of the requirement that Medicare patients seeking care in a SNF must be hospitalized three days prior to admission; (4) elimination of the 210-day annual limit on hospice care for the terminally ill; and (5) assistance in paying for prescription drugs.[10]

Pharmaceutical Assistance Program

PHARMACEUTICAL ASSISTANCE PROGRAMS are population-specific programs designed to assist the aged and disabled in purchasing medical prescriptions. The first Pharmaceutical Assistance Program was established by New Jersey in 1975. The program is partially funded by casino revenues. Many states, including North Carolina, limit the number of prescriptions an individual may receive under Medicaid. The high cost of medication forces many people to choose which prescriptions to fill or to go without the necessary medications.

A number of other states, including Delaware, Illinois, Maryland, Pennsylvania, and Rhode Island, have Pharmaceutical Assistance Programs. Program participants pay an annual fee of $10 to $20, as well as some type of co-payment with each prescription. The program will then pay 50 to 70 percent of prescription costs.

Safety-Net Programs

MANY STATES have begun to provide assistance at the local level to ensure that all people receive health care. Some states put a substantial amount of money in major metropolitan hospitals that provide charity care. Hospitals in Chicago (Cook County Hospital) and Fairfax County, Virginia are examples. In Fairfax County, the state provides money to a primary care clinic at the rate of $60 per visit. In these programs, the government is able to take advantage of existing referrals, and by providing additional financial assistance, the provider will have enough money to keep its doors open. States also are providing direct payments to outpatient clinics.

Few uninsured persons are covered by Medicaid because they are not aware they qualify for aid, and few states make aggressive efforts to inform them. Income eligibility levels for Medicaid vary widely among states, and an increasing number of physicians will not accept new Medicaid patients because the reimbursement is generally less than their fees.[11] Unemployed workers are generally not eligible for Medicaid because they still have more assets than the law allows. But without a regular paycheck, most

—continued

of them cannot afford the several hundred dollars a year they would need to buy private insurance policies for themselves and their families.

A 1987 federal law expands Medicaid coverage to four populations of people who have "fallen through the cracks" and are presently ineligible for cash assistance and Medicaid. The law gives states the option to extend Medicaid coverage to some of the currently ineligible poor who are pregnant, very young, elderly, blind or disabled with incomes below the poverty line. Nearly 40 states have expanded Medicaid eligibility criteria to cover these special populations.[12]

Restricting Patient Transfers

AS COMPETITION in the health care industry increases, the practice of patient diversion, or patient "dumping" increases. Patient dumping is a practice where hospitals avoid admitting poor uninsured patients or avoid keeping them by making referrals to other hospitals in the area. The practice of shifting patients to public hospitals has long been thought to be widespread. Experts now fear that economic pressures for better cost control and more stringent limitations of insurance benefits may be forcing an even greater burden on facilities than ever before. Nobody knows how many patients are dumped nationally; few hospitals keep records. The U.S. House Government Operations Committee estimated that more than 250,000 patients a year are inappropriately transferred.[13] A survey by the National Association of Public Hospitals found that in 1985, more than 72 percent of 1,066 patients transferred to 26 public hospitals were not in stable condition and required emergency treatment or inpatient admission.[14]

The practice of patient dumping has surged recently, largely as a result of cuts in Medicare and Medicaid support to individuals and health care institutions. In a speech to the American Association of Hospital Planning, NME executive John C. Bedrosian spoke on the issue of patient diversion from private hospitals to public facilities. Bedrosian points a finger at the federal government as the cause of the health care industry's ills and believes it is the government's responsibility to reform the health care system. Bedrosian says, ". . . [T]he worst case of dumping taking place now is what the federal government is threatening to do to the health care industry by reneging on promises made when Medicare prospective pricing was first conceived and approved by Congress in 1983—and by backing away from its original commitment to the poor and elderly in proposing cutbacks in both Medicare and Medicaid." Bedrosian sees this as the real cause of the growing numbers of medically indigent Americans. "Our industry didn't create this problem, and it can't be solved alone," said Bedrosian.[15]

Texas was the first state to adopt provisions that greatly restrict patient transfer. The Texas provision requires that a patient's condition be stabilized before transfer. Medical records must also be transferred. Florida and Louisiana have similar legislation to curtail patient transfers. Texas leads the nation in patient-dumping complaints (39 in 1987) filed with the federal government. The Health Care Financing Administration confirmed 17 patient-dumping violations in Texas in 1987.[16]

A for-profit hospital in Florida sued a public hospital for not accepting the transfer of indigent patients. In the case, *Hospital Development and Services Corporation v. North Broward Hospital District,* the for-profit facility, Plantation General Hospital, challenged Broward Hospital District on antitrust and equal protection grounds. Plantation General contended that Broward not only was obligated to accept the transfer of indigent patients in stabilized condition, but also must reimburse the hospital for services provided to indigent patients in the past. The district court upheld the hospital district's policy on transfers. The court said the hospital district's policy is "rational as a matter of fiscal responsibility, medical practice, and medical ethics" in light of the district's charter.[17]

A law governing the Medicare program mandates that any hospital which receives Medicare funding and has emergency room service cannot discriminate against patients on the basis of ability to pay. In August 1986, a new dumping law went into effect to further curb patient transfers. An amendment to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 prohibits hospital emergency departments from transferring medically unstable patients, including women in labor. The law gives the U.S. Department of Health and Human Services the authority to impose fines up to $25,000 for each violation. The Health Care Financing Administration is responsible for enforcing the new law.[18]

A California hospital charged with five cases of inappropriate patient transfers has reached an

—*continued*

agreement with the federal government to end a patient dumping case. In October 1987, the hospital agreed to pay $100,000 to the federal government to settle the dispute—the first since the 1985 COBRA law went into effect. An order that terminated the hospital's participation in Medicare and Medicaid was rescinded.[19]

In June 1988, the Department of Health and Human Services (HHS) finally issued regulations implementing the COBRA amendment that restricts patient transfers. The guidelines were published in the Federal Register. HHS has been criticized by Congress for the lengthy delay in proposing the anti-dumping regulations — making the amendment ineffective. The regulations clarify the anti-dumping law to ensure medical care to all who seek treatment. HHS seeks to strengthen existing rules by requiring that transfers to another hospital cannot take place until after the patient has been stabilized and the receiving hospital has approved the transfer. HHS has also proposed strict penalties for non-compliance. Hospitals and physicians that do not comply with the new regulation could be subject to suspension from the Medicare program and to fines up to $50,000 for each incident.[20]

The practice of inappropriate patient transfers does not appear to be as serious a problem in North Carolina, but as the health care environment becomes more competitive, it is something that should be watched closely. It remains to be seen whether laws regulating patient transfer policies will be effective in controlling patient diversion.

FOOTNOTES

[1]Christine M. Soloman, "Indigent Care — states still looking for answers," *Federation of American Health Systems Review*, March/April 1986, p. 78.

[2]"The 1987 State-by-State Legislative Survey," *Federation of American Health Systems Review*, September/October 1987, pp. 22-44. See also "The 1988 State-by-State Legislative Survey," *Federation of American Health Systems Review*, September/October 1988, pp. 28 - 41.

[3]Deborah Denaro Dine and Cathy Tokarski, "Mass. hospitals see benefits from new bill," *Modern Healthcare*, April 22, 1988, p. 4. See also "Mass. lawmakers OK universal health insurance," *The Raleigh News and Observer* (Raleigh, NC), April 14, 1988, p. 6A.

[4]"The 1988 State-by-State Legislative Survey."

[5]"Health care benefits cost firms an average of $1,985 per worker," *The Greensboro News and Record* (Greensboro, NC), February 10, 1988, p. A8.

[6]Christine Soloman, "Indigent Care - Where Do We Go From Here?," *Federation of American Health Systems Review*, September/October 1988, p. 24.

[7]"Health insurance expansion OK'd," *The Greensboro News and Record* (Greensboro, NC), February 18, 1988, p. A4.

[8]"News at Deadline," *Hospitals*, July 20, 1988, p. 14.

[9] P. L. 100-360.

[10]Lynn Wagner, "Passage of catastrophic coverage leaves some questions of payment unanswered," *Modern Healthcare*, June 24, 1988, p. 22. See also Alden T. Solovy, "Catastrophic care plan nets little for multis," *Hospitals*, July 5, 1988, p. 65.

[11]"Study finds maternity care causes most unpaid bills," *Modern Healthcare*, January 1, 1988, p. 30.

[12]Christine Soloman, September/October 1988.

[13]"News at Deadline," *Hospitals*, April 20, 1988, p. 12.

[14]David Burda, "Dumping law: a competitive weapon for hospitals," *Hospitals*, June 20, 1987, p. 74.

[15]John C. Bedrosian, "Uncompensated Care: A Critical National Issue," *Federation of American Health Systems Review*, September/October 1985, p. 43.

[16]Sandy Lutz, "Texas attorney general files 'patient dumping' lawsuit," *Modern Healthcare* (February 12, 1988), p. 4.

[17]John Horty, "Court rejects for-profit's challenge of public hospital's transfer policies," *Modern Healthcare*, February 13, 1987, pp. 102-103.

[18]David Burda.

[19]"California hospital to pay $100,000 to end patient dumping case," *Modern Healthcare*, November 20, 1987, p. 28.

[20]Martin Tolchin, "U.S. calls for hospitals to treat all," *The Raleigh News and Observer* (Raleigh, NC), June 18, 1988, p. 1A.

to the Center's survey is included as Appendix A of this report. Also, see Table 5.3 on page 172 which shows the counties which make appropriations to local hospitals for indigent care or other hospital services.

Conclusions and Recommendations

HEALTH CARE FOR THE MEDICALLY INDIGENT is a problem that affects many Americans. Nationwide, there are 35 million medically indigent people. The definition of indigent care varies widely. Most commonly, indigent care is considered to encompass charity care to patients who are unable to pay for part or all of the hospital bill. The many interpretations of indigent care make it difficult to accurately and uniformly quantify it across the spectrum of health care providers and third-party payers.

In North Carolina, there are 1.9 million people at risk of being medically indigent out of a population of more than six million. This group of residents are either *un*insured—have no health insurance coverage, or are *under*insured—at risk of being unable to pay fully their medical bills because of gaps in their health insurance coverage.

There have been a number of studies on the national level that examined the differences in uncompensated care provided by investor-owned and not-for-profit hospitals. In all but one study highlighted earlier in this chapter, for-profit hospitals provided less uncompensated care than not-for-profit hospitals. In North Carolina, the results were the same. A study conducted by Lewin and Associates for the Volunteer Trustees of Not-for-Profit Hospitals Foundation For Research and Education found that investor-owned hospitals commit significantly less of their resources to uncompensated care than do not-for-profit hospitals. The Center's own analysis reveals that for-profit hospitals provide 27.3% less uncompensated care, when bad debt and charity care are measured as a percentage of gross patient revenue. Not-for-profit hospitals, on average, spent 8.4% of total gross patient revenue on uncompensated care, while for-profit hospitals spent 6.6% on uncompensated care.

A. Recommendation #1: New Hospital Data Reporting on Indigent Care. The N.C. Center for Public Policy Research recommends that the legislature direct the N.C. Medical Database Commission to establish a uniform reporting and data collection system for hospitals in the state that includes reporting on the types and level of indigent care provided by all hospitals in the state. This new financial data should

City & State C

Greensboro News & Record — Obituaries, Classified Ads — Friday, December 12, 1986

Hospitals lobby for funding help in caring for poor

By LAWRENCE SPOHN

North Carolina's hospitals, juggling a $207 million annual bill for uncompensated care for the poor, are looking to Raleigh for relief.

The hospitals want health insurance and the state-run Medicaid programs to be available to more people, changes that could cost the state upwards $28 million.

The N.C. Hospital ... represents ...

... settle outlined the package Thursday night for 12 area legislators and about 35 regional hospital officials at Moses Cone Memorial Hospital in Greensboro.

"The haves pay for the have-nots," he said, explaining that hospitals ... cost-shifting. That puts ... tients foot ...

... health maintenance org... HMOs contract with indiv... supply the least costly, he ... for their ...

... Butler, president of High Point Re... ...ed incoming hospital asse... ...ercent of his hos... ... for ...

... for-profit community hospitals have experienced an 18 percent decline in patient occupancy since 1981, cutting revenues.

In addition, Medicare restrictions are ... ...ing hospitals to discharge patients soon... ...easements are 6 percent shy of ... ... when underpays the ...

Cover story

Who will pay indigents' bill?

About one of every seven Americans has no, or inadequate, health insurance. Providers and politicians are struggling to find solutions to the problem.

By Mark F. Baldwin
Washington bureau chief

The growing number of Americans without health insurance is prompting bolder calls for coverage for the nation's 35 million uninsured citizens. Healthcare providers and politi-

Gail Wilensky, Ph.D.
Hard to sort responsibility for indigent care.

cians agree that the problem of inade... health insurance needs to be ... consensus has pro... and

cation foundation in Millwood, Va.

"The minute you start laying out the particulars of a program, you lose (the support of) people who feel they're being asked to bear an unfair burden," said Daniel P. Bourque, president of the National Committee for Quality Health Care.

Budget crunch. In addition, budget limitations have prevented even the most well-intentioned lawmakers from allocating more money for Medicaid and other programs that might ensure healthcare for the medically indigent.

"It's an issue where more resources have to be committed if it's to be solved," said Carol McCarthy, Ph.D., president of the American Hospital Assn. "It requires statesmanlike positions because it does call for public and private expenditures at a time when competitive initiatives are very strong."

An Urban Institute study showed that 35 million Americans lacked health insurance at the end of 1983, the latest year for which data are available. By comparison, 26 million were without insurance in 1978.

The study also showed that two-thirds of these ... are in the states of Arkansas, Louisiana, Oklahoma and Texas have the highest percentage of uninsured citizens (20%), and the New England states of Maine, Massachusetts, New Hampshire and Vermont have the lowest percentage (10%).

Uncompensated care doubled. The increasing number of uninsured Americans has meant a doubling of the amount of uncompensated care provided by U.S. hospitals since 1980. Uncompensated care is defined as charity care plus bad debts for which payment is expected but not collected.

Hospitals' uncompensated services totaled $9.5 billion, or 5.8% of gross patient revenues, in 1985, compared with $4.6 billion, or 5.1% of gross patient revenues, in 1980.

Publicly owned facilities provide a disproportionate share of uncompen-

State Government

by
Christine M. Solomon
Director of State Legislation
Federation of American Health Systems

Indigent care — states still looking for answers

recent survey by the National Conference of State Legisla... ...tures (NCSL) of the 43 states meeting this year in regular ... session shows that: (1) medical malpractice, (2) health care ... indigent, and (3) acquired immune deficiency syndrome ... are at the top of ... ...ate legislative health agendas. ... ...al malpractice ... ... of the top three health ... ...16 states, ...alth malprac... ...ted state ... ...on in 1986 ... ...this ye... ...med ...

In *Missouri*, HB 1096 has been introduced to encourage the private sector to provide health insurance coverage for the uninsured. The bill would establish a Medical Assistance Insurance Trust to provide coverage for uninsured persons below specific income levels: "medically needy" persons and those below the Medicaid "categorically needy" criteria; victims of catastrophic illnesses with inadequate insurance, and the unemployed uninsured. The coverage premium would be subsidized by either a one-... ...sales tax increase or an equivalent increase in income taxes. ... ...mary and acute care would participate and be ... ...mary rates established by the trust. ... ...Bronman has introduced ... ...an annual ...

A Special Report

Uncompensated care: A critical national issue

Bedrosian

... ...re is not a hospital issue alone. It is a ... ...needs to be asked is: Can we as a ... ...to enable the health care poor to ... ...services? ... ...ated many years ago as poor ... ...hey provided food and shel... ...e, there was not ... ...ized medic... could make good on the ... ultimately, by playing ... the privately in... ...

provide state and local policymakers, legislators, and citizens with information on the amount of indigent care provided by hospitals, use of hospital services by indigent patients, and the financial impact on hospitals providing such care. This data should be published on a biennial basis by the Commission.

* * *

Who should fund indigent care? According to a poll conducted by SRI Gallup for *Hospitals* magazine, most Americans (62%) felt that government should fund health care for the medically indigent. Thirty-seven percent of the respondents indicated that the *federal* government should pay. Fifteen percent maintain that *state* government should take the leading role, while six percent state that *local* government should pay. How should indigent care be funded? According to the same survey, 69% of the respondents who felt that government should be responsible for providing indigent health care were also willing to pay higher taxes.[41] A survey commissioned by *Health Management Quarterly* found that two of every three Americans favor a national health insurance program. Most of the respondents, however, were unwilling to pay higher taxes to fund the program.[42]

NME Chief Executive Officer John C. Bedrosian once proposed this solution—"that we finance the care from the broadest tax base possible, and that we deliver the care from the broadest provider case possible." Bedrosian sees public hospitals and private community hospitals, as well as primary care physicians, playing an important role in the delivery of health care.[43]

B. Recommendation #2: A New Program For Funding and Allocating the Burden of Indigent Care in Hospitals. Indigent care has become a priority issue in nearly every state legislature. Many states have proposed and implemented a variety of programs to help resolve the problem of medical indigency. According to the Federation of American Health Systems, approximately 20 states have developed programs to fund indigent health care. The state programs are funded by a variety of mechanisms. Among them are: hospital assessments, county appropriations, state general revenue, and all-payer systems. What can North Carolina do to enable the uninsured and underinsured poor to obtain access to needed health services?

The N.C. Center for Public Policy Research recommends that the N.C. General Assembly enact one of the four options below, each of which is designed to address two goals: (a) to provide health care for indigent patients, and (b) to ensure that every hospital in North Carolina does its fair share in providing indigent care. The four options are as follows:

(1) to establish a state-level system of hospital assessments, with the revenue generated to be allocated to hospitals with high levels of uncompensated care;

(2) to require all hospitals to provide a certain amount of indigent care as measured by a percentage of gross patient revenues;

(3) to require each of the 100 counties to enact their own indigent care programs, leaving decisions both as to how to spread the burden and how to tax the hospitals to the counties; or

(4) to appropriate state funds for indigent care to hospitals with high levels of uncompensated care.

1. Under Option One, all North Carolina hospitals would be assessed an amount based on each hospital's gross patient revenues. The proceeds from these annual assessments would be earmarked for a state equalization fund for indigent care. Hospitals providing more than the previous year's average of uncompensated care would be eligible for state reimbursement for indigent care. For-profit hospitals should receive credit for any taxes they have paid. The advantage of the assessment option is that it can be adjusted to hospital size, level of patient revenue, and financial health, and it is flexible from year to year. A 1.5 percent assessment on hospitals in Florida was passed in 1984 to expand the state Medicaid program. The assessment has drawn mixed reviews. South Carolina has a program in which hospitals are assessed a tax to fund the state indigent health care program. The program is intended to distribute equitably the burden of indigent care. The program is funded jointly by assessments on hospitals and county governments. The N.C. Hospital Association strongly opposes the option of an assessment on hospitals.

2. Under Option 2, the legislature could require all hospitals to provide a minimum amount of indigent care. Under this proposal, every hospital in the state would be mandated to provide a certain minimum amount of indigent care. According to the N.C. Hospital Association, "North Carolina hospitals write off 7.6 percent of their gross revenue to charity and bad debt care. The national average is 6.5 percent."[44] At least 20 states now require hospitals to deliver a minimum amount of care to the medically indigent. If the legislature pursues this option, the Center recommends that in accordance with our findings based on 1984 data, each hospital should be required to devote at least 8.4 percent (the average for all not-for-profit hospitals) of its gross patient revenues to health care

NORTH CAROLINA SEEKS SOLUTIONS TO THE INDIGENT CARE PROBLEM

by Lori Ann Harris

A SPECIAL STUDY COMMISSION was set up in 1985 by the North Carolina General Assembly to "study the issues of access to and financing of health care services for North Carolinians who are unable to pay for their medical care."[1] The Indigent Health Care Study Commission was reauthorized in 1987[2] to continue its work and make a final report to the 1989 General Assembly. The 1985-86 Commission recommended that the 1987 General Assembly spend $37 million a year to expand Medicaid and provide health services to North Carolina's poor. The plan was to extend Medicaid to more than 160,000 additional persons. In addition to the blind, disabled, and elderly, the program was to include pregnant women and children in families whose incomes fall below the federal poverty level.[3] While all of the Commission's proposals were not approved during the 1987 General Assembly, significant progress was made toward addressing the problem of indigent health care. Over the next two years, $11 million will be appropriated to expand Medicaid coverage to an additional 50,000 recipients. An appropriation of $10,000 was made to create the N.C. Health Insurance Trust Commission, a multiple employer trust

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services for indigent patients. This option is perhaps the easiest to administer.

3. Under Option 3, the N.C. General Assembly could mandate that the 100 counties take a larger role in the provision of health care to indigent patients. Under this proposal, counties would be required to develop and fund their own indigent care programs. As Dorothy Kearns, a Guilford County Commissioner, puts it: "Local governments are closest to the people being served. Therefore, they [the counties] are in the best position to know the needs of the population. They can target resources effectively and spot problems before it's too late."[45] At present, only 23 counties appropriate money to local hospitals for health care services at the local level. (See Table 2.15, for a list of counties that appropriated money to local hospitals during the 1986-87 fiscal year.) The program would have to be funded by additional property or sales tax assessments. Thus, this option has the disadvantage of relying on a regressive tax and perhaps burdening the poorest counties with the greatest indigent care problems. It also is probably the most difficult to administer and to monitor at the state level.

The problem is compounded by those counties which have no hospital. In such cases, indigent patients are sent to public hospitals in nearby counties where the costs are absorbed by the hospitals and the citizens of those counties. Thus providers which are already overburdened with their own indigent patients have the additional load of patients from adjacent counties. Patients who are eligible for health care services in one county would be encouraged to receive their care in that county when possible. When patients must cross over county lines to obtain health care (16 counties in North Carolina do not have a general acute-care hospital), hospitals should be allowed to

designed to allow small companies to purchase health insurance at reasonable rates. The approved legislative package includes:

1. Medicaid Coverage for Pregnant Women and Children

Effective October 1, 1987, the N.C. Department of Human Resources is authorized to provide Medicaid coverage, to the extent permitted by federal law, for pregnant women and for children up to age five whose family income is equal to or less than 100% of the federal poverty guidelines. This Medicaid expansion program is fully funded by transfers from Maternal and Child Health Funds, Prenatal Funds, and the Children's Special Health Service Fund. No additional state appropriations were made. An estimated 15,500 women and more than 23,000 children under age 2 will have access to health care based on the new income guidelines. Health care for children up to age 5 will be phased in. As of March 1, 1988, qualified health care providers are also able to make initial eligibility determinations effective for up to 45 days to provide prenatal services to pregnant women. This concept is called presumptive eligibility. Several demonstration projects throughout the state have already begun.[4]

2. Aid to Families with Dependent Children for Unemployed Parents (AFDC-UP)

An appropriation of $2.2 million expands AFDC to provide financial assistance and Medicaid to low income families in which both parents are living in the home and are unemployed. In North Carolina, children in these families already receive Medicaid benefits. Under the program, an estimated 2,586 additional adults will become eligible for Medicaid coverage. An additional 2,000 families will be covered under the AFDC program.[5]

3. Medicaid Working Family Funds

An appropriation of $1.4 million allows a working family to continue to receive small AFDC payments after family members begin working. The program encourages recipients to find and keep jobs by reducing the AFDC check by only fifty cents for every dollar earned. These families will still be categorically eligible for Medicaid. It is estimated that an additional 8,154 people will benefit from this appropriation.[6]

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collect payment from the patient's county of residence. To ensure that counties comply with this mandate, the state Department of Human Resources should be given the responsibility for monitoring county programs.

4. Under Option 4, the General Assembly would appropriate state funds for indigent care to hospitals with high levels of uncompensated care. The state of North Carolina has already appropriated $49 million from the General Fund to assist certain hospitals in the state during the 1988-89 fiscal year. Nearly $40 million goes to N.C. Memorial Hospital ($30,540,316) and Pitt County Memorial Hospital ($9,197,522) for general support, which includes education, research, and hospital services. The state also appropriates funds to special programs administered by the Department of Human Resources, where a percentage of the appropriations is earmarked for inpatient care of program participants. These are programs for high-risk maternity, perinatal care, children's special needs, inpatient cancer treatment, etc. Hospitals across the state receive approximately $9 million through these programs. No state funds are appropriated specifically to hospitals for uncompensated care. In North Carolina, the burden of indigent care falls disproportionately on certain hospitals. The N.C. Center for Public Policy Research found that public and private not-for-profit hospitals provide more uncompensated care than for-profit hospitals. "The N.C. Hospital Association believes the only realistic solution to the indigent health care problem is to put more money in the health care system for indigent care."[46] State appropriations are one option for addressing the problem of certain hospitals bearing a disproportionate share of the indigent care burden.

— Footnotes begin on page 78

4. AFDC/Medically Needy Income Increase

The Medicaid medically needy income limit (the income level required for an individual or family to qualify for Medicaid) is tied to 133% of the AFDC payment level. The AFDC payment in North Carolina is approximately 33 percent of federal poverty guidelines, among the lowest in the country. An appropriation of $3.9 million, effective January 1, 1988, increased the AFDC and the Medicaid income limits by 2.5 percent.[7]

5. Medicaid for 19-21 Year Olds

An appropriation of $440,000 expanded Medicaid coverage to young people 19-21 years old, effective January 1, 1988. This program restored Medicaid coverage which had been removed in 1981. This expansion provides Medicaid to 4,293 additional youths. State appropriations for fiscal years 1987-88 and 1988-89 were $147,000 and $293,000 respectively.[8]

6. Eligibility Worker Funds

An appropriation of $1.5 million per year for fiscal years 1987-88 and 1988-89 will provide additional local Department of Social Services eligibility workers to support the expansion of public assistance programs.[9]

7. Multiple Employer Trust Authorized

Finally, the legislature created the N.C. Health Insurance Trust Commission to assist in making health insurance available at lower cost to individuals and their dependents who are presently uninsured and who are employed by small businesses. The hope is that with a low enough premium, many of the small employers who currently do not offer a health plan will begin to do so. The Commission will try to facilitate health insurance for employers with twenty-five or fewer employees.[10]

The Indigent Health Care Study Commission made recommendations to the General Assembly in the 1988 short session. Among the major recommendations were: (1) to increase the income guidelines for pregnant women and children up to 185% of the federal poverty guidelines (The N.C. General Assembly

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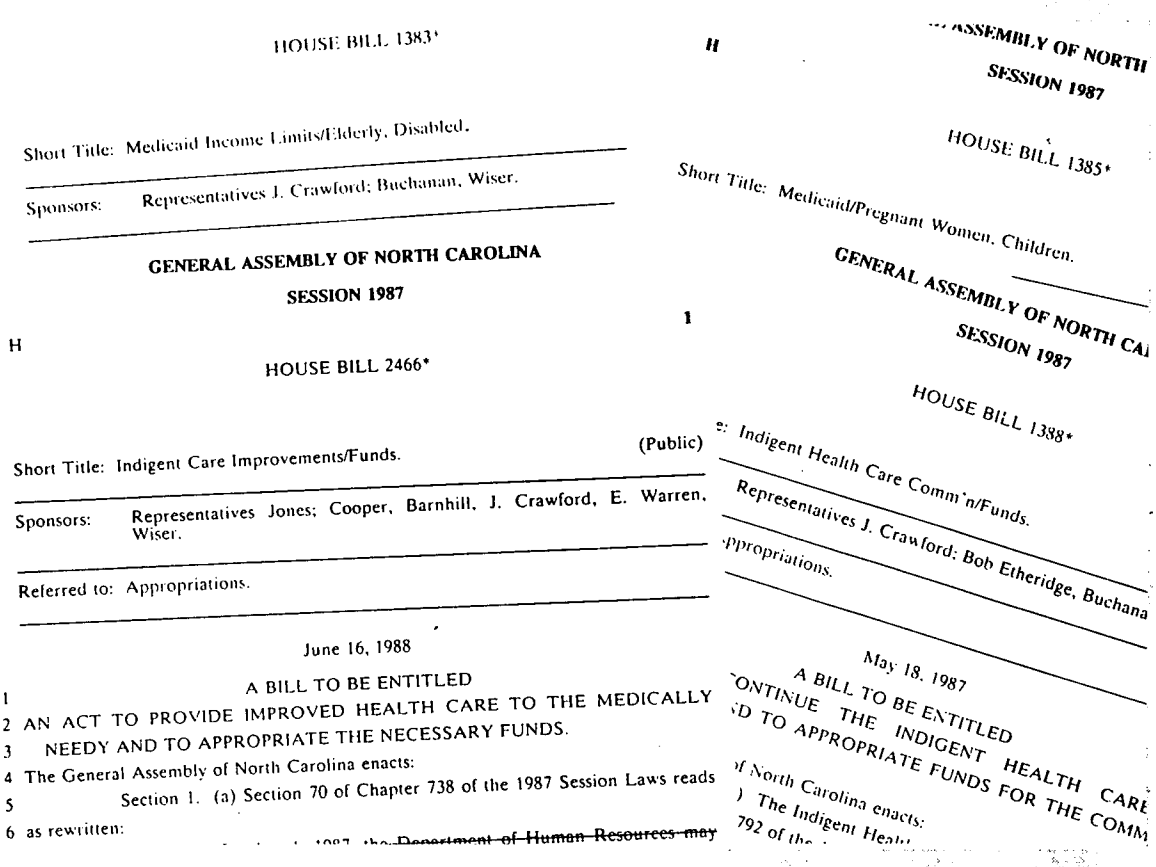

HOUSE BILL 1383*

Short Title: Medicaid Income Limits/Elderly, Disabled.

Sponsors: Representatives J. Crawford; Buchanan, Wiser.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

H

HOUSE BILL 2466*

Short Title: Indigent Care Improvements/Funds. (Public)

Sponsors: Representatives Jones; Cooper, Barnhill, J. Crawford, E. Warren, Wiser.

Referred to: Appropriations.

June 16, 1988

A BILL TO BE ENTITLED

AN ACT TO PROVIDE IMPROVED HEALTH CARE TO THE MEDICALLY NEEDY AND TO APPROPRIATE THE NECESSARY FUNDS.

The General Assembly of North Carolina enacts:

Section 1. (a) Section 70 of Chapter 738 of the 1987 Session Laws reads as rewritten:

H

ASSEMBLY OF NORTH

SESSION 1987

HOUSE BILL 1385*

Short Title: Medicaid/Pregnant Women, Children.

GENERAL ASSEMBLY OF NORTH CA

SESSION 1987

HOUSE BILL 1388*

e: Indigent Health Care Comm'n/Funds.

Representatives J. Crawford; Bob Etheridge, Buchana

ppropriations.

May 18, 1987

A BILL TO BE ENTITLED

ONTINUE THE INDIGENT HEALTH CARE

D TO APPROPRIATE FUNDS FOR THE COMM

f North Carolina enacts:

) The Indigent Healt

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increased the income guidelines to 100% of the federal poverty guidelines in 1987); (2) an additional increase in the AFDC payment level and Medicaid medically needy income limits (MNIL) by 10 percent each year for the next five years until the Medicaid MNIL reaches 75 percent of poverty; and (3) elimination of the state's 209(b) option in which North Carolina only provides Medicaid to elderly, blind or disabled individuals who would have been eligible for Medicaid using the rules in effect on January 1, 1972. If North Carolina eliminates the 209(b) option, all supplemental security income (SSI) recipients (low income individuals who are elderly, blind or disabled) would automatically receive Medicaid. The commission also recommended that the state increase the income guidelines for the elderly, blind and disabled individuals up to 75% of the federal poverty guidelines. None of the study commission recommendations were acted upon in 1988.

FOOTNOTES

[1]Chapter 792 (HB 344) of the 1985 Session Laws, Section 6.1.

[2]Chapter 738 (HB 1514) of the 1987 Session Laws, Section 71.

[3]The Indigent Health Care Study Commission recommended a package of bills for consideration during the 1987 General Assembly; many were enacted

[4]Chapter 738 (HB 1514) of the 1987 Session Laws, Section 70.

[5]Chapter 738 (HB 1514) of the 1987 Session Laws, Section 67(d).

[6]Chapter 738 (HB 1514) of the 1987 Session Laws, Section 79.

[7]Chapter 738 (HB 1514) of the 1987 Session Laws, Section 67.

[8]Chapter 738 (HB 1514) of the 1987 Session Laws, Section 69.

[9]Chapter 830 (HB 1515) of the 1987 Session Laws, Section 24.

[10]Chapter 765 (SB 759) of the 1987 Session Laws, now codified as N.C.G.S. Chapter 58A.

INDIGENT CARE IN GUILFORD COUNTY: THE BILL COMES DUE

by Lori Ann Harris

MANY HOSPITALS in North Carolina and across the country are facing financial difficulty. Hospitals are spending millions of dollars a year to provide care for indigent patients. How many hospital closures must take place before this problem receives proper attention? Here is the story of one hospital, and some efforts to sustain it.

L. Richardson Memorial Hospital, located in Greensboro North Carolina, was founded in 1923 by a group of concerned citizens whose goal was to serve better the health care needs of the black community. Today, the hospital still serves primarily a minority population and is located in southeast Greensboro. The hospital is named in memory of Lunsford Richardson Sr., founder of Vick Chemical Company in Greensboro. The Richardson family initially donated $50,000 to the hospital with numerous other subsequent gifts.

L. Richardson Memorial Hospital prospered over the years and moved to its current location in 1966 with the assistance of funds from the federal Hill-Burton program (see sidebar on Hill-Burton, p. 42). Construction cost over-runs, the hiring of additional staff, an increase in staff salaries, and higher operating expenses posed problems for the hospital. The hospital had no reserve funds for relief. Unable to raise money from local commercial lenders, the hospital board of directors turned to the city council and county commissioners for help. In 1967, L. Richardson received a $75,000 loan from the city council and a $75,000 loan from the county commissioners. The interest-free loans were to be repaid from the hospital's profits. The hospital has been financially unable to repay the loans. In November 1988, Guilford County forgave the $75,000 loan to the hospital. The City of Greensboro is expected to follow suit. "We are very grateful to the Guilford County Board of Commissioners. It will certainly make a difference in our accounts payable ledger," said J. C. Coleman, president of the hospital.

"Over the years, L. Richardson has accepted the care of indigent patients as a community commitment," Coleman emphasized. "The hospital has served unselfishly the City of Greensboro and Guilford

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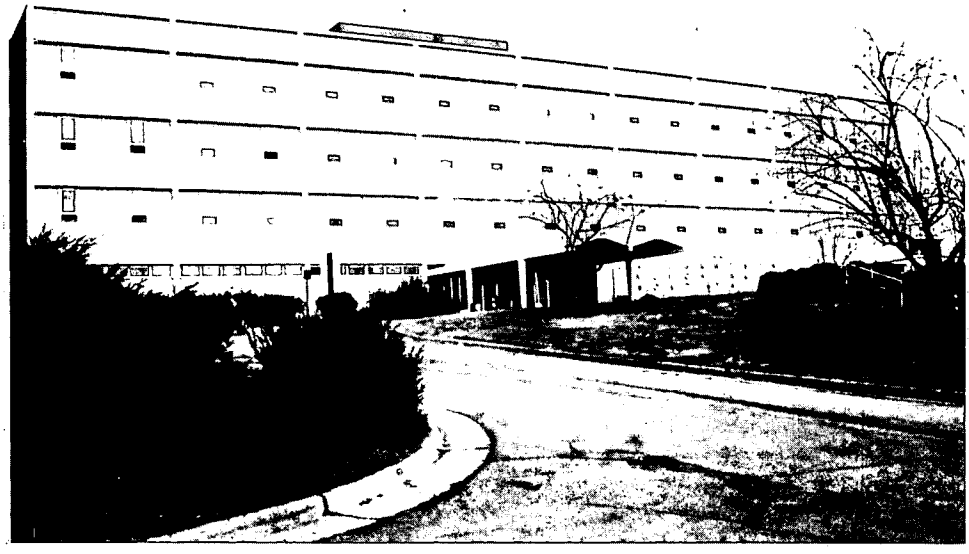
L. Richardson Memorial Hospital in Greensboro



Lori Ann Harris

FOOTNOTES

[1]"Access to Care and Investor-Owned Providers," *For-Profit Enterprise in Health Care* (Washington, D.C.: Institute of Medicine, National Academy Press, 1986), p. 97.

[2]Patricia M. Danzon and C. Johnston Conover, *Health Care for the Uninsured Poor of North Carolina* (Duke University: Center for Health Policy Research and Education, 1985).

[3]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), pp. 145-149.

[4]Public Law 97-35. Also see Jim Bryan, et al., *Federal Budget Cuts in North Carolina*, N.C. Center for Public Policy Research, 1982, pp. 7,9,12,and 25-30.

[5]Anne Fox Kiger, *Hospital Administration Terminology*, 2nd Edition, (AHA Resource Center, 1986), p. 29.

[6]Glenn Richards, "Special interests push indigent care solutions," *Hospitals* (March 5, 1987), p. 65.

[7]"Multis pessimistic about indigent care issue," *Hospitals*, March 5, 1987, p. 65.

[8]"Need new charity care definitions: CHA," *Trustee*, August 1988, p. 22.

[9]Lewin and Associates, "Unsponsored Charity Care Costs: A Proposed Definition for Hospital Care to the Medically Indigent," Prepared for the Pennsylvania Health Care Cost Containment Council, January 27, 1988.

[10]Mark Baldwin, "Who will pay indigents' bill?," *Modern Healthcare*, January 16, 1987, p. 27.

[11]"GAO finds inequities in state Medicaid programs," *Trustee*, August 1987, p. 7.

[12]"Hospitals absorbed $7 billion in indigent care in 1986: report," *Trustee*, March 1988, p. 3.

Indigent Care in Guilford County

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County. There has never been a question about the quality of health care provided at L. Richardson," he adds. The hospital maintains the maximum accreditation possible by the Joint Commission on Accreditation of Healthcare Organizations. Coleman argues that when a hospital closes, the health status of citizens in the community goes down. "We at L. Richardson Memorial don't want this to happen, it is our mission to provide health care services."

According to Coleman, L. Richardson depends solely on patient service revenues, to support its annual budget of $9.2 million. He adds, "The hospital receives no money from any public source and has no endowment." The hospital does receive some grant money from the Duke Endowment for free bed days of care. (See p. 182 for more on the Duke Endowment.)

L. Richardson Hospital has provided $14.35 million in free care over the last 10 years. This figure averages out to $1.4 million a year or approximately 18.65% of annual gross revenues. Medicare and Medicaid contractual adjustments totaled $17.35 million over the same period — an average of $1.78 million per year (22.5% of annual gross revenue). L. Richardson Hospital has incurred nearly a $3.6 million loss over the past 10 years. "If the hospital had received funding for 50% of the free care it provided over that period, the hospital would show a $3.6 million surplus from operation," says Coleman. "We can't continue to exist if we have to provide high levels of indigent care with no major source of funding." The high dollar amount that goes to pay for free care has a secondary effect on hospital operations. "We are often unable keep our hospital equipped with state of the art equipment, and make all the renovations needed to maintain our fine facility."[1]

L. Richardson did receive special legislative attention in 1987 because of its unique role in the community. State legislation was passed to allow the hospital to convert 65 acute-care hospital beds (almost half of the hospital's licensed beds) to nursing home beds for long-term care.[2] This legislative action allowed the hospital to avoid the normal review process by the N.C. Department of Human Resources as mandated in the state's Certificate of Need statute.[3] The hospital's low occupancy rate and its high uncompensated care costs have contributed to the financial losses incurred in recent years. According to Coleman, "This is a way to help end the hospital's financial troubles and to alleviate partially the shortage of nursing home beds in Guilford County."

L. Richardson Memorial is not the only hospital in Guilford County facing problems with high uncompensated care costs. In 1986, High Point Regional, Moses Cone Memorial, L. Richardson Memorial, and Wesley Long Community hospitals — all located in Guilford County —together lost $14.8 million to bad debt and charity care. At least two hospitals were considering denying medical

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[13]Chris Conover, personal communication, Summer 1988.

[14]"State Court May Hear 'Cost-Shifting' Case," *Modern Healthcare*, February 14, 1986, p. 24.

[15]The N.C. Hospital Association, personal communication, April 21, 1988.

[16]"Indigent care consumes more public hospital days," *Modern Healthcare*, August 21, 1988, p. 17.

[17]Ben Gilbert, personal communication, October 3, 1988.

[18]"Access to Care and Investor-Owned Providers," *For-Profit Enterprise in Health Care*, p. 97.

[19]Gloria J. Bazzoli, *Health Care for the Indigent: Literature Review and Research Agenda for the Future*. (American Hospital Association: Council on Research and Development, 1985) p. i.

[20]Danzon and Conover.

[21]*Ibid.*, pp. 4-7.

[22]*Ibid.*, p. 10.

[23]*Ibid.*, pp. 8-11.

[24]*Ibid.*, p. 13.

[25]*Ibid.*, pp. 15-18.

[26]*Ibid.*, p. 18.

[27]Eleanor Blakely, et al., *Geographic Distribution of the Medically Uninsured Poor and of Inpatient Patterns in North Carolina* (UNC-Chapel Hill: Health Services Research Center, March 1986).

[28]*Ibid.*, p. 27.

[29]Chris Conover, personal communication, Summer 1988.

[30]"Access to Care and Investor-Owned Providers," *For-Profit Enterprise in Health Care*, pp. 100-101.

[31]*Ibid.*, pp. 100-101.

services to patients who were unable to pay.

In Guilford County, all of the hospitals are private facilities. This phenomenon takes local government out of the picture of hospital care. Thus the question of "who has the responsibility for taking care of and paying for the county's indigent patients?" becomes an issue. At the request of local hospital administrators, the Guilford County Board of Commissioners formed the Task Force on Indigent Health Care to try to answer this question.

Guilford County has maintained limited involvement with the local hospitals. Moses Cone Hospital contracts with the county to provide outpatient care services for indigent patients in return for county appropriations. In 1984, Cone received $205,000 from Guilford County. Fast becoming a regional medical center, Moses Cone Hospital boasted an $8 million profit margin in 1987.[4]

The Indigent Care Task Force presented its report to the Guilford County Board of County Commissioners in December 1988.[5] One of the conclusions of the task force is that county government has the responsibility to provide health care for persons unable to afford it. An estimated 16,800 Guilford County individuals have no health insurance coverage. In addition, the panel concluded that Guilford County must make indigent health care a priority and appropriate more funds to provide health services.

The task force presented its recommendations to the county commissioners. The major recommendation was that Guilford County should provide medical services (primary, preventive, diagnostic, and rehabilitative) to the medically indigent. The commissioners were asked to provide funds to pay for indigent health care. The panel also recommended that Guilford County and its not-for-profit hospitals work together to share the costs of indigent care. How much money is needed to provide health services for the county's medically indigent? The task force said a comprehensive set of benefits would cost $49 per month or $588 per year for each individual. Based on these figures, the projected cost of covering the medically indigent population in Guilford County is $9.8 million. Guilford County's efforts to study the indigent care problem were a good first effort. All county governments across the state must take note of the indigent health care crisis.

FOOTNOTES

[1]Personal communication, December 1988. For a complete history of L. Richardson Memorial Hospital, see Wilson Elkins, "The History of L. Richardson Memorial Hospital," *Journal of the National Medical Association*, May 1969, pp. 205-212.

[2]Chapter 768 (HB 170) of the 1987 Session Laws.

[3]N.C.G.S. Chapter 131E.

[4]Ed Williams and Russ Robinson, "Cone Hospital: Large dose of fiscal therapy helped hospital heal itself," *Triad Business*, supplement to *The Greensboro News and Record* (Greensboro, NC), February 15, 1988, pp. 10-11.

[5]Guilford County Task Force on Indigent Health Care, Report to the Guilford County Board of Commissioners, December 1, 1988.

[32]"Indigent care issue focuses on financing." *Hospitals Factbook,* (1985 AHA Convention), June 16, 1985, pp. FB 46-49.

[33]"Access to Care," pp. 101-102.

[34]*Ibid.*, pp. 102-104.

[35]"Setting the Record Straight: The Provision of Uncompensated Care By Not-for-Profit Hospitals," Lewin and Associates, April 1988.

[36]Chris Conover, personal communication, Summer 1988.

[37]John C. Bedrosian, "Uncompensated care: A critical national issue," *Federation of American Health Systems Review,* September/October 1985, p. 42.

[38]Comments of Pam Silberman, N.C Legal Services, "Health Care for All" conference, Winston-Salem, N.C., April 11, 1987.

[39]Mark Schlesinger, Judy Bentkover, David Blumenthal, Robert Musacchio, and Janet Willer. "The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services," *The Milbank Quarterly,* Vol. 65, No. 1, 1987, p. 33.

[40]As reported in Jeanne Johnson Chamberlin, *Indigent Health Care: Ensuring Access, Equity and Cost Effectiveness,* State Health Planning, paper prepared for SHCC Task Force on Uncompensated Care, December 1, 1984.

[41]"Indigent Care: Public wants government to pay," *Hospitals,* October 5, 1987, p. 152.

[42]"Most Americans support national health insurance," *Modern Healthcare,* March 11, 1988, p. 14.

[43]Bedrosian, p. 43.

[44]The N.C. Hospital Association, personal communication, April 21, 1988.

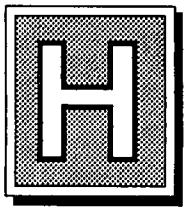
[45]Statement of Dorothy Kearns, Commissioner of Guilford County, North Carolina, on behalf of the National Association of Counties, before the Senate Committee of Finance Subcommittee on Health Care for the Poor, September 28, 1984, Washington, D.C.

[46]The N.C. Hospital Association, personal communication, April 21, 1988.

CHAPTER 3

COMPARING COSTS AND CHARGES AT INVESTOR-OWNED AND NOT-FOR-PROFIT HOSPITALS IN NORTH CAROLINA

by Marianne M. Kersey and Ran Coble



RAPIDLY RISING HEALTH CARE costs are an important concern for all Americans. The Consumer Federation of America identified rising health care costs as the top consumer issue of 1987 for good reason. Health care costs jumped nearly four times the general inflation rate in 1986, according to U.S. Department of Commerce statistics.[1] (See the sidebar on page 93 for more details.)

Competition among health care providers, including hospitals, is also in the news. One of every 10 U.S. hospitals is likely to close by 1995 due to declining admissions and shorter stays, according to health experts recently polled by Arthur Andersen & Co.[2]

Rising health care costs and competition between hospitals have sharpened the debate on the role of for-profit enterprise in health care. A philosophical debate is raging over which parts of the health care system should be a public responsibility, which parts left to the private sector, and which parts a mixed system. Debate also exists over whether investor-owned involvement has increased efficiency in the hospital system as a whole. But perhaps the sharpest debate has centered on whether for-profit or not-for-profit hospitals have higher costs, or charge more for services. This chapter focuses on costs and charges at North Carolina hospitals.

Costs and Charges in American Hospitals

FOR THE PAST 100 YEARS, hospital costs and charges have changed according to the various functions hospitals performed. Early U.S. hospitals—voluntary hospitals operated by charitable groups and public hospitals operated by municipal, county, and federal governments—originally were set up for custodial care and served primarily the poor. These hospitals were financed largely by charitable donations, so patients were not charged for the care they received. Around the turn of the century, however, hospitals began to place more emphasis on relieving acute illnesses and performing surgery. These new medical and surgical procedures, in turn, resulted in higher costs for hospitals. As Paul Starr notes in his Pulitzer Prize-winning book, *The Social Transformation of American Medicine:*

> As the functions and standards of hospitals changed, construction and operating costs both increased... [T]he greater emphasis on acute care intensified hospital work, requiring more employees and higher operating costs per patient. Hospital budgets soared beyond the capacity of charity to meet them.[3]

Hospitals in the early 20th century could no longer survive chiefly on charitable contributions. At the same time, more services and better care made hospi-

tals more attractive to the middle and upper classes. They were willing to pay for hospital care. As a result, "the principle answer to the hospitals' financial difficulties proved to be greater payments by patients."[4] *Charges* to patients had emerged as an important issue in hospital financing.

Early Competition Among Hospitals

ALL HOSPITALS, including the new proprietary hospitals, came to rely more on payments from patients early in the 20th century. These for-profit hospitals were set up mainly by physicians who had been denied hospital privileges at older voluntary hospitals. These new hospitals were operated on a for-profit basis to serve the middle and upper classes, and they were independently owned. The first signs of for-profit/not-for-profit competition appeared during this period, as hospitals vied for paying patients, an increasingly important source of income for all of them:

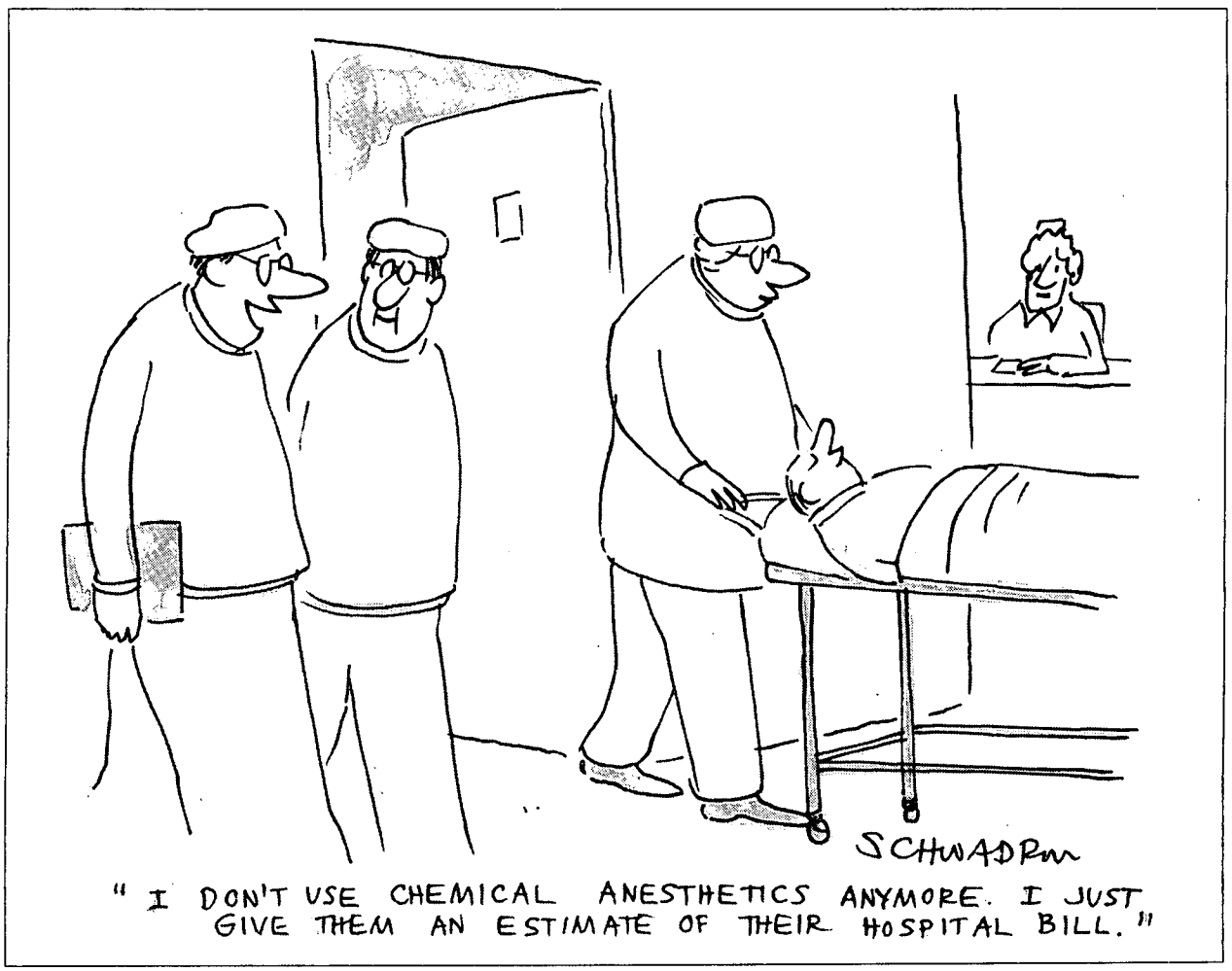
> The increased competition from these new enterprises catering to the middle and upper classes forced the older voluntary hospitals to make adjustments because of the threatened loss of clients and revenue.[5]

In response to this competition, not-for-profit hospitals granted hospital privileges to local physicians who would bring in more patients and thus more revenue for the hospital.

Although competition often leads to greater efficiency, the competition between proprietary and not-for-profit hospitals in the early decades of this century actually increased *inefficiencies* in the hospital system as a whole, says Starr. Voluntary, public, and proprietary hospitals, while competing for patients, were unwilling to work toward an integrated hospital system. Such a system might have held down hospital costs. Instead, each individual hospital remained responsible for raising its own funds for capital expenditures, recruiting staff, collecting fees, and purchasing supplies. These administrative tasks required staff, space, and money—adding up to more costs for hospitals to finance through patient charges.[6]

For-Profit Enterprise Limited

THERE WAS WIDESPREAD SUSPICION of commercial enterprise in medicine in the early decades of this



Harvey L. Schwadron

century, but criticism was not directed at the new, independent proprietary hospitals. Instead, the involvement of *corporations* in health care was kept in check. Court decisions which precluded the growth of profit-making medical care corporations illustrate the nature of the opposition to for-profit enterprise in health care:

> Between 1905 and 1917, courts in several states ruled that corporations could not engage in the commercial practice of medicine . . . on the grounds that a corporation could not be licensed to practice and that commercialism in medicine violated "sound public policy." These decisions were not models of rigorous legal reasoning . . . [y]et no one made much of a fuss. Respectable opinion did not favor "commercialism" in medicine.[7]

The arrival of national investor-owned hospital chains thus remained decades away.

Debate on the implications of corporate involvement in health care continues today. The debate has become increasingly heated since the dramatic increase in the number of hospitals affiliated with investor-owned corporations within the last decade, as noted in Chapter 1. Issues of political and economic philosophy are sometimes brought into the fray when costs and charges are compared at investor-owned and not-for-profit hospitals. But it is necessary to get beyond philosophical debates and look at concrete differences between for-profit and not-for-profit hospitals in order to draw conclusions on the impact of corporate involvement in health care.

For-Profit vs. Not-For-Profit

IN 1986, the Institute of Medicine of the National Academy of Sciences issued a significant report, *For-Profit Enterprise in Health Care*, which analyzes the issues surrounding the provision of health care by investor-owned corporations. Table 3.1 outlines the common distinctions between for-profit and not-for-profit organizations. Some notable distinctions are that for-profit organizations must pay property, sales, and income taxes and are accountable to stockholders, whereas not-for-profits are tax-exempt but may receive charitable contributions and are accountable to voluntary, self-perpetuating boards. (See page 181 in Chapter 5 for more on charitable contributions to N.C. hospitals.)

But while there are common distinctions between organizational types, it is important not to oversimplify the picture when trying to determine the role ownership plays in hospital behavior. Indeed, there are many conflicting opinions about whether hospitals operated on a for-profit basis really are much different from not-for-profit hospitals.

For example, it would be inaccurate to assume that all investor-owned hospitals, while aiming to achieve a profit for their stockholders, are run more efficiently than not-for-profits. Nor should one assume that only for-profit hospitals respond to economic incentives. Not-for-profit hospitals also can earn a profit, although it usually is called a surplus or fund balance instead. The same caution should be used when discussing a hospital's role in a community. It would be unfair to say that only not-for-profits respond to social responsibilities such as provision of certain services or care to indigents.

This caution is especially important in light of the fact that all hospitals, regardless of ownership type, are operating in an increasingly competitive atmosphere, a situation which may actually result in investor-owned and not-for-profit hospitals acting in similar rather than different ways. Earl Tyndall, executive director of Medical Park Hospital in Winston-Salem, with over 33 years experience in both investor-owned and not-for-profit settings, maintains, "The emphases on patient care and business orientation are identical at for-profit and not-for-profit hospitals."

One reason hospitals may be operating in similar ways today is that Medicare's prospective payment system, as discussed in Chapter 1, challenges the financial strategies of both investor-owned and not-for-profit hospitals. Second, not-for-profit hospitals' traditional sources of income are changing. As noted above, government grants and charitable donations were once the major source of revenue of not-for-profit hospitals. But now, not-for-profits—like investor-owned hospitals—are placing greater reliance on income from billing patients for services.[8] Third, many not-for-profit hospitals are entering into management contracts with nationwide chains like Charlotte-based SunHealth, the most active management company and alliance of not-for-profit hospitals in North Carolina. These affiliations allow them to take advantage of a larger personnel pool, potential savings from volume purchasing, or new borrowing sources in the event of tight cash flow.[9] (For more on SunHealth, see page 22 in Chapter 1.) And perhaps the most telling sign of the competitive atmosphere is the recent debate over whether to revoke the tax-exempt status of not-for-profit hospitals in many states.[10] (See Chapter 5 for a closer look at this issue.)

Despite these cautionary notes, most distinctions between for-profit and not-for-profit hospitals are still valid. And regarding cost of hospital care, two questions arise. First, are investor-owned hospitals—the vast majority of which now belong to multi-hospital chains—better able to control expenses than not-for-

Table 3.1: Common Distinctions Between For-Profit and Not-For-Profit Organizations

For-Profit	Not-For-Profit
Corporations owned by investors	Corporations without owners or owned by "members"
Can distribute some proportion of profits (net revenues less expenses) to owners	Cannot distribute surplus (net revenues less expenses) to those who control the organization
Pay property, sales, income taxes	Generally exempt from taxes
Sources of capital include a. Equity capital from investors b. Debt c. Retained earnings (including depreciation and deferred taxes) d. Return-on-equity payments from third-party payers (e.g., Medicare)	Sources of capital include a. Charitable contributions b. Debt c. Retained earnings (including depreciation) d. Governmental grants
Management ultimately accountable to stockholders	Management accountable to voluntary, often self-perpetuating boards
Purpose: Has legal obligation to enhance the wealth of shareholders within the boundaries of law; does so by providing services	*Purpose:* Has legal obligation to fulfill a stated mission (provide services, teaching, research, etc.); must maintain economic viability to do so
Revenues derived from sale of services	Revenues derived from sale of services and from charitable contributions
Mission: Usually stated in terms of growth, efficiency, and quality	*Mission:* Often stated in terms of charity, quality, and community service, but may also pursue growth
Mission and structure can result in more streamlined decision making and implementation of major decisions	Mission and diverse constituencies often complicate decision making and implementation

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profits? Second, does either type of hospital charge more for services? Before discussing the evidence at N.C. hospitals, it is helpful to review the findings of other studies comparing costs and charges at different types of hospitals.

Findings of Other Studies

THE INSTITUTE OF MEDICINE report cites one national study's finding that hospitals of the same *ownership* type (investor-owned or not-for-profit) are more similar than hospitals of the same *organizational* type (belonging to a multi-institutional system or free-standing).[11] Accordingly, the Institute of Medicine's review of eight recent empirical studies focuses chiefly on those comparing costs, charges, markup, and profitability at investor-owned chain hospitals and freestanding not-for-profit hospitals, the dominant ownership forms in both categories.*

*This chapter discusses costs and charges; the Institute of Medicine report refers to the same variables as hospital *expenses* and *prices* to patients, respectively.

— *continued on page 87*

Table 3.2: Summary of Findings in Other Studies Concerning Hospital EXPENSES

Study / Controls	Data Sources	Measure	Findings
Lewin et al. (1981)			
53 matched pairs of hospitals	1978 Medicare Cost Reports, California, Florida, Texas	Total operating cost per adjusted patient day and total inpatient care cost per inpatient day	For-profit chain hospitals 8 percent higher than independent not-for-profit hospitals
		Inpatient care costs per admission	No significant difference
Sloan and Vraciu (1983)			
Included only non-teaching hospitals under 400 beds	Data reported to Florida Hospital Cost Containment Board	Operating expenses per adjusted day	For-profit chain hospitals 3 percent lower than not-for-profit hospitals [a]
		Operating expenses per adjusted admission	For-profit chain hospitals 4 percent lower than not-for-profit hospitals [a]
Pattison and Katz (1983)			
Large teaching, Kaiser, rural, specialty and tertiary care hospitals excluded; proxy case-mix measure used	280 hospitals in California; data reported to the California Health Facilities Commission, 1980	Total operating expenses per patient day	For-profit chain hospitals 6 percent higher than private not-for-profit hospitals
		Operating expenses per admission	For-profit chain hospitals 2 percent higher than private not-for-profit hospitals
Becker and Sloan (1985)			
Numerous controls including case mix, teaching status, size, area characteristics; Regression analysis	2,231 community hospitals; AHA Reimbursement Survey & Annual Survey of Hospitals, 1979	Cost per adjusted patient day	For-profit chain hospitals 10 percent higher than chain not-for-profit hospitals
		Cost per adjusted admission	For-profit chain hospitals 8 percent higher than chain not-for-profit hospitals
Pattison (1986)			
Included only short-term 76- to 230-bed hospitals	Over 230 hospitals in California; data reported to the California Health Facilities Commission, 1977-1978, 1979-1980, 1981-1982	Operating expenses per adjusted discharge	For-profit chain hospitals 4-7 percent higher than voluntary hospitals (1977-1981)
Watt et al. (1986a)			
80 matched pairs of hospitals, adjusted for case-mix differences	Medicare Cost Reports, 1980 AHA Annual Survey of Hospitals	Cost per adjusted admission and cost per adjusted day (including capital and education costs)	For-profit chain hospitals higher than not-for-profit hospitals, but difference not statistically significant
Watt et al. (1986b)			
Regression analyses, length of chain affiliation, competition and regulation, case mix, input costs, capacity, utilization, medical education	561 general acute care hospitals, 1980 Medicare Cost Reports, AHA Annual Survey of Hospitals, and other sources	Total operating and patient care expenses per case	For-profit chain hospitals higher than the not-for-profit chain hospitals but the difference not statistically significant
Coelen (1986)			
Regression analysis geographic location, bed size, case mix	Medicare Cost Reports, AHA Annual Surveys, and others, 1975-1981	Total expenses per adjusted discharge	For-profit chain hospitals 4 percent higher than not-for-profit chain hospitals; independent for-profit lowest; differences statistically significant

[a] The findings of lower expenses in for-profit chain than in not-for-profit hospitals in Florida were confirmed by Lewin et al. (1983).

Table 3.3 : Summary of Findings in Other Studies Concerning Hospital PRICE

Study / Controls	Data Sources	Measure	Findings
Lewin et al. (1981)			
53 matched pairs of hospitals	1978 Medicare Cost Reports, California, Florida, Texas	Price per inpatient day for charge payers (total inpatient charges per patient day)	For-profit chain hospitals 23 percent higher than not-for-profit hospitals
		Price per inpatient admission for charge payers	For-profit chain hospitals 17 percent higher than not-for-profit hospitals
		Price per inpatient day for cost payers (inpatient allowable costs, plus return on equity for for-profit hospitals)	For-profit chain hospitals 13 percent higher than not-for-profit hospitals
		Price per admission for cost payers	For-profit chain hospitals 8 percent higher than not-for-profit hospitals
Pattison and Katz (1983)			
Large teaching, rural, specialty, Kaiser and tertiary care hospitals excluded	280 hospitals in California; data reported to the California Health Facilities Commission, 1980	Total inpatient charges per patient day	For-profit chain hospitals 29 percent higher than not-for-profit hospitals
		Total inpatient charges per admission	For-profit chain hospitals 24 percent higher than not-for-profit hospitals
Pattison (1986)			
Included only short-term 76- to 230-bed hospitals	Over 230 hospitals in California; data reported to the California Health Facilities Commission, 1977-1978, 1979-1980, 1981-1982	Gross patient charges per adjusted discharge (equivalent to inpatient charges per patient admission)	For-profit chain hospitals 18-23 percent higher than not-for-profits in 1977-1981 period
		Net patient revenue per adjusted discharge (weighted average of prices to charge payers and price to cost payers— actual average price realized by hospital)	For-profit chain hospitals 12-14 percent higher than not-for-profits in 1977-1981 period
Watt et al. (1986a)			
80 matched pairs of hospitals, adjusted for case-mix differences	Medicare Cost Reports, 1980; AHA Annual Survey of Hospitals, 1980; Office for Civil Rights Survey of Hospitals, 1980	Price per patient day for charge payers	For-profit chain hospitals 24 percent higher than not-for-profit hospitals
		Price per inpatient admission for charge payers	For-profit chain hospitals 22 percent higher than not-for-profit hospitals
		Price per inpatient day for cost payers	For-profit chain hospitals 11 percent higher than not-for-profit hospitals
		Price per inpatient admission for cost payers	For-profit chain hospitals 8 percent higher than not-for-profit hospitals
		Net patient revenue per adjusted day	For-profit chain hospitals 17 percent higher than not-for-profit hospitals

— table continued on next page

Table 3.3 : Summary of Findings in Other Studies Concerning Hospital PRICE, *continued*

Study / Controls	Data Sources	Measure	Findings
Watt et al. (1986b)			
Regression analyses, length of chain affiliation, competition and regulation case mix, input cost levels, capacity, utilization, medical education	561 general acute care hospitals, 1980 Medicare Cost Reports, AHA Annual Survey, and other sources	Price per admission for charge payers (total patient care revenues per adjusted admission)	For-profit chain hospitals 21 percent higher than not-for-profit chain hospitals
		Net patient revenues per adjusted admission (weighted average of prices to charge payers and price to cost payers—actual average charges realized by hospital)	For-profit chain hospitals 12 percent higher than not-for-profit chain hospitals
Coelen (1986)			
Regression analysis; geographic location, bed size, case mix; teaching hospitals excluded	Medicare Cost Reports, and others, 1975-1981	Medicare charge per case	For-profit chain hospitals 15 percent higher than not-for-profit chain hospitals

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1. Costs. Table 3.2 summarizes the results of eight studies on hospital **expenses or costs**. Overall, these studies found that not-for-profit hospitals control costs more effectively than investor-owned hospitals. Four out of five studies found that investor-owned chain hospitals had higher costs on a per *day* basis, while six out of seven studies reported the same findings on a per *admission* basis.[12]

2. Charges. Table 3.3 summarizes the Institute of Medicine's review of six studies which examined the issue of **prices or charges** at hospitals. Here, charges were also consistently higher at investor-owned hospitals. The findings were higher in per *day* analyses than in per *case* analyses, but hospital charges were still significantly higher per admission.[13]

The only previous study on hospital charges in North Carolina was done by Blue Cross and Blue Shield of North Carolina in 1983. This study compared the charges to Blue Cross subscribers in 1981-82 for three commonly performed procedures—hysterectomies, cholecystectomies (gall bladder removals), and normal baby deliveries at investor-owned and not-for-profit hospitals. Blue Cross and Blue Shield found that charges at the six investor-owned chain hospitals in the sample were higher than those at the not-for-profit hospitals with which they were compared, with one exception. Only one investor-owned hospital had lower charges for normal deliveries than the not-for-profit hospitals. Overall, however, the findings were consistent with other studies listed in Table 3.3.[14]

3. Markup. National studies have pointed to higher charges and costs at investor-owned hospitals, and it would follow that **markup,** the ratio of the two measures, would be significantly different for the ownership types as well. There are two areas to consider when examining markup. First is the ratio of charges to costs for routine and visible services such as room rates. The charges for these routine services are usually kept low, at or even below the actual cost to hospitals. This pricing strategy is used probably because charges for services such as room rates, which are the most visible price to the public, are the ones potential patients are most likely to compare among hospitals. The second area to consider is the ratio of charges to costs for the less-visible ancillary services, such as x-rays and diagnostic tests. Charges for ancillary services cross-subsidize routine services at most hospitals. That is, charges are usually marked up much higher than actual costs, enabling hospitals to recoup losses they incur on room rates and other routine services.[15] Four studies reviewed by the Institute of Medicine each showed routine services priced artificially low by *all* types of hospitals, and ancillary services marked up to be highly profitable, again re-

Table 3.4: Hospitals Owned by Investor-Owned Corporations in North Carolina, 1983

Hospital	Location		Corporate Affiliation in 1983	Year Affiliation Began
	City	County		
1. Raleigh Community Hospital	Raleigh	Wake	Hospital Corp. of America	1977
2. Glenn R. Frye Memorial Hospital[a]	Hickory	Catawba	American Medical International	1972
3. Medical Park Hospital[b]	Winston-Salem	Forsyth	Independent	1971
4. Humana Hospital[c]	Greensboro	Guilford	Humana, Inc.	1977
5. Central Carolina Hospital	Sanford	Lee	American Medical International	1980
6. Gordon Crowell Hospital[d]	Lincolnton	Lincoln	American Medical International	1972
7. Community Hospital of Rocky Mount[e]	Rocky Mount	Nash	American Medical International	1981

[a] Renamed Frye Regional Medical Center in 1984.
[b] Medical Park Hospital was sold to Carolina Medicorp, Inc., a private hospital corporation with for-profit and not-for-profit subsidiaries, in December 1986.
[c] Humana Hospital was sold to Moses H. Cone Memorial Hospital, a not-for-profit hospital, in 1988.
[d] Gordon Crowell Hospital closed in 1984.
[e] Community Hospital of Rocky Mount was bought by Best American Health Care, another investor-owned corporation, in 1986.

gardless of ownership type. For-profit hospitals, however, apparently employed these pricing strategies more vigorously than not-for-profit hospitals.[16]

4. **Profitability.** Comparing the **profitability** of hospitals is complicated by factors such as tax payments, income from nonpatient care such as charitable contributions, and different measures used. (See Chapter 5 for more on charitable contributions to N.C. hospitals.) Three of the four studies reviewed by the Institute of Medicine found, however, that investor-owned chain hospitals were more profitable than not-for-profit hospitals. These findings held true whether profitability was measured before or after taxes, and whether nonpatient care revenues were included or excluded.[17]

Methodology

IN ORDER TO DETERMINE whether investor-owned hospitals or not-for-profit hospitals in North Carolina a) controlled expenses better and b) had higher charges, the N.C. Center for Public Policy Research followed closely the methodology of a 1981 report by Lewin and Associates entitled *The Comparative Economic Performance of a Matched Sample of Investor-Owned and Not-for-Profit Hospitals.* As shown in Tables 3.2 and 3.3, the Lewin study used data from 1978 to compare 53 pairs of hospitals—53 investor-owned hospitals matched with 53 similar not-for-profit hospitals. The hospitals were located in Florida, Texas, and California.[18] This matched pair methodology was used for the Center's analysis in North Carolina as well.

1. **Data Set.** The data set for the Center's study in North Carolina depended upon the availability of audited Medicare Cost Reports, the sole source of publicly available, uniform hospital financial information filed with the federal Health Care Financing Administration. These reports contain financial information for all hospital patients, not just those covered by Medicare. Like Lewin and Associates, the Center focused on general acute care (i.e. nonspecialty) hospitals and excluded federal hospitals, such as the Veterans Administration Medical Center in Asheville, and teaching hospitals, such as N.C. Memorial Hospital in Chapel Hill. The most recent *audited* Medicare reports available in 1986, when the Center's research began, were for Fiscal Year 1983. At that time (1983), there were only seven hospitals in North Carolina that had been *owned* by an investor-owned corporation for the

Table 3.5: Not-for-Profit Hospitals Matched with Investor-Owned Hospitals in North Carolina, 1983

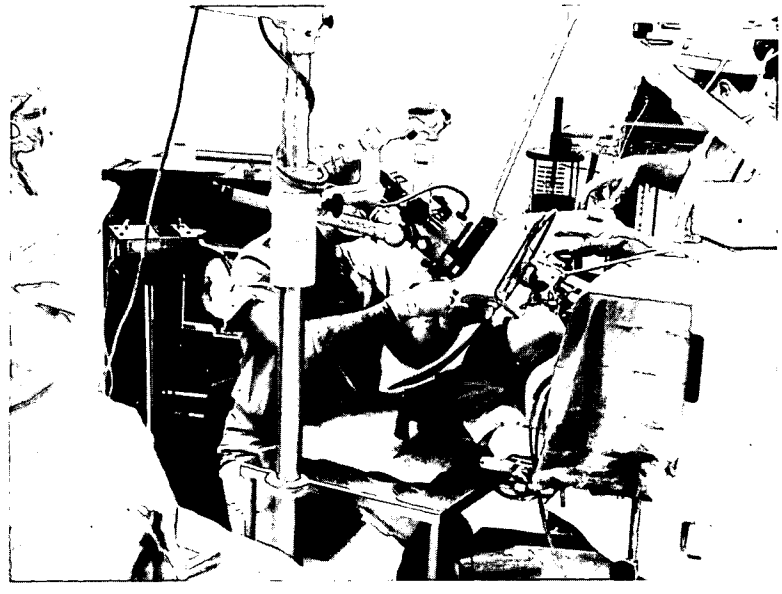
Hospital	Location		Ownership in 1983
	City	County	
1. Grace Hospital	Morganton	Burke	Private/Voluntary
2. Margaret R. Pardee Memorial Hospital	Hendersonville	Henderson	County
3. Alamance County Hospital[a]	Burlington	Alamance	County
4. Cape Fear Memorial Hospital	Wilmington	New Hanover	Private/Voluntary
5. Stanly Memorial Hospital	Albemarle	Stanly	Private/Voluntary
6. Fletcher Hospital[b]	Fletcher	Henderson	Private/Voluntary
7. J. Arthur Dosher Memorial Hospital	Southport	Brunswick	Township/Hospital District

[a] Alamance County Hospital was managed by SunHealth Enterprises (a subsidary of SunHeath Corporation, the holding company for a partnership of not-for-profit hospitals), but owned by the county, in 1983. In 1984, the county sold it to Alamance Health Services, a private, not-for-profit, parent holding company, which also owns Alamance Memorial Hospital. Alamance Health Services still contracts with SunHealth for management services.
[b] Renamed Park Ridge Hospital in 1985.

entire fiscal year. (Edgecombe General in Tarboro, now Heritage Hospital, was purchased by Hospital Corporation of America in 1982, while Davis Community Hospital in Statesville and Highsmith-Rainey Hospital in Fayetteville were both purchased by HCA in 1983; thus, these three hospitals were purchased too late to be included in this analysis.) Table 3.4 lists the seven investor-owned hospitals that formed the data base examined in this chapter.

2. Matching Process. The matching process attempted to control, as much as possible, for factors that affect economic performance in order to determine which differences in economic performance were due to type of hospital ownership. In order to compare the cost and charge data of hospitals of different ownership types, the seven investor-owned hospitals were paired with not-for-profit hospitals in North Carolina similar in size, number of admissions, and number of full-time-equivalent employees. Not-for-profit general acute care hospitals throughout the state were considered for matching with the seven investor-owned, or target hospitals, if they came within a range of plus or minus 10 percent of the target hospital on any one of the three variables — size, admissions, or full-time equivalent employees. Each investor-owned hospital had at least 10 possible match hospitals based on these criteria—and some had more than 25. A point score for each not-for-profit was then calculated, based on the differences between it and the target investor-owned hospital in these categories. The *smaller* the point score, the closer the not-for-profit hospital was to the target investor-owned hospital, which had a point score of zero. The potential matches were ranked according to these point scores.

Additional variables were then considered in the matching process: occupancy rate, number of live births, bed days in the cardiac intensive care unit, the



Courtesy Johnston Memorial Hospital

number of inpatient surgeries as a percentage of inpatient admissions, and whether there was another general acute care hospital within 15 miles. The methodology used for matching was reviewed by experts in the hospital finance and health care fields and modified based on their comments. Table 3.5 lists the not-for-profit hospitals matched with the seven investor-owned hospitals in Table 3.4.

Table 3.6 illustrates how the seven matched pairs of hospitals actually compared on the criteria discussed above. The number of beds, full-time-equivalent employees, and admissions were the most important variables used in the matching process. These three variables primarily address the capital, labor, and utilization concerns of a typical acute care hospital.

The number of acute care beds—which excludes psychiatric and rehabilitation unit beds—serves as a proxy for service complexity and capital costs. Four of the seven not-for-profit hospitals came within 10 percent of their target hospital on bed size. For example, Stanly Memorial Hospital's total of 130 beds was within the requisite 10 percent, or 14 beds, of Central Carolina Hospital's 142 beds. Comparisons on the number of acute care beds for the remaining three pairs were within 18%.

The number of full-time-equivalent (FTE) employees reflects labor costs for a hospital. Three of the seven not-for-profits came within 10 percent of the investor-owned hospitals on this variable. Two other matches came within 14% on FTE employees.

Admissions signify the level of activity at a hospital. For all 14 hospitals used in this study, the number of admissions per year varied greatly—from approximately 1500 at J. Arthur Dosher Hospital to more than 9000 at Margaret R. Pardee Memorial Hospital. Within each match, however, five of the seven not-for-profit hospitals came within the 10 percent range of their investor-owned match on the number of admissions.

Rate of occupancy also gives an indication of the level of activity at a hospital. Here, too, five of the seven not-for-profit hospitals came within 10 percent of their target hospital.

Some service-related variables—such as the number of live births, bed days in the cardiac intensive care

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Check out the hospital before you check in.

On October 1, 1983, the federal government began using the Prospective Payment System to pay hospitals for services provided to Medicare patients.

Since a great number of older citizens rely on Medicare to cover many of their medical bills, the American Association of Retired Persons (AARP) has developed a national effort to help older people understand this new system.

AARP is a nonprofit organization which is actively addressing the concerns and problems of the nation's mature citizens, whether they are members or not.

How the Prospective Payment System Works

Under the old payment system, the government simply paid hospitals for the costs of care provided to Medicare patients. There was no incentive to control costs and money was spent on services and supplies that may or may not have been needed. Under the Prospective Payment System, the government makes reimbursements to hospitals based on average costs for particular diagnoses.

It is important to know that Medicare patients continue to be entitled to all the hospital care necessary for the treatment of illness or injury.

Knowing Your Rights Makes a Difference

The new system is meant to reward hospitals that operate in a cost effective way. But there are incentives in the system that may tempt some hospitals to skimp on care. This means Medicare patients MUST become better informed about their rights.

AARP has received numerous letters from members who feel they have been sent home too early. If you are able, ask friends and neighbors about how well they were treated in a hospital before you decide to check in. If it is emergency treatment, remember that you have special rights if you are asked to leave too soon.

For millions of mature Americans, knowing their rights as a Medicare beneficiary can make a big difference. Keeping them well informed about everything from taxes to travel to medical treatment is what AARP is all about.

If you want to know more about Medicare coverage, send in the coupon for your FREE booklet, "Knowing Your Rights."

If you are 50 or over, retired or not, you are eligible to join AARP. You will receiv to join AARP your coupon AARP ha and service live richer, you shoul TODAY!

☐ Ple

The high cost of medicine is enough to make you sick.

Twenty-five percent of all prescription drugs used in this country are taken by Americans over the age of 65. More than half of them take at least one medication daily and many take six or more each day.

The American Association of Retired Persons (AARP) has been assisting a growing number of older people who don't know how to cut health care costs without reducing the quality of care. This nonprofit organization actively addresses the problems and concerns of the nation's mature citizens, whether they are members or not. One way AARP helps Americans age 50 and over is by recommending the use of non-brand name products, known as generic drugs.

Since generic drugs must meet the same FDA standards for safety, strength, purity and effectiveness as brand-name drugs, the differences between them are largely economic. Moreover, generics have the same active ingredients as their brand name counterparts and very often they are manufactured by the same drug company that produces the well-known brand.

More Money Saving Advantages

According to AARP, the savings available when generics are substituted for brand-name drugs can vary from product to product and store to store. However, the average saving is between 30 and 50 percent, but may be higher in some cases. And these savings can go a long way in helping America's mature citizens spend less money on overall health care.

AARP encourages older people to control their medical costs by asking their doctor to write a prescription for generic drugs, or in many instances, by asking the pharmacist if a prescription can be filled with a generic version.

If you want additional information on generic drugs and how to get the best possible care for your health dollar, send in the coupon for your FREE booklet, "The Prudent Patient."

If you are 50 or over, retired or not, you are eligible to join AARP. You will receive information on how to join AARP when you mail in your coupon.

Take advantage of an organization that helps you get the most out of the rest of your life. Send in your coupon TODAY!

☐ Please send me the FREE booklet "The Prudent Patient" and information on AARP membership.

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Address

City

State Zip

Mail to: The Prudent Patient AARP Publications P.O. Box 22718 Long Beach, CA 90801

AARP

Table 3.6: Key Variables Used in Matching General Acute Care Investor-Owned and Not-for-Profit Hospitals in North Carolina, 1983 †

Hospital Matches	Hospital Type	Number of Acute Care Beds	Number of Full-time Equivalent Employees	Number of Admissions	Rate of Occupancy	Number of Live Births	Bed Days in Cardiac ICU	Inpatient Surgeries as % of Inpatient Admissions	# of General Hospitals Within 15 Miles
1. **Raleigh Community Hospital** (Raleigh)	i-o	140	433	6960	84.1	0	0	59.4	2
Grace Hospital (Morganton)	nfp	161	438 *	8399	80.4 *	754	0 *	49.4	1
2. **Glenn R. Frye Memorial Hospital** (Hickory)	i-o	214	578	8730	70.1	797	1495	87.5	1
Margaret R. Pardee Memorial Hospital (Hendersonville)	nfp	233 *	590 *	9053 *	70.6 *	389	0	38.2	1
3. **Medical Park Hospital** (Winston-Salem)	i-o	136	276	7504	72.3	0	0	92.9	2
Alamance County Hospital (Burlington)	nfp	141 *	305	4877	59.9	434	1234	50.7	1
4. **Humana Hospital** (Greensboro)	i-o	100	243	4272	72.1	0	0	63.7**	3
Cape Fear Memorial Hospital (Wilmington)	nfp	110 *	304	4452 *	73.4 *	102	0 *	51.0	1
5. **Central Carolina Hospital** (Sanford)	i-o	142	299	4932	64.8	499	0	33.4	0
Stanly Memorial Hospital (Albemarle)	nfp	130 *	298 *	4699 *	69.0 *	438	0 *	32.0 *	0
6. **Gordon Crowell Hospital** (Lincolnton)	i-o	93	141	2790	43.3	259	0	39.7	1
Fletcher Hospital (Fletcher)	nfp	103	179	3028 *	49.3	406	0 *	36.3 *	1
7. **Community Hospital of Rocky Mount** (Rocky Mount)	i-o	49	148	1592	72.3	0	0	30.8	2
J. Arthur Dosher Hospital (Southport)	nfp	40	128	1534 *	73.4 *	0 *	0 *	23.8	1

† Not-for-profit hospitals were considered for matching purposes if they were within a range of plus or minus 10 percent of the target investor-owned hospital on bed size, full-time-equivalent employees, or admissions.

i-o = investor-owned hospital

nfp = not-for-profit hospital

* = Number is within the ± 10 percent range of the target investor-owned hospital on this variable.

** = Estimated figure based on 1982 and 1984 data.

Source of data for variables: State Center for Health Statistics, *Health Facilities Data Book, 1983*.

Courtesy McDowell Hospital

Birthing room at McDowell Hospital in Marion, North Carolina

unit, and inpatient surgeries as a percentage of inpatient admissions—were also considered in determining the hospital matches. The ratio of inpatient surgeries to inpatient admissions—which reflects the full-service nature of a hospital—was most helpful. Three of the seven not-for-profits came within 10 percent of their target hospital on this variable.

Another factor considered in this analysis was whether there was another hospital in the community, indicating potential competitive pressure in the health care marketplace. Each hospital in six of the matched pairs had at least one other general hospital within 15 miles. In the matched pair of Central Carolina and Stanly Memorial, neither hospital was within 15 miles of another general acute care hospital.

3. Calculations and Tests of Statistical Significance. Once the matching process was completed, approximately 150 statistical comparisons between investor-owned and not-for-profit hospitals were calculated. The formulas used for these comparisons—for example, hospital revenues derived from patient charges—were based on data from the Medicare Cost Reports and were, in many cases, the same as those used by Lewin and Associates (1981).[19]

After the calculations were completed for each hospital, percentage differences between the investor-owned and not-for-profit hospital in each pair were calculated. For example, if $125 and $85 were the values for a pair of investor-owned and not-for-profit hospitals, respectively, then the percentage difference for that pair was:

$$[(125 - 85)] \div [(125 + 85) \div 2] = 38\%.$$

Percentage differences were used to make values from different-sized hospitals comparable. The average percentage difference for all seven pairs of investor-owned and not-for-profits was then calculated.

In order to determine if the percentage differences between the two types of hospitals were statistically significant, a "t" test was used. The t-test is a standard statistical test that factors in the size of the sample, the differences between the two sample groups, and the size of the standard deviations (which tell how all the scores are spread out in relation to the mean, or average). A *two-tailed* t-test was used to test the theory that neither type of hospital, investor-owned or not-for-profit, was expected to charge patients more for services or hold down costs better. The t-test attempts to assess whether the average percentage differences calculated for each measure were due to chance or to the sampling or matching process, rather than to actual differences between the two groups of hospitals.

This latter assessment of whether the differences between ownership types were due to actual performance differences between investor-owned and not-for-profit hospitals is expressed in the following section on the Center's findings as "p(t)." This value indicates the observed significance level of the statistical differences; the lower the p(t) value, the greater the level of statistical significance of the percentage differences.

The maximum value for p(t) is 1.0. A common statistical practice is to set the significance level of .05 as a cutoff point. The p(t) value of .05 would indicate a 95% confidence level ("We are 95 percent sure. . .") that the percentage difference calculated was not due to chance or the matching process. In other words, any difference in the results would be most likely due to actual performance differences between the sample

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INFLATION AND THE COST OF HEALTH CARE

by Suzanne Goyer and Melissa Jones

DURING THE PAST TWO DECADES, the cost of health care in the U.S. has risen rapidly. In 1965, consumers spent $41.9 billion, or 5.9% of the gross national product (GNP), on medical care. By 1986, the amount of money spent on health care had soared to more than $458 billion—almost 11% of the GNP.[1] Although the aging and growth of the population have contributed to the rise in health care costs, price inflation in medical care and in the general economy have accounted for most of this dramatic increase.

The accompanying chart compares the Consumer Price Index (CPI) for all items with the price index for medical care. The overall medical care component (MCC) includes medical services and commodities. Physician and hospital services comprise *medical services*; prescription drugs, nonprescription drugs, and medical supplies comprise *medical commodities*.

The annual percent increase in overall CPI averaged 6.6% between 1970 and 1987. During the same time, the overall medical care component averaged an 8.1% annual increase, exceeding CPI by an average of 1.5% a year. Medical service costs outpaced the increase in medical commodities; medical service costs rose at an average annual rate of 8.4%, while medical commodities increased an average of 6.1% a year.

From 1970-1987, the overall medical care component (MCC) increase exceeded the overall CPI in all but five years. Only between 1972-1974 (during the Nixon administration's Economic Stabilization Program involving wage and price controls on the health care industry) and during 1979-1980 did the overall CPI increase more than medical care costs. Every year beginning in 1981, however, health care inflation (MCC) and its two components have accelerated faster than the general inflation rate. The economy-wide inflation rate averaged an increase of 7.7% a year from 1970-1980. From 1981-1987, while the general rate of inflation slowed dramatically to an average of 4.8% a year, medical costs continued to accelerate at an average rate of 8.1%. Medical services also rose an average of 8.1%, while medical commodities rose an average of 8.3% annually.

The differences between 1985 and 1986 are most striking. The general rate of inflation slowed to 1.9%, but overall medical costs rose 7.5%, medical services rose 7.7%, and medical commodities rose 6.6%. In 1987, however, while the general inflation rate rose at a rate of 4.4%, up from 1.9% in 1986, medical care inflation rose at a rate of 5.8%, less than in 1986. (Inflation in medical services slowed 5.6%, but medical care commodities rose 7.1%.) It is not yet clear if the decrease in the overall medical care inflation rate between 1986 and 1987 is the beginning of a new trend. However, government experts predict that health care costs will indeed continue to increase, and if they do so at current rates, health care spending by the year 2000 may comprise as much as 15% of GNP, the highest percentage among developed nations.[2]

What has driven the increase in health care costs beyond the general inflation rate in recent years? First of all, the consumers of medical services—patients—seek the best health care available and may equate *expensive* with *best*.[3] Patients may also be willing to forgo lower rates for health care services in favor of higher ones at a hospital where the staff has demonstrated concern and expertise.[4] Both physicians and hospitals, responding to consumer demand for quality, sometimes regardless of price—as well as to their own desire to serve

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Annual Percent Change in National Consumer Price Index (CPI) and Medical Care Components, 1970-1987

Year	Overall CPI	Overall Medical Care Component (MCC)	Medical Services	Medical Commodities
1970	+ 5.9 %	+ 6.3 %	+ 7.1 %	+ 2.3 %
1971	4.3	6.5	7.3	1.7
1972	3.3	3.2	3.7	0.2
1973	6.2	3.9	4.4	0.3
1974	11.0	9.3	10.3	3.5
1975	9.1	12.0	12.6	8.4
1976	5.8	9.5	10.1	6.1
1977	6.5	9.6	9.9	6.4
1978	7.7	8.4	8.6	7.0
1979	11.3	9.3	9.7	7.2
1980	13.5	10.9	11.3	9.3
1981	10.4	10.8	10.7	10.9
1982	6.1	11.6	11.9	10.3
1983	3.2	8.7	8.7	8.6
1984	4.3	6.2	6.0	7.3
1985	3.6	6.2	6.0	7.1
1986	1.9	7.5	7.7	6.6
1987	4.4	5.8	5.6	7.1
Average Yearly Increase 1970-87:	6.6 %	8.1%	8.4%	6.1%

Sources: U.S. Department of Commerce. Bureau of the Census. *Statistical Abstract of the United States, 1987.* "National Health Expenditures, 1986-2000." *Health Care Financing Review,* Vol. 8, No. 4, Summer 1987. U.S. Department of Labor statistics quoted in "Medical prices hold steady at 0.4%: CPI." *AHA News,* January 25, 1988, p. 5.

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patients' health needs and to achieve prestige in the medical community—try to offer a full range of services, including the latest in medical technology. As a result, an increase in costs for medical services may actually reflect higher quality. As Paul Starr explains, neither patients, physicians, hospital administrators, or insurance executives immediately lose from the growth in medical care prices.[5]

The American Hospital Association points out that the labor intensity and rapid technological changes of the health care industry also push medical inflation above CPI. The price of health insurance, a "highly volatile" component of health care costs, contributes to medical inflation as well. AHA economists even question the validity of using CPI data, contending that while hospital prices rise at rates above those of the general economy, these rates remain in line with other service industries like higher education.[6]

Medical care costs have continued to rise rapidly despite efforts to curb them. Prior to the introduction of diagnosis related groups (DRGs) and other prospective payment systems (PPSs) early in this decade, physicians and hospitals generally earned fees for each service and received insurance, Medicare, and Medicaid reimbursements based on their costs alone. This method of reimbursement provided little incentive for patients, hospitals, doctors, or insurers to contain costs. And although PPSs have contributed to a significant decline in hospital use over the past few years, as have reviews by insurers prior to a patient's admission to the hospital, the rise in the cost of health care has not abated.[7] Moreover, many hospitals are having trouble recovering costs under the new reimbursement system and are shifting unrecovered expenses from Medicare patients, as well as costs for indigent care not covered by Medicaid, to insured patients. As John Currin, administrator at Alamance Memorial Hospital in Burlington explains:

> [O]ne of the largest contributors to increasing charges in the past four years [is] inadequate Medicare payment. In most N.C. community hospitals, Medicare accounts for about half of the total utilization. When the payments from Medicare are inadequate to recover the hospital's operating and capital costs to care for Medicare patients, the only alternative to insolvency that the hospital has available to it is to alter its pricing to charge payers. As the population ages and Medicare utilization increases, the ability to shift these costs is diminishing.

And as the inflation in health care prices has continued, insurance companies, in turn, have raised their premiums.

In further efforts to curb health care costs, some state governments have implemented extensive programs to oversee and even limit hospital and physician charges. These cost containment programs are explained further in the sidebar on page 111.

It is important to note that the information for this sidebar is based on national data. A state-level consumer price index is not compiled in North Carolina, and the national figure cannot be broken down by individual states. State-level figures for the medical care component are also unavailable. **The N.C. Center for Public Policy Research recommends that the N.C. Office of State Budget and Management calculate and publish a consumer price index for North Carolina comparable to the federal data because such information is relevant to any discussion of health care costs and cost containment efforts.**

FOOTNOTES

[1]"National Health Expenditures, 1986-2000," *Health Care Financing Review*, Vol. 8, No. 4, Summer 1987.

[2]"HHS Chief of Staff Burke urges industry to face up to the economic facts of life," *Federation of American Health Systems Review*, March/April 1988, p.12. See also Spencer Rich, "Cost of medical care resisting constraints," *The News and Observer* (Raleigh, NC), October 25, 1987, p. 5D.

[3]See "Competition may push prices up, study says," *The News and Observer* (Raleigh, NC), June 19, 1987, p. 9A; Judith Graham, "Providers not picked by price," *Modern Healthcare*, November 7, 1986, p. 16; and Karen Sandrick, "Will '88 be the year of price competition?" *Hospitals*, December 20, 1987, pp. 34-39.

[4]Michael D. Hays, "Consumers base quality perceptions on patient relations, staff qualifications," *Modern Healthcare*, February 27, 1987, p. 33.

[5]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), pp. 386-387.

[6]Mary Gallivan, "Are 'real' medical costs really soaring?," *Hospitals*, April 5, 1987, p. 44; and Teri Shahoda, "What the CPI doesn't say about medical costs," *Hospitals*, January 5, 1987, pp. 27-28.

[7]For a more complete discussion of DRGs, see Chapter 1 of this report. See also Elizabeth M. "Lacy" Maddox, ed., *The Investor-Owned Hospital Movement in North Carolina* (Raleigh, NC: North Carolina Center for Public Policy Research, 1986), p. 90.

populations, in this case between investor-owned and not-for-profit hospitals.

For this study, however, as with the method used by Lewin and Associates, the significance of each percentage difference is placed *within a range* of p(t) values. If the p(t) value was less than or equal to .05, there are three asterisks for the finding in the tables in the following section, indicating a high level of statistical significance. If the p(t) value was greater than .05 but less than or equal to .10, there are two asterisks, and if the p(t) value was greater than .10 but less than or equal to .2, there is one asterisk. It is not common to report p(t) values in this range as "statistically significant," but such values are suggestive of real differences. If the p(t) value was .2 or more, "N/A" indicates that the difference between the investor-owned and not-for-profit hospitals was not statistically significant.

This method of presenting p(t) values within a range enables the reader to interpret the significance of the findings based on a less rigid classification system than that of an absolute cutoff point system.

Limitations of the Data

BEFORE DISCUSSING the Center's findings on the costs and charges at North Carolina investor-owned and not-for-profit hospitals, it is important to note limitations and strengths of the data set.

1. Change in the Medicare reimbursement system. The financial data used in this chapter, taken from audited Medicare Cost Reports for FY 1983, are from the pre-DRG era. For most of 1983, hospitals, regardless of ownership type, were reimbursed by Medicare *retrospectively*—based on actual costs of providing services to patients. As discussed in Chapter 1, however, a *prospective* payment system was established on October 1, 1983, the beginning of the federal fiscal year. Under the new system, which the federal government is using to control Medicare costs, hospitals are reimbursed based upon a pre-determined rate for the cost of care for a Diagnosis Related Group, or DRG. This system has brought major changes in financial strategies for both investor-owned and not-for-profit hospitals. However, a change in Medicare reimbursement policy does not necessarily mean that a hospital with higher charges before DRGs could not, or would not, have higher charges after that change. Further study on hospital costs and charges under the prospective payment system would obviously shed more light on this issue. But again, the N.C. Center used the most recently available Medicare Cost Reports when its research began. As of this writing, the latest year for which there is a complete set of audited Medicare Cost Reports is still 1983.

2. Some incomplete data. A few of the Medicare reports used for this study were incomplete in some areas, although not to a significant degree. Tax data for the investor-owned hospitals was incomplete because this reporting is not required under Medicare. Nursing costs at both types of hospitals were also insufficient. However, the Center was still able to make more than 100 statistical comparisons of hospital costs and charges and to draw conclusions based on those results.

3. Uniformity of the data set. The vast majority of investor-owned hospitals belong to chains which operate hospitals in a number of states. One of the seven investor-owned hospitals in this study, however—Medical Park in Winston-Salem—was independently owned in 1983. The Center decided that the need for a seventh matched pair in the study outweighed the drawback of using an independently owned for-profit hospital. Medical Park signed a management contract with HCA in 1984, and is currently owned by Carolina Medicorp, Inc., a private hospital corporation with for-profit and not-for-profit subsidiaries. (For more on Carolina Medicorp, Inc., see page 22.) Also, Alamance County Hospital had a management contract with SunHealth Enterprises — a subsidiary of SunHealth Corporation, the holding company for a partnership of not-for-profit hospitals — in 1983. Since most not-for-profits did not have such an arrangement during that year, this hospital was somewhat atypical as well.

4. Size of the sample. The data set used was limited due to the N.C. Center's decision to use *audited* Medicare Cost Reports and the study's focus on one state—North Carolina. Audited reports for FY 1983 were the most recent available when the project began, and as noted above, there were only seven hospitals in North Carolina owned by investor-owned corporations for that entire year. Whereas Lewin and Associates' findings and conclusions were based on 53 matched pairs of hospitals in three states, the Center's conclusions are based on only seven matched pairs of investor-owned and not-for-profit hospitals. It should be emphasized, however, that no investor-owned hospital was excluded from this comparison of costs and charges at North Carolina hospitals.

Despite any limitations, it is important to remember that at the time this project began, (a) the Center included *all* seven of the investor-owned hospitals then operating in North Carolina, and (b) the FY 1983 Medicare Cost Reports were the latest audited reports available then and now. The N.C. Center's research on costs and charges at for-profit and not-for-profit hospitals is the most comprehensive done in North Carolina to date and should add important information to the for-profit versus not-for-profit debate.

Findings

THE CENTER'S FINDINGS on the financial performance of matched pairs of investor-owned and not-for-profit hospitals in North Carolina are grouped under the following general categories:

1. Revenues/charges to patients
   - revenue from charge payers
   - revenue from cost payers
   - net patient revenue
2. Costs to hospitals
   - total operating costs
   - general service costs
   - patient care costs
   - ancillary department costs
3. Markup: ratio of charges to costs
4. Profitability

1. Revenues/Charges to Patients. Comparisons of hospital revenues derived from charges to patients are listed in Table 3.7. Numbers in the "N" column for this and the following tables range from three to seven, indicating the number of matched pairs used to calculate the average percentage difference between hospital types for each comparison. Positive signs in the "average percentage difference" column mean that the values for the investor-owned hospitals were higher than the not-for-profits as a group; negative signs mean the investor-owned hospitals had lower values on those particular measures. The p(t) column indicates the level of significance of the findings. Three asterisks indicate a high level of significance. Two or one asterisk(s) indicate lower levels of significance, while "N/A" indicates that the average percentage difference between pairs was not significant. The same system holds for all of the tables in this section.

A. *Revenue from Charge Payers.* Gross patient revenue is derived from charges to patients (including professional fees) before hospitals subtract contractual allowances, discounts, or bad debts. Professional fees are charges for hospital services provided by hospital-based physicians. Contractual allowances are the differences between what a hospital charges for services and the rates payable for those services under contracts with third-party payers, e.g., insurance companies. Discounts are reductions in charges for services made at the discretion of the hospital. Bad debt is the cost hospitals incur for patients who presumably can afford to pay for hospital bills, but for one reason or another do not. As shown under section A in Table 3.7, gross inpatient revenue on a per day basis was 18% higher for investor-owned hospitals, and 16% higher on a per admission basis. These charges determine what **charge payers**—those who pay hospital bills on their own, as well as through private insurance or Blue Cross—must pay for hospital care.

Findings for hospital types differed when gross inpatient charges were broken down into routine and ancillary service charges. An example of routine service revenue is a room rate, while an example of an ancillary service is an x-ray. Revenue from inpatient *routine* services were *lower* at investor-owned hospitals on both a per day and per admission basis—approximately 14% and 16% lower, respectively—but the differences were not statistically significant. (See sidebar on page 104 for more recent comparisons on room rates at the matched pair hospitals.) The same results—lower charges at investor-owned hospitals—were found for general (nonintensive care) and special (e.g., intensive care) care service categories under routine care.

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Table 3.7: Comparisons of Revenues/Charges to Patients Between Investor-Owned and Not-For-Profit Hospitals

Measure	N (Pairs in sample)	Average Percentage Difference Between Investor-Owned and Not-For-Profit Hospitals	P(t), or Level of Significance (*** = highly significant)
A. *Charge Payers* — self-pay, private insurance, Blue Cross (ipf)			
1. **Gross** inpatient revenue per day	7	+ 18.1 %	**
2. Gross inpatient revenue per admission	7	+ 16.0	*
Routine Care Service			
3. Gross inpatient routine revenue per day	7	- 13.7	N/A
4. Gross inpatient routine revenue per admission	7	- 15.7	N/A
5. **General** inpatient routine care service revenue per day	7	- 13.6	N/A
6. General inpatient routine care service revenue per admission	7	- 15.7	N/A
7. **Special** inpatient care service revenue per day	6	- 4.9	N/A
8. Special inpatient care service revenue per admission	6	- 5.8	N/A
Ancillary Services			
9. Gross inpatient ancillary revenue per day	6	+ 29.6	**
10. Gross inpatient ancillary revenue per admission	6	+ 27.6	*
11. Gross inpatient ancillary revenue as percentage of total inpatient revenue	6	+ 7.5	*
B. *Cost Payers* — Medicare and Medicaid (expf)			
12. Inpatient allowable costs (plus return on equity for investor-owned hospitals) per day	7	+ 21.5	***
C. *Net Patient Revenue* (ipf)			
13. Adjusted net patient service revenue per day	7	+ 27.4	***
14. Adjusted net patient service revenue per admission	7	+ 25.3	***

ipf = including professional fees
expf = excluding professional fees
\+ = investor-owned hospitals as a group had higher values on this measure
– = not-for-profit hospitals as a group had higher values on this measure
*** = $p(t) \leq .05$
** = $.05 < p(t) \leq .1$
* = $.1 < p(t) \leq .2$
N/A = percentage difference on this measure was not statistically significant

Gross inpatient revenue from inpatient *ancillary* care, however—which also determines what **charge payers** pay—was approximately 30% and 28% higher on a per day basis and per admission basis, respectively, for investor-owned hospitals. These differences were statistically significant. *Like the findings discussed in the Institute of Medicine's report,[20] investor-owned hospitals in North Carolina charged higher prices for ancillary services than not-for-profit hospitals.* And because gross inpatient ancillary revenue as a percentage of total inpatient revenue was 7.5% higher at investor-owned hospitals, it is clear that investor-owned hospitals derived more of their revenue from ancillary services than not-for-profit hospitals.

B. *Revenue from Cost Payers.* Table 3.7 also shows how investor-owned and not-for-profit hospitals in North Carolina compared on charges to **cost payers** in the pre-DRG era. Cost payers are Medicare and Medicaid patients who pay the hospital's allowable rates for services. (In 1983, before the prospective payment system was instituted, the federal government reimbursed hospitals for "reasonable costs incurred;" these rates were not determined in advance.) Hospital revenue from these patients differs at investor-owned and not-for-profit hospitals. Both types derive revenue from inpatient allowable costs, but investor-owned hospitals also earn a return on equity. Return on equity (ROE) is an allowance paid by Medicare to investor-owned hospitals enabling them to maintain their funding—known as equity financing—from their stockholders.[21] Although these payments have been eliminated for outpatient services as of January 1, 1988, and are being phased out for inpatient services, Bruce Chappell, supervisor of reimbursement services at Blue Cross and Blue Shield of North Carolina, notes that "return on equity payments in the pre-DRG era were a significant source of income for investor-owned hospitals." In this study, the N.C. Center found that charges to cost payers in North Carolina were 21.5% higher at investor-owned hospitals, and the difference was statistically significant.

C. *Net Patient Service Revenue.* Net patient service revenue, calculated after contractual allowances, discounts and bad debts are subtracted from gross patient revenues, was higher at investor-owned hospitals—more than 25% higher—whether measured on a per day or per admission basis. Both of these measures were adjusted so that inpatient days and admissions accounted for the hospitals' outpatient volume.* The differences were statistically significant.

In summary, then, the N.C. Center's findings on hospital charges to patients were consistent with the Institute of Medicine's observations after reviewing six national studies of hospital prices. *In North Carolina, both charge and cost payers paid higher prices at investor-owned hospitals than at not-for-profit hospitals.* Gross inpatient revenues—which determine what **charge payers** pay—were higher per day and per admission at investor-owned hospitals. When these revenues were broken down into routine and ancillary services, the findings differed. Revenues from *routine* services were higher at not-for-profits, but the differences were not statistically significant. More telling was the fact that revenues from inpatient *ancillary* services were considerably higher at investor-owned hospitals—more than 29% higher per day, and almost 28% higher per admission—and statistically significant. Investor-owned hospitals were clearly more aggressive in recouping any losses on routine care through higher prices in the ancillary service category. Charges to **cost payers**, as well as net patient service revenue, were also higher at North Carolina's investor-owned hospitals than at not-for-profit hospitals.

2. Costs/Expenses. Table 3.8 summarizes the Center's findings comparing total operating costs, general service costs, patient care costs, and ancillary department costs at investor-owned and not-for-profit hospitals in North Carolina.

A. *Total Operating Costs.* A hospital's total operating costs include patient and nonpatient care cost centers. Total operating costs per adjusted day were 20% higher at investor-owned hospitals, and the difference was statistically significant.

B. *General Service Costs.* General service costs from nonpatient care centers are hospital expenses such as building and fixture depreciation, operation of the hospital facility, housekeeping services, employee benefits, central services and supply, and medical records. These are "overhead" or indirect costs to the hospitals before they are allocated to patient care departments. General service costs per adjusted day for the matched pair hospitals were almost 27% higher at investor-owned than at not-for-profit hospitals, and this difference was statistically significant.

Administrative and general (A&G) costs are a hospital's overhead expenses that are not separated out as specific categories under general service costs. Nonmedical staff salaries are an example of a hospital's A&G costs. In North Carolina, administrative and general costs were substantially higher at investor-owned hospitals—48% higher. This difference was also statistically significant.

In addition to administrative and general costs incurred by each hospital regardless of ownership type, investor-owned hospitals often pay for services

*Measures termed "adjusted" in Table 3.7 or in succeeding tables indicate that outpatient volume was accounted for in the number of admissions and inpatient days.

provided by the central office of the chain to which they belong. These costs are known as home office costs. The reporting method of the seven investor-owned hospitals in this study varied, but six hospitals did have data for this measure. Although Medical Park Hospital, one of the six, did not belong to an investor-owned chain, it did list "costs incurred as a result of transactions with related organizations" on its Medicare Cost Report. These costs were passed from the group of physicians who owned the hospital to the facility. In the sense that these were costs beyond the administrative and general costs listed in the Medicare Cost Report, these costs were considered "home office costs" for the purposes of this study. The average home office cost for the investor- owned hospitals in North Carolina as a group was approximately $18 per adjusted patient day.

Other findings in the general service cost category per adjusted day were mixed. Building and fixture depreciation was much higher—more than 59%—at investor-owned hospitals and the difference was statistically significant. This finding was not unexpected since the investor-owned hospitals generally have newer physical plants than their not-for-profit match hospitals. The depreciation of movable equipment was slightly higher at investor-owned hospitals, but the differences were not statistically significant. Finally, costs from plant operations, laundry services, and housekeeping were slightly lower at investor-owned hospitals, but here the differences were not statistically significant.

These findings suggest that belonging to an investor-owned chain did not result in offsetting economies and lower costs in nonpatient care categories for hospitals in North Carolina.

C. ***Costs of Patient Care.*** Table 3.8 also lists findings comparing patient care costs at investor-owned and not-for-profit hospitals in North Carolina. After being adjusted for outpatient volume, total patient care costs per day and per admission were approximately 16% and 14% higher, respectively, at investor-owned hospitals. The difference was more significant on a per day basis. These measures included fees hospitals paid hospital-based physicians for professional services for patient care such as anesthesia.

Total costs for inpatient care alone, including professional fees, were higher at investor-owned hospitals than at not-for-profits. Inpatient care costs per inpatient day were more than 14% higher at investor-owned hospitals. They were more than 12% higher per admission, although the difference here was less statistically significant.

Comparing patient care costs *excluding* professional fees, investor-owned hospitals again had higher costs. These costs were approximately 16% higher per day and 14% higher per admission, although the per admission cost difference was less significant. Hospital expenses for routine inpatient services excluding professional fees were also higher at investor-owned hospitals—over 19% per day and 17% per admission. Again, the per day difference between hospital types was of greater statistical significance. *Thus, no matter how they were measured, patient care costs were higher at investor-owned hospitals.* They were higher per inpatient day — whether professional fees were included or excluded — and per admission.

D. *Ancillary Department Costs.* The last category of hospital costs examined in this section was ancillary department costs. Ancillary department costs are a component of patient care costs and were measured on a per inpatient day basis, excluding professional fees. Under section D in Table 3.8, it is evident that total inpatient ancillary service costs per day were approximately 13% higher at investor-owned hospitals. The difference was somewhat significant.

In three ancillary departments—operating room costs, the costs of drugs charged to patients, and delivery and labor room costs—the costs were higher at investor-owned hospitals and the differences were statistically significant. It is important to note that for one of these comparisons—delivery and labor room costs—data were available on only three matched pairs of hospitals. Not-for-profits, on the other hand, had substantially higher costs per day for electrocardiology, though this difference was not highly significant statistically. Higher costs were also found at not-for-profit hospitals for anesthesiology, radiology, and medical supplies, although the differences were statistically insignificant in all three cases.

These comparisons of hospital costs, or expenses, revealed that, overall, investor-owned hospitals had higher costs than not-for-profit hospitals in North Carolina. Investor-owned hospitals had higher total operating costs and higher general service costs—including administrative and general costs. Costs from patient care centers were higher in all categories: total patient care costs, inpatient care costs (both including and excluding professional fees), and routine inpatient service costs. Comparisons of ancillary costs per day differed by type of service, but the most statistically significant findings were higher costs at investor-owned hospitals for operating room services, drugs charged to patients, and labor and delivery services. Electrocardiology was the only service where costs were higher at not-for-profit hospitals *and* where the difference was somewhat statistically significant.

3. Markup: Ratio of Charges to Costs. The Center's research focused next on pricing strategies at investor-owned and not-for-profit hospitals in North

Table 3.8: Comparisons of Costs/Expenses Between Investor-Owned and Not-For-Profit Hospitals

Measure	N (Pairs in sample)	Average Percentage Difference Between Investor-Owned and Not-For-Profit Hospitals	P(t), or Level of Significance (*** = highly significant)
A. *Total Operating Costs*			
1. Total operating costs per adjusted day	7	+ 20.0 %	***
B. *General Service (Nonpatient) Costs*			
2. General service costs per adjusted day	7	+ 26.9	***
3. Administrative and general costs per adjusted day	7	+ 48.1	***
4. Building and fixture depreciation per adjusted day	7	+ 59.1	**
5. Movable equipment depreciation per adjusted day	6	+ 6.6	N/A
6. Plant operation, laundry service, and housekeeping costs per adjusted day	7	- 1.2	N/A
C. *Patient Care Costs*			
7. Total patient care costs per adjusted day (ipf)	7	+ 15.9	***
8. Adjusted total patient care costs per admission (ipf)	7	+ 13.8	*
9. Total inpatient care costs per inpatient day (ipf)	7	+ 14.3	**
10. Total inpatient care costs per admission (ipf)	7	+ 12.3	*
11. Total inpatient care costs per inpatient day (expf)	7	+ 16.5	***
12. Total inpatient care costs per admission (expf)	7	+ 14.4	*
13. Routine inpatient service costs per inpatient day (expf)	7	+ 19.5	***
14. Routine inpatient service costs per admission (expf)	7	+ 17.3	*
D. *Ancillary Department Costs*			
15. Total inpatient ancillary costs per day (expf)	7	+ 13.2	*
16. Operating room inpatient costs per day (expf)	7	+ 38.5	***
17. Drugs charged to patients costs per day (expf)	7	+ 25.2	**
18. Delivery and labor room inpatient costs per day (expf)	3	+123.8	***
19. Electrocardiology inpatient costs per day (expf)	5	- 52.3	*
20. Anesthesiology inpatient costs per day (expf)	7	- 3.5	N/A
21. Radiology inpatient costs per day (expf)	7	- 2.1	N/A
22. Medical supplies costs per day (expf)	7	- 4.5	N/A

ipf = including professional fees
expf = excluding professional fees
\+ = investor-owned hospitals as a group had higher values on this measure
\- = not-for-profit hospitals as a group had higher values on this measure
*** = $p(t) \leq .05$
** = $.05 < p(t) \leq .1$
* = $.1 < p(t) \leq .2$
N/A = percentage difference on this measure was not statistically significant

Table 3.9: Comparisons of Markup — The Ratio of Charges to Costs — Between Investor-Owned and Not-For-Profit Hospitals

Measure	N (Pairs in sample)	Average Percentage Difference Between Investor-Owned and Not-For-Profit Hospitals	P(t), or Level of Significance (*** = highly significant)
1. Net patient service revenue to total patient care costs (ipf)	7	+ 12.9 %	*
2. Inpatient ancillary charges to costs (ipf)	6	+ 46.2	***
3. Gross patient service revenue to total patient care costs (ipf)	7	+ 3.3	N/A
4. Gross inpatient charges to costs (ipf)	7	+ 6.0	N/A
5. Gross outpatient charges to costs (ipf)	5	+387.0	N/A
6. Routine inpatient charges to costs (expf)	7	- 40.0	*
7. Total ancillary charges to total ancillary costs (ipf)	6	+ 26.7	N/A
Ancillary Service Departments			
8. Total oxygen inhalation therapy charges to costs	6	+ 64.5	*
9. Total medical supplies charges to costs	7	+183.1	**
10. Total anesthesiology charges to costs (ipf)	7	+ 46.7	N/A
11. Total radiology charges to costs (ipf)	7	+ 14.7	N/A
12. Total laboratory charges to costs (ipf)	7	+ 26.0	N/A
13. Total electrocardiology charges to costs (ipf)	5	+ 50.2	N/A
14. Total operating room charges to costs	7	- 6.6	N/A
15. Total delivery and labor room charges to costs	3	- 55.7	N/A
16. Total drugs charges to costs	7	- 2.3	N/A

ipf = including professional fees
\+ = investor-owned hospitals as a group had higher values on this measure
\- = not-for-profit hospitals as a group had higher values on this measure
*** = $p(t) \leq .05$
** = $.05 < p(t) \leq .1$
* = $.1 < p(t) \leq .2$
N/A = percentage difference on this measure was not statistically significant

Carolina. **Markup** is the ratio of charges to costs for hospital services. If the ratio is high—that is, if the charges to patients for a service are greater than the costs incurred by the hospital—then that particular service is profitable for the hospital. As noted above, markup is often higher on ancillary services than on routine services like room rates (which includes board and nursing service), where hospitals try to keep charges close to or even below actual costs. Hospitals practice this pricing strategy regardless of ownership type, although the Institute of Medicine found that investor-owned hospitals have followed it more vigorously.[22] The markup comparisons at investor-owned and not-for-profit hospitals made by the N.C. Center were based on charges and costs including professional fees, and the results are summarized in Table 3.9 above. On the whole, the charge-to-cost ratios at investor-owned hospitals were higher than at not-for-profit hospitals, but the statistical significance of these differences was mixed.

Table 3.10: Comparisons of Profitability Between Investor-Owned and Not-For-Profit Hospitals

Measure	N (Pairs in sample)	Average Percentage Difference Between Investor-Owned and Not-For-Profit Hospitals	P(t), or Level of Significance (*** = highly significant)
1. Net income from patient services as a percentage of net patient revenue	7	+ 7.5 %	***
2. Adjusted net income from patient services per day	7	+118.8	***
3. Total net income as a percentage of total net revenue	7	+ 5.0	***
4. Adjusted total net income per day	7	+ 88.8	***

\+ = investor-owned hospitals as a group had higher values on this measure
\- = not-for-profit hospitals as a group had higher values on this measure
*** = $p(t) < .05$
** = $.05 < p(t) \leq .1$
* = $.1 < p(t) \leq .2$

The markup ratios of net patient service revenue to total patient care costs were approximately 13% higher at the investor-owned hospitals, and the difference was somewhat significant. This ratio is a comprehensive measure of how hospitals price their services relative to costs. The ratio of inpatient ancillary service charges to costs, a more specific category, was also higher—46% higher—at investor-owned hospitals, and this difference was very significant statistically.

Gross markup ratios—the ratios of gross patient service revenue to patient care costs, gross inpatient charges to inpatient costs, and gross outpatient charges to outpatient costs—were also higher at investor-owned hospitals. However, none of these differences was found to be statistically significant.

The ratio of charges to costs for inpatient *routine* services, on the other hand, was 40% *lower* at investor-owned hospitals. In other words, investor-owned hospitals appeared more willing to generate minimal revenue, break even, or even to accept losses, on routine services than not-for-profit hospitals in North Carolina. This is consistent with the finding in the section above on hospital revenues, where not-for-profits charged more for routine services (see especially Table 3.7). Total ancillary charges to costs were higher at investor-owned hospitals, but this difference was not statistically significant.

When examining the markup ratio of specific ancillary services, the majority of findings again showed investor-owned hospitals charging more than not-for-profits. For example, markup ratios for oxygen inhalation therapy and medical supplies were much higher at investor-owned hospitals than at not-for-profit hospitals. These differences of 64% and 183% were statistically significant.

The investor-owned markups for anesthesiology, radiology, laboratory, and electrocardiology services were also higher, but the differences between not-for-profit and investor-owned hospitals were not statistically significant. Not-for-profits had higher charge-to-cost ratios for operating room, delivery and labor room (where N = only 3), and drugs sold to patients, but the findings again were not statistically significant.

The most statistically significant finding comparing hospital markup reinforces the Center's findings in the charges and costs sections above. Investor-owned hospitals charged considerably higher for inpatient ancillary services than the costs incurred compared to not-for-profit hospitals in North Carolina. As Dwight Gentry, then Associate Director of New Hanover Memorial Hospital in Wilmington, said of one hospi-

—continued on page 106

COMPARING DAILY CHARGES FOR SEMI-PRIVATE ROOMS AT THE SEVEN MATCHED PAIRS OF INVESTOR-OWNED AND NOT-FOR-PROFIT HOSPITALS

TO DETERMINE how the hospitals in the seven matched pairs examined in this study compared on more recent charge data for routine services, the N.C. Center conducted telephone interviews in November of 1986 and again in November of 1987. Center staff asked each hospital what it was charging daily for a semi- private room, which includes room, board, and nursing services. (In a few instances, only private room rates were available.) The table below lists the Center's findings.

In 1986, the average room rate at investor-owned and not-for-profit hospitals differed by only one dollar—$147 for the investor-owned hospitals versus $148 for the not-for-profit hospitals. In 1987, the difference was larger; investor-owned hospitals averaged $150, while the not-for-profit hospitals charged an average of $156 for a semi-private room. Investor-owned hospitals increased their prices an average of $2.80 over the one year period. Not-for-profits, on the other hand, increased their room rates by $8.60 on average during the same time. These increases represent approximately 2% and 5% increases over 1986 rates at investor-owned and not-for-profit hospitals, respectively.

This finding—that there are relatively small differences in room rates between investor-owned and not-for-profit hospitals as a group—is consistent with studies done in other states. Both types of hospitals keep room rates—the most visible routine service—competitive, because consumers usually compare only room rates. Hospitals of both ownership types thus keep this service priced artificially low and try to recoup any losses through higher prices on ancillary services.

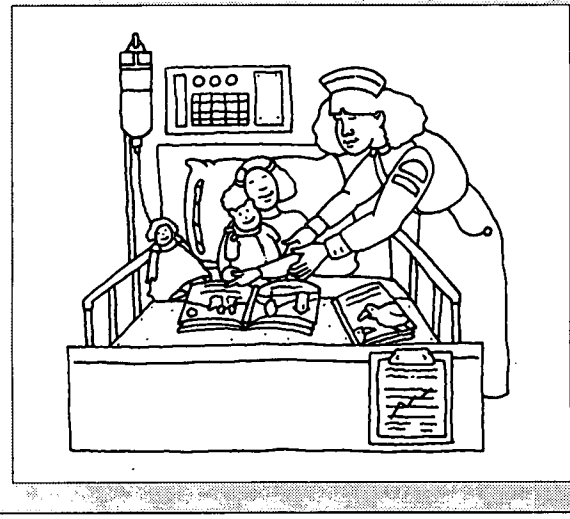
Compared to hospital room rates nationwide, however, North Carolina's hospital rooms remain a bargain. According to a study by the Health Insurance Association of America, hospitals in this state charge, on average, less for a semi-private room than do hospitals in every other state except Mississippi and Arkansas.[1] The five states with the highest room rates, and the five states at the other end of the scale, are listed below.

Average Rates For Semi-Private Room, 1987

Five States With Highest Room Rates		Five States With Lowest Room Rates	
Alaska	$ 347.14	Mississippi	$ 126.87
California	333.26	Arkansas	155.60
Pennsylvania	303.90	North Carolina	155.64
Michigan	296.55	Georgia	165.80
Illinois	280.74	South Carolina	166.18

FOOTNOTE

[1] *Survey of Hospital Semi-Private Room Charges as of July 1987*, (Chicago, IL: Health Insurance Association of America, 1987). For more on room rates and the cost of services at North Carolina and other states' hospitals, see *1987 Hospital Daily Service Charges* (Nashville, TN: EQUICOR, 1987).



Comparison of Daily Charges for Semi-Private Room for Seven Matched Pairs of Investor-Owned and Not-For-Profit Hospitals in North Carolina

Investor-Owned Hospital	Rates per day 1986	1987	Not-For-Profit Hospital	Rates per day 1986	1987
1. Raleigh Community Hospital (Raleigh)	$155	$155	Grace Hospital* (Morganton)	$175	$175
2. Frye Regional Medical Center (Hickory)	150	156	Margaret R. Pardee Memorial Hospital (Hendersonville)	137	143
3. Medical Park Hospital[a] (Winston-Salem)	124	135	Alamance County Hospital (Burlington)	172	172
4. Humana Hospital Greensboro[b]	155	155	Cape Fear Memorial Hospital (Wilmington)	124	141
5. Central Carolina Hospital (Sanford)	155	155	Stanly Memorial Hospital* (Albemarle)	139	169
6. Gordon Crowell Memorial Hospital (Lincolnton)	closed		Park Ridge Hospital* (Fletcher)	149	156
7. Community Hospital of Rocky Mount	143	143	J. Arthur Dosher Hospital (Southport)	139	139
Average daily room rate for investor-owned hospitals:	$147	$150	*Average* daily room rate for not-for-profit hospitals:	$148	$156
Median room rate for investor-owned hospitals:	$153	$155	*Median* room rate for not-for-profit hospitals:	$139	$156
* = rates available for private rooms only					

[a] Medical Park Hospital was purchased by Carolina Medicorp, Inc. in 1986 and is now a private, not-for-profit hospital.
[b] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

Source: Telephone interviews with hospitals on November 6, 1986 and November 2, 1987 by N.C. Center for Public Policy Research staff.

tal chain active in North Carolina in 1983, "They pump up high the I-V [intravenous solution] and all the ancillary charges—sky high."

4. Profitability. Profitability is an indicator of a hospital's financial viability. Lewin and Associates (1981) used three measures of profitability when comparing the financial performance of investor-owned and not-for-profit hospitals. In each case, investor-owned hospitals were found to be more profitable, whether comparing margins on patient care revenues, total net income from patient and nonpatient care sources before taxes, or total net income after taxes.[23]

The N.C. Center was able to compare the profitability of investor-owned and not-for-profit hospitals using measures of net income from patient services and total net income *before* taxes. Because the Medicare reports did not supply the necessary tax data for the investor-owned hospitals in the data set (this reporting is not required under Medicare), calculating total net income *after* taxes was not possible. (See Chapter 5, however, for more Center research on hospital tax payments obtained from a different source.)

Net income from patient services was calculated for each hospital by subtracting total operating expenses from net patient service revenues. As shown in Table 3.10, net income from patient services as a percentage of net patient service revenue was 7.5% higher at investor-owned hospitals in North Carolina. And when measured on an adjusted day basis, net income from patient services was almost 119% higher at investor-owned than at not-for-profit hospitals. The differences in both cases were statistically significant.

Profitability was also measured by total net income, which was calculated by subtracting a hospital's total expenses from total revenue. Using this second measure, profitability again was higher at investor-owned hospitals. Total net income as a percentage of total revenue was approximately 5% higher at investor-owned hospitals, and this difference was statistically significant. And total net income per adjusted day was about 89% higher at investor-owned hospitals; the difference was highly significant statistically. The smaller margin of difference for investor-owned hospitals on total net revenues than for patient care revenues is consistent with studies by Lewin and Associates and Coelen.[24] *This evidence reveals that investor-owned hospitals as a group had higher profits than comparable not-for-profit hospitals in North Carolina.*

It is helpful to note here that all hospitals have a real need to generate profits, often called surpluses in not-for-profit hospitals. Profits are needed to purchase or replace equipment, or to finance a major renovation or facility expansion, for example. Such investments of profits may actually result in higher quality medical care, an important consideration when choosing a health care provider. It is also important to note that *after-tax* measures of profitability, not calculated in this study, are useful when comparing hospitals. The Lewin study, for example, found that while investor-owned hospitals did have higher profits based on income *after* taxes, this difference was smaller than on *pretax* measures. And Sloan and Vraciu's 1983 study found no statistically significant differences in after-tax profit margins between for-profit and not-for-profit hospitals.[25]

Conclusions

THE NORTH CAROLINA CENTER for Public Policy Research found that investor-owned hospitals in North Carolina charged more for services and incurred higher costs than not-for-profit hospitals. These findings were similar to the majority of other comparison studies discussed at the beginning of this chapter.

Overall, investor-owned hospitals in North Carolina had higher **charges** than comparable not-for-profits. **Revenue** from routine services was lower at investor-owned hospitals, but higher for ancillary services and gross patient service revenues. Investor-owned hospitals also had significantly higher **costs** despite the assumption that belonging to a multi-hospital chain would enable these hospitals to keep costs down. **Markup,** or the ratio of charges to costs, was lower at investor-owned hospitals for *routine* services. Markup was higher at investor-owned hospitals, however, for comprehensive measures such as the ratio of net patient service revenue to total patient care costs, and inpatient ancillary service charges to costs. Markup was also higher for two *ancillary* services—oxygen inhalation therapy and medical supplies. Moreover, investor-owned hospitals in North Carolina had higher **profit margins** than not-for-profit hospitals.

Through this research, the N.C. Center seeks to provide the public with more information on hospital charges and costs than that reported occasionally in the news. In 1986 and 1987, the Center found comparative rates on hospitals in only a few newspapers, and these comparisons were only on room rates in a one- or two-county area. Few hospitals hesitate to disclose room rates, but information on ancillary service charges, often the lion's share of a patient's hospital bill, is much more difficult to track down. The detailed findings presented here add important empirical information to the hot debate over whether for-profit or not-for-profit hospitals better serve the public interest. Quality of care issues also should be addressed, but were beyond the focus of this study.[26] Because the

Courtesy McDowell Hospital

Center's findings are based on data from the era of cost-based reimbursement, it is clear that there is a need for research on the prospective payment system era.

If an analysis in the DRG reimbursement era shows that investor-owned hospitals belonging to multi-hospital chains are better able to keep costs down and show signs of being more efficient, will those hospitals pass any of these savings on to the public, or will they respond only to their stockholders and keep prices high? As Harry Nurkin, president of Charlotte Memorial Hospital, says of investor-owned hospitals, "If they are investor-owned, their first obligation is to their investors. Providing services to people who are sick and injured is secondary." On the other hand, as Chris Conover, research associate at Duke University's Center for Health Policy Research, points out, "if a post-DRG analysis shows that investor-owned hospitals are more efficient than not-for-profits in controlling costs, it is equally valid to ask what should be done to hold down health care costs at not-for-profit hospitals." These issues are a real concern for all consumers, particularly in light of the dramatic decade-long increases in health care costs.

It is important to note that choosing among health care providers—either among individual doctors for a checkup or among hospitals for surgery—is complicated by factors other than price. People are often unable to evaluate their own health care needs and often lack the information needed to make an informed decision. And as authors Brock and Buchanan observe, seriously ill patients "are often anxious, fearful, confused, and dependent in ways that further impair their capacities to assess for themselves their health care needs in an informed and rational fashion."[27] John Currin, administrator of Alamance Memorial Hospital, agrees: "I don't think price is foremost in the minds of people when they are sick or when their child, mother, father, or spouse is really ill. When decisions are made about *treatment*, it has been my experience that patients or others making the decision will most often choose what they perceive to be the *best available treatment and not the lowest available price.*" Despite these factors that complicate an individual's health care decisions, however, there is a clear need for more readily available information to help consumers become better informed when they face such difficult decisions.

Recommendations

SHEDDING LIGHT on the implications of investor ownership on North Carolinians' health care proved difficult, in large part because of the lack of recent,

uniform data. Consumers, insurance companies, businesses, the news media, and state and local governments need clear, comprehensive information about hospital costs in the state. Even hospitals can benefit from such information in their management and planning efforts. While some large private organizations such as Blue Cross and Blue Shield of North Carolina and the North Carolina Hospital Association conduct their own surveys, their data and reports are not always made available to the public. Universities, foundations, and consumer groups also undertake studies of the state's medical system, but the paucity of their data and funds can limit these studies' scope and influence. Newspapers and radio and television stations usually take only brief glances at a single health care issue rather than pursuing a long investigative series.

All these reports fail to provide the public with a guide to health care costs in North Carolina. Purchasers of health care—employers, Blue Cross, and commercial insurance carriers, for example—need to make comparisons between health care providers to develop preferred provider networks. And while average citizens may not comparison shop for a tonsillectomy the same way they hunt for a grocery store bargain on bread and milk, consumers still need to make informed choices about how they purchase increasingly expensive health care services. Conover explains, "one of the basic underlying premises which makes free markets work well in general is the assumption of rational consumers armed with good information. When that is lacking, the markets result in less efficient outcomes. Therefore, if the efficiency of hospital markets is to be improved, some might argue for more widely available price information."

Legislators also need to understand trends in the health care industry if they hope to devise workable solutions to the problem of rising health care costs. The state of North Carolina has both the resources and the authority to answer Tar Heels' questions about hospital costs and charges.

N.C. Medical Database Commission. In response to rising medical costs and to rapid changes in the health care system, the 1985 General Assembly established the North Carolina Medical Database Commission in the Department of Insurance to serve as a "clearinghouse" for information on the cost, use, and quality of health care in the state.[28] Appointed by the General Assembly on the recommendations of the Speaker of the House and the Lieutenant Governor, the nine voting commissioners include medical professionals, health care administrators, insurance executives, business people, and civil servants. (Both the State Insurance Commissioner and the Secretary of Human Resources serve as ex-officio members of the Commission.) Currently, the Commission has three staff members and is assisted by an outside contractor for system design, data processing, and reporting activities.

The Medical Database Commission has spent the past two years drafting its administrative rules, selecting a data processor, and developing the content of data reports. It began collecting data from 156 acute care hospitals, alcohol rehabilitation facilities, and psychiatric hospitals in North Carolina for all discharges as of Jan. 1, 1988. Using the UB-82, a billing form standard in the health care industry and mandated by the U.S. Department of Health and Human Services for Medicare and Medicaid, the Commission will have diagnostic, utilization, demographic and charge data for every patient discharged from North Carolina's nonfederal, licensed hospitals.[29] The Commission will publish the data in standard reports to be issued routinely, and will also publish topical reports in response to written requests. Through the Commission's work, North Carolina joins the ranks of more than 30 states which now collect medical data statewide (see sidebar on page 111 for more). The N.C. Center commends the progress and plans of the Medical Database Commission, but proposes the following recommendations to enable the Commission to address what the General Assembly called "an urgent need to understand patterns and trends in the use and cost of these medical services"[30] more completely.

1. The Medical Database Commission should collect and publish data on hospital *costs* as well as *charges*. The charge information currently being collected by the Medical Database Commission and planned for publication early in 1989 will provide the bottom line for health care purchasers and consumers. The lack of data on *costs* incurred by hospitals, however, prevents purchasers and consumers from comparing markup and profits for various services and hospitals. If hospitals with efficient management keep their expenses down, such cost, markup, and profitability figures would enable these groups to identify which hospitals pass savings along to patients, which pass dividends along to investors, and which reserve savings for additional services or financial rainy days.

The Commission has acknowledged that the data base currently being compiled would be even more useful to health care purchasers and consumers, as well as to health policy analysts and legislators, if used in conjunction with information from data sources such as Medicare Cost Reports which are filed annually with the federal Health Care Financing Administration.[31] Medicare Cost Reports were used for this study and are the only source of public, uniform data on hospital costs and charges. Illinois collects both UB-82s and Medicare Cost Reports for its data base,

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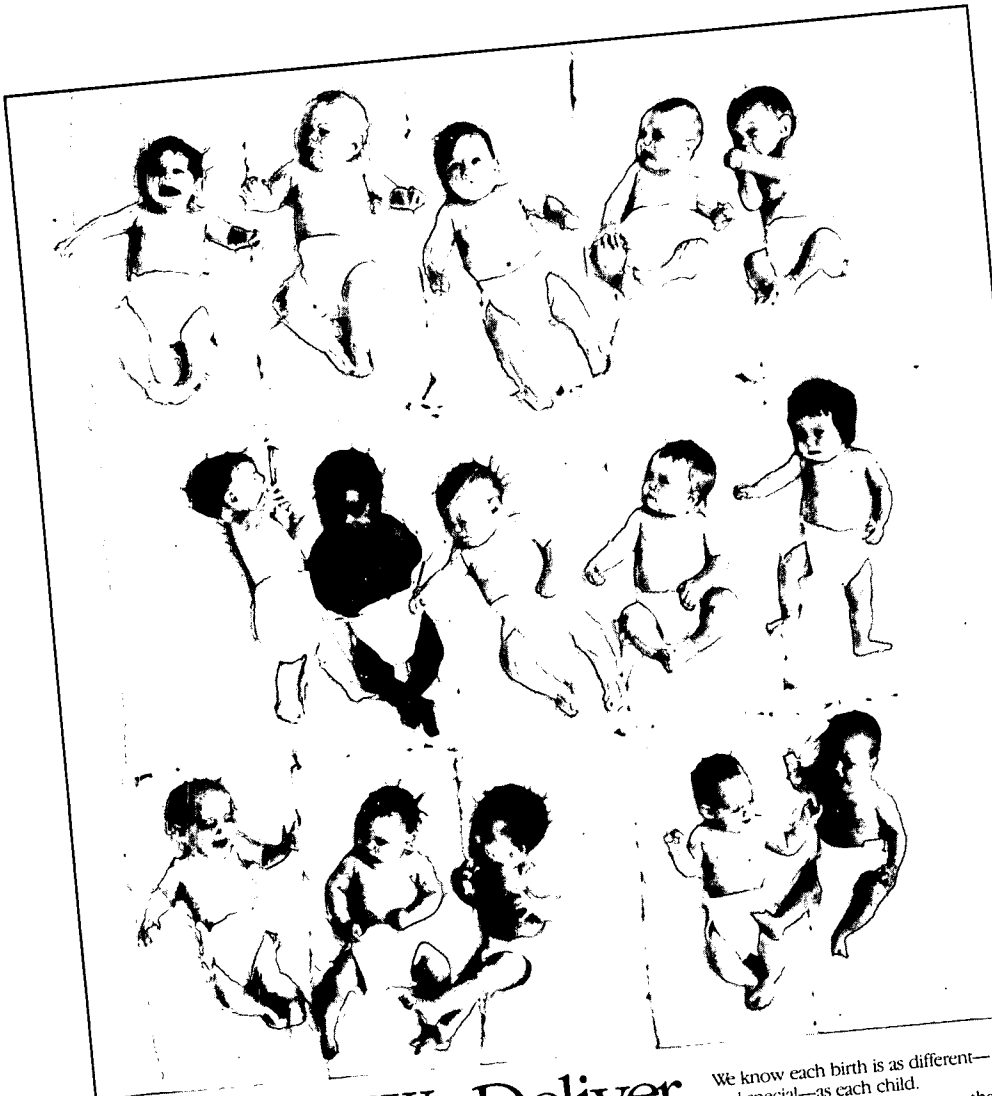

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and the Illinois Health Care Cost Containment Council is researching ways in which these two sources of financial information can be linked to provide a more complete picture of the hospital industry. As John Forneris, information systems administrator at the Illinois agency points out, "Medicare Cost Reports used in conjunction with UB-82 data has become essential for any in-depth analysis of the hospital system."

Accordingly, the N.C. Center recommends that (a) North Carolina hospitals be required to submit copies of their Medicare Cost Reports to the Medical Database Commission, and that (b) the General Assembly make an additional appropriation enabling the Commission to incorporate cost and charge information from the reports into its data base. The Commission should then calculate and publish the markup for routine and ancillary services and profit margins for hospitals in one of its routine reports.

Requiring N.C. hospitals to submit Medicare Cost Reports will cause controversy. For instance, some hospital administrators have raised concerns about the information *currently* being collected by the Medical Database Commission, the UB-82 data records. These administrators suggest that the time and energy devoted to providing the government with such data will drive up the price of health care. As John Taft, administrator of the not-for-profit Grace Hospital in Morganton contends, "The resources needed to report cost information may actually result in higher charges—the thing hospitals are trying to avoid." Because hospitals already use the UB-82 form, and because the Commission will reimburse hospitals for discharge data records on patients who lack a third party payer—necessitating records created solely for the data base—there will not be an additional cost to hospitals which would have to be passed on to consumers.

With regard to the proposal for the Medical Database Commission to collect and publish *cost* data, other hospital representatives worry that publicizing costs of health care services would reveal confidential information to their rivals and could undermine their hospital's position in the increasingly competitive medical marketplace. On the other hand, hospitals will be able to put the Commission's reports to use by comparing themselves to their competitors, identifying any relatively high costs or charges, and focusing their management resources to make those services more efficient. Data collection states such as Maryland and West Virginia, for example, report that their hospitals use the data in their planning efforts.[32]

The N.C. Center maintains that the additional appropriation* necessary for the Commission to collect and publish data on hospital costs is justified by the need to provide the public with such information. As the Medical Database Commission 1988 reference book notes, purchasers need more information when selecting health care providers. And because purchasers are relying more and more on higher deductibles and co-payments to reduce their costs, "Patients now have a real and well-founded concern about the out-of-pocket expenses they may incur for the health care services they receive," the Commission report explains.[33] Because the Center's research indicates that hospitals reduce their room rates and recoup profits from ancillary services, the price and markup on room rates and ancillary services provided on a hospital-by-hospital basis would be a particularly revealing piece of the information puzzle.

2. The Medical Database Commission should (a) create "non-confidential" files which ensure patient confidentiality, and (b) make individual patient records available to researchers for additional studies. The reports now planned for publication by the Medical Database Commission will be a positive step in making health care data available in North Carolina. The Commission has also agreed to compile data for additional research on request and will charge only for the cost of producing the custom reports. Those requesting these special compilations may receive data in printed form, on magnetic tape, or on a personal computer diskette.[34] Analyses using aggregate data from the UB-82 forms will prove useful to health care researchers, but individual data records, not now considered public records, could serve as an extensive data base for a variety of further studies. Indeed, research by others in the university community and elsewhere may well prove as significant to monitoring health care in the state as the Commission's own work.

In its 1987 annual report, the Medical Database Commission recognized "the value of dataset linkage in health care research." At the same time, the Commission ruled that release of individual patient records to be used in conjunction with other data sources would endanger the Commission's legislative mandate to preserve patient confidentiality.[35] The N.C. Center for Public Policy Research recognizes and respects the necessity, both legal and ethical, for preserving the confidentiality of a patient's individual records. However, the Center also views public access to the state's medical data base as vital to future health care research and subsequent policy development. The Center maintains that a compromise between the Commission and researchers can reconcile these two conflicting demands.

*The Medical Database Commission's budget for FY 1988-89 is $964,215.

Following the example set by the West Virginia Health Care Cost Review Authority and the Maryland Health Services Cost Review Commission, the N.C. Medical Database Commission should create "non-confidential files" by excluding Social Security numbers and other information which could identify specific patients. The individual data records remaining in these files should be open to public scrutiny. Maryland's experience with releasing individual data records without patient identification numbers (with modified items such as patient age instead of birthdate, and day of week of admission rather than specific date) has been successful. According to Theressa Johnson, research statistician at the Maryland Cost Review Commission, "Maryland's system has worked well for 10 years without jeopardizing patient identity."

Making a non-confidential data set available in North Carolina would enable researchers to link the state's data with other data sets such as census data and patient income in their own studies. Working with a non-confidential data set themselves, researchers would be able to make their own judgments when analyzing data and to respond to questions inevitably raised by data manipulation. As long as the North Carolina Medical Database Commission prohibits the release of non-confidential individual data records, an outside researcher's confidence in conclusions drawn from Commission staff's research will be limited, and any subsequent policy recommendations based on those conclusions subject to question. As a final note, redisclosure or redistribution of any non-confidential files should be subject to the same restrictions as the current data set.[36]

3. The Medical Database Commission should submit its reports annually to the Government Operations Commission of the N.C. General Assembly. In order to ensure that the state's Medical Database Commission does indeed provide data in a manner helpful and accessible to purchasers of health care (such as insurance companies), consumers, and researchers,

HOLDING DOWN THE COST OF HEALTH CARE: A SUMMARY OF ACTION BY OTHER STATES

by Melissa Jones

THE RISING PRICE of health care in America, coupled with federal belt-tightening on Medicare and Medicaid spending, has sent legislators scrambling to hold down costs in their states. The measures used to cope with mounting health care costs are as varied as the states themselves: prospective reimbursement systems for Medicaid, Certificate of Need laws, health insurance regulation, preferred provider arrangements, alternatives to nursing home care, special programs for indigent patients not covered by Medicaid, health care data reporting and publishing, rate setting laws, and limits on corporate health care profits.[1]

With the latter three measures—data reporting, rate setting, and limits on profits—state legislatures have sought to reveal and then restrict charges at hospitals and other medical facilities. The map below depicts the 39 states with laws encouraging or requiring collection or publication of health care data. While some states have gathered and reported medical data for nearly two decades, more than half of the 40 states enacted such laws within the past three years.[2] In most of the states which do not have such laws, business and consumer groups are lobbying actively for them; and several legislative commissions are studying proposals for data reporting.[3]

Some data reporting laws consist only of a voluntary program to provide consumer information. Others, however, require uniform accounting of medical facilities' costs and charges, as well as data on diagnoses and the use of various services. Many states publish portions of the data they collect, not only to help consumers make decisions about where they seek medical care but also to encourage further research, highlight any excessive charges, and encourage hospitals and other medical facilities to offer care at competitive rates. The more elaborate laws, which can involve linking diagnostic and financial data sets, often serve as the basis for medical rate regulation.[4]

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the N.C. General Assembly should amend N.C.G.S. 131E-212(h) to require the Commission to present its reports on the charges and *costs* of medical services to the legislature's Government Operations Commission each year. This committee is a joint House and Senate committee which meets between sessions and is charged with legislative oversight of executive agency activities. Presentation of the Medical Database Commission's reports will ensure that policymakers who need to keep a close watch on health care costs and on innovative measures to contain them will have the necessary information when considering any future legislation.

A number of states use their medical data bases not only to inform consumers and legislators about medical costs and to encourage future health care research, but also to serve as a basis for regulating the price of health care. (For an explanation and analysis of state cost containment laws and rate setting commissions, see the sidebar on page 111.) Because North Carolina's hospital rates remain low compared to other states (as noted in the sidebar on page 104), and because these rate-setting commissions generally demand a sizable staff and substantial state appropriations, the N.C. Center does *not* recommend that the state enact such a law at this time. In lieu of regulation, the Center has adopted a market-oriented approach of advocating provision of more information to the public. In fact, the Medical Database Commission's publication of the cost and

A Summary — *continued*

As indicated on the map below, 12 state governments set health care rates or approve the budgets of health care facilities. Five of these 12 states control charges to *all payers*—private insurance companies, Medicare and Medicaid funds, and patients themselves. These state commissions regulate medical rates much the same way the North Carolina Utilities Commission controls increases in the cost of electricity.

Giving a state commission the power to limit health care costs—or even considering the idea of government mandating such limits—always sparks intense debate. Supporters of rate-setting legislation avow that in times of rapidly escalating health care prices (described in the sidebar on page 93), such state action gives individual consumers and businesses (which offer health insurance as part of a benefit package) the chance to purchase one of life's necessities at a reasonable price. State government, they point out, is heavily involved in planning and funding health care, and thus has both the interest and the expertise necessary to control medical costs. To substantiate their claims, proponents point to a study conducted by the Johns Hopkins Center for Hospital Finance and Management. After examining all-payer rate-setting systems in four states from 1982 through 1985, that study found that hospital charges in those states rose at rates somewhat lower than those in other states across the nation.[5]

Those who oppose rate-setting regulation, however, note that the study also found that hospital profit margins in the states with all-payer systems were lower than those in other states.[6] Rate regulation, they contend, is a double-edged sword which, though it may reduce rising prices in the short run, slashes hospitals' reserve funds and increases their debt in the long run. This financial pressure, they say, hinders a hospital's ability to deal with crises such as nursing shortages or increasing numbers of expensive and often uninsured AIDS cases.[7] In some instances, opponents of rate-setting laws contend, the quality of hospital care may suffer, and hospitals may close. In lieu of government rate control—which groups like the American Medical Association, the Federation of American Hospitals, and the Health Insurance Association assert creates an inefficient bureaucracy[8]—these and other organizations advocate a variety of voluntary cost restraints, such as negotiated agreements between insurers and hospitals.[9]

Although no rate-setting commission exists in Nevada, a state with some of the highest medical costs in the nation, its governor has spearheaded an effort to contain costs by mandating lower hospital charges *and* profits. The law, effective in July 1987, curtails most sharply profits and revenues at those hospitals with profit margins exceeding 17%, which include three investor-owned hospitals in Las Vegas. Other restrictions apply to hospitals if their profit margins exceed 10%, and this may affect not-for-profit hospitals as well.

The Nevada law has stirred intense controversy throughout the state. In his criticism of profits made by the state's for-profit hospitals, Gov. Richard Bryan argued that "out-of-state investors" should not "reap these kinds of profits from sick people in

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price of medical services at North Carolina hospitals and any media coverage of the price differences may help curtail the rate of growth in health care prices. The market, the Center contends, should have a chance to hold down the price of medical care, but the state, through detailed and frequent Medical Database Commission reports, should help consumers make more informed choices within the health care market.

4. Financial penalties should be imposed on hospitals which do not comply with the Medical Database Commission's collection efforts. As further insurance that the Medical Database Commission will in fact be able to carry out its legislative mandate to make a "significant contribution to health care management and health policy development in North Carolina,"[37] a range of penalties for a hospital's failure to supply financial information to the Commission should be enacted as an amendment to N.C.G.S. 131E-212, the statute which outlines the authority of the Commission. Currently, if a hospital fails to file timely or complete reports with the Medical Database Commission, state government cannot do much. Neither the North Carolina General Statutes nor the state's Administrative Code spell out specific sanctions—such as fines in worst cases or the suspension of a hospital's license—which could be used to enforce compliance with Commission orders. The Center suggests that, in most cases, fines would provide sufficient incentive to comply with the law.

—continued on page 116

Nevada." The Nevada Hospital Association, on the other hand, suggested that instead of limiting hospital charges, employers should be able to negotiate privately for discounted rates with hospitals. And an administrator at one of Nevada's not-for-profit hospitals, worried by the law's less severe restraints, asserted that the "governor is trying to nail the investor-owned hospitals," and that not-for-profit hospitals "are being carried along."[10] Despite the law's controversy, however, Daniel J. O'Donnell, administrator of the Division of Health Resources and Cost Review in Nevada's Department of Human Resources, says that hospitals in the state "seem to have decided that compliance is the best order of business."[11]

North Carolina has not been immune to rising health care costs, although prices have not risen as high as those in many other states. As this inflationary trend pushed up the cost of Medicaid and state employees' health insurance premiums, state legislators took notice. The Medical Cost Containment Commission, formed during the 1977 session of the General Assembly, recommended several measures designed to reduce health care costs, curb the growth in the state Medicaid program, and provide less costly alternatives to long-term nursing home care.[12] Upon the Commission's recommendation, the 1978 General Assembly enacted a Certificate of Need (CON) law. At the time, the federal government required all states to enact such laws. The law required anyone wanting to build a new health care facility or expand an existing one to get a certificate of need (in effect, a license) from the state certifying that such a facility was needed. Today, this law applies to both hospitals and nursing homes. A CON is required for capital expenses of more than $2 million and for operating expenses of more than $1 million a year.[13] The N.C. Medical Cost Containment Commission, as well as the Commission on Prepaid Health Plans, also took steps to encourage health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to set up shop in the state.

Although North Carolina legislators actually discussed regulating medical rates in the late seventies, they decided against such a state role in controlling prices and sought instead a mix of public regulation and private competition.[14] As recently as 1985, the legislature declined to establish another Medical Cost Containment Commission, largely because controlling Medicaid costs has become an ongoing necessity for the N.C. Department of Human Resources' Division of Medical Assistance. (Since 1982, the state has reimbursed hospitals at a flat, or prospective, rate for every day of a Medicaid patient's stay, rather than funding the full cost to the hospital.) And although hospitals in North Carolina have taken some voluntary steps to lower their costs, even to the point of laying off employees in some instances, their rates have risen to absorb federal Medicaid cuts and to accommodate the other inflationary factors in health care.[15]

Two legislative study commissions on public hospitals and indigent care have been examining issues related to health care costs and will report to the 1989 session of the General Assembly. In addition, a scaled-down Certificate of Need process still

—continued

A Summary — *continued*

seeks to control growth in health care facilities and technologies across the state, with the goal of avoiding duplication of services and keeping costs down. However, no concerted effort has been made to regulate hospital rates directly or to limit the profits of investor-owned hospitals in North Carolina.

FOOTNOTES

[1]For an explanation of efforts to control the price of health care in the various states, see Michelle Polchow, *State Efforts at Health Care Cost Containment: 1986 Update*, (Denver, CO: National Conference of State Legislatures, December 1986). See also William A. Glaser, "Hospital Rate Regulation: American and Foreign Comparisons," Vol. 8, No. 4, *Journal of Health Politics, Policy and Law* (Winter 1984), pp. 702-731.

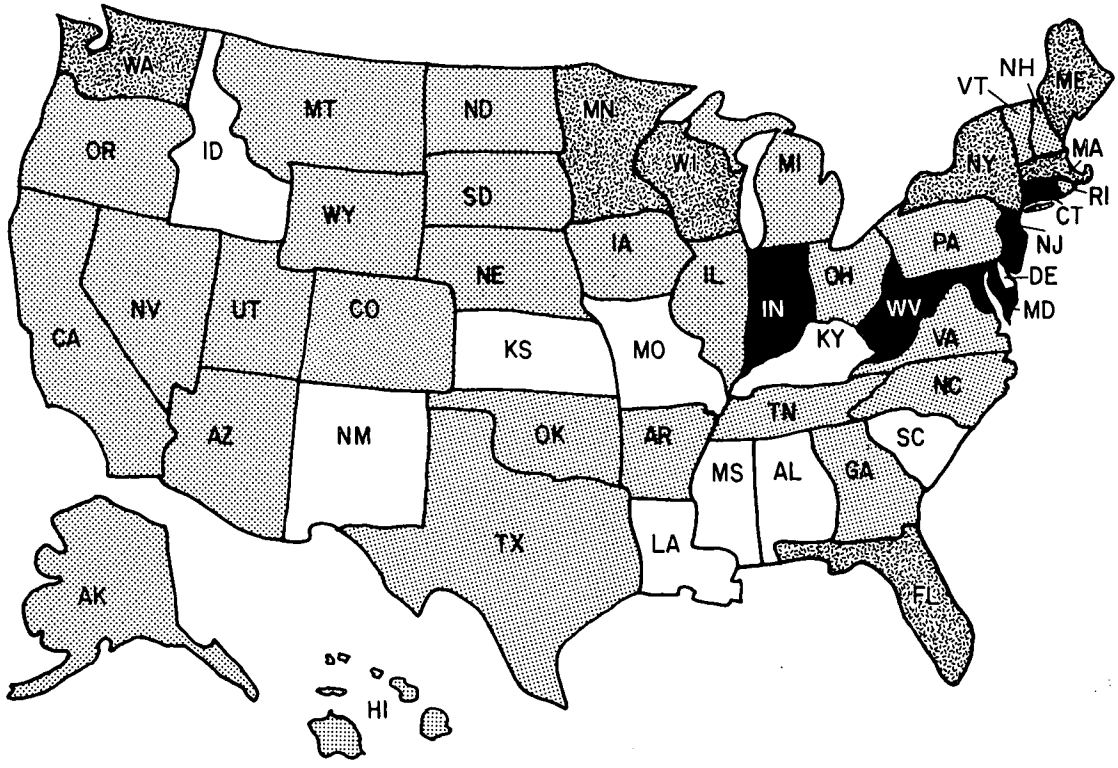
[2]Debbie C. Tillett, "Health Cost Commissions: The Effort to Contain Health Costs," *CSG Backgrounder*, (Iroil Works Pike, KY: States Information Center, Council of State Governments, August 1982), p. 2, and Teri Shahoda, "States create 2,972 programs to ratchet costs," *Hospitals*, March 20, 1987, p. 122.

[3]"The 1987 state-by-state legislative survey," *Federation of American Health Systems Review*, September/October 1987, pp. 24-44. This article provides an overview of health care issues considered by state legislators across the country.

[4]For more detailed information on data bases in states which regulate medical rates, see *Centralized Data Collection: Statewide Hospital Data Systems* (Raleigh, NC: N.C. Foundation for Alternative Health Programs, Inc., July 1984), pp. 54-88.

[5]The study found that hospital costs per admission rose 7.9% per year in the states with all-payer rate-setting systems compared with 9.8% in the non-regulating states and the District

STATE ACTIVITY IN HEALTH CARE COST CONTAINMENT, 1986-87



- State does not collect data or regulate rates (10)
- State requires data collection but does not regulate rates (28)
- State regulates rates, but not for all payers (7)
- State regulates rates for all payers (5)

of Columbia. Revenue per admission rose 7.8% per year in the all-payer states, 10.7% in the others. The Coalition on State All-Payer Hospital Payment Systems and the Health Insurance Association of America commissioned the study. "All-payer systems better at capping costs—study," *Modern Healthcare*, October 9, 1987, p. 19.

[6]1.1% in all-payer states versus 6.8% in other states. *Ibid.*

[7]Judith Graham, "Massachusetts hospitals attack rate limit proposal," *Modern Healthcare*, September 25, 1987, p. 9.

[8]Tillet, "Health Cost Commissions: The Effort to Contain Health Costs," p. 2.

[9]"Let the free market regulate Nevada," editorial in *Modern Healthcare*, June 5, 1987, p. 7.

[10]Cynthia Wallace, "Nevada's investor-owned hospitals irked by governor's proposed payment reform," *Modern Healthcare*, April 24, 1987, p. 72.

[11]For further information on the Nevada statute, see "Nevada Governor Signs Bill to Curb Hospital Costs," *The Wall Street Journal*, Thursday, June 11, 1987, p. 5; Cynthia Wallace, "Nevada enacts legislation that limits hospital profits," *Modern Healthcare*, June 19, 1987, p. 8; and "The 1987 state-by-state legislative survey," *Federation of American Health Systems Review*, p. 38.

[12]For a summary of the N.C. Medical Cost Containment Commission's recommendations, see pp. 31-32 in the third edition of *A Legislator's Guide to the Medicaid Program*, published in 1980 by the General Assembly's Fiscal Research Division.

[13]N.C.G.S. Chapter 131E, Article 9.

[14]*Legislative Commission on Medical Cost Containment, Interim Report* to the 1977 General Assembly of North Carolina, Second Session, 1978, pp. 73-4.

[15]David Brown, "Series of hospital rate hikes spurred by cuts in Medicaid," *The News and Observer* (Raleigh, NC), May 13, 1982.

1. States collect health care data, including hospital prices, but do not regulate rates (28):

Alaska	**North Carolina**
Arizona	North Dakota
Arkansas*	Ohio
California	Oklahoma
Colorado	Oregon
Georgia	Pennsylvania
Hawaii	Rhode Island
Illinois	South Dakota
Iowa	Tennessee
Michigan*	Texas
Montana	Utah
Nebraska**	Vermont
Nevada***	Virginia
New Hampshire	Wyoming

2. States regulate medical rates, including hospital reimbursement rates, and/or review and approve hospital budgets, but do not control reimbursement rates for all payers (7):

Florida	New York
Maine	Washington
Massachusetts	Wisconsin
Minnesota	

3. States regulate medical rates, including hospital reimbursement rates, for all payers (5):

Connecticut	New Jersey
Indiana	West Virginia
Maryland	

4. States do not collect health care data or regulate hospital rates (10):

Alabama	Louisiana
Delaware	Mississippi
Idaho	Missouri
Kansas	New Mexico
Kentucky	South Carolina

* Voluntary program only.
** Nebraska hospitals must make information available to the public upon request, but state does not collect the data.
*** As explained above, Nevada does not regulate hospital rates but does limit hospital profits.

Sources: Polchow, Michelle. *State Efforts at Health Care Cost Containment: 1986 Update.* Denver, CO: National Conference of State Legislatures, December, 1986.

"The 1987 state-by-state legislative survey." *Federation of American Health Systems Review*, September/October, 1987, pp. 24-42.

* * *

The N.C. Center's research comparing the costs and charges at for-profit and not-for-profit hospitals was designed to shed more light on the implications of one important aspect of corporate involvement in the health care field. These policy recommendations are offered as a step along the way toward better and more readily accessible data for purchasers of health care (such as employers) and consumers. It is important that present and future efforts to collect and make medical cost and charge data available continue as long as the information is helpful and accurate. As Larry Lewin, a nationally known health care consultant, summarized at an April 1988 meeting of the Medical Database Commission, there needs to be "a spirit of cooperation, commitment, and accessibility in providing health care data in North Carolina."

FOOTNOTES

[1]U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 1987.*

[2]Arthur Andersen & Co. and the American College of Healthcare Executives, *The Future of Healthcare: Changes and Choices* (Chicago: Arthur Andersen & Co. and the American College of Healthcare Executives, 1987), p. 6.

[3]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), p. 160.

[4]*Ibid.*, p. 161.

[5]*Ibid.*, p. 165.

[6]*Ibid.*, p. 177.

[7]*Ibid.*, p. 204.

[8]"Profits and Health Care: An Introduction to the Issues," *For-Profit Enterprise in Health Care* (Washington, DC: Institute of Medicine, National Academy Press, 1986), p. 9.

[9]Robert Derzon, Lawrence S. Lewin, and J. Michael Watt, "Not-for-profit chains share in multihospital system boom," *Hospitals,* May 16, 1981, pp. 65-71. See also Howard J. Anderson, "Systems, alliances see growth as more independents join them," *Modern Healthcare,* January 2, 1987, p. 50.

[10]Mark F. Baldwin, "Legislatures, agencies debating whether not-for-profit hospitals deserve their tax-exempt status," *Modern Healthcare,* May 22, 1987, pp. 34-46.

[11]J. Michael Watt, Robert A. Derzon, Steven C. Renn, and Carl J. Schram, "The Comparative Economic Performance of Investor-Owned Chain and Not-For-Profit Hospitals," Vol. 314, *The New England Journal of Medicine* (January 1986), pp. 89-96.

[12]"Investor-Ownership and the Costs of Medical Care," *For-Profit Enterprise in Health Care,* pp. 76-77.

[13]*Ibid.*, p. 80.

[14]Blue Cross and Blue Shield of North Carolina, *Proprietary Hospital Charges to Blue Cross/Blue Shield of North Carolina Subscribers,* a report prepared by the Health Economics Research Unit (Durham, NC: Blue Cross and Blue Shield of North Carolina, 1983), pp. 2-7.

[15]Dan W. Brock and Allen Buchanan, "Ethical Issues in For-Profit Health Care," *For-Profit Enterprise in Health Care,* p. 225.

[16]"Investor Ownership and the Costs of Medical Care," *For-Profit Enterprise in Health Care,* p. 81.

[17]*Ibid.*, p. 85.

[18]Lewin and Associates, "The Comparative Economic Performance of a Matched Sample of Investor-Owned and Not-For-Profit Hospitals," *Studies in the Comparative Economic Performance of Investor-Owned and Not-For-Profit Hospitals,* Volume IV, 1981, p. 3.

[19]*Ibid.*, p. A.2-A.8.

[20]"Investor Ownership and the Costs of Medical Care," *For-Profit Enterprise in Health Care,* p. 81.

[21]For more on return on equity see "Financial Capital and Health Care Growth Trends," *For-Profit Enterprise in Health Care,* p. 51.

[22]"Investor Ownership and the Costs of Medical Care," *For-Profit Enterprise in Health Care,* p. 81.

[23]Lewin and Associates, "The Comparative Economic Performance of a Matched Sample of Investor-Owned and Not-For-Profit Hospitals," pp. 20-23.

[24]*Ibid.* See also Craig G. Coelen, "Hospital Ownership and Comparative Hospital Costs," *For-Profit Enterprise in Health Care,* pp. 328-329.

[25]Lewin and Associates, "The Comparative Economic Performance of a Matched Sample of Investor-Owned and Not-For-Profit Hospitals," pp. 20-23; and Frank A. Sloan and Robert A. Vraciu, "Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues," *Health Affairs,* Vol. 2 (Spring 1983), p. 31.

[26]However, a 1988 report by the U.S. Office of Technology Assessment made a recommendation regarding quality of care information. The OTA report recommended that hospitals publicly disclose details of their accreditation surveys to help consumers make informed health care decisions. Any hospital not making such information public would lose their right to participate in the Medicare program. From "News at Deadline," *Hospitals,* June 20, 1988, p.12.

[27]Brock and Buchanan, "Ethical Issues in For-Profit Health Care," *For-Profit Enterprise in Health Care,* pp. 236-237.

[28]Chapter 757 of the 1985 Session Laws, now codified as N.C.G.S. 131E-210–213.

[29]North Carolina Medical Database Commission, "1987 Annual Report to the North Carolina General Assembly" (March 12, 1987), p. 1.

[30]N.C.G.S. 131E-210(b).

[31]North Carolina Medical Database Commission, "The North Carolina Hospital Discharge Database: A Reference Book" (April 1988), p. 3.

[32]Based on phone interviews with the West Virginia Health Care Cost Review Authority and the Maryland Health Services Cost Review Commission.

[33]North Carolina Medical Database Commission, "The North Carolina Hospital Discharge Database: A Reference Book," p. 15.

[34]*Ibid.*, p. 24.

[35]North Carolina Medical Database Commission, "1987 Annual Report to the North Carolina General Assembly," pp. 4-5; and 11 N.C.A.C. 15 .0009.

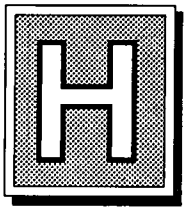
[36]11 N.C.A.C. 15 .0009.

[37]North Carolina Medical Database Commission, "The North Carolina Hospital Discharge Database: A Reference Book," p. 4.

CHAPTER 4

COMPARING THE RANGE OF SERVICES AT FOR-PROFIT AND NOT-FOR-PROFIT HOSPITALS IN NORTH CAROLINA

by Marianne M. Kersey *



THE POTENTIAL advantages and disadvantages of the increased involvement of investor-owned corporations in health care, particularly hospitals, have been debated on many fronts, including the Center's first report on *The Investor-Owned Hospital Movement in North Carolina.*[1] For-profit hospitals are analyzed both in terms of their economic incentive to achieve a profit for stockholders, as well as the responsibilities they have in providing health care to their communities. Comparing the range of services at for-profit and not-for-profit hospitals is one key area where such issues are raised by citizens and health care policymakers. Specifically, do for-profit hospitals offer a broader or narrower range of services than not-for-profits? This chapter compares the evidence at North Carolina's for-profit and not-for-profit general acute care hospitals.

The Development of Specialized Services in American Hospitals

THE FIRST HOSPITALS in this country did not even offer what could be called a *range* of services. As Paul Starr documents in *The Social Transformation of American Medicine*, there were three main phases in the development of the modern American hospital system, and it was many years before specialized services were offered.

1. Three Phases in the Development of the American Hospital System. The first phase of the hospital system in the U.S.—from the mid-18th century to the mid-19th century—was characterized by two kinds of institutions. There were voluntary hospitals operated by charitable lay boards, and public hospitals operated by municipal, county, and federal governments. Both types relied heavily on charitable contributions. They were primarily for the poor and were viewed with disdain by the middle and upper classes. Patients typically stayed for weeks in these hospitals and were responsible for providing some of the health care and doing housekeeping chores.[2]

The second phase of the hospital system began in the middle of the 19th century when more specialized hospitals were formed to take care of particular diseases or categories of patients, such as women and children. Religious and ethnic groups also opened hospitals during this period. Here too, patients were mostly poor and stayed for the duration of their illnesses. Hospitals had yet to ". . .[emerge] from the underlife of society to become a regular part of accepted experience. . . ."[3]

The third phase of the hospital system, from the late 19th century through the first two decades of this century, witnessed the beginning of what Starr calls "the moral assimilation of the hospital."[4] During

* *Research assistance for this chapter was provided by former N. C. Center intern H. Lee Cheek Jr.*

these years, the number of hospitals increased dramatically from 178 in 1872 to more than 4,000 in 1910, and profit-making hospitals operated by physicians and corporations arrived on the scene.[5] Hospitals moved away from being largely dependent on charitable gifts to being financed increasingly by payments from patients, and were "no longer a well of sorrow and charity but a workplace for the production of health."[6] Medical and surgical procedures were used to treat acute illnesses for all classes of patients. Care went beyond custodial to active treatment.

The internal organization of hospitals correspondingly changed dramatically during this era:

> Authority over the conduct of the institution passed from the trustees to the physicians and administrators. Nursing became a trained profession, and the division of medical labor was refined and intensified, as conceptions of efficient and rational organization prevailing elsewhere in the economy were applied to care of the sick. The sick began to enter hospitals, not for an entire siege of illness, but only during its acute phase to have some work performed on them.[7]

2. Levels of Care and Categories of Patients. Starr notes that "[t]he hospital system had no design since it was never planned, but it had a pattern because it reflected a definite system of class relations."[8] Accordingly, each type of hospital in the early 20th century had its own organizational structure, patients, and methods of finance. Voluntary hospitals had the closest ties to medical schools and focused on acute care. They served both the very poor and the very rich; treating the poor helped the voluntary hospitals further their teaching function, and treating the rich helped their financial viability since these hospitals continued to receive charitable contributions. Hospitals run by city and county governments, on the other hand, cared for chronic as well as acute illnesses. These public hospitals treated all classes including the less desirable poor, relying on government subsidies to care for these mostly chronic cases. Religious and ethnic hospitals, smaller than the other two groups, served the working and middle classes chiefly for short-term illnesses. Finally, the relatively new profit-making hospitals owned by physicians concentrated mainly on surgical procedures. And because they relied on fees from patients, these proprietary hospitals served the middle and upper classes. Thus while the hospital system in the U.S. reflected a system of class relations, "the split between public and private hospitals did not become a straightforward class boundary" because both private and public hospitals treated poor patients.[9]

3. Standardization of Services. By the beginning of the 20th century, then, American hospitals had achieved a higher level of organization than in the past, but unlike other corporations in this country, "hospitals remained at an earlier stage of industrial development. . . ."[10] Hospitals were typically small and underutilized, but no group worked toward a more efficient, integrated system.

Despite efforts to maintain their distinct identities, however, hospitals actually became more similar in the following decades. There were some early reform efforts aimed at increasing efficiency through standardization of hospital organization. Hospitals did respond, but chiefly to avoid more governmental regulation. In effect, the hospitals actually became more similar in their service offerings:

> Emulating one another, hospitals became more standardized than might have been desirable, offering the same services regardless of the needs of their communities. They came to present the familiar American paradox of a system of very great uniformity and very little coordination.[11]

The chief aim of this chapter is to examine just how uniform hospitals are today, particularly since the recent arrival of national investor-owned corporations on the health care scene. Do investor-owned and -managed hospitals offer only profitable services? Or do they offer a similar range of services

when compared to not-for-profit hospitals? The following sections will provide a unique look at the situation in North Carolina hospitals.

Skimming the Cream

THE RANGE OF SERVICES available at different types of hospitals today is often discussed in terms of what many analysts have labeled the "skimming the cream" issue. Skimming the cream essentially refers to hospitals offering only the most profitable services to the best-paying patients.[12] For example, Dr. George Barrett, a physician at Presbyterian Specialty Hospital in Charlotte maintains, "Investor-owned hospitals limit the services they offer—the high cost, high profit services." Critics like Barrett contend that for-profit hospitals—the majority of which are now run by national, investor-owned corporations rather than physicians—skim the cream, resulting in a negative impact on not-for-profit hospitals, as well as the community as a whole. They maintain that for-profit hospitals attract paying patients away from not-for-profit hospitals, making the practice of cross-subsidization more difficult for not-for-profit hospitals. *Cross-subsidization* refers to the dual practices of (a) financing indigent care by charging higher prices to paying patients and (b) subsidizing the more expensive services with inflated prices on less costly services.[13] Defenders of for-profit hospitals, however, point out that there is little evidence pointing to that result.[14] In fact, most hospitals—regardless of ownership type—practice cross-subsidization, or cost-shifting. Daniel Butler, senior vice president of health affairs at Blue Cross and Blue Shield of North Carolina, explains that "it is the only avenue hospitals have" to avoid taking a loss from the less profitable services. Room rates are a good example of where hospitals cost-shift. They often set the charge for this routine care at or even below actual cost because that is where the public is likely to compare hospitals. In such an instance, hospitals would be using a room rate as a "loss leader"—they will accept losses and make more money on other services. (See page 104 in Chapter 3 for the Center's findings on room rates at N.C. hospitals.)

At the community level, critics say for-profit hospitals skim the cream by providing less indigent care, by building or acquiring hospitals only in wealthy urban and suburban areas, and by offering only the most profitable services. The issue of indigent care, which involves decisions to treat fewer unprofitable patients or sometimes allegations of refusing to treat patients with no health insurance, is discussed in detail in Chapter 2 of this book. The question of whether for-profit hospitals tend to locate in prosperous areas in North Carolina is discussed in the sidebar in this chapter on page 122. Do for-profit hospitals eliminate or avoid offering services which are used infrequently or are unprofitable—even though there may be a need for them in the community? Or do for-profit hospitals offer services comparable to not-for-profits both in terms of range and quality?

Advocates of for-profit hospitals point out that investor-owned corporations, by purchasing hospitals in serious financial trouble, sometimes actually prevent hospital services from being lost in a community. And Walter Weisman, former Chairman of the Board and CEO of American Medical International, one of the largest investor-owned hospital corporations in the country, said of the company, "We will continue to provide services that are responsive to the needs of the communities we serve."

Before turning to the Center's comparison of hospital services in North Carolina, it is helpful to first review the findings of other studies focusing on the range of services offered at different types of hospitals.

Findings of Other Studies

IN 1986 the Institute of Medicine published *For-Profit Enterprise in Health Care*, the most comprehensive study of the influence of for-profit hospitals to date. The summary chapter on access to health care discusses the fact that it is widely agreed that hospitals *do* lose money on some services. This is due to the difficulty in charging full cost on services which are used infrequently and the fact that some services, such as emergency rooms, attract an unusually large proportion of uninsured patients.[15] These points are related to the issue of cross-subsidization discussed above.

The Institute of Medicine then tried to determine which services can be characterized as unprofitable, but found the data from other studies unsatisfactory. It did note that maternity and emergency room care are a primary source of bad debts but cautioned that the same might not be true for all hospitals. The report then focused on the central question of which services do for-profits tend to offer or not to offer? Using American Hospital Association data, the Institute of Medicine drew four conclusions.

First, it concluded that there *is* a basic set of services that almost all hospitals offer, regardless of ownership type, echoing the historical trend of standardization noted by Paul Starr above. These services are emergency room, post-operative recovery room, respiratory therapy, physical therapy, and

—*continued on page 124*

THE LOCATION OF NORTH CAROLINA HOSPITALS OWNED, LEASED, OR MANAGED BY INVESTOR-OWNED MULTI-HOSPITAL SYSTEMS

by Bill Long and Marianne M. Kersey

BEFORE PURCHASING OR PURSUING management contracts with hospitals, do investor-owned multi-hospital systems try to operate more in populous and wealthy areas to ensure that they will be able to make a profit? *Fortune* magazine suggested that at least one for-profit chain does:

> Humana prefers to own facilities in suburbs where young working families are having lots of babies. Though young people use hospitals less than the elderly, they are more likely to be privately insured and in need of surgery, which makes the most money. The babies provide a second generation of customers.[1]

Research by the N.C. Center shows that the answer to the same question appears to be yes in North Carolina as well.

To test this theory, the Center looked at the location of the 44 general and specialty hospitals affiliated with for-profit multi-systems in North Carolina, as of June 1987. Researchers ranked the counties in which these 44 hospitals were located in terms of per capita income and percent of county population considered urban. Per capita income is an indicator of wealth of an area; the wealthier the area, the more likely the hospital is to attract paying patients and better its financial prospects. And locating in a suburban or urban area also helps boost the supply of patients, thereby helping a hospital keep its beds filled, another important factor in financial solvency. The two rankings were based on data gathered from the 1980 census and the Bureau of Economic Analysis in the U.S. Department of Commerce.

County wealth seemed to be a more important factor than percent urbanization. The chart on the facing page is set up to reflect this; the counties are listed in order of their rank in per capita income.

Looking at both sets of rankings, it is clear that investor-owned corporations have located in the wealthier and more populous of North Carolina's 100 counties, particularly when they are buying a hospital. For example, almost half (12 of 25) of the hospitals *owned* by a for-profit chain were located in the 10 wealthiest counties in North Carolina, and all but two of these 12 hospitals were located in the state's 10 most urban counties as well. Moreover, 17 of the 25 investor-owned hospitals were located in the 24 wealthiest counties and 16 of these hospitals were also in the 25 most urban counties.

Indicators were not as strong for hospitals *managed* or *leased* by investor-owned corporations. Six of the 17 investor-managed hospitals were in the 25 wealthiest counties and four of these six hospitals were also in the 25 most urban counties. And the only two hospitals leased by investor-owned corporations at that time were in rural Brunswick and Bertie counties, which ranked 80th and 71st in per capita income, respectively. One explanation for these findings could be that when a hospital is *owned* by a for-profit corporation, the purchase or decision to build truly reflects the corporation's choice of location. By contrast, in a management contract or leasing agreement, a hospital corporation is more likely to be responding to a request for help from a hospital with financial difficulties, in which case ownership may be a less attractive option for the corporation. In such an instance, a decision on hospital location is out of control of the investor-owned corporation, but may enter into the corporate decision on whether such a contract could be profitable.

When the three groups—owned, managed and leased—were combined, the indicators again were strong that investor-owned corporations take area wealth and population size into consideration. Twenty-three of the 44 hospitals owned, managed or leased by a for-profit chain were located in the 25 wealthiest counties, and 20 of these 23 hospitals were also in the top 25 counties in terms of urbanization.

Investor-owned hospital corporations certainly cannot be faulted for taking such factors into consideration. All hospitals, whether for-profit or not-for-profit, are concerned about their financial performance, particularly in light of increased competition in the health care field. And any for-profit corporation has to consider prospects for profit before beginning operation.

Bill Long is a former intern at the N.C. Center.

FOOTNOTES

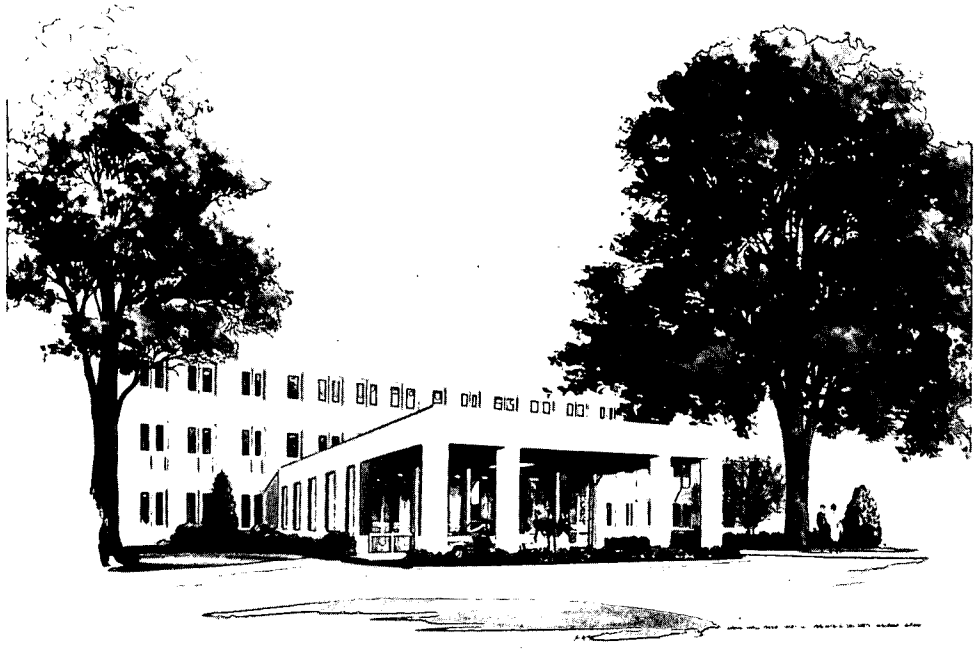
[1]Gwen Kinkhead, "Humana's Hard-Sell Hospitals," *Fortune*, November 17, 1980, p. 70, as quoted in Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, Inc., 1982), p. 436.

Location of N.C. Hospitals Affiliated With Investor-Owned Multi-Hospital Systems, June 1987 In Relation To County Rank in Per Capita Income and in Percent Urban Population

Rank in Per Capita Income (1980)	County	Rank in Percent Urban Population (1980)	Number and Ownership Type Of General and Specialty Hospitals Affiliated With Investor-Owned Multi-Hospital Systems in that County
1	Mecklenburg	1	3 I-O
2	Forsyth	6	1 I-O, 1 M
3	Guilford	5	2 I-O
4	Wake	7	3 I-O
7	Catawba	15	2 I-O
8	Henderson	55	1 M (part)
10	New Hanover	2	1 I-O
11	Wilson	16	1 M (part)
13	Lee	25	1 I-O
14	Buncombe	12	2 I-O
17	Yadkin	N/A	1 M
18	Gaston	8	1 M (part)
23	Nash	27	1 I-O
24	Edgecombe	21	1 I-O
25	Rockingham	24	1 M
28	Iredell	35	2 I-O
30	Surry	58	1 M
35	McDowell	71	1 M
40	Craven	18	1 M (part)
41	Johnston	44	1 M
49	Rutherford	41	1 M
54	Caldwell	43	1 I-O
57	Cumberland	3	3 I-O
60	Macon	63	1 M
64	Person	46	1 M
67	Mitchell	N/A	1 M
71	Bertie	N/A	1 L
77	Ashe	N/A	1 M
78	Franklin	69	1 I-O
80	Brunswick	64	1 L
84	Onslow	10	1 I-O
85	Duplin	61	1 M
99	Yancey	N/A	1 M

I-O = investor-owned hospital
M = hospital managed by an investor-owned corporation
M (part) = hospital is not-for-profit, but some or all of its psychiatric beds are managed by an investor-owned corporation
L = hospital leased by an investor-owned corporation
N/A = the county was unranked in urban population because its entire population was classified as rural.

Source: U. S. Department of Commerce, Bureau of Economic Analysis. Data published in *State Data Center Newsletter*, Vol. 4, No. 3 (August 1982). Also *County and City Data Book*, N.C. Office of State Budget and Management.



Courtesy Franklin Regional Medical Center

Franklin Memorial Hospital in Louisburg was a county-owned facility until it was purchased by Health Management Associates, a for-profit corporation, in 1986. Renamed Franklin Regional Medical Center in March 1988, the hospital is undergoing an extensive refurbishing project as depicted in the artist's rendering above. Franklin Regional Medical Center is one of three hospitals owned or leased by HMA in North Carolina.

pharmacy. Second, there is a large group of services more commonly offered in not-for-profits than in investor-owned hospitals. This group numbered approximately 10 services, including premature nursery, home care, and psychiatric services. Third, only two services were more commonly offered in investor-owned hospitals than in not-for-profits (with 100-199 beds). They were abortion services and patient representatives. (In smaller hospitals, investor-owned facilities offered four other services more frequently than not-for-profit hospitals.) Finally, the Institute of Medicine concluded that there is some evidence that investor-owned hospitals offer a *narrower* range of services compared to not-for-profits. The study pointed out, however, that the data do not show the extent to which services not offered by hospitals are essential services which are not otherwise available in the community.[16]

Other studies leading up to the Institute of Medicine report have looked at the range of services at acute care hospitals while examining additional issues in the for-profit/not-for-profit debate as well. Although the focus was not on for-profit/not-for-profit comparisons, Biggs' 1980 analysis provides insight into the behavior of hospitals *managed,* but not owned by, investor-owned corporations. In a management contract, all hospital personnel remain employees of the institution except the administrator, and in some cases, the controller. The local hospital's board of trustees retains its policymaking authority. The administrator, however, must report to the board of trustees *and* to the management corporation. Service offerings at the hospital can therefore be changed by the management company, but only with the approval of the trustees.[17] Biggs and others compared service offerings at not-for-profit hospitals managed by investor-owned corporations and traditionally managed not-for-profit hospitals in 18 states using 32 matched pairs. Using data from the 1975 *American Hospital Association Guide,* they found that contract-managed hospitals tended to offer a somewhat broader range of services, particularly in the outpatient area, although the differences were not statistically significant.

In 1983, Pattison and Katz focused on the economic performance of investor-owned and not-for-profit hospitals in California. They focused more on the issue of profitability than on the tendency of different types of hospitals to offer particular services. In their discussion of hospitals' managerial strategies, Pattison and Katz found that ancillary services like clinical laboratories, central services

and supply, pharmacies, and inhalation therapy were profitable for all classes of hospitals, and that for-profit chain hospitals tended to earn higher, per-unit profits on these services than not-for-profit hospitals. On the other hand, ancillary services such as blood banks, radiology, emergency, and home health services—along with routine services like room and board—were found to be generally unprofitable for all classes of hospitals. For-profit chains also had smaller per-unit losses on unprofitable services than not-for-profit hospitals.[18] (See Chapter 3 of this report for findings on markup of ancillary services at N.C. hospitals.)

That same year, Sloan and Vraciu released a detailed study of service availability at investor-owned and private not-for-profit hospitals using Florida data. They found that *independent* investor-owned hospitals — those not belonging to a chain — offered a more limited range of services than private not-for-profits or investor-owned system hospitals, but no pattern emerged when looking at profitable versus unprofitable services. Overall, their comparisons suggested equality between not-for-profits and investor-owned systems in terms of service sophistication and willingness to offer unprofitable services, concluding that hospitals tend to structure themselves similarly, regardless of ownership type.[19] This study was sponsored by the for-profit Hospital Corporation of America.

Using 1984 data, Shortell and others examined the effects of hospital ownership on the provision of *non-traditional* services rather than acute inpatient care services. Their study also considered the influence of competition from nearby hospitals, the level of rate review regulation, and Medicaid eligibility levels on the provision of services. Among their findings were that not-for-profit system hospitals provided more alternative services—such as ambulatory and long term care—than investor-owned system hospitals. Also, investor-owned hospitals offered fewer of the unprofitable, but more of the profitable alternative services, than not-for-profit system hospitals.[20]

And finally, a 1986 survey of 300 U.S. hospitals by Jackson and Coker provides information on the profitability of particular hospital services, based on recent trends. According to results published in *Hospitals* magazine, services such as neurosurgery and thoracic (chest) surgery—when measured by hospital revenue from physicians with these specialties—have been increasingly profitable for hospitals in the last couple of years.[21] And based on patient revenue from different specialties, hospitals in the survey reported that general surgery, general medicine, psychiatry, and urology were increasingly profitable.[22] Patient revenues from thoracic surgery, orthopedic surgery, pediatrics, and obstetrics/gynecology had also shown an increase in recent years, but less so than other services.

These studies' findings and conclusions will be helpful in explaining some of the N.C. Center for Public Policy Research's findings in North Carolina.

Methodology

THE N.C. CENTER BEGAN its comparison of services at North Carolina hospitals with a hypothesis that ownership type would not be predictive of what range of services would be offered. *All* non-federal general acute care hospitals in North Carolina were included in the Center's analysis—hospitals owned, managed, or leased by investor-owned corporations, and both private and public not-for-profit hospitals.

1. Data Source. The data source used by the N.C. Center was the most recent information available on N.C. hospitals from the State Center for Health Statistics, which is in the Division of Health Services under the N.C. Department of Human Resources. Each year, the Division of Facility Services—also in the N.C. Department of Human Resources—mails an "Application for Renewal of License to Operate a Hospital" to all non-federal hospitals in the state. The data collected from these licensure reports are compiled and published by the State Center for Health Statistics in the *Health Facilities Data Book*. The book provides a summary of each hospital's services and utilization rates. The most recent year available when the Center's analysis of this issue began was 1985. (Data on specialty hospitals, such as psychiatric and chemical dependency hospitals, are included in the *Data Book* but were not used by the Center.*)

In 1985, there were 125 non-federal general acute care hospitals in North Carolina. Tables 4.1, 4.2, and 4.3 list them alphabetically by ownership type including the city and county location of each hospital. Table 4.1 shows that there were 10 hospitals owned, 12 managed, and one leased by investor-owned corporations in North Carolina in 1985. The most active corporation at that time was Hospital Corporation of America (HCA) which owned four, managed seven,

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* The data used in Chapter 3's analysis of hospital costs and charges were from 1983; the data in this chapter were from 1985 because the reporting procedures for Medicare Cost Reports differ from those regarding statewide hospital facility data. The State Center for Health Statistics publishes the *Health Facilities Data Book* annually in September, the year following the collection of data.

Table 4.1: General Acute Care Hospitals Owned, Managed, or Leased by Investor-Owned Corporations (23), 1985

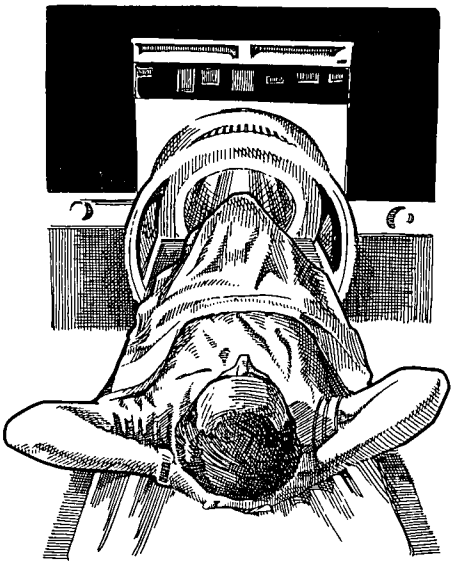
Hospital	Location		Investor-Owned Corporation
	City	County	
*A. **Owned** by Investor-Owned Corporations (10)*			
1. Blackwelder Memorial Hospital	Lenoir	Caldwell	HealthCare Management Corporation
2. Central Carolina Hospital	Sanford	Lee	American Medical International
3. Community Hospital of Rocky Mount	Rocky Mount	Nash	American Medical International
4. Davis Community Hospital	Statesville	Iredell	Hospital Corporation of America
5. Frye Regional Medical Center	Hickory	Catawba	American Medical International
6. Heritage Hospital	Tarboro	Edgecombe	Hospital Corporation of America
7. Highsmith-Rainey Memorial Hospital	Fayetteville	Cumberland	Hospital Corporation of America
8. Humana Hospital Greensboro[1]	Greensboro	Guilford	Humana, Inc.
9. Medical Park Hospital[2]	Winston-Salem	Forsyth	Independent
10. Raleigh Community Hospital	Raleigh	Wake	Hospital Corporation of America
*B. **Managed** by Investor-Owned Corporations (12)*			
11. Angel Community Hospital	Franklin	Macon	Hospital Corporation of America
12. Ashe Memorial Hospital	Jefferson	Ashe	Hospital Corporation of America
13. Blue Ridge Hospital System[3]	Burnsville/ Spruce Pine	Yancey/ Mitchell	Hospital Corporation of America
14. Cape Fear Valley Medical Center[4]	Fayetteville	Cumberland	National Medical Enterprises, Inc.
15. Franklin Memorial Hospital	Louisburg	Franklin	Hospital Corporation of America
16. Hugh Chatham Memorial Hospital	Elkin	Surry	Hospital Management Professionals
17. Johnston Memorial Hospital	Smithfield	Johnston	Hospital Corporation of America
18. Lowrance Hospital[5]	Mooresville	Iredell	Hospital Corporation of America
19. The McDowell Hospital	Marion	McDowell	The Delta Group, Inc.
20. Morehead Memorial Hospital	Eden	Rockingham	Health Management Professionals
21. Person County Memorial Hospital	Roxboro	Person	Hospital Corporation of America
22. Rutherford Hospital	Rutherfordton	Rutherford	Hospital Management Professionals
*C. **Leased** by Investor-Owned Corporations (1)*			
23. The Brunswick Hospital	Supply	Brunswick	Hospital Corporation of America

— table continued

and leased one of the 22 general hospitals affiliated with investor-owned corporations. American Medical International (AMI) was the second most active, owning three general hospitals in North Carolina. Only one investor-owned general hospital, Medical Park, was independently owned in 1985. Table 4.2 lists the 52 hospitals owned by not-for-profit corporations, and Table 4.3 lists the public hospitals, according to which of six types of governmental entities owned the hospital. These categories are county-owned, city-owned, those owned by hospital authorities or hospital districts, township-owned, and state-owned.

2. Categorizing by Size. The 125 general acute care hospitals were then grouped according to three standard categories of bed size. *Bed complement,* which is beds currently set up and staffed, rather than *licensed bed capacity,* was used. Small hospitals are those with a bed complement of less than 100 beds. There were 50 hospitals in this category in 1985. There were 62 medium-sized hospitals with 100 or more but less than 400 beds. Large hospitals, those with 400 or more beds in use, were the smallest group—13 hospitals. This categorizing helped factor out the role which hospital size might play in whether a service is offered, thus giving ownership type more weight in the analysis.

3. Categorizing by Ownership Type Within Size Categories. Within each size category, the hospitals were again separated by ownership type. Tables 4.4, 4.5, and 4.6 list hospitals in each of the three size groupings and note the bed count and one of five types of ownership—investor-owned, managed by an investor-owned corporation, leased by an investor-owned corporation, private not-for-profit, and public.



Of the 50 *small* hospitals listed in Table 4.4, two were investor-owned, seven were managed by an investor-owned corporation, and one was leased by an investor-owned corporation; 20 were owned by private not-for-profit corporations; 20 were public. Small hospitals made up 40% of all general North Carolina hospitals. In the *medium-sized* hospital category, Table 4.5 lists the eight investor-owned, four investor-managed, 27 private not-for-profit, and 23 public hospitals. These 62 hospitals represented 50% of all general hospitals in the state. And finally, Table 4.6 lists the 13 *large* hospitals. Only one large hospital—Cape Fear Valley Medical Center—was managed by an investor-owned corporation in 1985, consistent with the observation that investor-owned corporations are usually only interested in building and acquiring small and medium-sized hospitals.[23] Five of the 13 large hospitals were owned and managed by private not-for-profit corporations and seven were public hospitals. This group accounted for 10% of North Carolina's general acute care hospitals. There were no hospitals leased by an investor-owned corporation in either the medium or large categories.

4. Selection of Service Categories. The services analyzed in this chapter were largely determined by the categories and information available in the 1985 *Health Facilities Data Book.* Most were fairly

FOOTNOTES, Table 4.1

[1] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

[2] Medical Park Hospital was purchased by Carolina Medicorp in 1986 and is now a private, not-for-profit hospital. Medical Park has been managed by Hospital Corporation of America since 1984.

[3] The Blue Ridge Hospital System includes Burnsville Hospital and Spruce Pine Community Hospital, both of which are managed by Hospital Corporation of America. Data are reported for the system as a whole.

[4] Cape Fear Valley Medical Center's management contract with National Medical Enterprises ended in September of 1985. It is currently managed by SunHealth Enterprises, Inc., a subsidiary of SunHealth Corporation, an alliance of not-for-profit hospitals.

[5] Lowrance Hospital was renamed Lake Norman Regional Medical Center in 1987 and was purchased by Health Management Associates in 1986.

— Based on the State Center for Health Statistics' *Health Facilities Data Book, 1985,* and original research by the N.C. Center for Public Policy Research.

Table 4.2: General Acute Care Hospitals Owned by Private Not-For-Profit Corporations (52), 1985*

Hospital	Location	
	City	County
1. Alamance County Hospltal [1]	Burlington	Alamance
2. Alexander County Hospital	Taylorsville	Alexander
3. Alleghany County Memorial Hospital	Sparta	Alleghany
4. Annie Penn Memorial Hospital	Reidsville	Rockingham
5. Blowing Rock Hospital	Blowing Rock	Watauga
6. C. J. Harris Community Hospital	Sylva	Jackson
7. Caldwell Memorial Hospital	Lenoir	Caldwell
8. Cape Fear Memorial Hospital	Wilmington	New Hanover
9. Charles A. Cannon Memorial Hospital	Banner Elk	Avery
10. Chatham Hospital	Siler City	Chatham
11. Community General Hospital	Thomasville	Davidson
12. Crawley Memorial Hospital	Boiling Springs	Cleveland
13. Duke University Hospital	Durham	Durham
14. Forsyth Memorial Hospital	Winston-Salem	Forsyth
15. Gaston Memorial Hospital	Gastonia	Gaston
16. Good Hope Hospital	Erwin	Harnett
17. Grace Hospital	Morganton	Burke
18. Highlands-Cashiers Hospital	Highlands	Macon
19. High Point Regional Hospital	High Point	Guilford
20. L. Richardson Memorial Hospital	Greensboro	Guilford
21. Lenoir Memorial Hospital	Kinston	Lenoir
22. Lexington Memorial Hospital	Lexington	Davidson
23. Maria Parham Hospital	Henderson	Vance
24. Memorial Hospital of Alamance County [1]	Burlington	Alamance
25. Memorial Mission Medical Center	Asheville	Buncombe
26. Mercy Hospital	Charlotte	Mecklenburg
27. Montgomery Memorial Hospital	Troy	Montgomery
28. Moore Regional Hospital	Pinehurst	Moore
29. Moses H. Cone Memorial Hospital	Greensboro	Guilford
30. North Carolina Baptist Hospital	Winston-Salem	Forsyth
31. Our Community Hospital	Scotland Neck	Halifax
32. Park Ridge Hospital	Fletcher	Henderson
33. Presbyterian Hospital	Charlotte	Mecklenburg
34. Pungo District Hospital	Belhaven	Beaufort
35. Randolph Hospital	Asheboro	Randolph
36. Rex Hospital	Raleigh	Wake
37. Richmond Memorial Hospital	Rockingham	Richmond
38. Roanoke-Chowan Hospital	Ahoskie	Hertford
39. Robersonville Community Hospital	Robersonville	Martin
40. Rowan Memorial Hospital	Salisbury	Rowan
41. Scotland Memorial Hospital	Laurinburg	Scotland
42. Sea Level Hospital	Sea Level	Carteret
43. Sloop Memorial Hospital	Crossnore	Avery
44. Southeastern General Hospital	Lumberton	Robeson
45. St. Joseph's Hospital	Asheville	Buncombe
46. St. Luke's Hospital	Columbus	Polk
47. Stanly Memorial Hospital	Albemarle	Stanly
48. Swain County Hospital	Bryson City	Swain
49. Transylvania Community Hospital	Brevard	Transylvania
50. Union Memorial Hospital	Monroe	Union
51. Valdese General Hospital	Valdese	Burke
52. Wesley Long Community Hospital	Greensboro	Guilford

* Table does not include private, not-for-profit hospitals *managed* by investor-owned corporations; hospitals managed by investor-owned corporations in 1985 are listed in Table 4.1.

[1] Alamance County Hospital was sold in 1984 to Alamance Health Services, a private, not-for-profit parent holding company, which also owns Memorial Hospital of Alamance County.

—Based on the State Center for Health Statistics' *Health Facilities Data Book, 1985*, and original research by the N.C. Center for Public Policy Research.

broad categories of services providing a comprehensive view of the hospitals, but some specialties were listed too.[24] The N.C. Center checked each hospital's profile for the following 18 inpatient and four outpatient services:

Inpatient Services (18)	Outpatient Services (4)
cardiology	emergency room
cardiac intensive care unit (ICU)	outpatient clinic
eye, ear, nose and throat (EEN&T)	outpatient surgery
general medicine	psychiatric outpatient
general surgery	
gynecology	
medical/surgical intensive care unit (ICU)	
neonatal intensive care unit (ICU)	
newborn nursery	
neurosurgery	
obstetrics	
orthopedics	
pediatrics	
pharmacy (full- or part-time)	
physical therapy	
psychiatry	
thoracic surgery	
urology	

5. Criteria for Determining Hospital Service Offerings. In most cases, it was clear from the *Data Book* whether a service was offered by looking at a hospital's profile and/or utilization statistics, which list the number of discharges for various service categories. The availability of a service was indicated by a "yes" or "no" response in a column in the *Data Book,* or by a figure indicating the number of patients that were provided that service. If a service was listed as contracted out—such as psychiatric outpatient services in some cases—it *was* considered offered because the hospital did provide some way for the patient to obtain the service.

In a few categories, there was no indication that a service was offered other than a listing of an active staff person with that specialty at the hospital. This criterion was somewhat problematic because physicians often practice in areas other than their particular specialty and often have privileges at more than one hospital. Tables 4.8 and 4.11, which summarize the Center's findings, note the categories for which this was the case. An asterisk indicates that the criterion of a staff person with that specialty was the only information available for that service for one or more hospitals in any ownership group.

Although the information used was what the hospitals themselves reported, some of the data were unclear. Any discrepancies or problems were followed up by Center staff by telephone inquiries to the hospital for confirmation or correction as to whether a service was actually offered.

6. Limitations of the Data. Before presenting the Center's findings on the range of services at N.C. hospitals, some observations and comments about the potential limits of the data in this analysis are warranted. First of all, the accuracy of the information in the *Health Facilities Data Book* is dependent on each hospital's reporting standards and procedures, which may vary from hospital to hospital. For example, Heritage Hospital, Murphy Medical Center, University Memorial Hospital, and Swain County Hospital lumped data under the heading of general medicine instead of itemizing discharges under specific service utilization categories. Another example is the Blue Ridge Hospital System's method of combining data for Burnsville Hospital and Spruce Pine Community Hospital. Although there are two hospitals in this system, they were treated as one for the purposes of this analysis because that is the way the data were reported. The different age categories used by different hospitals in reporting pediatric cases was another potential problem. What one hospital lists as pediatric discharges, another may list as general medicine discharges which include adult patients.

Second, as mentioned above, some assumptions about whether a service was actually offered at a hospital were necessary. An example of such a judgment call was in the category of orthopedic services, which was considered to have been offered if there was a staff member with that specialty at the hospital. In other words, the hospital was given the benefit of the doubt in questions as to whether the service was offered.

Third, there was only one *large* hospital in 1985 managed by an investor-owned corporation, an insufficient number for a comparison by hospital type. For-profit/not-for-profit comparisons on services, therefore, were limited to the small and medium-sized categories. Moreover, even in the small and medium-sized categories, there was a relatively small number of investor-owned hospitals—only two of small size and eight in the medium-sized category. Thus, the best place to draw conclusions about comparisons of service offerings was in the medium-sized hospital category.

Fourth, some of the hospitals involved with investor-owned corporations began or changed their corporate affiliation not long before providing the 1985 information. In these cases, whether a service was offered at the hospital may not necessarily reflect the

—continued on page 133

Table 4.3: General Acute Care Public Hospitals Owned by State or Local Governmental Bodies (50), 1985*

Hospital	Location	
	City	County
A. County-Owned Hospitals (40)		
1. Albemarle Hospital	Elizabeth City	Pasquotank
2. Anson County Hospital	Wadesboro	Anson
3. Beaufort County Hospital	Washington	Beaufort
4. Bertie County Memorial Hospital	Windsor	Bertie
5. Bladen County Hospital	Elizabethtown	Bladen
6. Cabarrus Memorial Hospital	Concord	Cabarrus
7. Carteret General Hospital	Morehead City	Carteret
8. Catawba Memorial Hospital	Hickory	Catawba
9. Chowan Hospital	Edenton	Chowan
10. Cleveland Memorial Hospital	Shelby	Cleveland
11. Columbus County Hospital	Whiteville	Columbus
12. Craven County Hospital[1]	New Bern	Craven
13. Davie County Hospital	Mocksville	Davie
14. Duplin General Hospital	Kenansville	Duplin
15. Durham County General Hospital	Durham	Durham
16. Eastern Wake Hospital	Zebulon	Wake
17. Granville Hospital	Oxford	Granville
18. Hamlet Hospital	Hamlet	Richmond
19. Haywood County Hospital	Clyde	Haywood
20. Hoots Memorial Hospital	Yadkinville	Yadkin
21. Iredell Memorial Hospital	Statesville	Iredell
22. Kings Mountain Hospital	Kings Mountain	Cleveland
23. Lincoln County Hospital	Lincolnton	Lincoln
24. Margaret R. Pardee Memorial Hospital	Hendersonville	Henderson
25. Martin General Hospital	Williamston	Martin
26. Nash General Hospital	Rocky Mount	Nash
27. New Hanover Memorial Hospital	Wilmington	New Hanover
28. Northern Wake Hospital	Wake Forest	Wake
29. Onslow Memorial Hospital	Jacksonville	Onslow
30. Pender Memorial Hospital	Burgaw	Pender
31. Pitt County Memorial Hospital	Greenville	Pitt
32. Sampson County Memorial Hospital	Clinton	Sampson
33. Southern Wake Hospital	Fuquay-Varina	Wake
34. Stokes-Reynolds Memorial Hospital	Danbury	Stokes

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Table 4.3: General Acute Care Public Hospitals Owned by State or Local Governmental Bodies (50), 1985*, *continued*

Hospital	Location	
	City	County
A. County-Owned Hospitals (40), continued		
35. Wake Medical Center	Raleigh	Wake
36. Washington County Hospital	Plymouth	Washington
37. Watauga County Hospital	Boone	Watauga
38. Wayne Memorial Hospital	Goldsboro	Wayne
39. Western Wake Hospital	Apex	Wake
40. Wilson Memorial Hospital	Wilson	Wilson
B. City-Owned Hospitals (2)		
41. Betsy Johnson Memorial Hospital	Dunn	Harnett
42. Wilkes General Hospital	North Wilkesboro	Wilkes
C. Hospital Authority-Owned Hospitals (4)		
43. Charlotte Memorial Hospital and Medical Center	Charlotte	Mecklenburg
44. Mountain Park Medical Center [2]	Andrews	Cherokee
45. Murphy Medical Center	Murphy	Cherokee
46. University Memorial Hospital	Charlotte	Mecklenburg
D. Hospital District-Owned Hospitals (2)		
47. Halifax Memorial Hospital	Roanoke-Rapids	Halifax
48. Northern Hospital of Surry County	Mt. Airy	Surry
E. Township-Owned Hospitals (1)		
49. J. Arthur Dosher Memorial Hospital	Southport	Brunswick
F. State-Owned Hospitals (1)		
50. North Carolina Memorial Hospital	Chapel Hill	Orange

* Table does not include publicly-owned hospitals *managed* by investor-owned corporations; hospitals managed by investor-owned corporations in 1985 are listed in Table 4.1.

[1] Craven County Hospital was renamed Craven Regional Medical Center in 1988.

[2] Mountain Park Medical Center was renamed District Memorial Hospital in 1987.

—Based on the State Center for Health Statistics' *Health Facilities Data Book, 1985*, and original research by the N.C. Center for Public Policy Research.

Table 4.4: Small (Less Than 100 Beds) General Acute Care N.C. Hospitals (50), 1985, By Ownership Type

	Bed Complement	Location	
		City	County
A. Investor-Owned Hospitals (2)			
1. Blackwelder Memorial Hospital	31	Lenoir	Caldwell
2. Community Hospital of Rocky Mount	48	Rocky Mount	Nash
B. Hospitals Managed by Investor-Owned Corporations (7)			
3. Angel Community Hospital	81	Franklin	Macon
4. Ashe Memorial Hospital	76	Jefferson	Ashe
5. Blue Ridge Hospital System[1]	92	Burnsville/ Spruce Pine	Yancey/ Mitchell
6. Franklin Memorial Hospital	54	Louisburg	Franklin
7. Hugh Chatham Memorial Hospital	96	Elkin	Surry
8. The McDowell Hospital	65	Marion	McDowell
9. Person County Memorial Hospital	54	Roxboro	Person
C. Hospitals Leased by Investor-Owned Corporations (1)			
10. The Brunswick Hospital	60	Supply	Brunswick
D. Hospitals Owned and Managed by Private Not-For-Profit Corporations (20)			
11. Alexander County Hospital	62	Taylorsville	Alexander
12. Alleghany County Memorial Hospital	46	Sparta	Alleghany
13. Blowing Rock Hospital	28	Blowing Rock	Watauga
14. C. J. Harris Community Hospital	80	Sylva	Jackson
15. Charles A. Cannon Memorial Hospital	79	Banner Elk	Avery
16. Chatham Hospital	68	Siler City	Chatham
17. Crawley Memorial Hospital	51	Boiling Springs	Cleveland
18. Good Hope Hospital	72	Erwin	Harnett
19. Highlands-Cashiers Hospital	27	Highlands	Macon
20. L. Richardson Memorial Hospital	68	Greensboro	Guilford
21. Lexington Memorial Hospital	94	Lexington	Davidson
22. Montgomery Memorial Hospital	57	Troy	Montgomery
23. Our Community Hospital	20	Scotland Neck	Halifax
24. Pungo District Hospital	49	Belhaven	Beaufort
25. Richmond Memorial Hospital	76	Rockingham	Richmond
26. Robersonville Community Hospital	12	Robersonville	Martin
27. Sea Level Hospital	26	Sea Level	Carteret
28. Sloop Memorial Hospital	38	Crossnore	Avery
29. St. Luke's Hospital	74	Columbus	Polk
30. Swain County Hospital	48	Bryson City	Swain
E. Public Hospitals: Owned and Managed by State or Local Governmental Bodies (20)			
31. Anson County Hospital	52	Wadesboro	Anson
32. Bertie County Memorial Hospital	36	Windsor	Bertie
33. Bladen County Hospital	62	Elizabethtown	Bladen
34. Chowan Hospital	70	Edenton	Chowan

— continued

investor-owned corporation's decision or willingness to offer it, or any of the other services the Center examined.

Finally, although the number of discharges for most of the service categories were listed in the *Data Book*, caution should be exercised concerning the reliability of these numbers. Therefore, the Center did not attempt to analyze utilization levels and whether a service was offered "for show or for go." Instead, the Center used a check-off system, where a service was checked off as being offered or not offered. This means that a service could have been offered infrequently or limited in its availability. This possibility would be especially important if such a service was generally thought to be profitable or essential. If an essential service is not offered by a particular hospital, it may not necessarily signal a serious drawback for the community because other hospitals nearby may offer the service. The quality of care at the different hospitals was also beyond the scope of this study.

Despite these cautionary notes, however, the N.C. Center's study on the range of services at general hospitals—the first done in North Carolina—has important strengths. For example, the Center used the most recent data (1985) available from the State Center for Health Statistics when the study began. This data is more recent than many of the national studies of hospital services. Second, *all* non-federal acute care hospitals in North Carolina were included in this analysis. This approach contributed to a third strong point—the number of medium-sized hospitals and small hospitals examined provided a good basis on which to compare service offerings at hospitals of different ownership types. As a result of these strengths, the comparisons and conclusions presented in the following sections give a comprehensive view of N.C.'s general hospitals and provide more insight into an important issue in the debate over for-profit and not-for-profit hospitals.

—continued on page 136

Table 4.4: Small (Less Than 100 Beds) General Acute Care N.C. Hospitals (50), 1985, By Ownership Type, *continued*

	Bed Complement	Location	
		City	County
35. Davie County Hospital	66	Mocksville	Davie
36. Duplin General Hospital	80	Kenansville	Duplin
37. Eastern Wake Hospital	20	Zebulon	Wake
38. Granville Hospital	66	Oxford	Granville
39. Hamlet Hospital	56	Hamlet	Richmond
40. Hoots Memorial Hospital	72	Yadkinville	Yadkin
41. J. Arthur Dosher Memorial Hospital	40	Southport	Brunswick
42. Martin General Hospital	49	Williamston	Martin
43. Mountain Park Medical Center [2]	61	Andrews	Cherokee
44. Murphy Medical Center	50	Murphy	Cherokee
45. Northern Wake Hospital	20	Wake Forest	Wake
46. Pender Memorial Hospital	43	Burgaw	Pender
47. Southern Wake Hospital	28	Fuquay-Varina	Wake
48. Stokes-Reynolds Memorial Hospital	60	Danbury	Stokes
49. Washington County Hospital	49	Plymouth	Washington
50. Western Wake Hospital	20	Apex	Wake

[1] The Blue Ridge Hospital System includes Burnsville Hospital and Spruce Pine Community Hospital. Data are reported for system as a whole.

[2] Mountain Park Medical Center was renamed District Memorial Hospital in 1987.

— Based on the State Center for Health Statistics' *Health Facilities Data Book, 1985*, and original research by the N.C. Center for Public Policy Research.

Table 4.5: Medium-Sized (100 or More Beds But Less Than 400 Beds) General Acute Care N.C. Hospitals (62), 1985, By Ownership Type

	Bed Complement	Location	
		City	County
A. Investor-Owned Hospitals (8)			
1. Central Carolina Hospital	142	Sanford	Lee
2. Davis Community Hospital	149	Statesville	Iredell
3. Frye Regional Medical Center	260	Hickory	Catawba
4. Heritage Hospital	127	Tarboro	Edgecombe
5. Highsmith-Rainey Memorial Hospital	150	Fayetteville	Cumberland
6. Humana Hospital Greensboro [1]	103	Greensboro	Guilford
7. Medical Park Hospital [2]	136	Winston-Salem	Forsyth
8. Raleigh Community Hospital	140	Raleigh	Wake
B. Hospitals Managed by Investor-Owned Corporations (4)			
9. Johnston Memorial Hospital	180	Smithfield	Johnston
10. Lowrance Hospital [3]	121	Mooresville	Iredell
11. Morehead Memorial Hospital	133	Eden	Rockingham
12. Rutherford Hospital	165	Rutherfordton	Rutherford
C. Hospitals Owned and Managed by Private Not-For-Profit Corporations (27)			
13. Alamance County Hospital	147	Burlington	Alamance
14. Annie Penn Memorial Hospital	152	Reidsville	Rockingham
15. Caldwell Memorial Hospital	128	Lenoir	Caldwell
16. Cape Fear Memorial Hospital	137	Wilmington	New Hanover
17. Community General Hospital	129	Thomasville	Davidson
18. Gaston Memorial Hospital	340	Gastonia	Gaston
19. Grace Hospital	161	Morganton	Burke
20. High Point Regional Hospital	318	High Point	Guilford
21. Lenoir Memorial Hospital	247	Kinston	Lenoir
22. Maria Parham Hospital	100	Hendersonville	Vance
23. Memorial Hospital of Alamance	139	Burlington	Alamance
24. Memorial Mission Medical Center	392	Asheville	Buncombe
25. Mercy Hospital	371	Charlotte	Mecklenburg
26. Moore Regional Hospital	302	Pinehurst	Moore
27. Park Ridge Hospital	103	Fletcher	Henderson
28. Randolph Hospital	145	Asheboro	Randolph
29. Rex Hospital	394	Raleigh	Wake
30. Roanoke-Chowan Hospital	106	Ahoskie	Hertford
31. Rowan Memorial Hospital	315	Salisbury	Rowan
32. Scotland Memorial Hospital	125	Laurinburg	Scotland
33. Southeastern General Hospital	299	Lumberton	Robeson

—continued

Table 4.5: Medium-Sized (100 or More Beds But Less Than 400 Beds) General Acute Care N.C. Hospitals (62), 1985, By Ownership Type, *continued*

	Bed Complement	Location	
		City	County
34. St. Joseph's Hospital	283	Asheville	Buncombe
35. Stanly Memorial Hospital	130	Albemarle	Stanley
36. Transylvania Community Hospital	104	Brevard	Transylvania
37. Union Memorial Hospital	160	Monroe	Union
38. Valdese General Hospital	134	Valdese	Burke
39. Wesley Long Community Hospital	341	Greensboro	Guilford
D. Public Hospitals: Owned and Managed by State or Local Governmental Bodies (23)			
40. Albemarle Hospital	205	Elizabeth City	Pasquotank
41. Beaufort County Hospital	151	Washington	Beaufort
42. Betsy Johnson Memorial Hospital	117	Dunn	Harnett
43. Carteret General Hospital	117	Morehead City	Carteret
44. Catawba Memorial Hospital	260	Hickory	Catawba
45. Cleveland Memorial Hospital	300	Shelby	Cleveland
46. Columbus County Hospital	166	Whiteville	Columbus
47. Craven County Hospital [4]	238	New Bern	Craven
48. Halifax Memorial Hospital	190	Roanoke-Rapids	Halifax
49. Haywood County Hospital	200	Clyde	Haywood
50. Iredell Memorial Hospital	182	Statesville	Iredell
51. Kings Mountain Hospital	102	Kings Mountain	Cleveland
52. Lincoln County Hospital	110	Lincolnton	Lincoln
53. Margaret R. Pardee Memorial Hospital	233	Hendersonville	Henderson
54. Nash General Hospital	282	Rocky Mount	Nash
55. Northern Hospital of Surry County	108	Mount Airy	Surry
56. Onslow Memorial Hospital	150	Jacksonville	Onslow
57. Sampson County Memorial Hospital	146	Clinton	Sampson
58. University Memorial Hospital	130	Charlotte	Mecklenburg
59. Watauga County Hospital	141	Boone	Watauga
60. Wayne Memorial Hospital	333	Goldsboro	Wayne
61. Wilkes General Hospital	133	North Wilkesboro	Wilkes
62. Wilson Memorial Hospital	277	Wilson	Wilson

[1] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

[2] Medical Park Hospital was purchased by Carolina Medicorp in 1986 and is now a private, not-for-profit hospital. Medical Park Hospital has been managed by Hospital Corporation of America since 1984.

[3] Lowrance Hospital was renamed Lake Norman Regional Medical Center in 1987 and was purchased by Health Management Associates in 1986.

[4] Craven County Hospital was renamed Craven Regional Medical Center in 1988.

—Based on the State Center for Health Statistics' *Health Facilities Data Book, 1985*, and original research by the N.C. Center for Public Policy Research.

Table 4.6: Large (More Than 400 Beds) General Acute Care N.C. Hospitals (13), 1985, By Ownership Type

	Bed Complement	Location	
		City	County
A. Hospitals Managed by Investor-Owned Corporations (1)			
1. Cape Fear Valley Medical Center *	492	Fayetteville	Cumberland
B. Hospitals Owned and Managed by Private, Not-For-Profit Corporations (5)			
2. Duke University Hospital	959	Durham	Durham
3. Forsyth Memorial Hospital	695	Winston-Salem	Forsyth
4. Moses H. Cone Memorial Hospital	468	Greensboro	Guilford
5. North Carolina Baptist Hospital	642	Winston-Salem	Forsyth
6. Presbyterian Hospital	524	Charlotte	Mecklenburg
C. Public Hospitals: Owned and Managed by State or Local Governmental Bodies (7)			
7. Cabarrus Memorial Hospital	457	Concord	Cabarrus
8. Charlotte Memorial Hospital and Medical Center	777	Charlotte	Mecklenburg
9. Durham County General Hospital	481	Durham	Durham
10. New Hanover Memorial Hospital	420	Wilmington	New Hanover
11. North Carolina Memorial Hospital	576	Chapel Hill	Orange
12. Pitt County Memorial Hospital	560	Greenville	Pitt
13. Wake Medical Center	513	Raleigh	Wake

* Cape Fear Valley Medical Center's management contract with National Medical Enterprises ended in September of 1985. It is currently managed by SunHealth Enterprises, Inc., a subsidiary of SunHealth Corporation, which is an alliance of not-for-profit hospitals.

— Based on the State Center for Health Statistics' *Health Facilities Data Book, 1985*, and original research by the N.C. Center for Public Policy Research.

Findings

TABLES 4.8 and 4.11 summarize the Center's findings on the range of services at medium-sized and small for-profit and not-for-profit hospitals in North Carolina. The findings for medium-sized hospitals (Table 4.8) are presented first because that category had the largest number of hospitals. The first three columns of these tables pertain to *hospitals involved with investor-owned corporations* and the percentage of hospitals in these categories that have the 22 services selected for this analysis. The first column shows the percentage of hospitals **owned** by investor-owned corporations that offer each service; the second column shows the percentages of hospitals **managed** (and **leased** in the small category only) by investor-owned corporations that offer each service; the third column lists the percentages for the **for-profit-owned and -managed groups combined.**

The percentages in the next three columns of these tables pertain to the service offerings at *not-for-profit hospitals.* The fourth column is for hospitals owned and operated by **private** not-for-profit corporations; the fifth column is for all **public** hospitals; the sixth column is for these two groups, or all **not-for-profit hospitals combined.** The last column (7) in

Table 4.8 lists the percentage of hospitals with a service for *all* of the medium-sized hospitals in North Carolina; in Table 4.11, the seventh column lists the average for *all* small hospitals combined. This column indicates the presence of each service for all hospitals of a certain size, without hospitals being separated by ownership type, which is also helpful for comparison purposes. The actual number of hospitals in each column is noted in parentheses under hospital type (N = #).

Before comparing the findings on the range of services at hospitals of different ownership types, it is helpful to make some general observations about some of the service offerings at all of the hospitals in this study, including the large N.C. hospitals. Similar to the Institute of Medicine's conclusions in *For-Profit Enterprise in Health Care* (see page 121 above), the N.C. Center found that there are a few services which it is possible to characterize as standard at all N.C. general acute care hospitals. Not surprisingly, all hospitals—regardless of size, ownership, or management type—offered general medicine and had a full- or part-time pharmacy. General surgery probably also can be labeled as standard, since 100% of all large and medium-sized hospitals, and 98% of the small hospitals indicated they offered this service. Only one private not-for-profit hospital—Highlands-Cashiers in Macon County—did not offer general surgery. Emergency room services were similarly universal at general hospitals. Only one investor-owned hospital, Medical Park, did not list emergency room service. (Medical Park is now a private not-for-profit hospital.) Since 99.2% of all hospitals did list it, emergency room service was considered a standard service in this analysis.

Table 4.7: Standard Services (7) at Medium-Sized N.C. Hospitals

	Percentage of all medium-sized hospitals with service
1. general medicine	100 %
2. general surgery	100
3. pharmacy	100
4. physical therapy	100
5. outpatient surgery	100
6. urology	98.4
7. emergency room	98.4

Hospital size is apparently an important factor in the provision of some services. Comparing column seven in Tables 4.8 and 4.11 clearly illustrates the importance of hospital size in the range of services a hospital can offer.

Because all of the medium-sized hospitals offered physical therapy compared to 88% of the small hospitals in North Carolina, it can be considered a standard service in the medium-sized category, but perhaps not in small hospitals. Outpatient surgery was also offered at all medium-sized hospitals, but not in all small hospitals. And because 61 of the 62 medium-sized hospitals offered urology (98.4%), it can be considered a standard service at those hospitals as well (see Table 4.7).

The presence of a neonatal intensive care unit (ICU) seemed to depend upon hospital size more than any other service. None of the 50 small hospitals had such a unit, and only a handful of medium-sized hospitals did—four of the 62 hospitals (one investor-owned and three private not-for-profits) for an average of 6.5% of all medium-sized hospitals. On the other hand, 10 of the 13 large hospitals, or 76.9%, had a neonatal ICU. In the past, the presence of a neonatal intensive care unit in some N.C. hospitals was dependent upon which hospitals were eligible for reimbursement funds from the state for indigent babies who needed such care. According to Dr. Richard Nugent, medical consultant to the Maternal and Child Care Section in the Division of Health Services in the N.C. Department of Human Resources, since this fund has been cut, the formal reason for which hospitals have units no longer exists. The presence of neonatal ICU in some N.C. hospitals, however, still reflects this policy.

Size was apparently a major factor in the provision of seven other services at N.C. hospitals as well. In each case, more medium-sized hospitals offered the service. Medium-sized hospitals were at least 30% more likely to offer cardiac ICU, cardiology, medical/surgical ICU, neurosurgery, pediatrics, psychiatry, and thoracic surgery than small hospitals. The percentage of large hospitals offering these services was even higher—100% offered medical/surgical ICU, neurosurgery, pediatrics, psychiatry, and thoracic surgery, while 92.3% of the large hospitals offered cardiac ICU and 76.9% offered cardiology. As James Bernstein, chief of the Health Resources Development Section in the Division of Facility Services explains, "This is because larger hospitals can more easily afford both the physicians and the technology necessary to offer specialized services."

1. Comparisons of the Range of Services at *Medium-Sized* Hospitals. Tables 4.7 and 4.8 show the Center's findings for medium-sized North Caro-

Table 4.8: Percentage of Hospitals With Certain Services at North Carolina's *Medium-Sized,* Non-Federal, General Acute Care Hospitals, 1985

	Hospital Type						
	(1) Owned by Investor Owned (I-O) Corp. (N=8)	(2) Managed by I-O Corp. (N=4)	(3) Investor-Owned and -Managed (N=12)	(4) Private Not-For-Profit (N=27)	(5) Public (N=23)	(6) All Not-For-Profit (N=50)	(7) All Medium-Sized Hospitals (N=62)
	Percentage of Hospitals With Service						
Inpatient Services							
1. Cardiac Intensive Care Unit	37.5%	0 %	25.0%	48.1%	60.9%	54.0%	48.4%
2. Cardiology[1]	62.5	25.0	50.0	59.3	47.8	54.0	53.2
3. Eye, Ear, Nose & Throat	75.0	75.0	75.0	96.3	95.7	96.0	91.9
4. General Medicine	100.0	100.0	100.0	100.0	100.0	100.0	100.0
5. General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0
6. Gynecology	75.0	100.0	83.3	100.0	95.7	98.0	95.2
7. Medical/Surgical Intensive Care Unit	100.0	100.0	100.0	92.6	87.0	90.0	91.9
8. Neonatal Intensive Care Unit	12.5	0	8.3	11.1	0	6.0	6.5
9. Neurosurgery	50.0*	0	33.3*	48.1*	17.4*	34.0*	33.9*
10. Newborn Nursery	50.0	100.0	66.7	92.6	100.0	96.0	90.3
11. Obstetrics[2]	50.0	100.0	66.7	92.6	100.0	96.0	90.3
12. Orthopedics	75.0	100.0	83.3	100.0	100.0*	100.0*	96.8*
13. Pediatrics	75.0*	100.0*	83.3*	96.3*	100.0*	98.0*	95.2*
14. Pharmacy (full- or part-time)[3]	100.0	100.0	100.0	100.0	100.0	100.0	100.0
15. Physical Therapy	100.0	100.0	100.0	100.0	100.0	100.0	100.0
16. Psychiatry	75.0*	75.0*	75.0*	63.0*	65.2*	64.0*	66.1*
17. Thoracic Surgery	50.0*	25.0*	41.7*	44.4*	34.8*	40.0*	40.3*
18. Urology	87.5*	100.0	91.7*	100.0	100.0*	100.0*	98.4*
Outpatient Services							
19. Emergency Room	87.5	100.0	91.7	100.0	100.0	100.0	98.4
20. Outpatient Clinic	75.0	75.0	75.0	44.4	43.5	44.0	50.0
21. Outpatient Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0
22. Psychiatric Outpatient[3]	0	50.0	16.7	18.5	17.4	18.0	17.7

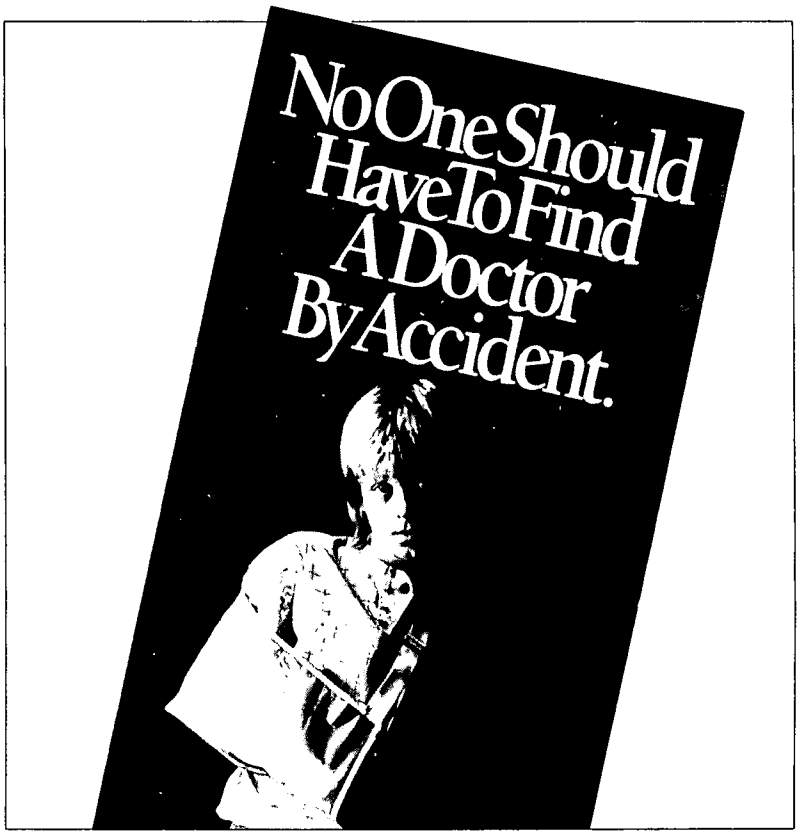
* There was an active staff person with this specialty at the hospital, and thus the service was considered to have been offered, although there were no beds in the unit or no utilization statistics listed for at least one hospital in this category.

[1] This service was considered to have been offered based solely on the presence of an active staff person with that specialty.

[2] A few hospitals had less than five births listed and no obstetrical unit or nursery beds, so the service was assumed to be offered only in emergency situations, and not considered offered for purposes of this analysis.

[3] Though the service was contracted out, it was considered offered by the hospital.

Source: State Center for Health Statistics, *Health Facilities Data Book, 1985*



lina hospitals—hospitals with bed complements of 100 or more beds but less than 400 beds. Of the 62 hospitals in this size category, eight were investor-owned, four were managed by investor-owned corporations, 27 were private not-for-profit, and 23 were public.

Table 4.7 shows that *all* medium-sized hospitals, regardless of ownership type, offered the standard services of general medicine, general surgery, pharmacy (full- or part-time), physical therapy, and outpatient surgery. As noted above, two other services—urology and emergency room services—were each offered by all but one of the medium-sized hospitals, bringing the total of standard services up to seven for this size category. These services are also listed in Table 4.8. The comparisons that follow, therefore, will only discuss the remaining 15 of the 22 service categories where differences in service offerings between hospital types were found. The Center first compared investor-owned and -managed hospitals *as a group* with *all* not-for-profits, both public and private (columns 3 vs. 6 in Table 4.8). The two groups of hospitals affiliated with investor-owned corporations were analyzed together because, as Biggs and others explained in their study, hospitals *managed* by investor-owned corporations have an incentive to cut costs similar to that of investor-*owned* hospitals which may affect service offerings.[25] Therefore, the comparisons that follow sometimes use the term "for-profit" to characterize both investor-owned and -managed hospitals as a group.

a. Medium-Sized Investor-Owned and -Managed vs.* All *Not-for-Profit Hospitals. Ten services were offered more frequently by medium-sized not-for-profits, public and private, than by investor-owned and -managed hospitals. The largest percentage difference was found in obstetrics and newborn nursery. Ninety-six percent of medium-sized not-for-profits, but only 66.7% of investor-owned and -managed hospitals, offered these two services. Cardiac ICU offerings also differed; 54% of the not-for-profits versus 25% of investor-owned and -managed had such a unit. Eye, ear, nose and throat* (EEN&T) services were offered by 96% of the not-for-profits versus 75% of the investor-owned and -managed hospitals. Orthopedics was offered by all of the not-for-profit hospitals compared to 83.3% of the for-profit hospitals. Gynecology and pediatrics were both offered by 98% of the not-for-profits and 83.3% of the for-profit hospitals. The percentage differences between hospital types were smallest for cardiology, psychiatric outpatient services, and neurosurgery.

In five categories, investor-owned and -managed hospitals offered the service more often than all not-for-profit medium-sized hospitals. The largest difference was in outpatient clinic services; 75% of for-profits compared to 44% of not-for-profits offered the service. Psychiatry was offered by 75% of for-profits versus 64% of not-for-profits. Medical/surgical ICU was offered by all of the for-profits, while 90% of not-for-profits had a unit. Very small differences were found for neonatal ICU and thoracic surgery. Table 4.9 summarizes these findings.

b. Medium-Sized Investor-owned and -Managed vs.* Private *Not-for-Profit Hospitals. Comparisons on the for-profit hospitals as a group versus *privately*

* According to Alice Hammond, assistant administrator for public affairs and planning at Randolph Hospital in Asheboro, EEN&T is an out-of-date specialty. Eye (ophthalmology) and ear, nose, and throat (otolaryngology) are currently recognized as two distinct specialties. However, because the 1985 *Health Facilities Data Book*—the data source for this chapter—lists them together, the Center used the classification EEN&T.

owned, not-for-profit hospitals in North Carolina (columns 3 vs. 4 in Table 4.8) produced similar results to the comparison of *all* not-for-profits except for two services. In addition to the 10 services offered more frequently by all not-for-profits than by for-profit hospitals, private not-for-profits also offered neonatal ICU and thoracic surgery more frequently than investor-owned and -managed hospitals. The differences for these two services, however, were small.

Table 4.9: Comparisons of Services Offered More Frequently by *Medium-Sized* For-Profit and Not-For-Profit N.C. Hospitals in 15 Non-Standard Services†
(Ranked in order of greatest percentage difference)

A. Services offered more frequently by all Medium-Sized Not-For-Profit Hospitals (10)

1. obstetrics
2. newborn nursery
3. cardiac ICU
4. eye, ear, nose, and throat (EEN&T)
5. orthopedics
6. gynecology
7. pediatrics
8. cardiology*
9. psychiatric outpatient*
10. neurosurgery*

B. Services offered more frequently by all Medium-Sized For-Profit Hospitals (5)

1. outpatient clinic
2. psychiatry
3. medical/surgical ICU*
4. neonatal ICU*
5. thoracic surgery*

† Non-standard services are those *not* offered by *all* medium-sized hospitals.
* Percentage difference between hospital types was 10% or less.

Accordingly, there were only three services offered more frequently by for-profit hospitals than by private not-for-profit hospitals. There were five—including neonatal ICU and thoracic surgery—when for-profits were compared with all not-for-profits.

c. Medium-Sized Investor-Owned and Managed vs. Public Hospitals. Comparing investor-owned and -managed hospitals with only *public* hospitals shows that the number of services offered more frequently by not-for-profit hospitals dropped from 10 to eight. (See columns 3 vs. 5 in Table 4.8.) Unlike the comparison between for-profit and private not-for-profits—where only three services were offered more frequently by for-profit hospitals—here, investor-owned and -managed hospitals offered seven services more frequently than public hospitals. These seven services were cardiology, medical/surgical ICU, neonatal ICU, neurosurgery, outpatient clinic, psychiatry, and thoracic surgery.

Because private not-for-profit and public hospitals each offered a broader range of services than for-profit hospitals, however, it follows that medium-sized not-for-profit hospitals as a group had a broader range of services than investor-owned and -managed hospitals of comparable size. Beyond the variations between private not-for-profit and public hospitals discussed above, there were eight services which each of these groups offered more frequently than for-profit hospitals: obstetrics, newborn nursery, cardiac ICU, EEN&T, orthopedics, gynecology, pediatrics, and psychiatric outpatient services.

It is also helpful to take a closer look at service offerings for each of the two groups of for-profit hospitals—those **owned** by an investor-owned corporation versus those **managed** by an investor-owned corporation (but owned by a private not-for-profit corporation or a governmental body). Comparing these two groups (columns 1 vs. 2 in Table 4.8) reveals that where the largest percentage differences were found

Table 4.10: Standard Services (4) at Small N.C. Hospitals

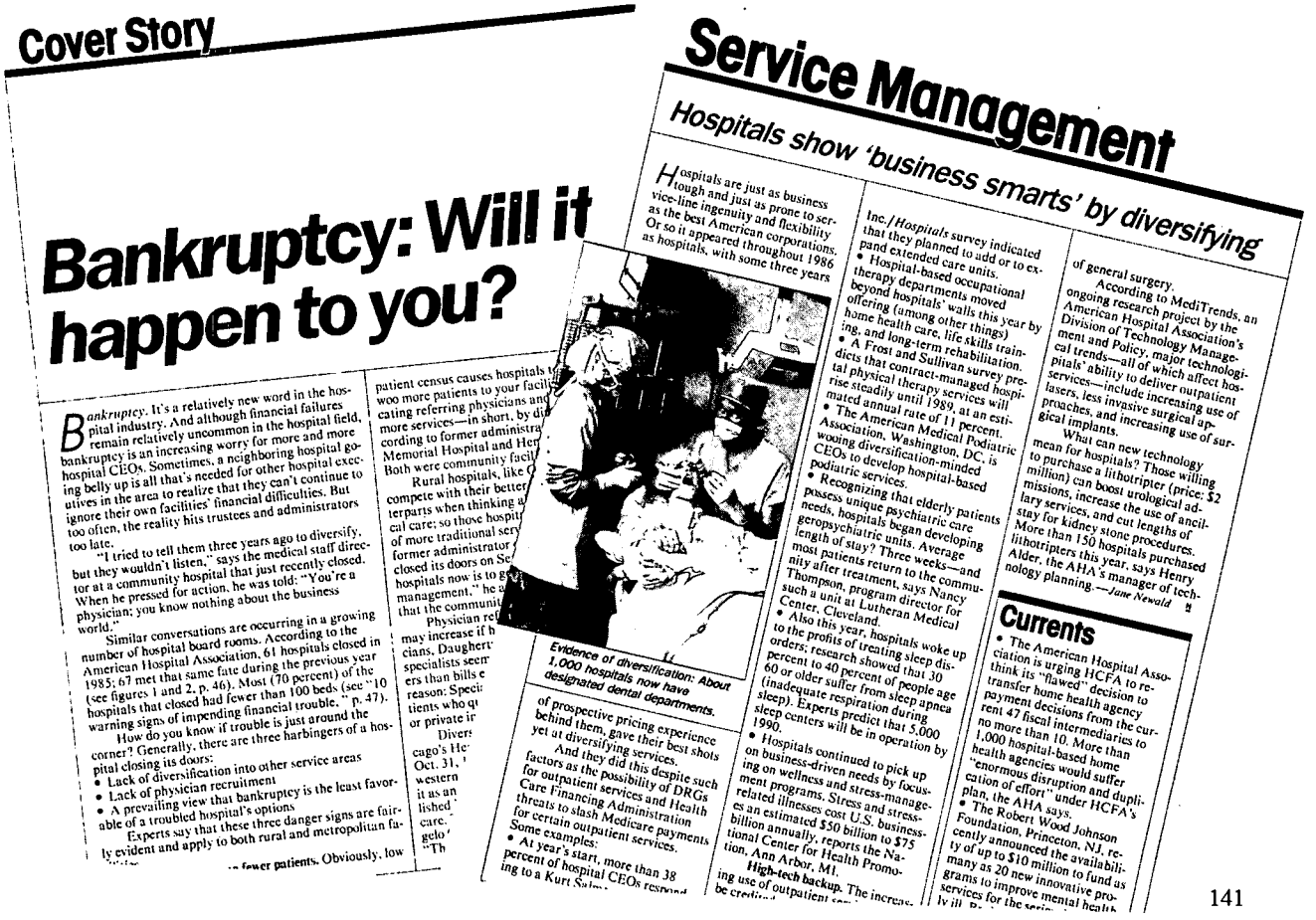
	Percentage of all small hospitals with service
1. general medicine	100 %
2. pharmacy	100
3. emergency room	100
4. general surgery	98

between all for-profits and not-for-profits—obstetrics and newborn nursery—investor-*owned* hospitals were less likely than investor-managed hospitals to have these services.

2. Comparisons of the Range of Services at *Small* N.C. Hospitals. Table 4.11 shows how the different types of small hospitals, where bed size is less than 100, compared on the 22 services offerings. The for-profit hospitals in this size category include investor-owned and -managed hospitals, as well as the one hospital leased by an investor-owned corporation in 1985. Column 7 in Table 4.11 shows that all small hospitals offered general medicine, pharmacy, and emergency room services, and all but one small hospital offered general surgery; these four services, therefore, were considered standard at small hospitals in North Carolina. Table 4.10 lists these standard services. Table 4.11 also shows that none of the small hospitals had neonatal ICU. The following comparisons, therefore, discuss the remaining 17 of the 22 service categories.

a. Small Investor-Owned, –Managed and –Leased vs.* All *Not-for-Profit Hospitals. Comparing columns 3 and 6 in Table 4.11, it is evident that in three service categories, the percentage of offerings by for-profit hospitals and all not-for-profits were exactly the same. Eighty percent of all investor-owned, -managed, and -leased hospitals and of all not-for-profits offered urology, 60% of both groups offered pediatrics, and 10% of both for-profits and not-for-profits offered cardiology.

Further comparisons of for-profit and not-for-profit hospitals reveal that small for-profit hospitals offered more services percentage-wise than small not-for-profit hospitals. *This is the opposite finding from what occurred when comparing medium-sized hospitals.* In the small hospital category, investor-owned, –managed, and –leased hospitals offered 11 of the 17 non-standard services more frequently than all not-for-profit hospitals. The percentage difference was largest in outpatient clinics—60% of for-profits versus 25% of the public and private not-for-profits had such a clinic. This finding is similar to that for medium-sized hospitals and may reflect an ability or desire on the part of for-profit hospitals in North Carolina to keep up with the recent trend toward outpatient services in health care. (See Chapter 1 for more on recent trends in the hospital industry.) The percentage differences were smaller for thoracic surgery, outpatient surgery, and cardiac ICU; twenty percent of for-profits versus 5% of the not-for-profits offered thoracic surgery, while 100% of for-profits offered outpatient surgery compared to 85% of not-for-profits, and 20% of for-profits—compared to 7.5% of not-for-profits—offered cardiac ICU. More for-



Cover Story

Bankruptcy: Will it happen to you?

Bankruptcy. It's a relatively new word in the hospital industry. And although financial failures remain relatively uncommon in the hospital field, bankruptcy is an increasing worry for more and more hospital CEOs. Sometimes, a neighboring hospital going belly up is all that's needed for other hospital executives in the area to realize that they can't continue to ignore their own facilities' financial difficulties. But too often, the reality hits trustees and administrators too late.

"I tried to tell them three years ago to diversify, but they wouldn't listen," says the medical staff director at a community hospital that just recently closed. When he pressed for action, he was told: "You're a physician; you know nothing about the business world."

Similar conversations are occurring in a growing number of hospital board rooms. According to the American Hospital Association, 61 hospitals closed in 1985; 67 met that same fate during the previous year (see figures 1 and 2, p. 46). Most (70 percent) of the hospitals that closed had fewer than 100 beds (see "10 warning signs of impending financial trouble," p. 47).

How do you know if trouble is just around the corner? Generally, there are three harbingers of a hospital closing its doors:

- Lack of diversification into other service areas
- Lack of physician recruitment
- A prevailing view that bankruptcy is the least favorable of a troubled hospital's options

Experts say that these three danger signs are fairly evident and apply to both rural and metropolitan fa-

...fewer patients. Obviously, low

patient census causes hospitals t... woo more patients to your facili... cating referring physicians and... more services—in short, by di... cording to former administra... Memorial Hospital and Her... Both were community facil...

Rural hospitals, like ... compete with their better... terparts when thinking a... cal care; so those hospit... of more traditional ser... former administrator ... closed its doors on Se... hospitals now is to g... management," he a... that the communit...

Physician re... may increase if h... cians. Daughert... specialists seem... ers than bills e... reason: Speci... tients who q... or private ir...

Divers... cago's He... Oct. 31, ' ... western ... it as an ... lished.' ... care.' ... gelo' ... "Th...

Service Management

Hospitals show 'business smarts' by diversifying

Hospitals are just as business tough and just as prone to service-line ingenuity and flexibility as the best American corporations. Or so it appeared throughout 1986 as hospitals, with some three years

Inc./*Hospitals* survey indicated that they planned to add or to expand extended care units.

- Hospital-based occupational therapy departments moved beyond hospitals' walls this year by offering (among other things) home health care, life skills training, and long-term rehabilitation.
- A Frost and Sullivan survey predicts that contract-managed hospital physical therapy services will rise steadily until 1989, at an estimated annual rate of 11 percent.
- The American Medical Podiatric Association, Washington, DC, is wooing diversification-minded CEOs to develop hospital-based podiatric services.
- Recognizing that elderly patients possess unique psychiatric care needs, hospitals began developing geropsychiatric units. Average length of stay? Three weeks—and most patients return to the community after treatment, says Nancy Thompson, program director for such a unit at Lutheran Medical Center, Cleveland.
- Also this year, hospitals woke up to the profits of treating sleep disorders; research showed that 30 percent to 40 percent of people age 60 or older suffer from sleep apnea (inadequate respiration during sleep). Experts predict that 5,000 sleep centers will be in operation by 1990.
- Hospitals continued to pick up on business-driven needs by focusing on wellness and stress-management programs. Stress and stress-related illnesses cost U.S. businesses an estimated $50 billion to $75 billion annually, reports the National Center for Health Promotion, Ann Arbor, MI.

High-tech backup. The increasing use of outpatient ...

Evidence of diversification: About 1,000 hospitals now have designated dental departments.

...of prospective pricing experience behind them, gave their best shots yet at diversifying services.

And they did this despite such factors as the possibility of DRGs for outpatient services and Health Care Financing Administration threats to slash Medicare payments for certain outpatient services. Some examples:

- At year's start, more than 38 percent of hospital CEOs respond... ing to a Kurt Sal...

of general surgery.

According to MediTrends, an ongoing research project by the American Hospital Association's Division of Technology Management and Policy, major technological trends—all of which affect hospitals' ability to deliver outpatient services—include increasing use of lasers, less invasive surgical approaches, and increasing use of surgical implants.

What can new technology mean for hospitals? Those willing to purchase a lithotripter (price: $2 million) can boost urological admissions, increase the use of ancillary services, and cut lengths of stay for kidney stone procedures. More than 150 hospitals purchased lithotripters this year, says Henry Alder, the AHA's manager of technology planning.—*Jane Newald*

Currents

- The American Hospital Association is urging HCFA to rethink its "flawed" decision to transfer home health agency payment decisions from the current 47 fiscal intermediaries to no more than 10. More than 1,000 hospital-based home health agencies would suffer "enormous disruption and duplication of effort" under HCFA's plan, the AHA says.
- The Robert Wood Johnson Foundation, Princeton, NJ, recently announced the availability of up to $10 million to fund as many as 20 new innovative programs to improve mental health services for the ...

Table 4.11: Percentage of Hospitals With Certain Services at North Carolina's *Small*, Non-Federal, General Acute Care Hospitals, 1985

	Hospital Type						
	(1) Owned by Investor Owned (I-O) Corp. (N=2)	(2) Managed and Leased by I-O Corp. (N=8)	(3) Investor-Owned, -Managed, and -Leased (N=10)	(4) Private Not-For-Profit (N=20)	(5) Public (N=20)	(6) All Not-For-Profit (N=40)	(7) All Small Hospitals (N=50)
	Percentage of Hospitals With Service						
Inpatient Services							
1. Cardiac Intensive Care Unit	0. %	25.0%	20.0%	5.0%	10.0%	7.5%	10.0%
2. Cardiology [1]	50.0	0	10.0	15.0	5.0	10.0	10.0
3. Eye, Ear, Nose & Throat	50.0*	62.5	60.0*	60.0	65.0	62.5	62.0*
4. General Medicine	100.0	100.0	100.0	100.0	100.0	100.0	100.0
5. General Surgery	100.0	100.0	100.0	95.0	100.0*	97.5*	98.0*
6. Gynecology	50.0*	75.0*	70.0*	80.0	85.0*	82.5*	80.0*
7. Medical/Surgical Intensive Care Unit	50.0	50.0	50.0	50.0	60.0	55.0	54.0
8. Neonatal Intensive Care Unit	0	0	0	0	0	0	0
9. Neurosurgery	50.0*	0	10.0*	5.0*	0	2.5*	4.0*
10. Newborn Nursery	0	100.0	80.0	80.0	70.0	75.0	76.0
11. Obstetrics[2]	0	100.0	80.0	75.0	65.0	70.0	72.0
12. Orthopedics	50.0*	87.5	80.0*	80.0*	65.0	72.5*	74.0*
13. Pediatrics	100.0	50.0*	60.0*	70.0*	50.0*	60.0*	60.0*
14. Pharmacy (full- or part-time)[3]	100.0	100.0	100.0	100.0	100.0	100.0	100.0
15. Physical Therapy	50.0	100.0	90.0	85.0	90.0	87.5	88.0
16. Psychiatry	50.0*	37.5*	40.0*	40.0*	20.0*	30.0*	32.0*
17. Thoracic Surgery	50.0*	0	20.0*	10.0*	0	5.0*	6.0*
18. Urology	50.0*	87.5*	80.0*	75.0	85.0*	80.0*	80.0*
Outpatient Services							
19. Emergency Room	100.0	100.0	100.0	100.0	100.0	100.0	100.0
20. Outpatient Clinic	0	75.0	60.0	20.0	30.0	25.0	32.0
21. Outpatient Surgery	100.0	100.0	100.0	75.0	95.0	85.0	88.0
22. Psychiatric Outpatient[3]	0	25.0	20.0	10.0	10.0	10.0	12.0

* There was an active staff person with this specialty at the hospital, and thus the service was considered to have been offered, although there were no beds in the unit or no utilization statistics listed for at least one hospital in this category.

[1] This service was considered to have been offered based solely on the presence of an active staff person with that specialty.

[2] A few hospitals had less than five births listed and no obstetrical unit or nursery beds, so the service was assumed to be offered only in emergency situations, and not considered offered for purposes of this analysis.

[3] Though the service was contracted out, it was considered offered by the hospital.

Source: State Center for Health Statistics, *Health Facilities Data Book, 1985*

profit hospitals than not-for-profits also offered neurosurgery, newborn nursery, obstetrics, orthopedics, physical therapy, psychiatry, and psychiatric outpatient services. The percentage differences between the two groups, however, were only 10% or less for each of these seven services.

Private not-for-profit and public hospitals as a group offered only three services—gynecology, medical/surgical ICU, and EEN&T—more frequently than the investor-owned, -managed or -leased hospitals in the small category, and the percentage differences were small. Table 4.12 summarizes the differences between investor-owned, -managed and -leased and all not-for-profit hospitals in service offerings.

Table 4.12: Comparisons of Services Offered More Frequently by *Small* For-Profit and Not-For-Profit N.C. Hospitals in 18 Non-Standard Services† *(Ranked in order of greatest percentage difference)*

A. Services offered more frequently by all Small For-Profit Hospitals (11)

1. outpatient clinic
2. thoracic surgery
3. outpatient surgery
4. cardiac ICU
5. obstetrics*
6. psychiatric outpatient*
7. psychiatry*
8. neurosurgery*
9. orthopedics*
10. newborn nursery*
11. physical therapy*

B. Services offered more frequently by all Small Not-For-Profit Hospitals (3)

1. gynecology
2. medical/surgical ICU*
3. eye, ear, nose, and throat (EEN&T)*

C. Services offered by same percentage of Small For-Profit and Not-for-Profit Hospitals (4)

1. urology (80%)
2. pediatrics (60%)
3. cardiology (10%)
4. neonatal ICU (0%)

† Non-standard services are those *not* offered by *all* small hospitals.

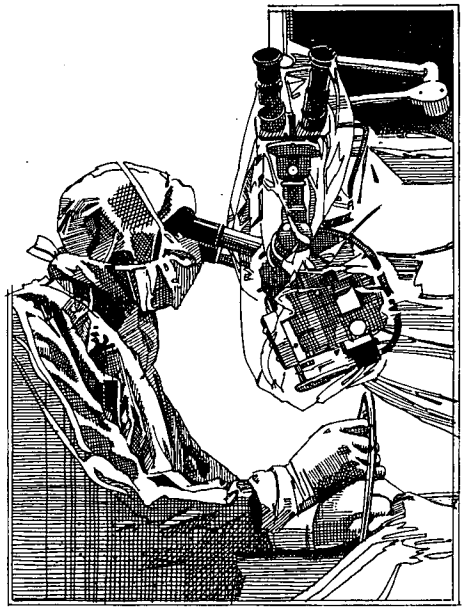
* Percentage difference between hospital types was 10% or less.

b. Small Investor-Owned, -Managed, and -Leased vs.* Private *Not-for-Profit Hospitals. Comparing columns 3 and 4 in Table 4.11 shows that besides the set of four standard services of general medicine, pharmacy, emergency room, and general surgery at small hospitals, for-profit hospitals and *private* not-for-profits offered five additional services with the same frequency: EEN&T (60%), medical/surgical ICU (50%), newborn nursery (80%), orthopedics (80%), and psychiatry (40%). And, as noted above, no small hospital offered neonatal ICU services.

Hospitals owned, managed, and leased by investor-owned corporations offered nine services—cardiac ICU, neurosurgery, obstetrics, physical therapy, thoracic surgery, urology, outpatient clinic, outpatient surgery, and psychiatric outpatient services—more frequently than *private* not-for-profits. The biggest differences were in outpatient clinics and outpatient surgery. Sixty percent of the for-profit hospitals offered outpatient clinics, but only 20% of private not-for-profits did, while all of the for-profits (compared to 75% of private not-for-profit hospitals) offered outpatient surgery. Cardiac ICU was offered at 20% of the investor-owned, -managed, and -leased hospitals, compared to only 5% of the private not-for-profits. For the remaining six categories—neurosurgery, obstetrics, physical therapy, thoracic surgery, urology, and psychiatric outpatient services—the differences between for-profits and private not-for-profits in frequency of offerings were small.

In only three categories—cardiology, gynecology, and pediatrics—did private not-for-profits offer services more frequently than investor-owned, -managed, and -leased hospitals, and these differences were small.

c. Small Investor-Owned, -Managed and -Leased vs.* Public *Hospitals. In addition to the four standard service categories at small N.C. hospitals noted above in Table 4.10, the same percentage of for-profit hospitals and *public* not-for-profit hospitals offered physical therapy (90%). (Compare columns 3 vs. 5 in Table 4.11.) No small hospital had neonatal ICU. Investor-owned, -managed, and -leased hospitals offered 12 services more frequently than public hospitals. Again, the largest difference was for outpatient clinics, which were present in 60% of the investor-owned, -managed, and -leased hospitals, but in only 30% of the public hospitals. Frequency of psy-



chiatry and thoracic surgery offerings also differed—40% of for-profit hospitals versus 20% of public hospitals offered psychiatry, while 20% of the for-profits but none of the public hospitals offered thoracic surgery. Obstetrics and orthopedics were both offered by 80% of the investor-owned, -managed, and -leased hospitals compared to 65% of the public hospitals. For-profit hospitals also offered cardiac ICU, neurosurgery, newborn nursery, pediatrics, psychiatric outpatient services, cardiology, and outpatient surgery more frequently than public hospitals, but the differences were small. Seven of these 12 services were also offered more frequently by for-profits when they were compared to private not-for-profit hospitals (comparing columns 3 vs. 4 in Table 4.11) above: cardiac ICU, neurosurgery, obstetrics, outpatient clinic, outpatient surgery, physical therapy, and psychiatric outpatient services.

On the other hand, small public hospitals offered four services—EEN&T, gynecology, medical/surgical ICU, and urology—more frequently than small for-profit hospitals (comparing columns 3 vs. 5). Like the comparisons with private not-for-profit hospitals, however, no large differences were found.

In summary, then, small for-profit hospitals overall had a broader range of services than comparable private not-for-profit and public hospitals. This is the opposite conclusion drawn from the N.C. Center's research on medium-sized hospitals. However, it should be noted that more for-profit hospitals are of medium size. And although obstetrics and newborn nursery were offered more frequently by for-profits in small hospitals, comparing investor-owned versus -managed and -leased (columns 1 vs. 2) reveals a finding similar to that in medium-sized hospitals. Investor-*owned* hospitals were less likely to offer obstetrics and newborn nursery than investor-*managed* hospitals. In fact, neither of the two small investor-owned hospitals offered these services, while each of the investor-managed and -leased hospitals did.

Conclusions

BASED ON ITS RESEARCH, the N.C. Center for Public Policy Research is able to make some general observations about the tendency of different North Carolina hospitals to offer particular services. The Center also gathered evidence about whether for-profit hospitals of medium or small size "skim the cream" by offering only the more profitable services. Some of the Center's findings were consistent with the conclusions of other studies and raise important points regarding access to services at N.C. hospitals.

1. **First, like the Institute of Medicine study, the Center did find a set of standard services at N.C. hospitals regardless of size or ownership status.** Not surprisingly, the N.C. Center found that *all* general acute care hospitals offered general medicine and pharmacy. General surgery and emergency room services were each offered at 124 of the 125 hospitals in the data set, and therefore could also be considered standard services.

2. **Some service offerings seemed to depend on hospital size more than ownership type or management status.** The most notable example in North Carolina was neonatal intensive care unit (ICU), which was offered at 10 of the 13 large hospitals (77%), but at only four of the 62 medium-sized hospitals (6.5%), and at none of the 50 small hospitals. Other examples of services where hospital size seemed to be a factor include physical therapy, outpatient surgery, and urology.

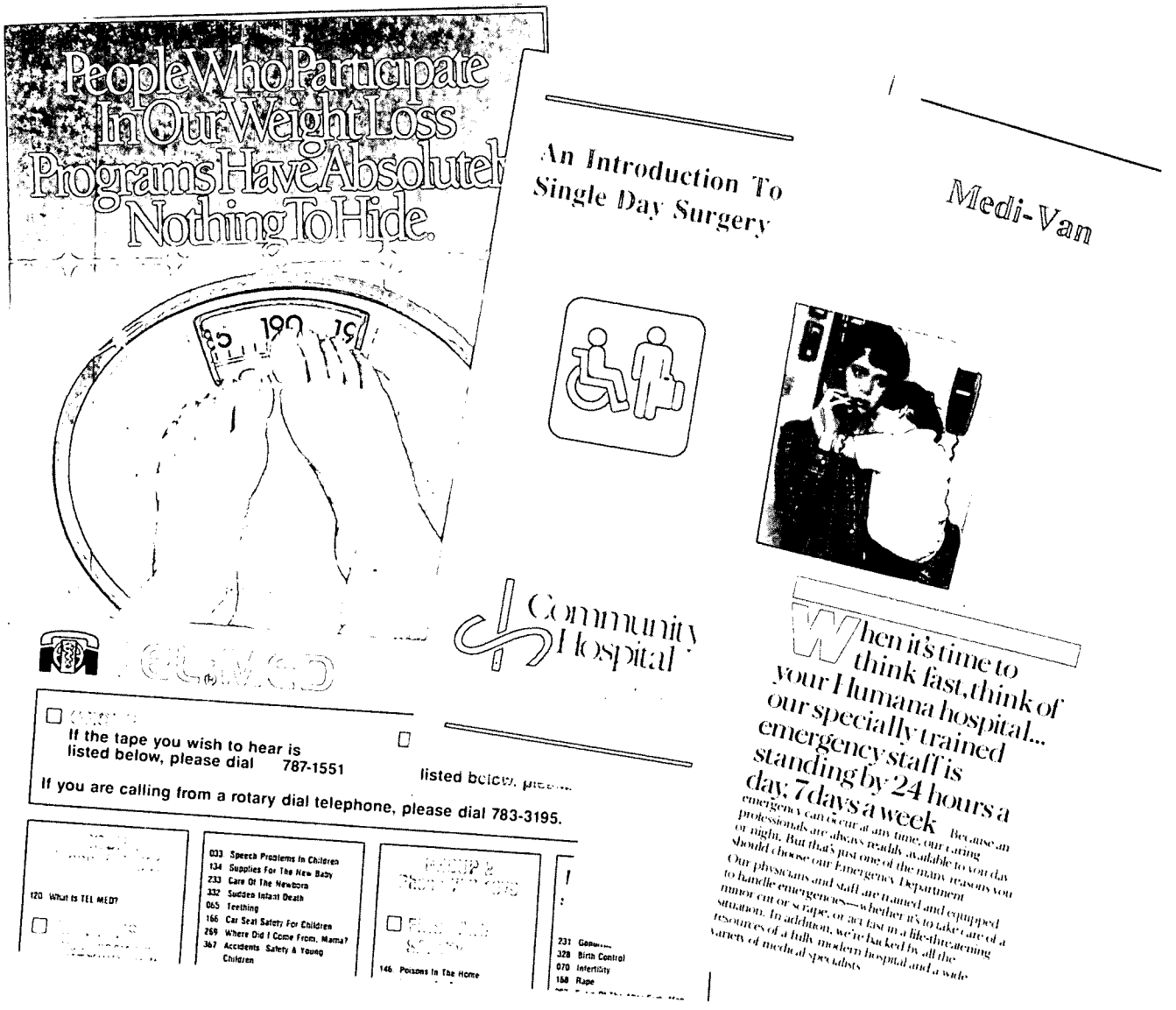
Unlike the Institute of Medicine report, physical therapy was not standard at N.C.'s small hospitals, because six of the 50 hospitals with less than 100 beds did not offer it. All medium-sized hospitals, however, did offer physical therapy. The same was true for outpatient surgery; all medium-sized hospitals offered it, but six small hospitals did not. Urology was also considered a standard service at medium-sized hospitals because all but one of the 62 hospitals in this category offered it. Medium-sized hospitals, therefore, had seven standard services, compared to only four at small hospitals.

3. As noted in the beginning of this chapter, the range of services at hospitals is often examined to see if for-profit hospitals skim the cream by offering only

the more profitable services and treating only patients who have insurance or are otherwise likely to be able to pay for services. The Center's findings on the tendency of for-profits to offer a narrower range of services or avoid unprofitable ones were mixed, depending on hospital size.

a. **Among *medium-sized* hospitals—the grouping which contains the largest number of hospitals in North Carolina—the findings indicate that *not-for-profit* hospitals had a *broader* range of services than for-profit hospitals.** Both private not-for-profit and public hospitals as a group offered 10 of the 15 non-standard services more frequently than the for-profit hospitals. The largest percentage differences were found for obstetrics and newborn nursery. Of the two types of for-profit hospitals in this analysis (owned vs. managed), investor-*owned* hospitals were less likely than investor-*managed* hospitals to offer these services.

Whether medium-sized for-profit hospitals skimmed the cream by failing to offer unprofitable services, however, is problematic. For example, while most analysts generally agree that emergency room and obstetrical services are unprofitable for a hospital, other factors need to be considered. As Alice Hammond of Randolph Hospital in Asheboro points out, "The emergency room is the portal of entry for 10-20% of inpatients. This is one illustration of how the emergency room is not a revenue loser in every case." Doctor George Barrett of Presbyterian Specialty Hospital agrees: "The emergency room feeds profitable services, which counterbalances the cost negatives to



a hospital." Moreover, only one acute care hospital in the state did not offer emergency room services—Medical Park in Winston-Salem. (Medical Park Hospital was an investor-owned hospital in 1985, but is now a private not-for-profit hospital managed by Hospital Corporation of America.) And because other large hospitals in the area—Forsyth Memorial and N.C. Baptist Hospital—have emergency rooms, the community does have access to those services.

A similar observation can be made concerning the fact that fewer medium-sized for-profit hospitals offered obstetrical and newborn nursery services. In Raleigh, for example, although Raleigh Community Hospital (owned by for-profit Hospital Corporation of America) does not have these services, Rex Hospital and Wake Medical Center, also in Raleigh, do offer them. It can be argued therefore, that the absence of these services at Raleigh Community Hospital does not necessarily signal a drawback, because the community does have access to them. And although it is usually a revenue-loser on a strict cost and charge basis, obstetrical care arguably *can* be a revenue winner in the long run. Barrett says that obstetrics help a hospital attract entire families as patients: "Parents bring their babies back, and when those babies grow up, they will go back to that same hospital."

b. **By contrast, at *small* hospitals, the Center found that *for-profit* hospitals offered a *broader* range of services than not-for-profit hospitals.** Investor-owned, -managed, and -leased hospitals offered 11 of the 17 non-standard services at small hospitals more frequently than all not-for-profit hospitals. In this case, the largest percentage differences were found for outpatient clinic services. Investor-*managed* hospitals offered this service more frequently than investor-*owned* hospitals.

Interestingly, small for-profit hospitals offered obstetrics and newborn nursery care more often than the not-for-profits, unlike the finding among medium-sized hospitals. However, neither of the two small investor-*owned* hospitals offered these generally unprofitable services, while each of the eight investor-*managed* or -*leased* hospitals did so. A closer look at these services, therefore, reveals a finding similar to that in medium-sized hospitals—investor-*managed* hospitals offered a broader range of services than investor-*owned* hospitals.

4. **In terms of targeting and attracting the best paying patients, additional research by the Center (see the sidebar on page 122) indicates that investor-owned corporations tend to purchase, build, or manage hospitals in wealthier and urban areas.** As a result, for-profits probably are making cross-subsidization of costly services at not-for-profit hospitals more difficult.

However, competition for paying patients among all hospitals is not just a result of investor-owned corporations getting involved in health care. Nor is the difficulty in cross-subsidization—financing more expensive services with higher prices on less costly services and financing indigent care with higher charges to paying patients—solely the result of increased competition. Alternative delivery systems, declining admissions and rates of occupancy, and the rapid rise in health care costs are other important players in this game. (See Chapter 1 for more on the difficulties facing all N.C. hospitals.)

5. While the Center's comparisons of the range of services between for-profit and not-for-profit medium-sized hospitals differed from a similar comparison among small hospitals, there were a few consistent differences which showed up on the scoreboard, regardless of hospital size. **In both small and medium-sized hospitals, for-profits offered outpatient clinics, psychiatry, and thoracic surgery more frequently than private and public not-for-profits, while not-for-profit hospitals offered gynecology and eye, ear, nose and throat (EEN&T) more frequently than for-profit hospitals.** Again, it is difficult to evaluate the profitability of various hospital services. However, as Robert Fitzgerald, assistant director of the Division of Facility Services in the N.C. Department of Human Resources points out, "Outpatient clinic, psychiatry, and thoracic surgery generally are profitable hospital services."

6. **Focusing only on *outpatient services*, the N.C. Center's research shows that *small* investor-owned, -managed, and -leased hospitals offered**

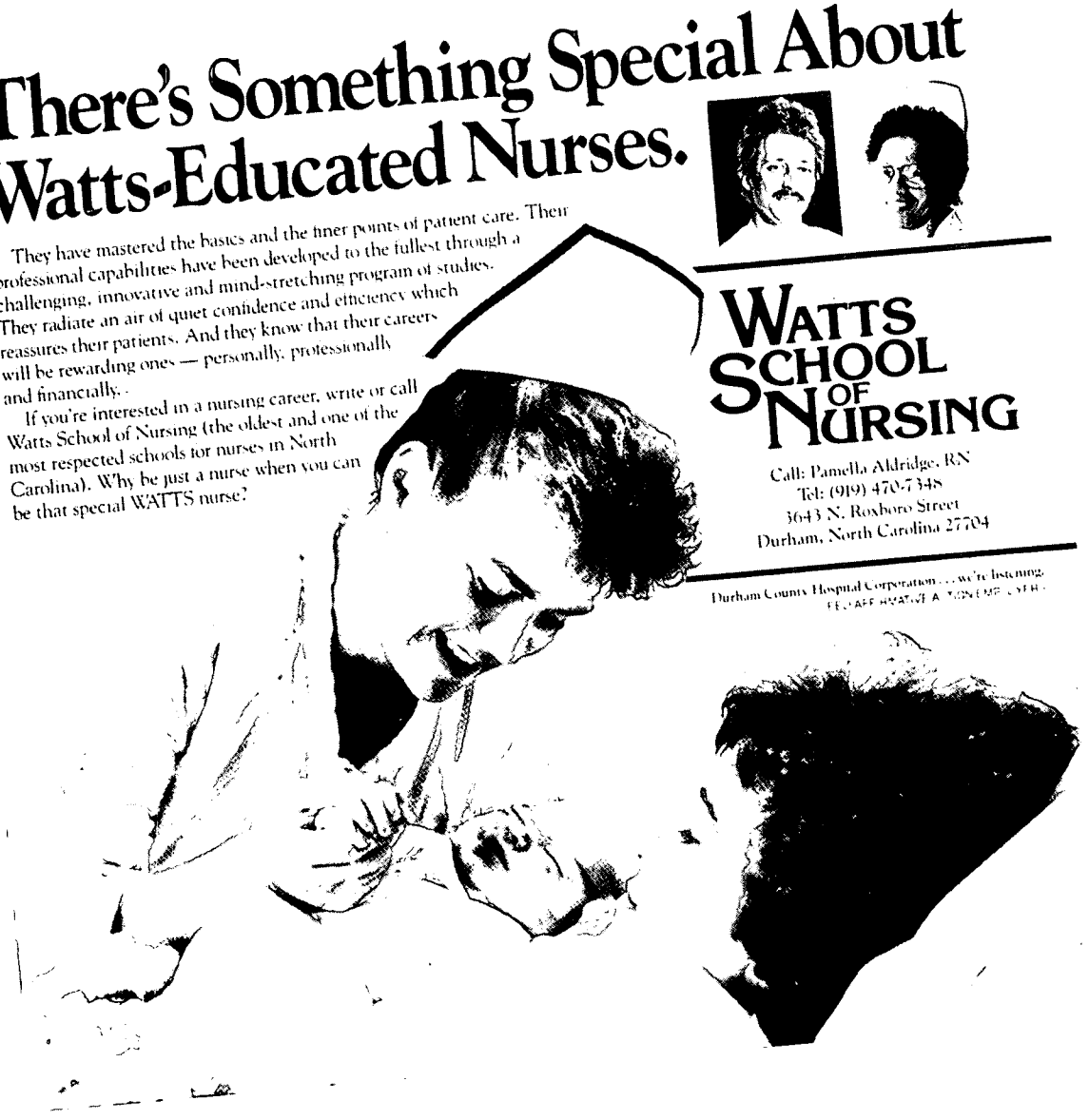
outpatient clinics, outpatient surgery, and psychiatric outpatient services more frequently than did private not-for-profit and public hospitals. All *medium-sized* hospitals offered outpatient surgery, but only outpatient clinic services were offered more frequently by investor-owned and -managed than by not-for-profit hospitals.

The fact that, overall, a higher percentage of for-profit hospitals offered outpatient services than not-for-profit hospitals in North Carolina is consistent with the Biggs' study's conclusion with respect to contract-managed hospitals. Biggs concluded that hospitals managed by investor-owned corporations offered a broader range of services in the outpatient area than traditionally managed not-for-profit hospitals.[26]

Recommendations

USING DATA FROM 1985 hospital licensure reports, this analysis focused on hospital services at one point in time. As a result, the Center was unable to determine if any hospital—whether for-profit or not-for-profit—had recently reduced or eliminated any services due to cost considerations, which is the chief concern of critics of for-profit hospitals. However, as the cost of health care is rising, both for-profits and not-for-profits may be forced to consider such a move in the future. Today's expensive, competitive health care market and restrictive government reimbursement policies compel all hospitals—public, private not-for-profit, and investor-owned alike—to become more cost-conscious and more marketing-oriented. This business orientation increases the chance that some services may be cut to save money.

It is important to note, too, that cost may not be the only reason a hospital might consider cutting a service. Alice Hammond points out that physician shortages, particularly in the obstetrics-gynecology field, are becoming an increasing problem for many hospitals. She says "It can't be done without the doctors. If they refuse to deliver the babies—and more are refusing all the time—the hospital can hardly ask the switchboard operator to do it."



Courtesy Durham County Hospital Corporation

Nursing shortages present a similar problem. Wake Medical Center, for example, was forced to temporarily close its pediatric intensive care beds late in 1987 until the number of nurses on the staff was stabilized. Moreover, the need for a hospital service may decrease over time because the population may not be large enough to support it. In such an instance, a hospital's level of proficiency in providing the service would be an important consideration. If a service was cut, it might be a drawback for those people who were forced to travel longer distances to a larger hospital which offered it. But as Dr. Barrett points out: "It may be inconvenient to travel to have a test done, but it's also inconvenient to have that complex test done sloppily." In addition, cutting a service used infrequently may actually save money for everyone—the hospital and the community.

The N.C. Center for Public Policy Research believes that those people affected by changes in a hospital service need to know if and when any hospital—not just those regulated by the Municipal Hospital Act (see sidebar on page 149)—plans to reduce or terminate a service. A public hearing, for example, would make citizens aware of the change and assess the impact on the community. In turn, the hospital may use the public hearing to seek community support for its decision to cut the service. In fact, by getting the word out that it can no longer offer obstetrics-gynecology due to a physician shortage, for example, the hospital may advertise its need to a doctor who could help remedy the situation by assisting with physician recruiting or expanding the hospital's resources to continue the service. As John Taft, administrator of Grace Hospital in Morganton stresses, if a hospital should decide to eliminate a service, it should have to "demonstrate that it has made a substantial effort to assure that availability and accessibility to that service will not be significantly compromised" in the community. Therefore, the N.C. Center proposes the following recommendations regarding the range of services at all hospitals in the state.

1. The N.C. Center recommends that a new article be added to the Health Care Facilities and Services Act, Chapter 131E of the N.C. General Statutes, requiring *any* hospital—public or private, not-for-profit or investor-owned—to give notice and hold a public hearing in any of the following instances:

a. If the hospital plans to *eliminate permanently or indefinitely* any health care service (as listed in the hospital licensure application);

b. If the hospital plans to *reduce permanently* the volume of a service to the extent that the hospital plans to deliberately limit its treatment to fewer patients than used the same service the year before; or

c. If a hospital has *temporarily eliminated or reduced* a service for more than 30 days. (If the hospital restores the service prior to the date of the public hearing, it should proceed with the hearing and explain the interruption in the service.)

At least 30 days prior to the hearing, the hospital should give notice by publication in one or more papers of general circulation in the area served by the hospital. Specific notice, by certified mail, should be given at least 15 days prior to the hearing to (1) the Health Care Facilities Section of the Division of Facilities Services in the Department of Human Resources, (2) the County Manager, and (3) all County Commissioners in the main counties served by the hospital. These requirements are similar to those governing all public rulemaking hearings under the N.C. Administrative Procedure Act in G.S. 150B-12. The Division of Facilities Services should be given the authority to monitor and enforce compliance with this proposed statute.

If a hospital's annual licensure report filed with the Division of Facility Services indicates that a service was cut by the hospital the previous year, and the hospital had failed to hold a hearing to inform the public in any of the above instances, the hospital should be fined. The public then should be notified by the local news media of the hospital's violation and the penalty invoked by the Division of Facility Services. County Commissioners should also be made aware by the Division of a hospital's failure to inform them and the public of a change in service availability.

Under this recommendation, the N.C. Center does not intend to force every hospital in the state to offer every service. That would not be realistic, for as the findings in North Carolina illustrate, service offerings differ not only among hospitals of different ownership type, but among hospitals of different sizes as well.

As mentioned above, there is already a law on the books which governs services at some N.C. hospitals. But this law, known as the Municipal Hospital Act, has three limits. First, it only regulates medical-surgery, obstetrics, pediatrics, outpatient, and emergency services at public hospitals sold or leased to *for-profit* corporations after July 1, 1984. (As of this writing, only three of North Carolina's 71 public general acute care hospitals have been affected by the 1984 amendments to the act.) It does *not* regulate those services at public hospitals sold or leased to *nonprofit* corporations.

Second, the act does not specifically address a reduction in the level of these five services — only their termination.

Third, there are no rules governing termination of the services in the few cases where the statute does apply. Despite a legislative mandate to develop rules

in N.C.G.S. 131E-13(a)(l), the Department of Human Resources has not promulgated rules to govern termination of services "to guarantee public participation." (See sidebar below for more on the Municipal Hospital Act.) As a result, the N.C. Center makes the following recommendation.

2. The N.C. Center for Public Policy Research recommends that the Division of Facility Services in the N.C. Department of Human Resources promulgate rules governing termination of services when a municipality or hospital authority is selling, leasing, or conveying a hospital to a for-profit corporation in order to comply with the legislative mandate under N.C.G.S. 131-13(a)(l). If the General Assembly enacts recommendation #1 above, that would obviate the need for the Department to implement this recommendation.

It is clear that hospitals are facing financial and staffing challenges which may affect the delivery of some services. The N.C. Center's recommendations, therefore, are intended as insurance that the public will be informed of any such changes in the range of hospital services as the health care industry continues to evolve.

FOOTNOTES

[1] Elizabeth M. "Lacy" Maddox, ed., *The Investor-Owned Hospital Movement in North Carolina* (Raleigh, NC: The North Carolina Center for Public Policy Research, 1986), pp. 14-16.

[2] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), pp. 157-159.

[3] *Ibid.*, p. 145.

[4] *Ibid.*

[5] *Ibid.*, p. 169.

[6] *Ibid.*, p. 146.

[7] *Ibid.*

[8] *Ibid.*, p. 171.

[9] *Ibid.*, p. 172.

[10] *Ibid.*, p. 177.

[11] *Ibid.*

[12] Arnold S. Relman, "The New Medical-Industrial Complex," *The New England Journal of Medicine*, Vol. 303 (October 1980), p. 968.

[13] Dan W. Brock and Allen Buchanan, "Ethical Issues in For-Profit Health Care," *For-Profit Enterprise in Health Care* (Washington, DC: Institute of Medicine, National Academy Press, 1986), p. 225.

[14] *Ibid.*, pp. 225-227.

[15] "Access to Care and Investor-Owned Providers," *For-Profit Enterprise in Health Care*, p. 107.

—continued on page 153

THE NORTH CAROLINA MUNICIPAL HOSPITAL ACT'S LIMITED EFFECT ON HOSPITAL SERVICES

by Melissa Jones

NORTH CAROLINA'S MUNICIPAL HOSPITAL ACT governs the range of services to some extent at hospitals in the state, but the law has its limits. In 1983, the General Assembly set out to give public hospitals leeway to cope with growing financial strains. While legislators allowed a municipal hospital* to enter a management contract, lease, or sale agreement with *nonprofit* companies, they insisted that the hospital continue to serve the general community, including indigent patients.

Proposals permitting the lease or sale of public hospitals to *for-profit* firms, however, sparked a heated debate within the joint Senate and House subcommittee drafting the legislation in 1983. Some legislators voiced concern that investor-owned hos-

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*Municipal hospitals are defined as those owned by counties, cities, other local governments, or hospital districts. Hospital authorities are also regulated in the statute, N.C.G.S. 131E-5 – 14.

pitals might eliminate services or reduce indigent patients' access to health care.[1] Because of such fears and because of a lack of information at that time on the investor-owned hospital movement in the state, legislators enacted a moratorium on the sale of public hospitals to investor-owned corporations for the first six months of 1984.[2] This same legislation limited leases of public hospitals to such firms to a 10 year period and required any hospitals that were leased to remain open to the public and admit Medicare and Medicaid patients.

North Carolina was the first state in the nation to impose such a moratorium, but the investor-owned corporations already in North Carolina expressed little concern. An official of Hospital Corporation of America explained that municipal hospitals did not represent "a substantial market" for investor-owned firms seeking to expand their holdings in North Carolina. Royce Diener, then Chief Executive Officer of American Medical International, another for-profit hospital corporation, also argued against the moratorium, asserting that "a truly comprehensive, factual

Hospitals That Have Been Subject to the 1984 Amendments to North Carolina's Municipal Hospital Act (N.C.G.S. 131E-13 and -14)*

Hospital	City	County	Affiliated with Investor-Owned (I-O) or Private Not-For-Profit (PFNP) Corporation	Owned (O) or Leased (L) by Corporation	Date of Most Recent Sale or Lease of Public Hospital to I-O or PFNP Corporation	Applicable to All Public Hospitals Sold or Leased After 7/1/84: Public Notice Requirements Under §131E-13(d) and -14	Applicable Only When Public Hospital Sold or Leased to a *For-Profit Corp.* After 7/1/84: Range of Services, Indigent Access, and Annual Reporting Requirements Under §131E-13(a)
1. Alamance County Hospital	Burlington	Alamance	PNFP	O	1986	yes	N/A**
2. Alamance Memorial Hospital	Burlington	Alamance	PNFP	O	1986	yes	N/A**
3. Franklin Memorial Hospital	Louisburg	Franklin	I-O	O	1986	yes	yes
4. Hamlet Hospital	Hamlet	Richmond	I-O	L	1987	yes	yes
5. Lake Norman Regional Medical Center	Mooresville	Iredell	I-O	O	1986	yes	yes

* The Municipal Hospital Act mandates that after July 1, 1984, municipalities and hospital authorities must hold public hearings before selling or leasing hospitals to for-profit or nonprofit corporations. However, the act regulates services only at those public hospitals purchased or leased by *for-profit* corporations after that date; it does not regulate services at public hospitals purchased or leased by *nonprofit* corporations.

** Alamance County Hospital and Alamance Memorial Hospital are owned by Alamance Health Services, a private, *not-for-profit* parent holding company, and therefore are subject only to the public notice provisions in the statute.

Source: Original research by N. C. Center for Public Policy Research staff.

and objective study" would show the for-profit hospital industry's "substantial health care and economic benefits" for the state.[3] Privately, representatives of the for-profit hospitals told the N.C. Center in 1983 that they thought the legislation violated the guarantees in the state and federal Constitutions of "equal protection under the laws," but that they would not challenge the moratorium in court unless the legislature extended it beyond the six-month period.

As the executives of investor-owned firms predicted, the General Assembly did allow the moratorium to expire on June 30, 1984, upon the recommendation of the Legislative Research Commission on Public Health Facilities. However, the legislative study committee also recommended amendments to the Municipal Hospital Act which were designed to safeguard the public interest when investor-owned corporations purchased a public hospital.

The act's 1984 amendments outline extensive requirements for public hearings and state government consultations surrounding the sale or lease of a public hospital to both investor-owned or private nonprofit corporations. They mandate that the municipality or hospital authority consider how the change might affect hospital prices, services, and access to care for people who are poor, have handicaps, or belong to racial minorities. And in the case of for-profit corporations only, the hospitals must compile annual reports following a sale or lease showing compliance with these conditions. If a for-profit hospital fails to abide by the law, its ownership reverts to the municipality or hospital authority which sold or leased it. Just five public hospitals were subject to the act's public hearings requirements when the sale or lease was proposed—Alamance County Hospital, Alamance Memorial Hospital, Franklin Memorial Hospital, Hamlet Hospital, and Lake Norman Regional Medical Center (formerly Lowrance Hospital).

Designed to maintain a consistent level of hospital services, the 1984 amendments to the Municipal Hospital Act require that for-profit corporations "provide the same or similar clinical hospital services . . . that the hospital provided prior to the lease, sale, or conveyance" in the following areas: medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, and emergency services for the indigent.[4] According to the statute, these services can be terminated only in one of two ways. One way is through an application for a change in services under the state Certificate of Need (CON) Law.[5] If that law does not apply, services may be terminated after a review guaranteeing public involvement as outlined in rules of the state Department of Human Resources.

There are, however, three areas where the Municipal Hospital Act falls short in its requirement of a certain set of services. First, the services named above are not regulated when a public hospital is sold or leased to a *nonprofit* corporation. At present, therefore, only three hospitals have come under the act's requirements about services—Franklin Memorial Hospital, Hamlet Hospital, and Lake Norman Regional Medical Center. (See table on facing page.)

Second, the act does not specifically address a *reduction* in the *level* of these services—only their *termination*.

Third, although the General Assembly has assumed that the Department of Human Resources would adopt rules governing termination of services when a public hospital is sold or leased to a for-profit corporation, the Department has not done so. (N.C.G.S. 131E-13(a)(1) states: "These services may be terminated only as prescribed by Certificate of Need Law . . . or if Certificate of Need Law is inapplicable, by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Human Resources.") There are no rules affecting the three hospitals currently regulated under this part of the act, nor any public hospitals sold or leased to for-profit corporations in the future. The absence of such rules is particularly troublesome since the Certificate of Need Law was amended in 1987.[6] As attorney William Shenton explained to a conference of N.C. health care lawyers in November 1987:

> At present, due to amendments to the Certificate of Need Law during the 1987 General Assembly, terminations of services are no longer subject to certificate of need review, so there is no certificate of need mechanism for the review and approval of the reduction or elimination of a service. As best as now can be determined, no parallel procedure has ever been adopted in the rules of the Department of Human Resources.[7]

Thus, at those few hospitals where the Municipal Hospital Act would mandate the same or similar clinical services, there is no mechanism to enforce its provisions regarding services because the Department has not promulgated rules.

It is possible that more hospitals could come under the Municipal Hospital Act's requirements governing services if there were sales of public hospitals to for-profit corporations in the future. As

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Public Hospitals in North Carolina *Managed* by Private Multi-Hospital Corporations Which Are *Not* Subject to 1984 Amendments to the N.C. Municipal Hospital Act's Provisions on Maintaining Services, 1988 (13)*

	Hospital	City	County	Management Corporation: Investor-Owned (I-O) or SunHealth (SH)**
1.	Angel Community Hospital	Franklin	Macon	HCA (I-O)
2.	Anson County Hospital	Wadesboro	Anson	SH
3.	Beaufort County Hospital	Washington	Beaufort	SH
4.	Bertie County Memorial Hospital	Windsor	Bertie	FHI (I-O)
5.	Cape Fear Valley Medical Center	Fayetteville	Cumberland	SH
6.	Chowan Hospital	Edenton	Chowan	SH
7.	District Memorial Hospital	Andrews	Cherokee	HCA (I-O)
8.	Granville Medical Center	Oxford	Granville	HMP (I-O)
9.	Hoots Memorial Hospital	Yadkinville	Yadkin	HCA (I-O)
10.	Johnston Memorial Hospital	Smithfield	Johnston	HCA (I-O)
11.	The McDowell Hospital	Marion	McDowell	DG (I-O)
12.	Martin General Hospital	Williamston	Martin	SH
13.	St. Luke's Hospital	Columbus	Polk	SH

* Table does not include N.C. public hospitals with only psychiatric units managed by a multi-hospital corporation.
** SunHealth Enterprises Inc. is a subsidiary of SunHealth Corporation, the holding company for a partnership of not-for-profit hospitals based in Charlotte.

Full Names for the Corporations:
DG ..... The Delta Group, Inc.
FHI ..... Forum Health Investors
HCA ..... Hospital Corporation of America
HMP ..... Hospital Management Professionals Inc.

Source: Original research by N.C. Center for Public Policy Research staff.

explained in the N.C. Center for Public Policy Research's 1986 report, most of the existing investor-owned hospitals in the state have *always* been for-profit facilities, because they were built by the current for-profit owner or purchased from a group of doctors or other proprietary organization.[8] And the law does not, as presently written, apply to hospitals purchased by corporations prior to the passage of amendments to the Municipal Hospital Act in 1984—hospitals such as Central Carolina Hospital in Sanford, bought by American Medical International in 1980. However, the N.C. Center's first report also noted that the investor-owned hospital movement can grow further within the state only if for-profit corporations purchase public or private not-for-profit hospitals.[9] And the legislative study committee on Public Health Facilities in 1984 found that many public hospitals in the state fit the profile of those typically bought by investor-owned corporations—"an aging institution with a substandard plant and equipment and a weak financial structure."[10] Such a trend might bring more public hospitals under the

law's coverage. Although legislators may have passed the Municipal Hospital Act in anticipation of a flurry of investor-owned takeovers of public hospitals—a change which thus far has not occurred—the law does not control services offered by the vast majority of North Carolina hospitals.

Even if local governments and hospital authorities decide not to sell or lease financially troubled hospitals in the future, they may try to find help through *management contracts*. The Municipal Hospital Act's provisions regarding the range of services, however, do not apply to the 13 (of North Carolina's 71) non-federal public hospitals *managed* by multi-hospital chains. (See table on page 152.) Currently, seven public hospitals are managed by investor-owned firms, and six are managed by SunHealth Enterprises Inc., a subsidiary of SunHealth Corporation, the holding company for a partnership of not-for-profit hospitals. (For more on SunHealth see page 22 in Chapter 1.) And although local government officials may exercise veto power over major changes proposed by the management firms they hire, these firms may seek to cut expenses at the public hospitals they run by eliminating or reducing the level of health care services available. The Municipal Hospital Act would not affect any such changes in services.

FOOTNOTES

[1]Legislative Research Commission, Committee on Public Health Facilities, Report to the 1983 General Assembly of North Carolina, 1984 Session, June 7, 1984, p. 6.

[2]Chapter 775 of the 1983 Session Laws, 1st Session.

[3]Linda Punch, "Public hospital buyouts blocked," *Modern Healthcare*, November 1983, p. 56.

[4]N.C.G.S. 131E-13(a)(1).

[5]N.C.G.S. 131E-175 – 191. The Certificate of Need (CON) Law mandates that health facilities get state approval before pursuing capital expenditures of $2 million or more or operating expenses of $1 million or more. The law is designed to avoid duplication of health care equipment and services in order to curb health care costs.

[6]Chapter 511 of the 1987 Session Laws, amending G.S. 131E-176(16)j., -181(b), and -183(a)(4).

[7]William R. Shenton, "A Brief Survey of North Carolina Licensure Considerations in Access," paper presented at the program *Access to Hospital Care: A Hospital Perspective* before the North Carolina Society of Health Care Attorneys, Chapel Hill, NC, November 6, 1987, p. 2.

[8]Elizabeth M. "Lacy" Maddox, ed., *The Investor-Owned Hospital Movement in North Carolina* (Raleigh, NC: North Carolina Center for Public Policy Research, 1986), p. 42.

[9]*Ibid.*

[10]Legislative Research Commission, Committee on Public Health Facilities, p. 17.

FOOTNOTES, *continued*

[16] *Ibid.*, pp. 107-109.

[17] Errol L. Biggs, John E. Kralewski, and Gordon D. Brown, "A Comparison of Contract Managed and Traditionally Managed Nonprofit Hospitals," *Medical Care*, Vol. 18 (June 1980), p. 586.

[18] Robert V. Pattison and Hallie M. Katz, "Investor-Owned and Not-For-Profit Hospitals," *Hospital Economics*, Vol. 309 (August 1983), pp. 347-353.

[19] Frank A. Sloan and Robert A. Vraciu, "Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues," *Health Affairs*, Vol. 2 (Spring 1983), pp. 25-37.

[20] Stephen M. Shortell et al., "The Effects of Hospital Ownership on Nontraditional Services," *Health Affairs*, Vol. 5, No. 4 (Winter 1986), pp. 97-111.

[21] Susan Nelson, "How much revenue does a physician bring in?," *Hospitals* (June 5, 1987), p. 56.

[22] Susan Nelson, "Hospital visits fewer but more costly: survey," *Hospitals* (July 5, 1987), pp. 58-59.

[23] Pattison and Katz, "Investor-Owned and Not-For-Profit Hospitals," p. 345.

[24] State Center for Health Statistics, Division of Facility Services, N.C. Department of Human Resources, *Health Facilities Data Book, 1985*.

[25] Biggs, Kralewski, and Brown, "A Comparison of Contract Managed and Traditionally Managed Nonprofit Hospitals," p. 586.

[26] *Ibid.*, p. 590.

CHAPTER 5

TAXES PAID AND CHARITABLE CONTRIBUTIONS RECEIVED: A COMPARISON OF FOR-PROFIT AND NOT-FOR-PROFIT HOSPITALS

by Lori Ann Harris and Ran Coble

Introduction

ONE OF THE MAIN ARGUMENTS in support of investor-owned hospitals is that they pay taxes. As for-profit organizations, investor-owned hospitals must pay local, state and federal taxes. At the same time, there are increasing concerns in Congress and at the state and local level that not-for-profit hospitals are not providing enough charity care. The debate over the tax-exempt status of not-for-profit hospitals has reached a critical point, as state and local governments are forced to assume more and more of the responsibilities traditionally handled by the federal government. It has also been suggested that the tax-exemption for not-for-profit hospitals gives them an unfair competitive advantage over for-profit institutions. Investor-owned hospitals must pay taxes on the expenditure side but are unable to receive income in the form of tax-deductible charitable contributions on the revenue side of the ledger. This chapter will examine the issues surrounding this debate. Here, the Center examines the amounts of taxes paid by for-profit hospitals and the question of whether those tax payments by for-profits offset the lesser amounts they spend on indigent care as found in Chapter 2. This chapter also contains the Center's findings on the level of charitable giving by foundations and corporations to hospitals in North Carolina.

The question of whether not-for-profit hospitals merit their tax-exempt status is being examined by Congress, state legislatures, and local governments. Today, there are more than 850,000 organizations which qualify for nonprofit status under section 501(c)(3) of the Internal Revenue Code (IRC). These nonprofit organizations pay no federal, state or local property taxes, state sales tax, or corporate income tax, resulting in savings of nearly $6 billion a year to the organizations.[1] According to the Internal Revenue Service, nonprofit organizations had total revenues in excess of $300 billion in 1985.[2] A large number of the tax-exempt organizations are health-related, charitable, educational, or religious in nature. Health-related organizations generated revenues equaling $108 billion (36%) of the $300 billion nonprofit total in 1985.[3]

In an effort to make up for the loss of federal funding due to congressional budget cuts and an expected decline in charitable contributions as a result of changes in the tax laws that went into effect in 1987, many nonprofit organizations, including hospitals, are expanding into money-making ventures. The for-profit sector has become increasingly concerned with this trend, arguing that nonprofit operations are gaining a competitive advantage over taxable businesses. John Motley, director of federal government relations for the National Federation of Independent Business (NFIB) has this to say:

> During the past few years, there has been a virtual explosion in the number of nonprofit organizations. An increasing number of those groups are competing with tax-paying businesses. The small-business community and chambers of commerce across the country see the government allowing this to happen, and they want to debate the direction the situation is going. They want to know whether this country is going to rely on private, for-profit free enterprise or allow more and more nonprofit business activity.[4]

The Advantages of Tax-Exempt Status

1. Exemption from Federal, State, and Local Taxes. Tax-exempt organizations including not-for-profit hospitals have many distinct advantages over their for-profit counterparts. One advantage is an exemption from taxes under Section 501(c)(3) of the Internal Revenue Code. This exemption allows nonprofits to devote more of their gross revenues to internal operations and expansion.[5] Tax-exempt organizations have other advantages over their for-profit counterparts. Among other tax advantages to not-for-profit hospitals are tax-exempt bond financing, lower postal rates, state appropriations, and access to foundation grants and other tax-deductible charitable contributions.

On the state and local level, not-for-profit hospitals benefit from a number of additional exemptions. Not-for-profit hospitals are exempt from state and local taxation, including property taxes, an important break for hospitals. Although each state and locality has different determining factors, property tax exemption may derive from constitutional, legislative, and/or regulatory grounds. Tax exemptions for hospitals on the state and local level have been challenged in recent years (see section on state legislation later in this chapter). Additionally, hospitals are exempt from state and local sales taxes (for hospital purchases) and corporate income taxes. County hospitals can qualify for an additional exemption. As organizations that perform an essential governmental function, county hospitals are exempt under Section 115 from even filing the IRS Form 990.[6] This form, called the Return of Organization Exempt From Income Tax, must be filed by other exempt organizations.

2. Tax-Exempt Bond Financing. Governmental, tax-exempt bond issues are a major source of financing for public and private not-for-profit hospitals' capital projects for construction, expansion, or renovation. Bonds issued by states, local governments, and public authorities to finance health care facilities are attractive to investors because the interest is exempt from federal income taxes. A hospital obtains a lower interest rate through the use of tax-exempt financing and the total cost of the project is less. Tax-exempt bond financing is more important than ever before. Public and private not-for-profit hospitals are unable to turn toward the federal Hill-Burton construction program for hospital construction, renovation, or expansion because the Hill-Burton program is now defunct, so they are going to the bond market instead. (For more on the Hill-Burton Act, see p. 42.)

Private not-for-profit hospitals also have access to tax-exempt bond financing. This financing mechanism enables not-for-profit hospitals to issue revenue bonds with lower interest rates, thereby increasing the marketability of the bonds. If the hospital is also in good financial shape, the bonds may receive a high rating (e.g., AA, A1), again lowering interest rates. The elimination of tax exemptions for not-for-profit hospitals would result in substantially higher financing costs for hospitals' capital projects. The long amortization periods and low interest rates they currently receive would no longer be available. A hospital, like any company, uses debt to finance future projects. When the net income drops, it reduces the hospital's ability to take on debt. Kenneth Kaufman, an Illinois financial adviser predicts that the loss of tax exemptions and the need for capital might force not-for-profit hospitals to seek for-profit status so that they might explore alternative financing sources, such as the sale of common stock.[7]

By contrast, investor-owned corporations issue corporate bonds, in addition to raising capital through the sale of shares of stock in their corporations. Corporate bonds are interest-bearing certificates, issued by a business, promising to pay the holder a specified sum on a specified day. Another financing method available to investor-owned companies for hospital construction is the state- or locally-sponsored industrial development bond. Industrial development bonds are tax-exempt bonds that are used to help bring private business to economically disadvantaged or under-served areas of a state. Although industrial development bonds are typically available to investor-owned hospitals across the country, they are not available to investor-owned hospitals in North Carolina.[8] In general then, *investor-owned* hospitals in North Carolina may be a bit more disadvantaged by the lack of access to tax-exempt bond financing in North Carolina.

3. Lower Postal Rates. Postal regulations grant reduced rates to nonprofit organizations that are organized and operated primarily for religious, educa-

tional, scientific, philanthropic, agricultural, labor, veteran, and fraternal purposes. Tax-exempt organizations thus have the advantage of mailing promotional literature at reduced rates. The activities of the nonprofit organizations which benefit from lower postal rates are often in direct competition with the activities of taxable businesses. While lower postal rates benefit nonprofit organizations, the savings are often small.

4. Eligibility for State Appropriations. Thanks to their tax status, not-for-profit hospitals also are eligible for state appropriations from the N.C. General Assembly. By contrast, the state cannot make appropriations to for-profit entities and still meet the constitutional test of a "public purpose" for such an appropriation.[9] In 1987, at least seven hospitals received legislative appropriations. North Carolina Memorial, a state-owned and -supported hospital, received $30.5 million for operating and general expenses. Pitt Hospital in Greenville received $9.2 million from the General Fund.[10] Hospitals also receive appropriations—commonly known as 'pork barrel' funds. Mercy Hospital in Charlotte received $5,000 for a restoration project. Robersonville Community Hospital in Robersonville was granted $5,000 to upgrade lab equipment, while Thoms Rehabilitation Hospital in Asheville got $2,500 for a head injury program. Person County Memorial Hospital in Roxboro received $16,000 for renovation of hospital facilities, and Pitt County Memorial Hospital in Greenville received $700 for a counseling education/emotional support program.[11]

5. Charitable Contributions from Foundations, Corporations, and Individuals. The 501(c)(3) designation is important to not-for-profit hospitals because it also provides access to additional sources of support such as tax-deductible gifts from foundations, corporations, and individuals. The Center's research on the extent of giving by foundations and corporations in North Carolina is reviewed later in this chapter. Some argue that recent changes in federal tax laws may lessen the amounts contributed to hospitals.

The Attack on Not-For-Profit Hospital Tax Exemptions: What Does It Mean?

THE DEBATE OVER THE TAX-EXEMPT STATUS of nonprofit organizations is due, at least in part, to efforts of not-for-profit hospitals to initiate new patient and non-patient services to generate additional revenue. In order to survive in an increasingly competitive health environment, hospitals are diversifying

into commercial services. Not-for-profit hospitals are developing outpatient services such as wellness and stress management programs, sleep disorder centers, home health care, and long-term rehabilitation. Other commercial ventures include pharmacies, helicopter and taxi services, interior decorating, laundries, and real estate development firms.[12] Hospitals which provide non-patient services pay property taxes on the income derived from these activities. Representatives of various for-profit health care entities attack the tax-exempt status, citing unfair competition from not-for-profit hospitals. They are urging Congress to review the law and recommend changes to limit unfair business activity.

Current law stipulates that a not-for-profit hospital must pay taxes on any net business income not "substantially related" to its charitable purpose. Income from unrelated profit-making activities are subject to an unrelated business income tax (UBIT). The law enacted in 1950 was designed to address the alleged unfair competition between for-profit businesses and not-for-profit organizations. Additionally, UBIT would prevent a potential loss in federal tax revenue if a tax-exempt organization were to purchase and operate a taxable business on a tax-free basis.

The UBIT legislation is set forth under Sections 511 through 514 of the Internal Revenue Code. Section 511 establishes a tax on unrelated business income; section 512 defines unrelated business taxable income; section 513 defines an unrelated trade or business; and section 514 discusses how income derived from debt-financed property should be handled. An activity is subject to unrelated business income tax if it meets the following criteria:

—It must be a trade or business. This includes any activity which produces income from the sale of goods or the performance of services.

—It must be regularly carried on. A trade or business is regularly carried on if the activity is as frequent or as continuous as it might be if conducted by a non-exempt taxable organization.

—It must not be substantially related to the organization's exempt purpose. A trade or business is considered substantially related if it contributes importantly to the accomplishment of the organization's exempt purpose.[13]

The language of the Internal Revenue Code often makes administration and enforcement of the regulations difficult. IRS officials agree that terms such as "substantially related" or "regularly carried on" are vague, subjective and difficult to define, leading to problems of interpretation. However, the IRS contends that despite the problems of vague definitions, its personnel strive to apply the interpretations on a consistent basis to each venture under study. Officials

of tax-exempt organizations are often confused about how to allocate portions of the organization's total expenses to unrelated business activities. Of the 850,000 tax-exempt groups in the United States, only 27,000 of them filed 990T forms to report unrelated business income exceeding the $1,000 threshold. The IRS has begun an audit of 3,000 tax-exempt groups which reported unrelated business income. They hope to gather data that would help them gauge the activities of tax-exempt groups and develop criteria to utilize when identifying tax returns for future audits.[14]

Congress has also begun a study of the business income of tax-exempt organizations. Changes are being considered in tax exemptions for hospitals because not-for-profit hospitals are setting up for-profit subsidiaries and competing directly with for-profit hospitals. Advocates for removing the tax exemption for hospitals say the nonprofits are engaging in "unfair competition," and they say that the not-for-profit hospitals are not doing enough indigent care.

Steven Simpson and Robert L. Wilson Jr., both attorneys in Raleigh, say those who complain of "unfair competition" have not defined the term "unfair competition." They argue, "These complaints generally refer only to the existence of 'competition' and do not attempt to define let alone quantify, the extent of alleged 'unfair competition'." Simpson and Wilson believe that the complaints are founded upon a fear of competition and not merely unfair competition. They go on to say, "Why it should be 'unfair' for a hospital to set up a taxable subsidiary in order to conduct a particular activity is not clear. It is simply a situation where two tax-paying entities compete. It would seem that in this situation, the competition would be 'fair' rather than 'unfair'."[15]

Many not-for-profit hospitals fear that Congress may limit the types of activities that are currently tax-exempt. A series of hearings were held in the spring of 1987 by a U.S. House of Representatives Ways and Means oversight subcommittee investigating the unrelated business income tax law. Rep. Fortney "Pete" Stark (D-California), chairman of the Subcommittee on Health, does not favor continued tax exemptions for not-for-profit hospitals. He says that not-for-profit hospitals provide little charity care when compared to the tax exemptions they receive.[16] "Some bad apples are using their tax-exempt status to compete with taxable entities," Stark adds, as he warns hospitals not to be "too outrageous in starting new lines of business."[17] Stark challenges not-for-profit hospitals to prove how their community services and charity care activities justify a tax-exempt status.

In May 1988, the Ways and Means oversight subcommittee recommended retaining two provisions used in the current tax laws to test whether an activity is tax-exempt—whether it is "substantially related" and "regularly carried on." The subcommittee had previously discussed replacing the "substantially related" test—which defines a nonprofit's business activity as tax-exempt if it contributes significantly to the accomplishment of the organization's exempt purpose—with a much more stringent "commerciality" or "directly related" test for business activities. The test would determine whether each income-producing activity standing alone is exempt. The subcommittee had also considered repealing the "regularly carried on" test—which exempts from taxation some "special event" fundraising activities not carried out on a regular basis. The subcommittee is expected to present its final UBIT proposal to the full House Ways and Means Committee in the spring of 1989.[18]

Even if there are no substantial changes in the federal tax law, tax exemption is an issue hospitals must face. Robert Taylor, an associate professor of health administration at Duke University, agrees, asserting that "for-profit hospitals are providing a lot of social benefit." He maintains that for-profit hospitals provide emergency room services, employ a great number of people, and provide a certain amount of free care to indigent patients. The differential in the social benefit provided by not-for-profit and for-profit hospitals is not as great as a lot of people might think, he adds. Taylor asks three questions: "Why shouldn't hospitals pay taxes? What do not-for-profit hospitals do that is unique? And why do we tax an HCA hospital making $8 million a year and not tax the not-for-profit hospital with the same bottom line?"[19] These questions often put hospital administrators in a difficult position.

Not-for-profit hospital executives defend the tax-exempt status, saying that not-for-profit hospitals not only provide a large amount of uncompensated care to indigent patients, but also a majority of the community health care. They believe that the claim that tax-exempt organizations are competing unfairly with the for-profit sector is a red herring used by those who advocate increased taxation of not-for-profit organizations' activities. They further defend the tax exemption because not-for-profit hospitals employ a lot of people and because not-for-profit hospitals have a charitable purpose as outlined in their mission statements. Not-for-profit hospitals also provide many specialty programs such as burn units and neonatal intensive care units, which unlike for-profit institutions, produce little if any revenue, according to Merlin K. Duval, former president of the American Healthcare Institute.[20] In order to ensure their survival and yet continue to provide charitable services, not-for-profit hospitals say they have been forced to find new ways to produce income. John Leech, a hospital trustee at Hillcrest Hospital in Mayfield Heights, Ohio, maintains that "any change in tax policy that would decrease the ability of these hospitals to engage in appropriate revenue-raising activities would undermine the competitive model of health care and the promise of continued high quality services."[21] Dan Bourque of Voluntary Hospitals of America summarizes the difference between for-profit and not-for-profit hospitals this way: "A not-for-profit hospital in financial trouble would find a way to stay in the community, while a for-profit hospital would close its doors and leave town."[22]

State Legislative, Executive and Judicial Actions

A. Challenging the Tax Status of Not-For-Profit Hospitals. At the state level, the tax-exempt status of hospitals is also beginning to draw attention. In 1987, at least 13 states considered changes in the tax-exempt status of not-for-profit hospitals. Several states established study commissions to look into the tax-exempt status for not-for-profit hospitals. In Georgia, the assembly considered but killed legislation to make property of not-for-profit hospitals subject to taxation.[23] Legislation to remove certain tax exemptions from not-for-profit hospitals has been introduced in California, Florida, Minnesota, Oklahoma, Pennsylvania, Utah, Washington, and West Virginia.

In an important legal opinion by the California Attorney General, "a not-for-profit hospital which had earned surplus revenue in excess of ten percent during the preceding fiscal year might still qualify for the welfare exemption from taxation" under the state's revenue and taxation code.[24] The opinion was re-

quested by Yuba County officials who taxed the 128-bed Rideout Memorial Hospital because of its high yearly revenues. Rideout Memorial in Marysville, paid a total of $305,000 in taxes for the 1986 and 1987 tax years.[25]

In 1986, the Florida legislature approved a five percent sales tax on *all* service industries. Under the initial legislation, hospital and physician services would be subject to the sales tax. The revenue raised would help finance indigent care. Revisions of the legislation later permitted hospitals and physicians to retain their tax exemption from state sales tax on services provided.[26] Pressured by intense opposition, including a large senior citizen population, the Florida legislature completely repealed the sales tax on services in 1987 and raised the five percent sales tax on goods to six percent.[27]

The Minnesota legislature is considering a proposal by Governor Rudy Perpich to levy the state's six percent sales tax on purchases by not-for-profit hospitals. Under current law, not-for-profit hospitals receive an exemption from sales tax payments. Additionally, the state House of Representatives is studying legislation that would impose property tax payments on not-for-profit hospitals.[28] More recently, a preliminary report by the Citizens League, a policy research group, recommended that Minnesota's not-for-profit organizations be required to pay taxes. The group has called for the abolition of all sales tax exemptions and a requirement that not-for-profit organizations pay a fee instead of property taxes.[29]

Oklahoma's governor proposed to remove the sales tax exemption on services provided by not-for-profit hospitals. The governor later withdrew the proposal, thereby enabling the hospitals to retain their sales tax exemption.[30]

A proposal in the Pennsylvania legislature has focused on restricting the unrelated business practices of not-for-profit organizations. Under Pennsylvania state law, not-for-profit organizations are exempt from taxation if they are "founded, maintained, and endowed as a purely public charity." In 1986, legislation was proposed that would levy a property tax on the holdings of not-for-profit groups, including hospitals. Other bills proposed during that year would restrict activities between not-for-profit organizations and for-profit subsidiaries.[31] During the 1988 session of the General Assembly, a bill was introduced by state Rep. Italo S. Cappabianca that would authorize the state revenue department to look into the business practices of not-for-profit organizations. All non-profit corporations would be required to "supply information as to affiliation, activities and tax status" to the state.[32] It is believed to be the strongest effort proposed in any state assembly to monitor the operations of not-for-profit groups. Rep. Cappabianca has accused hospital administrators of the "simultaneous wearing of the nonprofit halo while unfairly competing with for-profit enterprises." The bill was referred to the Committee on Business and Commerce. A legislative commission has been formed to study the competition between not-for-profit and for-profit enterprises.[33]

A 1985 ruling by the Utah Supreme Court has established strict requirements for tax-exempt groups. Not-for-profit hospitals and nursing homes are now required to pay property taxes unless they can meet the requirements of a six-point test. Among the requirements, hospitals must provide services without immediate expectation of payment, receive support from donations and gifts, not require payment from charity care patients, and not operate any commercial ventures. Counties in the state can apply the standards on a case-by-case basis to determine whether hospitals will retain their tax exemptions. For example, four of Salt Lake County's nine not-for-profit hospitals and six not-for-profit ambulatory centers are now liable for property tax based on court-set guidelines. Salt Lake County is the first local government in the state to deny a tax exemption to not-for-profit hospitals. County commissioners have ordered the facilities to pay two years of back taxes totaling $2.4 million. The hospitals appealed the decision.[34]

The Utah court ruling may generate an estimated $7 to $10 million annually in additional state tax revenues.[35] In 1986, Utah voters narrowly rejected a constitutional amendment that would have nullified the state Supreme Court ruling of 1985—thereby granting blanket tax exemptions to all not-for-profit hospitals.[36] This is clear evidence that the public, while not necessarily advocating a tax on hospitals, wants to make sure not-for-profit hospitals retain their charitable mission.

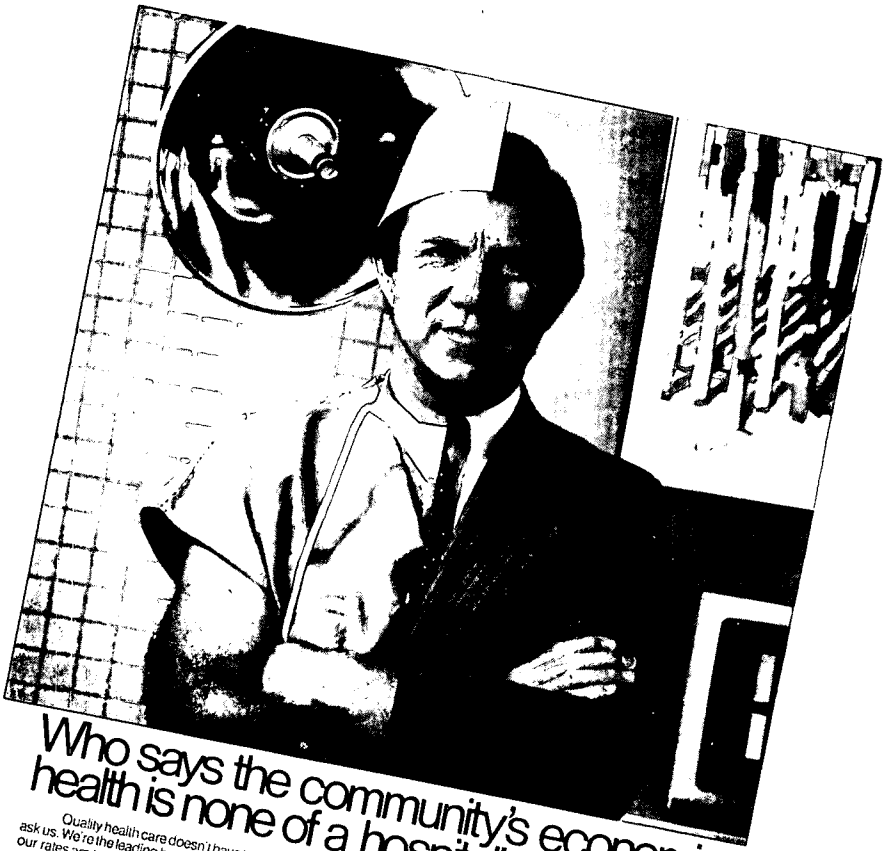
In Washington, the state revenue department once considered a plan that would require hospitals to pay property taxes on their outpatient departments. The property tax payment would be required only if "revenues from non-patient services exceed ten percent of the unit's gross revenues." The state revenue department could impose the tax on hospitals even without approval by the state legislature.[37] The proposal has been put on hold. Still, seven large not-for-profit hospitals in Seattle have been required to pay county taxes on their unrelated business income in recent years. In other action, the state Supreme Court decided not to protect the interest on municipal and local government bonds from taxation. This decision will likely have an effect on future health care bonds.[38]

The West Virginia state revenue department proposed regulations to end not-for-profit hospitals'

property tax exemptions. Hospitals would have to meet strict eligibility tests, covering specific amounts of indigent care, to qualify for exemptions.[39]

B. Expanding the Range of Permissible Activities for Not-For-Profit Hospitals. In Kansas and North Carolina, the movement is in the opposite direction—that of expanding the range of permissible activities for not-for-profit hospitals and of protecting not-for-profit hospitals' tax exempt status. The Kansas legislature is working to protect the tax exemptions of hospitals. Proposed state legislation would change the legal definition of a hospital. This proposal would give hospitals the flexibility to enter new businesses without jeopardizing their tax exemptions.[40]

In North Carolina, public hospitals in general and the N.C. Hospital Association are seeking a constitutional amendment that would enable public hospitals to enter into joint ventures or partnerships with private, profit-making groups. Proponents of the legislation and a resulting referendum on the constitutional amendment say they want to ensure the survival of public not-for-profit hospitals in North Carolina. To remain competitive in the marketplace and "level the playing field," public hospitals say they must be able to enter into joint ventures and engage in for-profit enterprises.[41] They say constitutional restrictions and legislation presently on the books prevent public hospitals from participating in the financial and innovative arrangements that are available to for-profit and not-for-profit hospitals. In particular, public hospitals would be able to form partnerships with physicians to build medical offices and purchase expensive medical equipment such as CAT scanners and lithotripters. Says John Currin, administrator at Alamance Memorial Hospital, "The inability to joint venture is a major competitive disadvantage for public hospitals. If you look at why public hospitals want to joint venture, you'll find the basic reason is the need to find the money to replace dwindling public financial support of the public hospital."



The state Constitution's "public purpose doctrine" precludes the use of public tax revenues for anything not considered a public purpose.[42] In the area of joint ventures, the question inevitably would be raised as to whether the venture is primarily for the benefit of the private venture rather than the public. Raymond Champ, president of Wake Medical Center states, "The medical office building would give the public hospital a dependable source of private patients so that the hospital would have enough revenue to deal with those who cannot pay. If the public hospital is not allowed to enter into a joint venture such as this, physicians may build an office building with the competing for-profit hospitals."[43]

The State of Illinois has repeatedly denied tax exemptions to public and not-for-profit hospitals which have formed subsidiaries to buy and own real estate in order to build outpatient clinics and medical office buildings. While the subsidiaries were organized under 501(c)(2) of the Internal Revenue Service Code to give hospitals the flexibility to expand, they do not meet the state's six-point test requirement for exemption.[44] The state will likely continue to get embroiled in tax decisions on exemptions for subsidiaries. Thus, it is possible that the state of North Carolina would also get caught up in many local tax exemption decisions on for-profit subsidiaries should public hospitals be granted permission to enter for-profit ventures.

J. Phil Carlton, attorney for Wake Medical Center, believes that because of the volatile changes in the health care market, public hospitals which provide only inpatient care and the traditional hospital-based outpatient care will not survive in the future.[45] "If they don't stay competitive, if they are not able to buy this expensive equipment, then your hospital becomes rundown," he said. "The first thing you know, your county hospital is just for indigent people, and you have two classes of hospitals ... If we want public hospitals, then we have to figure out a way to keep them financially viable."[46] Attorneys Steven Simpson and Robert L. Wilson Jr. view joint ventures as a way for public hospitals to attract qualified physicians to rural hospitals. While metropolitan areas in North Carolina do not have trouble attracting doctors, the rural counties (especially in eastern and western North Carolina), have great difficulty attracting qualified physicians. Simpson and Wilson say, "In order to attract qualified physicians to rural counties, public hospitals and tax-exempt hospitals must offer recruitment packages sufficient to attract physicians away from the metropolitan areas."[47]

The question of unfair competition from nonprofit entities has been raised in numerous instances. Opponents of joint ventures say not-for-profit hospitals have a distinct cost advantage over their investor-owned counterparts and are well-cushioned, while most organizations are tightening the belt and trying to control costs. The joint venture and partnership deals are designed to make a profit, thereby subsidizing the not-for-profit hospital. According to Susan Valauri, N.C. state director of the National Federation of Independent Business, the issue is so important to the small business community that they identified unfair competition from the nonprofit sector as the third most critical issue at a meeting of the White House Conference on Small Business in 1986. She states that the National Federation of Independent Business is also well aware of governmental competition in the past, and that "the Federation has developed a consensus decision to oppose governmental intrusions into business."[48]

Local Attacks on Tax Exemptions

LOCAL GOVERNMENTS are also beginning to examine whether hospitals merit exemption from property taxes and other levies. Taxing not-for-profit hospitals has become very popular politically. In many cities, newspaper editorials and the broadcast media have been favorable to the idea. The public wants proof that not-for-profit hospitals are charitable organizations. And some city tax officials feel hospitals are taking money out of taxpayers pockets. Local governments present three reasons for wanting to tax not-for-profit hospitals. First, hospitals have become a big business producing huge revenues. Second, local governments need the revenues. Third, not-for-profit hospitals are in the apparently contradictory position of wanting to compete with for-profits while remaining tax-exempt.

Several cities have sought to tax not-for-profit hospitals. In Pennsylvania, the city of Pittsburgh has denied property tax exemptions for three not-for-profit hospitals. According to Dan Pellegrini, city solicitor for Pittsburgh, hospitals are no longer carrying out their part of the bargain made between hospitals and municipalities—that if hospitals would provide free care to the poor, cities would not charge taxes. The bargain has changed dramatically, he contends. The advent of Medicare, Medicaid and other third-party payers means that hospitals do less free care now. "Hospitals compete for patients through extensive marketing campaigns and form partnerships with doctors to gain patients, further changing the bargain made with municipalities," he adds. Pellegrini says that "from a municipal approach, no hospital should be exempt. It's simply a social justice issue."[49] The City of Pittsburgh and the hospitals have reached an agreement. Three medical centers have agreed to pay $11.1 million in municipal service fees over the next ten

—continued on page 166

HOSPITAL BOND ISSUES IN NORTH CAROLINA

by Lori Ann Harris

PUBLIC AND PRIVATE NOT-FOR-PROFIT HOSPITALS in North Carolina often issue bonds to raise capital for hospital construction, expansion, renovation, or new equipment. For a public hospital to obtain bond financing in North Carolina, it must first gain approval by municipal or county officials. A local government can only issue general obligation bonds on behalf of a public hospital. General obligation bonds are tax-free bonds secured by the full taxing power and general credit of the municipal government issuing the bonds. The hospital project must obtain approval by the N.C. Local Government Commission in the Department of the State Treasurer. The Commission examines the project's financial feasibility and must be assured of the hospital's ability to service debt. A hospital with financial problems is unlikely to be able to meet the Commission's approval. The hospital must also obtain approval from the Certificate of Need Section in the State Division of Facility Services in the Department of Human Resources. If the hospital obtains approval from both the Local Government Commission and the Certificate of Need Section, the appropriate local government officials still must bring the hospital bond referendum to the voters. Between November 1970 and May 24, 1988, 46 counties presented hospital bond referenda to the voters (see Table A). More than $199 million in bond authorizations were approved for hospital projects. In its first report on North Carolina hospitals, the Center found no significant relationship between the defeat of a local hospital bond referendum and a public hospital's decision to join an investor-owned system. Referenda in only eight counties were defeated during that period; in only three of these counties has the hospital subsequently joined an investor-owned system.[1]

The N.C. Medical Care Commission, also in the Division of Facility Services in the Department of Human Resources, conducts financing activities to "acquire, construct, equip, or provide health care facilities for any public or nonprofit agency," pursuant to the N.C. Health Care Facilities Finance Act. The law provides that to qualify for assistance under the Act a project must meet several criteria: the applicant must be a nonprofit corporation with 501(c)(3) designation under the Internal Revenue Code; the Commission must be satisfied that there is a need for the project in the area where it is to be located; the project applicant must be financially responsible and capable of fulfilling its obligation for making debt service payments; all public facilities such as utilities and other public services necessary for the health care facility must be made available; and all costs associated with the project must be borne by the applicant and not the state. The Medical Care Commission has issued tax-free revenue bonds on behalf of many private not-for-profit hospitals Revenue bonds are tax-free bonds in which revenue from the facility financed by the bonds is used to repay principal and pay interest on the bonds. Between December 1977 and June 30, 1988, the Commission had issued revenue bonds or notes for 56 hospital projects. The total authorized principal amount of all such financings was $1,218,437,033 (see Table B). The Commission also issued nine revenue bonds for nursing homes, retirement homes, and the Carolina Chapter of the American Red Cross.

[1]N.C. Department of the State Treasurer, Local Government Commission; see also Elizabeth M. "Lacy" Maddox, *The Investor-Owned Hospital Movement in North Carolina,* (Raleigh, NC: The North Carolina Center for Public Policy Research, 1986), pp. 42-46.

[2]N.C. Department of Human Resources, *The N.C. Medical Care Commission Annual Report,* June 30, 1988.

—continued

Table A: Public Hospital Bonds in North Carolina
November 1970 - May 1988
General Obligation and Local Government Revenue Bonds

Election Date	Municipalities or Counties	Approved	Defeated
11-03-70	Pitt	$ 9,975,000	
06-29-71	Davie	975,000	
11-20-71	Craven	6,500,000	
07-08-72	Mecklenburg	2,500,000	
07-08-72	Mecklenburg	2,500,000	
11-07-72	Haywood		$ 4,500,000
06-16-73	Brunswick	2,500,000	
09-21-73	Bladen		2,500,000
10-06-73	Columbus	6,000,000	
11-06-73**	Martin	1,000,000	
05-07-74	New Hanover	9,360,000	
11-05-74	Pasquotank	3,900,000	
02-01-75	Stokes	2,500,000	
03-03-75*	Columbus	124,000	
03-22-75	Watauga	4,900,000	
07-08-75	Haywood	14,500,000	
03-23-76	Richmond	8,200,000	
04-27-76	Sampson		5,000,000
05-18-76	Mecklenburg	10,000,000	
06-22-76	Caldwell		2,500,000
08-23-77	Forsyth (refunding)	13,000,000	
12-19-77*	Alamance	430,000	
05-30-78	Lee		12,300,000
11-07-78	Cumberland	5,300,000	
03-26-79*	Alamance	250,000	
09-19-79*	Henderson	285,000	
10-22-79*	Alamance	360,000	
11-06-79	Mecklenburg	15,000,000	
12-11-79	Union	13,000,000	
11-14-80	Franklin		5,800,000
04-06-81*	Henderson	70,000	
06-16-81	Johnston	7,500,000	
11-02-81*	Henderson	215,000	
11-02-82	Iredell		22,750,000
02-01-83	Pender	3,000,000	
04-26-83	Carteret	5,900,000	
10-25-83	Granville	2,800,000	
05-08-84	Onslow		5,000,000
12-10-85*	Union (refunding)	11,700,000	
12-10-85	Wilkes	16,900,000	
05-06-86	Beaufort	3,500,000	
05-06-86	Yadkin	3,000,000	
09-30-86	Martin	1,500,000	
10-06-87	Dunn	3,500,000	
03-08-88	Bladen	4,000,000	
05-24-88*	Watauga (refunding)	2,510,000	
	TOTAL	$ 199,154,000	$ 60,350,000

General obligation bonds are tax-free bonds secured by the full taxing power and general credit of the municipal government issuing the bonds.

* In these cases, a vote of the people authorizing the bonds was not required, so the bond order adoption date is shown. The North Carolina Constitution states in Article V, Section 4 that a local governmental unit cannot "contract debt secured by a pledge of its faith and credit" unless the debt is approved by a majority of voters in the jurisdiction. One important exception to this rule is that the county may issue bonds for any authorized purpose without voter approval for an amount up to two-thirds of the debt that was retired in the immediate previous year. See N.C.G.S 159-49.

** Authorization extended for three years pursuant to action of the governing board.

Table B: Revenue Bonds Issued by the N.C. Medical Care Commission, December 1977 - June 1988

Name of Facility	Date of Issue	Authorized Principal Amount
Presbyterian Hospital Charlotte	12/21/77	$ 20,000,000
Lexington Memorial Hospital Lexington	3/1/78	6,510,000
Rex Hospital Raleigh	6/1/78	31,535,000
Duke University Hospital Durham	7/1/78	79,000,000
Cape Fear Memorial Hospital Wilmington	7/1/78	3,600,000
Memorial Mission Hospital of Western North Carolina Asheville	1/1/79	35,100,000
Duke University Hospital Durham	1/1/79	6,650,000
Annie Penn Memorial Hospital Reidsville	5/1/79	7,650,000
Stanly Memorial Hospital Albemarle	5/1/79	7,535,000
Moore Regional Healthcare Corp. Pinehurst	8/23/79	10,710,000
Duke University Hospital Durham	7/1/80	7,930,000
Carolinas Hospital and Health Services Charlotte	7/22/80	200,000
Mercy Hospital Charlotte	1/1/81	8,275,000
Memorial Hospital of Alamance County Burlington	4/1/81	7,000,000
Carolinas Hospital and Health Services Charlotte	4/8/81	500,000
Scotland Memorial Hospital Laurinburg	6/1/81	10,800,000
Rex Hospital Raleigh	12/15/81	760,000
Morehead Memorial Hospital Eden	2/1/82	6,000,000
Chatham Hospital Siler City	6/16/82	355,000
Grace Hospital Morganton	8/1/82	9,465,000
Carolinas Hospital and Health Services Charlotte	8/4/82	600,000
Southeastern General Hospital Lumberton	9/1/82	14,100,000
Community General Hospital Thomasville	12/1/82	3,100,000
Grace Hospital Morganton	7/1/83	10,855,000
High Point Regional Hospital High Point	9/1/83	29,820,000
Grace Hospital Morganton	11/1/83	8,870,000
Mercy Hospital Charlotte	11/10/83	2,205,000
Rowan Memorial Hospital Salisbury	3/16/84	1,833,000
High Point Regional Hospital High Point	4/16/84	915,000
Memorial Mission Hospital of Western North Carolina Asheville	5/2/84	1,475,000
St. Joseph's Hospital Asheville	6/15/84	30,330,000
Moses H. Cone Memorial Hospital Greensboro	8/1/84	29,330,000
Alamance County Hospital Burlington	2/22/85	2,504,000
Wesley Long Community Hospital Greensboro	4/1/85	10,670,000
Carolina Medicorp, Inc. Winston-Salem	5/1/85	36,550,000
Presbyterian Hospital Charlotte	5/24/85	8,700,000
Southeastern General Hospital Lumberton	7/1/85	16,345,000
Duke University Hospital Durham	7/1/85	48,245,000
North Carolina Baptist Hospitals, Inc. Winston-Salem	7/15/85	86,000,000
Bowman Gray School of Medicine of Wake Forest University Winston-Salem	7/15/85	42,000,000
Mercy Hospital Charlotte	8/1/85	29,980,000
Duke University Hospital Durham	10/2/85	43,500,000
Presbyterian Hospital Charlotte	12/1/85	24,000,000
Southminster, Inc. Charlotte	12/1/85	23,825,000
Pooled Equipment Financing Project Raleigh	12/1/85	100,000,000
Moses H. Cone Memorial Hospital Greensboro	12/1/85	15,000,000
Moore Regional Healthcare Corporation Pinehurst	12/1/85	10,980,000
Memorial Mission Hospital of Western North Carolina Asheville	12/1/85	25,855,000
Duke University Hospital Durham	12/18/85	34,415,000
The McDowell Hospital Marion	6/1/86	8,935,000
Pooled Financing Project Raleigh	7/1/86	100,000,000
Grace Hospital Morganton	2/1/87	23,450,000
High Point Regional Hospital High Point	2/1/87	34,280,000
Carolina Medicorp, Inc. Winston-Salem	8/1/87	53,142,316
Wesley Long Community Hospital Greensboro	8/15/87	25,715,000
Memorial Mission Hospital of Western North Carolina Asheville	6/15/88	21,337,717
TOTAL		**$ 1,218,437,033**

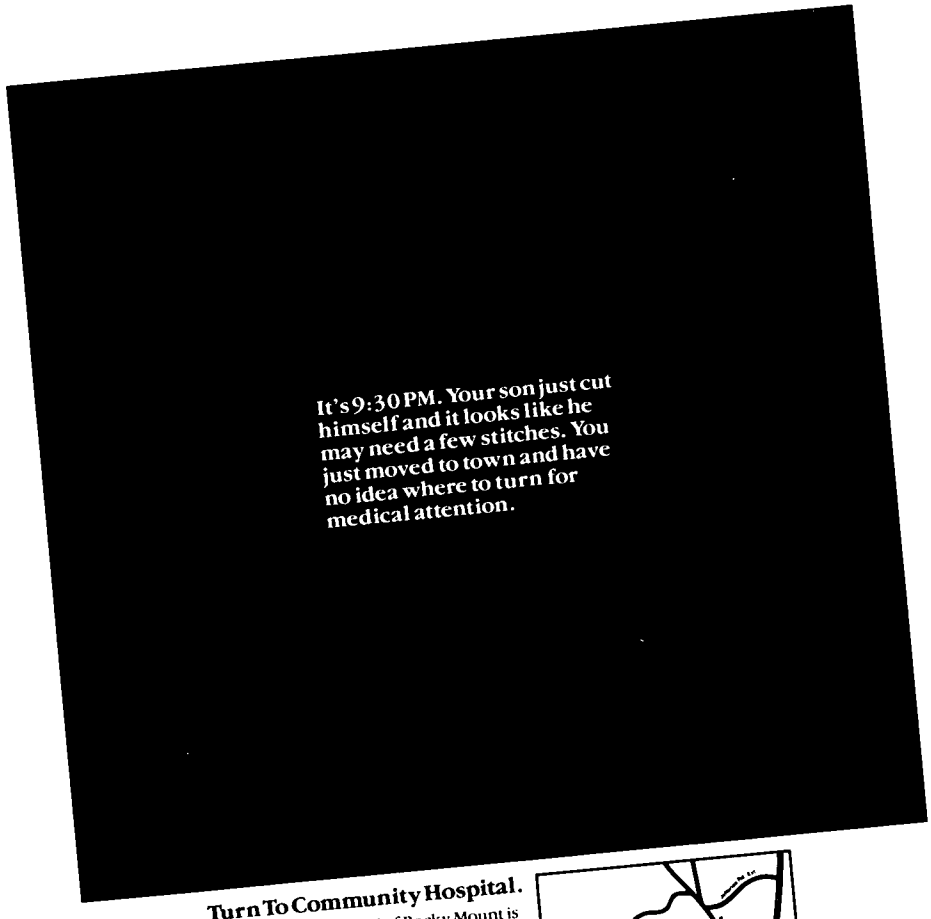
Revenue bonds are tax-free bonds in which revenue from the facility financed by the bonds is used to repay principal and pay interest on the bonds

* The N.C. Medical Care Commission also issued nine revenue bonds between December 1977 and June 1988 for nursing homes, retirement homes, etc. The total authorized principal amount of *all* financings by the commission as of June 30, 1988 was $1,266,393,013.

Source: N.C. Department of Human Resources, *The N.C. Medical Care Commission Annual Report*, June 30, 1988.

years to retain the property tax exemption. The municipal service fee is based on the hospital's potential tax liability as well as the percentage of non-city residents that use the hospital.[50]

Tennessee's not-for-profit hospitals have not escaped the watchful eye of county tax assessors. In Chattanooga, the state Board of Equalization ruled that the not-for-profit Downtown Hospital was not exempt from paying taxes. The decision was later overturned. The judge said the board "exceeded its statutory authority" when it decided that the hospital must pay taxes, and that the ruling conflicts with the state exemption statute for nonprofit organizations. According to state law, any nonprofit organization which devotes its efforts to the improvement of conditions in the community is a charitable institution and is exempt from property taxation. The state board has appealed the case.[51] In Nashville, the county tax assessor decided that not-for-profit hospitals do not have full property tax exemptions. Six not-for-profit hospitals faced tax bills of $5.4 million in 1987. The not-for-profit hospitals already pay property taxes on



Courtesy Community Hospital of Rocky Mount

non-patient services such as gift shops, cafeterias, parking lots, medical office buildings, and other facilities used by the public. Metro officials contend the six hospitals are not acting in a charitable manner by charging rates comparable to for-profit hospitals. "I've looked at their financials and they are making more money than the for-profit hospitals and don't appear to be providing any more free care," said Jim Clary, property tax assessor for the metropolitan government of Nashville and Davidson County. "They aren't acting like the charity hospitals set forth in our (state) constitution," he adds. The city's lawsuit was dismissed in June 1988, after the trial court judge ruled the court lacked jurisdiction to hear the case. The presiding judge felt that the lawsuit should go back to the state Board of Equalization for final determination.[52]

In Burlington, Vermont, the city sent a $2.83 million property tax bill to one of its private, not-for-profit hospitals. The city cited high hospital profits and low amounts of charity care as the primary reasons to deny the hospital a continued exemption. Medical Center Hospital, the city's major hospital, then sued the city to retain its tax-exempt status. Although the hospital won the decision, the city has appealed to the state supreme court.

These examples show that not-for-profit hospitals across the country increasingly will have to prove that they operate as charities and deserve to maintain their tax-exempt status.[53] Subsequent rulings on the state and local level will be watched closely by hospitals guarding their tax status and by cities and states seeking additional revenues.

Summary of Other Research on the Tax Issue

THE QUESTION of whether for-profit hospitals accept as great a burden in taxes and charity care as not-for-profit hospitals accept in charity care alone defies an easy answer. Only five other studies have focused on this question. Two studies by Lewin and Watt examined the difference between the gross patient service charges of the investor-owned and not-for-profit hospitals, in order to determine whether the difference is due to the tax burden the investor-owned hospitals bear, or other factors (e.g., differences in expected net non-patient care revenues, or the costs of purchasing services). They found that even after removing taxes from the differences in price, for-profits were charging ten percent more than not-for-profits.[54]

A third study sponsored by Hospital Corporation of America of Nashville, Tennessee examined the financial performance of a group of Florida hospitals. Frank Sloan and Robert Vraciu measured the cost of hospital services, comparing investor-owned and not-for-profit hospitals. Their comparison took into consideration the tax-exempt status of not-for-profit hospitals as well as the payment of taxes by investor-owned hospitals and adjusted for these differences. Sloan and Vraciu used an unconventional research method to compare community cost in terms of "net operating funds." The results of the study showed that there were few differences between not-for-profit and investor-owned hospitals on the measure of "community cost."[55]

Most recently, Regina Herzlinger, a professor at Harvard University Business School, and William Krasker, a former professor and now vice-president at Salomon Brothers, a brokerage house in New York City, also examined the performance of for-profit and not-for-profit hospitals. They compared the performance of 14 major hospital chains—six for-profit and eight not-for-profit—between 1977 and 1981. They concluded that not-for-profit hospitals do not operate as efficiently as their for-profit counterparts. Furthermore, they said not-for-profit hospitals are undeserving of the subsidies they receive in the form of tax exemptions because they are not treating a significant portion of the medically indigent and uninsured population. By contrast, for-profit hospitals are more efficient, said Herzlinger and Krasker, providing the same services to the community at a lower cost. They based this conclusion on findings that investor-owned hospitals use fewer full-time employees and replace facilities and equipment more rapidly.[56] This study has drawn heavy criticism from experts in the health care field. Their assertion that investor-owned and not-for-profit hospitals provide nearly the same amount of indigent care conflicts with other research on the same question (see Chapter 2). Critics of the study also cite flawed methodology and misleading assertions as major problems with the study's findings. Furthermore, the article was not submitted to peer review prior to publication.

Finally, the national Institute of Medicine attempted to answer the question of whether for-profit hospitals make as great a "social commitment"—in taxes paid and charity care given—as not-for-profit hospitals do in charity care alone.[57] In this method of analysis, one would accept the for-profit hospital industry argument that researchers should add (1) outright expenditures within the hospital for indigent care, and (2) taxes paid to the county, which theoretically could then also be spent for indigent care. If this equaled the amount of expenditures by not-for-profits on indigent care, then one could argue that for-profit hospitals are doing their fair share, or fulfilling their social commitment. The Institute of Medicine

Table 5.1: 1984 Taxes Paid By For-Profit Hospitals (Investor-owned, -managed, and -leased)

Hospitals Paying Taxes in N.C.	County	Local Property Tax Paid	State & Local Sales Tax Paid	State Income Tax Paid
1. Frye Regional Medical Center (IO)	Catawba	$ 177,349	$ NA	$ 290,709
2. Raleigh Community Hospital (IO)	Wake	161,571	164,564	258,294
3. Highsmith-Rainey Memorial Hospital (IO)	Cumberland	203,203	50,195	146,525
4. Central Carolina Hospital (IO)	Lee	123,468	14,636	95,344
5. Davis Community Hospital (IO)	Iredell	61,056	70,985	9,129
6. Humana Hospital Greensboro (IO)[a]	Guilford	119,652	NA	NA
7. Medical Park Hospital (IO)	Forsyth	73,286	16,773	0 [c]
8. Heritage Hospital (IO)[d]	Edgecombe	61,323	NA	NA
9. Community Hospital of Rocky Mount (IO)	Nash	29,704	NA	NA
10. Cape Fear Valley Medical Center (IM)	Cumberland	3,800 [c]	0	0
11. Angel Community Hospital (IM)	Macon	2,939	NA	NA
TOTAL:		$ 1,017,351	$ 317,153	$800,001

IO = Investor-Owned IM = Investor-Managed NA = Not Available

noted that Steven Renn, a researcher and now adjunct professor at John Hopkins University, had found that the four leading hospital chains (Hospital Corporation of America, Humana, National Medical Enterprises, and American Medical International) paid 2.5 percent of their gross revenues in state and federal income taxes. And a 1983 American Hospital Association study found that for-profit hospitals provided uncompensated care equaling 3.1 percent of gross revenues.[58] The Institute of Medicine then calculated what it called "social commitment" of for-profit hospitals, by adding these percentages—2.5 percent of gross revenue in taxes paid and 3.1 percent in indigent care—to obtain a total of 5.6 percent social commitment by for-profit hospitals. This figure was larger than the 4.1 percent of gross revenues devoted to indigent care and 0 percent in taxes paid by not-for-profit hospitals. Thus, these for-profits companies can argue they did their fair share.[59] Bradford Gray, editor of *For-Profit Enterprise in Health Care*, however, is quick to point out that "social commitment" is not the only basis on which to rate not-for-profit hospitals. Not-for-profit hospitals provide many services to the community through educational activities, unsponsored research, as well as charity care.[60]

Methodology of the N.C. Center's Study

IN A 1985 SURVEY of the 127 general acute care hospitals in North Carolina (see p. 50 for more on the survey), the N.C. Center for Public Policy Research asked for and received data on taxes paid in 1984. This study is unique in examining actual taxes *paid;* two of the four studies mentioned above used *estimated* taxes, and all used taxes *accrued,* not taxes *paid.* A few hospitals refused to supply the requested

Federal Income Tax Paid	Other Taxes Paid	Total Taxes Paid	County Appropriations for Hospital Services
$ 2,095,042	$ 535	$ 2,563,635	$ 0
1,701,943	0	2,286,372	3,846,000
1,055,961	33,819	1,489,703	0
491,637	11,163	736,248	0
62,195	0	203,365	0
NA	NA	119,652 [b]	205,000
0[c]	0	90,059	0
NA	NA	61,323 [b]	0
NA	NA	29,704 [b]	0
0	0	3,800	0
NA	NA	2,939 [b]	0
$ 5,406,778	$ 45,517	$ 7,586,800 [f]	

[a]Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

[b]Denotes hospitals which did not respond to the North Carolina Center for Public Policy Research survey. Property tax information was supplied instead by the county tax supervisors. Thus, this figure may not accurately depict total taxes paid by the hospital to other levels of government.

[c]Because Medical Park was a limited partnership in 1984, the hospital itself did not pay any state and federal income taxes. The holding corporation (Maplewood Corp. and Casstevens Co.) made all tax payments. Medical Park Hospital was sold to Carolina Medicorp, Inc. in 1986.

[d]Formerly Edgecombe General Hospital.

[e]Taxes were paid on property leased by the hospital. Cape Fear Valley Medical Center ended its management contract with National Medical Enterprises, Inc. in 1985, and is currently managed by SunHealth Enterprises.

[f]94% of the federal, state, and local taxes paid by the 75 hospitals responding to the Center's survey came from five investor-*owned* hospitals (7% of the total sample of 75 hospitals). These five investor-owned hospitals which provided complete tax information contributed $7,279,323.

tax data. In all cases, the tax figures supplied were later verified by Center researchers with county tax supervisors in North Carolina. The Center did not have statistics on taxes paid by an exempt hospital's taxable subsidiaries, or the unrelated business income tax paid by not-for-profit hospitals from their non-patient activities.

Findings

THIS STUDY IS BASED largely on the procedure suggested by the Institute of Medicine. The N.C. Center's research revealed that for-profit hospitals in North Carolina paid a total of $7.5 million in taxes in 1984 (see Table 5.1). About the only hospitals paying taxes are the hospitals *owned*—not managed or leased—by for-profit corporations, since 95% of all taxes paid by hospitals in North Carolina came from only six investor-*owned* hospitals. These hospitals paid a total of $7.4 million in local, state, and federal taxes in 1984. Contributing the most in total taxes paid among investor-*owned* hospitals was Frye Regional Medical Center in Hickory with $2,563,635. Highsmith-Rainey Memorial Hospital paid the most ($203,203) in *local* taxes (for personal and real property), and Davis Community Hospital paid the least ($61,056). Two investor-*managed* hospitals, Cape Fear Valley Medical Center and Angel Community, paid a small amount of money in local property taxes. The Center checked these local tax figures with county and city tax officials and found the numbers to be accurate. When combining the state and local sales tax and the state income tax, Raleigh Community Hospital in Raleigh paid the most in *state-level* taxes ($422,858). From a *federal* income tax standpoint, the largest taxpayer was Frye Regional Medical Center

Table 5.2: 1984 Taxes Paid by Investor-Owned Hospitals in North Carolina (Taxes Paid Per Bed, Taxes Paid as a Percentage of Gross Patient Revenues, and Taxes Paid Per Admission)

Investor-Owned Hospital	Federal, State and Local Taxes Paid	Number of Acute-Care Beds	Taxes Paid Per Bed	Taxes Paid as a Percentage of Gross Patient Revenues
1. Raleigh Community Hospital	$2,286,372	140	$16,331	10.0%
2. Highsmith-Rainey Memorial Hospital	1,489,703	150	9,931	8.4%
3. Frye Regional Medical Center	2,563,635	275	9,322	7.4%
4. Central Carolina Hospital	736,248	142	5,185	4.0%
5. Davis Community Hospital	203,365	149	1,365	1.5%
6. Medical Park Hospital[2]	90,059	136	662	.7%
TOTALS AND AVERAGES	$7,369,382	165 (average)	$7,133 (average)	5.3% (average)
TOTALS AND AVERAGES (Excluding Medical Park)	$7,279,382	171 (average)	$8,427 (average)	6.3% (average)

[1] Includes outpatient visits, emergency room visits, outpatient surgery visits, and all inpatient admissions.

[2] Medical Park Hospital was purchased by Carolina Medicorp in 1986 and is now a private, not-for-profit hospital. It has been managed by Hospital Corporation of America since 1984.

with $2,095,042.

Other measures are more indicative of taxes paid in proportion to the total hospital operation. On a per-bed basis, the six hospitals paid $7,133 on the average in local, state, and federal taxes, with Raleigh Community Hospital paying the most ($16,331) (see Table 5.2). Examining taxes paid as a percentage of gross patient revenues, the average for the six hospitals was 5.3 percent, with Raleigh Community Hospital the highest again with 10.0 percent. In terms of taxes paid per inpatient admission, the average was $200, with Highsmith-Rainey paying the most ($363). On taxes paid per total admissions (inpatient and outpatient combined), the average was $42, with Highsmith-

1984 Inpatient Admissions	Taxes Paid Per Inpatient Admission	Total (Inpatient and Outpatient) Admissions[1]	Taxes Paid Per Total (Inpatient and Outpatient) Admissions
6,599	$346	37,152	$62
4,102	363	16,062	93
8,413	305	49,708	52
5,281	139	26,778	27
5,510	37	19,408	10
6,989	13	15,731	6
6,149 (average)	$200 (average)	27,473 (average)	$42 (average)
5,981 (average)	$238 (average)	29,822 (average)	$49 (average)

Source: Survey of Hospital Chief Executive Officers, N.C. Center for Public Policy Research, 1984, and State Center for Health Statistics' *Health Facilities Data Book, 1984*.

Rainey again paying the most ($93). In each of these four measures, Medical Park Hospital in Winston-Salem and Davis Community Hospital in Statesville paid the least taxes. This is understandable in Medical Park's case, since it was a limited partnership in 1984. That is, the hospital itself did not pay any state and federal income taxes, since the holding corporation was responsible for all tax payments. The Center was unable to obtain information on tax payments by the holding company. Medical Park was purchased by Carolina Medicorp in 1986 and is now a private, not-for-profit hospital. It has been managed by Hospital Corporation of America since 1984. Medical Park Hospital's property tax information was supplied by

Table 5.3: Counties Appropriating Money To Local Hospitals for Indigent Care or Other Hospital Services, 1984

County	Amount Appropriated by County for Indigent Care or Other Hospital Services
1. Mecklenburg	$6,448,000
2. Wake	3,846,000
3. Durham	1,958,000
4. Buncombe	754,000
5. Martin	472,000
6. Guilford	205,000
7. Bertie	186,000
8. Brunswick*	162,000
9. Duplin	153,000
10. Warren	117,000
12. Stokes	101,000
13. Carteret	70,000
14. Granville	60,000
15. Person	58,000
16. Yadkin	40,000
16. Wilson	36,000
17. Pender	30,000
18. Rutherford	26,000
19. Wilkes	20,000
Hertford	20,000
21. Harnett**	8,000
22. Jackson	5,000
23. Vance	4,000
24. Sampson	3,000
25. Clay	1,000
Lincoln	1,000
TOTAL	$14,784,000

* Includes operating subsidies paid to J. Arthur Dosher Memorial Hospital, a township-owned facility in Southport. These payments are made from a tax levied by Smithfield Township.

** Includes operating subsidies paid to Betsy Johnson Memorial Hospital, a city-owned facility in Dunn. These payments are made from taxes levied by the city of Dunn.

Source: Figures obtained from the N.C. Local Government Commission in the N.C. Department of the State Treasurer.

the county tax supervisor. Almost all of the averages went up when Medical Park was removed from the analysis.

It is interesting to note that most counties and cities in which these six investor-owned hospitals reside do *not* appropriate any government funds for indigent care. An argument can be made that if a county is receiving tax contributions from a for-profit hospital, it ought then to funnel or earmark that money for indigent care in the county. That is, knowing that for-profits provide less indigent care (see Chapter 2), the county ought to use one of the advantages of for-profit hospitals—taxes paid—to offset one of the disadvantages—lower levels of indigent care. In 1984, only 26 counties in North Carolina appropriated money to local hospitals for hospital services (see Tables 5.3 and 5.4). During the 1986-87 fiscal year, the number of counties providing funds to hospitals dropped to twenty-three (see Table 2.15, p. 65). Among the 10 counties which had for-profit hospitals paying taxes, only Wake County and Guilford County also appropriated money for indigent care, hospital operations, or hospital-based services in 1984. Wake County Commissioners appropriated $3,846,000, while Guilford County appropriated $205,000. Raleigh Community Hospital's local property tax contribution that year was $161,571, while Humana Hospital's contribution in Guilford County was $119,652. The counties and cities in which the remaining for-profit hospitals are located did not appropriate any funds for indigent care. Throughout the state that year, counties and cities appropriated a total of $14,784,000 for indigent care, hospital operations, and hospital-based services.

Five investor-*managed* hospitals—Ashe Memorial, Blue Ridge Hospital System, Cape Fear Valley Medical Center, Johnston Memorial, and McDowell—responded to the Center survey. These investor-managed hospitals are owned by private not-for-profit companies or are public facilities and thus not subject to taxation. Cape Fear Valley Medical Center, located in Fayetteville, however, reported a $3,800 local tax payment for property leased by the hospital. Of these five investor-managed facilities, only two hospitals are public facilities—Cape Fear Valley Medical Center, which is owned by Cumberland County, and Johnston Memorial, which is owned by Johnston County. The remaining hospitals are owned by private, not-for-profit corporations. Thus, ironically, counties, which choose to sign management contracts rather than selling their hospital to a for-profit company, do not receive one of the main advantages of for-profit investor-*owned* hospitals—obtaining a new taxpayer. Yet, the county may still suffer the consequences of for-profit managed hospitals providing

lower levels of indigent care or offering a narrower range of services (see Chapters 2 and 4). County officials might argue that the tradeoff is worth it in order for the county to retain local control of the hospital—which they do under a management contract but do not when they sell a hospital.

A comparison of taxes paid and indigent care provided by hospitals which are the sole providers of hospital care in the community shows that AMI's Central Carolina Hospital in Lee County paid the most in local taxes—$123,468 (see Table 5.5). The other sole provider investor-owned hospital—Heritage Hospital—paid $61,323 in taxes. Seven hospitals *managed* by investor-owned corporations were also sole providers. Because they were owned by private, not-for-profit companies or were public facilities, the hospitals were tax-exempt at the time of the Center's survey. Of the nine sole provider hospitals listed in Table 5.5, the investor-managed Johnston Memorial Hospital provided the most indigent care—nearly $1.9 million, or 14.2% of the hospital's gross patient revenues.

In an effort to refine the analysis above even further, the Center re-examined the total amount of taxes paid by hospitals that go back to county coffers, because the figure for *total* taxes paid does not provide a true picture of local hospital contributions in the community. The only taxes that actually are paid to the county and thus potentially can be appropriated by Boards of Commissioners for indigent care are property tax revenues and a portion of sales tax revenues. The federal income tax revenue is used for other purposes—defense, Social Security, interest on debt, and other federal expenditures. Using this standard of examining taxes paid to *local* governments, the hospi-

—continued on page 178

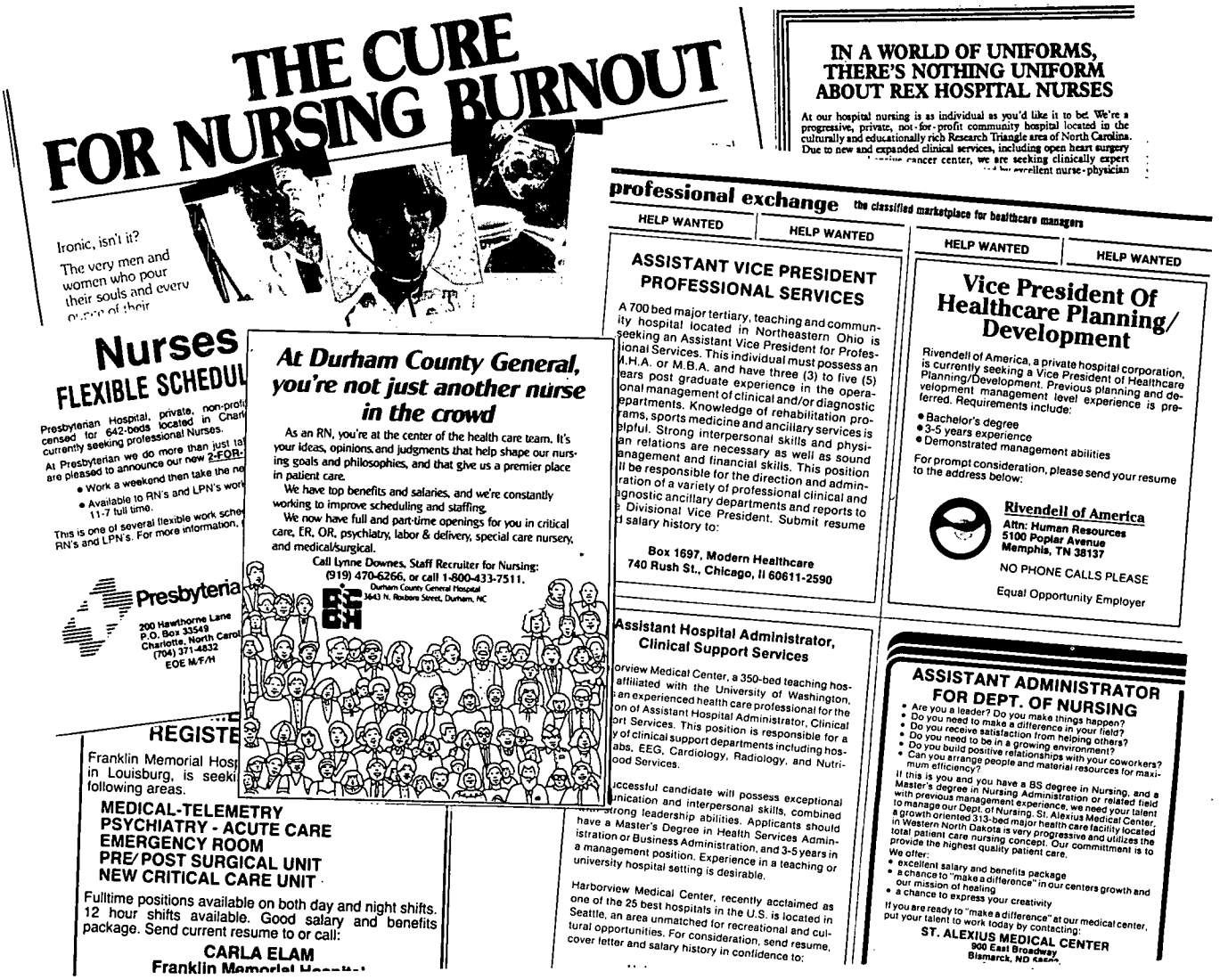


Table 5.4: Comparisons of 1984 Taxes Paid and Indigent Care Provided By Investor-*Owned* Hospitals with Other Hospitals in the Same County (Where Investor-Owned Hospitals Are *Not* the Sole Providers of Hospital Services)

Hospital	County	Gross Patient Revenues (GPR)	Local Taxes Paid [real and personal] (% of GPR)	Total Indigent Care (% of GPR)
1) Frye Regional Medical Center (IO)	Catawba	$34,766,667	$177,349 (.51%)	$2,086,000 (6.0%)
Catawba Memorial Hospital (CO)		$26,063,347	tax-exempt	$2,690,526 (10.3%)
2) Davis Community Hospital (IO)	Iredell	$13,913,199	$ 61,056 (.44%)	$ 746,604 (5.4%)
Iredell Memorial Hospital (CO)		$21,443,776	tax-exempt	$1,216,866 (5.7%)
Lowrance Memorial Hospital (IM)		NA	tax-exempt	NA
3) Highsmith-Rainey Hospital (IO)	Cumber-land	$17,635,969	$203,203 (1.2%)	$ 808,081 (4.6%)
Cape Fear Valley Medical Center (IM)		$68,597,699	tax-exempt (paid $3,800 on leased property)	$7,065,563 (10.3%)
4) Humana Hospital (IO)[a]	Guilford	NA	$119,652 [b]	NA
High Point Memorial Hospital (NFP)		$34,290,832	tax-exempt	$3,657,757 (10.7%)
L. Richardson Mem. Hospital (NFP)		NA	tax-exempt	NA
Moses H. Cone Memorial Hospital (NFP)		$76,893,944	tax-exempt	$6,908,010 (9.0%)
Wesley Long Community Hospital (NFP)		NA	tax-exempt	NA

Total Dollar Amount Spent Locally (% of total county revenues)	1984 County Appropriations for Hospital Services	Total County Revenues 1984
$2,263,349 (6.9%) $2,690,526 (8.3%)	0	$32,381,211
$ 807,660 (4.4%) $1,216,866 (6.7%)	0	$18,208,104
$1,011,284 (1.4%) $7,069,363 (10%)	0	$70,382,072
$ 119,652 (.1%) $3,657,757 (3.7%) $6,908,010 (7.1%) NA	$205,000	$97,889,538

—table continued

Table 5.4: Comparisons of 1984 Taxes Paid and Indigent Care Provided By Investor-*Owned* Hospitals with Other Hospitals in the Same County (Where Investor-Owned Hospitals Are *Not* the Sole Providers of Hospital Services), *continued*

Hospital	County	Gross Patient Revenues (GPR)	Local Taxes Paid [real and personal] (% of GPR)	Total Indigent Care (% of GPR)
5) Community Hospital of Rocky Mount (IO)	Nash	NA	$ 29,704 [b]	NA
Nash General Hospital (CO)		NA	tax-exempt	NA
6) Raleigh Community Hospital (IO)	Wake	$22,878,586	$161,571 (.71%)	$ 928,288 (4.1%)
Wake County Medical Center (CO)		$97,638,321	tax-exempt	$8,663,271 (8.9%)
Rex Hospital (NFP)		$62,600,000	tax-exempt	$2,525,555 (4.0%)
Eastern Wake Hospital (CO)		NA	tax-exempt	NA
Northern Wake Hospital (CO)		NA	tax-exempt	NA
Southern Wake Hospital (CO)		NA	tax-exempt	NA
Western Wake Hospital (CO)		NA	tax-exempt	NA
7) Medical Park Hospital (IO)[c]	Forsyth	$12,400,000	$ 73,286 (.59%)	$ 148,889 (1.2%)
Forsyth Memorial Hospital (NFP)		$85,790,036	tax-exempt	$4,898,893 (5.7%)
N.C. Baptist Hospital (NFP)		$122,821,303	tax-exempt	$6,636,000 (5.4%)

IO = Investor-Owned NFP = Private, Not-For-Profit
IM = Investor-Managed CO = County-Owned
NA = Not Available. The hospital did not respond to the Center survey.

Total Dollar Amount Spent Locally (% of total county revenues)	1984 County Appropriations for Hospital Services	Total County Revenues 1984
$ 29,704 (.16%)	0	$18,208,642
NA		
$1,089,859 (.9%)	$3,846,000	$116,614,511
$8,663,271 (7.4%)		
$2,525,555 (2.2%)		
NA		
NA		
NA		
NA		
$ 222,175 (.25%)	0	$ 87,199,675
$4,898,893 (5.6%)		
$6,636,000 (7.6%)		

[a] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.
[b] Tax information provided by county tax supervisors.
[c] Medical Park Hospital was purchased by Carolina Medicorp in 1986 and is now a private not-for-profit hospital. It has been managed by Hospital Corporation of America since 1984.

Table 5.5: Comparison of 1984 Taxes Paid and Indigent Care Provided By Investor-Owned and -Managed Hospitals Where They *Are* Sole Providers of Hospital Services

Hospital	County	Gross Patient Revenues (GPR)	Local Taxes Paid [real and personal] (% of GPR)	Total Indigent Care (% of GPR)
1) Central Carolina Hospital (IO)	Lee	$18, 240,791	$123,468 (.68%)	$1,222,133 (6.7%) (includes Medicare/ Medicaid)
2) Heritage Hospital (IO)[a]	Edgecombe	NA	$ 61,323[b]	NA
3) McDowell Hospital (IM)	McDowell	$ 6,900,000	tax-exempt	$ 529,784 (7.7%)
4) Johnston Memorial Hospital (IM)	Johnston	$13,272,019	tax-exempt	$1,886,638 (14.2%)
5) Ashe Memorial Hospital (IM)	Ashe	$ 5,714,980	tax-exempt	$ 260,684 (4.6%)
6) Person County Hospital (IM)	Person	NA	tax-exempt	NA
7) Burnsville Hospital (IM)	Yancey	NA	tax-exempt	NA
8) Franklin Memorial Hospital (IM)	Franklin	NA	tax-exempt	NA
9) Spruce Pine Community Hospital (IM)	Mitchell	NA	tax-exempt	NA

IO = Investor-Owned
IM = Investor-Managed
NA = Not Available. The hospital did not respond to the Center survey.

tal contributing the most in taxes returning to the county was Highsmith-Rainey with $203,963. Medical Park paid the least ($73,538).

The N.C. Center was unable to determine how much hospital management companies paid in state income taxes. By law, any corporation that does business in North Carolina and is not exempt under the state revenue law, is subject to taxation on its North Carolina source income. It is possible that the hospital management companies did not make money on the contracts and therefore owed no income tax to the state. Since tax payments to the state are not public information, the Center can not determine how much in taxes hospital management companies paid to the state as a result of management contracts with hospitals in North Carolina.

Total Dollar Amount Spent Locally (% of Total County Revenues)	1984 County Appropriations for Hospital Services	Total County Revenues 1984
$1,345,601 (10.9%)	0	$12,298,733
$ 61,323 (.4%)	0	$14,153,763
$ 529,784 (6.6%)	0	$ 7,959,010
$1,886,638 (9.4%)	0 in 1984; ($100,000 in 1985)	$19,970,241
$ 261,474 (5.2%)	0	$ 5,014,845
NA	$58,000	$ 9,782,532
NA	0	$ 5,144,058
NA	0	$ 7,828,491
NA	0	$ 3,591,355

[a] Formerly Edgecombe General Hospital.
[b] Tax information provided by county tax supervisor.

Do Hospitals Have a "Social Commitment" Obligation?

IT HAS BEEN a long-held-belief that public and not-for-profit hospitals ought to serve the community by providing health care services—a social benefit. David Falcone, associate professor of health administration at Duke University, poses a new equation this way: "Do not-for-profit hospitals provide a measure of social benefit equal in quantifiable amounts to the value of the tax exemptions (state and federal income tax, sales and property tax) accorded them?" He suggests that "on average, they [not-for-profit hospitals] would fail this social benefit = exemptions test."[61]

The tax data and the figures for uncompensated care that the N.C. Center for Public Policy Research

Table 5.6: A Measurement of the Social Commitment of North Carolina Hospitals in Counties With Both Investor-Owned and Not-for-Profit Hospitals

Hospital	County	% of Gross Revenues Paid in Local Taxes	% of Gross Revenues Provided in Indigent Care	Social Commitment Index (% of Taxes Paid plus % of Indigent Care Provided)
Frye Regional Medical Center (IO)	Catawba	.51%	6.0%	6.51
Catawba Memorial Hospital (CO)		tax-exempt	10.3	10.3
Davis Community Hospital (IO)	Iredell	.44	5.4	5.84
Iredell Memorial Hospital (CO)		tax-exempt	5.7	5.7
Lowrance Memorial Hospital (IM)		tax-exempt	NA	NA
Highsmith-Rainey Hospital (IO)	Cumberland	1.2	4.6	5.8
Cape Fear Valley Medical Center (IM)		tax-exempt	10.3	10.3
Humana Hospital (IO)[1]	Guilford	NA	NA	NA
High Point Memorial Hospital (NFP)		tax-exempt	10.7	10.7
L. Richardson Memorial Hospital (NFP)		tax-exempt	NA	NA
Moses Cone Memorial Hospital (NFP)		tax-exempt	9.0	9.0
Wesley Long Community Hospital (NFP)		tax-exempt	NA	NA
Community Hospital of Rocky Mount (IO)	Nash	NA	NA	NA
Nash General (CO)		tax-exempt	NA	NA
Raleigh Community Hospital (IO)	Wake	.71	4.1	4.81
Wake County Medical Center (CO)		tax-exempt	8.9	8.9
Rex Hospital (NFP)		tax-exempt	4.0	4.0
Medical Park Hospital (IO)[2]	Forsyth	.59	1.2	1.79
Forsyth Memorial Hospital (NFP)		tax-exempt	5.7	5.7
N.C. Baptist Hospital (NFP)		tax-exempt	5.4	5.4

IO = Investor-Owned NFP = Not-For-Profit
IM = Investor-Managed CO = County-Owned
NA = Not Available. The hospital did not respond to the Center survey

[1] Humana Hospital was purchased by Moses Cone Memorial Hospital, a private, not-for-profit hospital, in 1988.

[2] Medical Park Hospital was purchased by Carolina Medicorp in 1986 and is now a private, not-for-profit hospital. It has been managed by Hospital Corporation of America since 1984.

obtained enabled the Center to compute the social commitment of some investor-owned and not-for-profit hospitals in North Carolina. Using the Institute of Medicine's research method (combining expenditures within the hospital for indigent care and taxes paid to the county which theoretically could also be spent for indigent care), then one could argue that some for-profit hospitals are doing their fair share.

A comparison of North Carolina hospitals in the same county reveals that in two instances, the "social commitment" of investor-owned hospitals, as defined here, was greater than that of not-for-profit hospitals. In Iredell County, Davis Community Hospital, an investor-owned facility, had a social commitment index of 5.84 (.44 percent of gross revenues in taxes paid *plus* 5.4 percent of gross revenues in indigent care provided). On the other hand, Iredell Memorial Hospital, a county-owned facility, had an index of 5.7 (the percentage of gross revenues in indigent care provided). In Wake County, for-profit Raleigh Community Hospital's social commitment index was 4.81. This figure lagged far behind the index for the public Wake County Medical Center (8.9), but it was higher than the 4.0 social commitment index for Rex Hospital, a private not-for-profit hospital.

By contrast, in Cumberland County, Cape Fear Valley Medical Center, a public hospital, had a social commitment index of 10.3 which exceeded that of investor-owned Highsmith-Rainey Hospital (5.8). In Catawba County, Catawba Memorial, a county-owned facility, measured 10.3 in social commitment compared to the Frye Regional Medical Center's 6.5 social commitment index. And in Forsyth County, both the not-for-profit hospitals—Forsyth Memorial and N.C. Baptist—had a much higher social commitment index than Medical Park Hospital. The N.C. Center was unable to make comparisons in Guilford and Nash counties because the investor-owned hospitals there did not respond to the Center survey. (See Table 5.6 for how these figures were derived).

It is important to point out that the payment of taxes and the amount of indigent care provided is not the only way to determine a hospital's total service to the community. These measures, however, are the most easily quantifiable ones that are available. According to "Mission Matters," a report by the United Hospital Fund of New York, measures of community service include medical research, education, community health services, and the delivery of unprofitable health care services (neonatal pediatric, burn and trauma centers, and cardiac intensive care units).[62] Other measures of service include educating and training doctors and other health care personnel; providing medical care to people with unpopular conditions and diseases such as AIDS, alcoholism, and drug addiction; assuring access to medical care in rural communities and to inner-city, low income populations; medical clinics; and discounts on services to the elderly and poor.

If taxes are in some way related to uncompensated care, and if the measure of social commitment used above is indeed meaningful, then some investor-owned hospitals in North Carolina are doing their fair share. Others, however, would argue that all hospitals, whether investor-owned or not-for-profit, have an obligation to provide care to those who cannot pay. From this viewpoint, the payment of taxes as a trade-off to providing indigent care is irrelevant.

Charitable Contributions to Hospitals

WILLIAM LANGLAND'S 14th Century poem "The Vision of Piers Plowman" lists the ways a wealthy merchant might distribute his riches to save his soul:

and therewith repair hospitals
help sick people
mend bad roads
build up bridges that had been
broken down
help maidens to marry or make
them nuns
find food for prisoners and
poor people
put scholars to school or some
other crafts
help religious orders, and
ameliorate rents or taxes.

(emphasis added)

Not-for-profit hospitals have long taken advantage of their tax-exempt status by soliciting charitable gifts from individuals, corporations, and foundations. The New York City-based American Association of Fund-Raising Counsel (AAFRC) Trust for Philanthropy reports that over a 32-year period, philanthropic giving in the United States has skyrocketed from $7.7 billion in 1955 to $93.68 billion in 1987. The $93.68 billion figure, the highest giving total ever recorded, represents a 6.45 percent increase over the $88 billion given in 1986. This growth has surprised many, especially those who predicted that charitable giving would drop off due to recent tax reforms and the October 1987 stock market crash. Donations to health organizations and hospitals escalated from 8.9 percent ($.7 billion) of total national philanthropy in 1955 to 14.5 percent ($13.65 billion) in 1987. According to AAFRC, individual gifts continue to be an important source of contributions to charitable organizations. In 1987, individual contributions comprised

$76.82 billion, or 82 percent of the total. Foundations contributed nearly seven percent ($6.38 billion) of the total, while corporations provided six percent. For the first time in 20 years, corporate contributions did not increase from the previous year, while foundation giving increased 8.14 percent over 1986 giving.[63]

Similarly, the National Association for Hospital Development (NAHD) of Falls Church, VA, reported a 37 percent increase in charitable contributions to hospitals and other health care institutions between 1986 and 1987. During this period, individual contributions to hospitals increased from 55 percent to 64 percent while corporate contributions to hospitals declined from 16.7 percent to 12.7 percent. Cash donations in 1987 increased 25 percent to $1.56 billion, compared with $1.25 billion in 1986. Non-cash gifts such as property and art, increased 20 percent to $161 million, up from $134 million. NAHD also reported that in 1987, hospitals with development programs more than four years old earned a median of $3.90 per dollar invested.[64]

An American Hospital Association survey on trends in hospital philanthropy to *community* hospitals indicates a steady increase in the dollar amount of gifts and the number of hospitals receiving gifts. An increased emphasis on fundraising is evident, as more and more hospitals are establishing development departments. In 1979, *metropolitan community* hospitals received nearly five times more money than non-metropolitan community hospitals. This trend stems from the fact that metropolitan hospitals serve larger communities and therefore are able to target their fundraising activities to a larger segment of the population.[65]

The American Hospital Association's 1982 Annual Survey indicated a large decline in charitable contributions for hospital *construction*. In 1981, philanthropy made up only 4 percent of the funding sources for hospital construction, down considerably from 21 percent in 1968.[66]

Hospital Philanthropy in North Carolina

HOSPITALS AND HEALTH ORGANIZATIONS are major beneficiaries of foundation and corporate philanthropy in North Carolina. In 1985, the N.C. Center for Public Policy Research released a major report entitled *Grantseeking in North Carolina*. The report examined charitable giving by all 589 foundations in North Carolina and by 81 corporate-giving programs which voluntarily supplied data to the Center. In 1982, North Carolina hospitals and health institutions received 28.4 percent ($25.3 million) of all charitable contributions by foundations and corporations.[67] Nationally, hospitals and health organizations received 20.8 percent of grant dollars awarded during the same year.[68] Included in this category were hospitals, hospices, clinics, health funds, societies (such as the Heart Fund, Cancer Fund, or Society for the Prevention of Blindness), medical research, science-oriented organizations, and health services. Table 5.7 lists the 10 largest grants given by North Carolina foundations to hospitals during 1982.

The Duke Endowment plays a major role in making grants to not-for-profit hospitals in North Carolina. It is the largest foundation in the state and the twelfth largest in the country. In 1982, the Duke Endowment had assets of $462.6 million and awarded $36.1 million in grants, the largest amount of any foundation in the state. In 1982, hospitals in North Carolina received more than $10 million of the Endowment's gifts. Forty-one hospitals received $8,055,000 for construction, and purchase of equipment. Another $2.5 million was disbursed for a variety of programs, including financing charity care based on a formula system of "free bed days of care" ($1,206,959), health and medical education, programs for the elderly, establishment of clinics, improving hospital administration, and development of a hospice.[69] In recent years, North Carolina and South Carolina hospitals have received nearly $15 million annually from the Duke Endowment.[70]

Grantseeking in North Carolina contains lists of sample grants for each foundation and corporate-giving program. The sample grants for the foundations were based on their IRS 990 tax forms, which are available to the public. Between 1981 and 1983, at least 48 North Carolina hospitals received foundation and corporate grants from 52 foundations and 12 corporations. These grant recipients are listed in Table 5.8. For example, Cabarrus Memorial, a county-owned hospital in Concord, received grants in excess of $1.7 million in 1983 for emergency room services and medical education programs. The grants to Cabarrus Memorial Hospital were gifts from the four charitable entities established by Charles A. Cannon, the late chairman of Cannon Mills: The Cannon Foundation, Inc. and The Charles A. Cannon Charitable Trusts Number One, Two and Three.

Philanthropic giving remains an important source of operating revenue for not-for-profit hospitals. As non-patient revenues decline, hospitals are increasingly likely to look to foundations and corporations for continued support. Large cutbacks in federal domestic spending have reduced the amount of federal funds going to hospitals since 1981. President Ronald Reagan suggested that the private sector—especially the philanthropic community—fill in the gaps left by the federal government. However, priorities of phil-

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Table 5.7: The 10 Largest Grants Made in 1982 by Foundations in North Carolina to North Carolina Hospitals

	Amount	Recipient	Foundation
1.	$1,950,000	Duke University Medical Center Durham, NC	The Duke Endowment Charlotte
2.	986,500	Cabarrus Memorial Hospital Concord, NC	Charles A. Cannon Charitable Trust Number One Concord
3.	480,000	Cabarrus Memorial Hospital Concord, NC	The Cannon Foundation Concord
4.	250,000	Durham County Hospital Corporation Durham, NC	The Duke Endowment Charlotte
5.	250,000	Lenoir Memorial Hospital Kinston, NC	The Duke Endowment Charlotte
6.	250,000	Memorial Hospital of Alamance County Burlington, NC	The Duke Endowment Charlotte
7.	250,000	Mercy Hospital Charlotte, NC	The Duke Endowment Charlotte
8.	250,000	Northern Hospital of Surry County Mount Airy, NC	The Duke Endowment Charlotte
9.	250,000	Presbyterian Hospital of Charlotte Charlotte, NC	The Duke Endowment Charlotte
10.	250,000	Scotland Memorial Hospital Laurinburg, NC	The Duke Endowment Charlotte

Source: Anita Gunn Shirley, *Grantseeking in North Carolina: A Guide to Foundation and Corporate Giving*, North Carolina Center for Public Policy Research, p. 11.

Table 5.8. Sample Grants to N.C. Hospitals by Foundations in North Carolina — 1981, 1982, and 1983

by Whitney Warren and William C. Long

NOTE: In 1982, The Duke Endowment made grants to 41 hospitals in North Carolina for construction, equipment, and purchases totaling $8,055,000. The Duke Endowment also made grants to North Carolina hospitals totaling $1,026,959 for free bed days, hospital administrative services, and a professional activity study in 1982. Some of those grants are included in the table below.

A. Foundation Grants to North Carolina Hospitals

	Name of Hospital	City	County
1.	Alamance County Hospital	Burlington	Alamance
2.	Amos Cottage Rehabilitation Hosp.	Winston-Salem	Forsyth
3.	Blowing Rock Hospital	Blowing Rock	Watauga
4.	Cabarrus Memorial Hospital	Concord	Cabarrus
5.	Caldwell Memorial Hospital	Lenoir	Caldwell
6.	Charles A. Cannon, Jr. Memorial Hospital, Inc.	Banner Elk	Avery
7.	Catawba Memorial Hospital —Catawba Medical and Cancer Foundation	Hickory	Catawba
8.	Charlotte Memorial Hospital and Medical Center	Charlotte	Mecklenburg
9.	Charlotte Treatment Center	Charlotte	Mecklenburg
10.	The Chatham Hospital, Inc.	Siler City	Chatham
11.	Cleveland Memorial Hospital —Cleveland Memorial Hospital Women's Auxiliary	Shelby	Chatham

Foundation Making Grant	Year	Amount
The Duke Endowment	1982	$ 40,000
Kate B. Reynolds Poor and Needy Trust	1983	6,196
Broyhill Foundation, Inc.	1982	1,000
The Cannon Foundation, Inc.	1983	5,000
Century Foundation	1982	1,000
The Goodman Foundation, Inc.	1982	200
Levin Foundation	1982	50
The Cannon Foundation, Inc.	1983	480,000
Charles A. Cannon Charitable Trust Number One	1983	986,500
Charles A. Cannon Charitable Trust Number Two	1983	138,500
Charles A. Cannon Charitable Trust Number Three	1983	150,000
The Coffey Foundation, Inc.	1983	10,000
Kate B. Reynolds Charitable Trust	1983	70,000
Charles A. Cannon Charitable Trust Number One	1983	35,000
Petro Kulynych Foundation, Inc.	1982	200
Marsh Foundation	1982	250
Century Foundation	1982	100
The Ballenger Foundation	1983	600
Alwinell Foundation	1982	3,000
Rush S. Dickson Family Foundation	1982	3,435
Alex Hemby Foundation	1982	100
Marsh Foundation.	1982	250
O'Herron Foundation, Inc.	1982	600
Dickson Foundation	1982	500
Rush S. Dickson Family Foundation	1982	500
Foundation for the Carolinas	1982	3,700
The Philip L. Van Every Foundation	1982	10,000
Wren Foundation, Inc.	1982	1,000
O. Max Gardner Foundation, Inc.	1983	250
The Dover Foundation	1983	1,000

— table continued

Table 5.8: ***continued***

	Name of Hospital	City	County
12.	Community General Hospital	Thomasville	Davidson
	—Thomasville Hospital Guild		
13.	Davie County Hospital	Mocksville	Davie
14.	Duke University Medical Center	Durham	Durham
	(for Center for Health Policy Research and Education)		
	(for new nursing education program)		
	—Cardiovascular Education Center		
	—Comprehensive Cancer Center		
	—Oncology Recreational Therapy Program		
15.	Durham County Hospital Corporation	Durham	Durham
16.	Garrett Memorial Hospital*	Crossnore	Avery

* Now known as Sloop Memorial Hospital.

Foundation Making Grant	Year	Amount
The Dillard Fund, Inc.	1982	$ 1,000
Brown F. Finch Foundation	1982	1,000
Thomas Austin Finch Foundation	1982	50,000
The Thomas Foundation	1981	1,000
Thomasville Community Foundation, Inc.	1982	2,000
Thomasville Furniture Industries Foundation	1982	100,000
Thomasville Community Foundation Incorporated	1982	100
Margaret C. Woodson Foundation, Inc.	1982	20,000
The Kathleen Price & Joseph M. Bryan Family Foundation, Inc.	1982	1,000
Burroughs Wellcome Fund	1983	15,000
The R. L. Davis Charitable Trust Fund, Inc.	1983	275
The Duke Endowment	1982	250,000
The Duke Endowment	1982	178,000
The Goodman Foundation, Inc.	1982	350
Hillsdale Fund, Inc.	1982	10,000
Mary Lynn Richardson Fund	1982	5,000
The Alexander Worth McAlister Foundation, Inc.	1982	4,986
Brody Brothers Foundation	1983	100
Harry L. Dalton Foundation	1983	500
The Dillard Fund, Inc.	1982	1,000
Ralph N. Jones Foundation	1983	100
Petro Kulynych Foundation, Inc.	1982	200
Mills Family Foundation	1982	3,100
Myers-Ti-Caro Foundation	1983	5,000
Garrison Community Foundation of Gaston County, Inc.	1982	1,000
Kate B. Reynolds Charitable Trust	1983	62,620
The Duke Endowment	1982	22,300
The Goodman Foundation, Inc.	1982	100
Marsh Foundation	1982	500
Myers-Ti-Caro Foundation	1983	2,500
Petro Kulynych Foundation	1982	200

— table continued

Table 5.8: ***continued***

	Name of Hospital	City	County
17.	Gaston Memorial Hospital	Gastonia	Gaston
18.	Good Hope Hospital	Erwin	Harnett
19.	Grace Hospital	Morganton	Burke
20.	Haywood County Hospital	Clyde	Haywood
21.	High Point Memorial Hospital	High Point	Guilford
22.	Hoots Memorial Hospital	Yadkinville	Yadkin
23.	Huntersville Hospital Auxiliary**	Huntersville	Mecklenburg
24.	Lexington Memorial Hospital	Lexington	Davidson
25.	Marion General Hospital***	Marion	McDowell
26.	McPherson Hospital Foundation	Durham	Durham
27.	Memorial Hospital of Alamance	Burlington	Alamance
28.	Mercy Hospital	Charlotte	Mecklenburg
29.	Montgomery Memorial Hospital	Troy	Montgomery
30.	Moore County Memorial Hospital	Pinehurst	Moore
31.	Moses H. Cone Memorial Hospital	Greensboro	Guilford
32.	North Carolina Baptist Hospital , Inc. —Bowman Gray School of Medicine (for Cancer Center) (for oncology support program) (for pediatric sickle cell program) —Medical Center Challenge Fund	Winston-Salem	Forsyth

** Huntersville Hospital closed in 1984.

*** Marion General Hospital changed its name to The McDowell Hospital in 1983.

Foundation Making Grant	Year	Amount
Z. Smith Reynolds Foundation	1983	$ 18,221
Blue Bell Foundation	1982	2,000
Wellons Foundation	1982	1,000
The J. Alex & Vivian G. Mull Foundation	1983	4,800
Josephus Daniels Charitable Foundation	1982	2,500
The Thomas Foundation	1981	1,000
The Duke Endowment	1982	6,600
The Blumenthal Foundation	1983	100
Dacotah Foundation, Inc.	1983	11,000
The Thomas Foundation	1981	1,000
Baldwin Foundation Trust	1983	10,000
Broyhill Foundation, Inc.	1982	10,000
Cozart Foundation, Inc.	1982	1,000
ABC Foundation	1983	15,000
Burlington Industries Foundation	1983	50,000
Cone Mills Corporation	1982	15,000
Liberty Hosiery Mills Foundation	1983	600
Alwinell Foundation	1982	12,500
The Blumenthal Foundation	1983	1,000
Harry L. Dalton Foundation	1983	100
Dowd Foundation	1983	1,000
O'Herron Foundation, Inc.	1982	100
The Surtman Foundation	1983	500
Capel Charitable Trust	1982	50,288
Doak Finch Foundation	1982	2,800
The Alexander Worth McAlister Foundation, Inc.	1982	1,000
Wilbur Lee Carter Charitable Trust	1982	9,459
Fieldcrest Foundation	1982	8,000
Brenner Foundation	1983	500
The Dillard Fund, Inc.	1982	100
The Winston-Salem Foundation	1982	31,119
The Winston-Salem Foundation	1982	26,563
The Akzona Fund	1982	5,000
Carolina Steel Foundation	1982	3,000

— table continued

Table 5.8: ***continued***

	Name of Hospital	City	County
33.	Northern Hospital of Surry County	Mt. Airy	Surry
34.	Pitt County Memorial Hospital	Greenville	Pitt
35.	Presbyterian Hospital (for hospital foundation)	Charlotte	Mecklenburg
36.	Randolph Hospital	Asheboro	Randolph
37.	Rex Hospital	Raleigh	Wake
38.	Rowan Memorial Hospital	Salisbury	Rowan
39.	Rutherford Hospital, Inc.	Rutherfordton	Rutherford
40.	Scotland Memorial Hospital	Laurinburg	Scotland
41.	St. Joseph's Hospital	Asheville	Buncombe
42.	St. Luke's Hospital	Columbus	Polk
43.	Stanly County Hospital	Albemarle	Stanly
44.	Thoms Rehabilitation Hospital	Asheville	Buncombe

Foundation Making Grant	Year	Amount
The McAdenville Foundation	1982	$ 5,000
Piedmont Aviation Foundation	1982	750
North Carolina Foam Industries Foundation	1982	30,000
R. L. Davis Charitable Trust Fund Inc.	1983	2,273
Kate B. Reynolds Charitable Trust	1983	147,468
Alwinell Foundation	1982	2,000
Associated Foundation Incorporated	1983	5,000
Blythe Brothers Foundation	1982	5,000
Dowd Foundation	1983	16,000
Foundation for the Carolinas	1982	26,968
Foundation for the Carolinas	1982	22,600
Alex Hemby Foundation	1982	12,500
Ivey's Trust Fund of Charlotte, N.C.	1982	3,400
Ralph N. Jones Foundation	1983	100
Lowe's Charitable and Educational Foundation	1983	1,000
Marsh Foundation	1982	200
The McAdenville Foundation	1982	10,000
Robert Lee Stowe, Jr. Foundation, Inc.	1982	10,000
The Philip L. Van Every Foundation	1982	20,000
S. A. Bossong Trust Fund	1982	10,000
Acme-McCrary Foundation, Inc.	1982	2,500
Josephus Daniels Charitable Foundation	1982	1,000
George Smedes Poyner Foundation, Inc.	1982	100
Trent Ragland, Jr. Trust	1982	100
The Goodman Foundation, Inc.	1982	500
Margaret C. Woodson Foundation, Inc.	1982	5,000
Stonecutter Foundation, Inc.	1983	3,000
Tanner Foundation	1982	7,500
Fieldcrest Foundation	1982	15,000
The Memorial Fund, Inc.	1983	70,000
Morgan Trust for Charity, Religion and Education	1982	100,000
Community Foundation of Western N.C.	1983	100
Polk County Community Foundation, Inc.	1982	5,059
E. J. Snyder Family Foundation	1982	20,000
Mills Family Foundation	1982	100

— table continued

Table 5.8: ***continued***

	Name of Hospital	City	County
45.	UNC-CH Memorial Hospital **** (for Cancer Center) —The Medical Foundation of North Carolina, Inc.	Chapel Hill	Orange
46.	Wilkes General Hospital	N. Wilkesboro	Wilkes
47.	Wilson Memorial Hospital	Wilson	Wilson

**** North Carolina Memorial Hospital received $27,805,159 in state appropriations for current operations, 1987-1988.

B. Corporate Contributions to North Carolina Hospitals

1.	Community General Hospital	Thomasville	Davidson
2.	Duke University Medical Center —Comprehensive Cancer Center	Durham	Durham
3.	Durham County Hospital Corporation	Durham	Durham
4.	Haywood County Hospital	Clyde	Haywood
5.	Margaret Pardee Hospital	Hendersonville	Henderson
6.	Northern Hospital of Surry County	Mt. Airy	Surry
7.	Presbyterian Hospital	Charlotte	Mecklenburg
8.	Rex Hospital	Raleigh	Wake
9.	Scotland Memorial Hospital	Laurinburg	Scotland
10.	UNC-CH Memorial Hospital (for Burn Center)	Chapel Hill	Orange

Source: Anita Gunn Shirley, *Grantseeking in North Carolina: A Guide to Foundation and Corporate Giving*, North Carolina Center for Public Policy Research, 1985.

Whitney Warren and William Long served as interns at the N.C. Center for Public Policy Research in 1987.

Foundation Making Grant	Year	Amount
Myers-Ti-Caro Foundation	1983	$ 1,500
BarclaysAmerican Foundation, Inc.	1982	5,000
Victor Bates Foundation, Inc.	1982	1,000
Battle Foundation, Inc.	1982	10,000
Carter Foundation, Inc.	1982	1,000
The Chatham Foundation	1982	5,000
The Dover Foundation	1983	3,500
A. E. Finley Foundation	1982	1,000
The Felix Harvey Foundation	1983	1,000
Lundy Foundation, Inc.	1982	1,000
J. P. Riddle Charitable Foundation	1982	10,000
Petro Kulynych Foundation	1982	200
The R. L. Davis Charitable Trust Fund, Inc.	1983	72
Total (all years combined):		$ 3,591,202
Total in 1981:		$ 3,000
Total in 1982:		1,255,227
Total in 1983:		2,332,975
The Wachovia Corporation	1982	24,000
Sellers Manufacturing Company, Inc.	1982	1,400
Union Carbide Agricultural Products Co., Inc.	1982	1,000
Champion International Corporation	1982	35,000
Olin Corporation	1982	15,000
The Planters National Bank and Trust Company	1982	1,000
Harris-Teeter Super Markets, Inc.	1982	6,000
Monsanto Agricultural Products Company	1982	1,000
MCM Corporation	1982	1,000
North Carolina Natural Gas Corporation	1982	2,000
J. P. Stevens & Co., Inc.	1982	20,000
Carolina Power and Light Company	1982	10,000
Total in 1982:		$117,400

anthropic organizations are not expected to change greatly. Hospitals will continue to be among the major beneficiaries of this tax-exempt support. Clearly, the philanthropic dollar is a major tax advantage for not-for-profit hospitals in North Carolina.

Conclusions and Recommendations

COMPETITION BETWEEN taxable businesses and tax-exempt organizations in providing similar services has become a major concern of both communities. Not-for-profit organizations are turning more to business ventures as a means of supporting themselves. A recent U.S. General Accounting Office study estimated that non-profit reliance on commercial activities as a source of revenue has nearly doubled since World War II. Among the major tax advantages for not-for-profit organizations are: exemption from federal, state and local taxes; tax-exempt bond financing; eligibility for state appropriations; and access to charitable contributions. For-profit hospitals must pay taxes, while most investor-managed and not-for-profit hospitals are exempt from paying taxes.

The analysis of tax payments in North Carolina shows that the investor-owned hospitals paid more than $7.4 million in federal, state and local taxes in 1984. In addition, computing the "social commitment" of hospitals in North Carolina (taxes paid plus charity care provided as a percentage of gross revenues) shows that some investor-owned hospitals have a very strong argument that they are doing their fair share.

Not-for-profit hospitals may solicit charitable gifts from individuals, corporations and foundations. Nationwide, charitable contributions are a major source of funding for not-for-profit hospitals. North Carolina's not-for-profit hospitals benefit tremendously from charitable gifts, which in 1982, totaled $25.3 million. In recent years, North Carolina hospitals have received nearly $15 million annually from the Duke Endowment alone.

The analysis in this chapter on taxes paid by hospitals and charitable gifts to hospitals in North Carolina leads to five specific recommendations.

1) All private not-for-profit and public hospitals should be required to pass a "social benefit = tax exemptions" test. Not-for-profit hospitals would submit a "community benefit report" to the N.C. Medical Database Commission documenting services to the poor, educational services for all income levels, and other community services. The commission should submit this data to the N.C. Department of Revenue, which would then determine if the community benefit provided justifies each not-for-profit hospital's tax exemption. Currently, under the state's revenue law, any organization that is exempt from federal income tax under the Internal Revenue Code is also exempt from state income tax. The Center proposes that the linkage between the state and federal exemption policies be severed, but only as it pertains to hospitals. Every hospital seeking exemption from the state income tax would have to meet all criteria for tax exemption. Current state law allows any corporation to seek a determination on tax exemption. This provides for-profit hospitals with a mechanism to achieve tax-exempt status if they are deserving. For-profit hospitals seeking an exemption would submit a report on tax payments and the amount of community benefit provided. This would give the Department of Revenue a means of determining the benefit provided by a hospital versus the tax payments foregone.

This recommendation will help ensure that *all* private not-for-profit and public hospitals provide a true benefit to the community. If a hospital fails to provide a measure of social benefit reasonably equal in quantifiable dollar amounts to the value of the tax exemptions (state and federal income tax, sales and property tax), then the hospital should be subject to taxation. Duke researcher Chris Conover said, "If you're going to have tax-exemptions, then it's quite legitimate that they be earned." And as Steven Kroll, a former Duke graduate student suggests, "A defensible position must be forged, where those who deserve exemptions receive them, and those who do not either change their methods or prepare to join the ranks of for-profit providers."

If state policymakers do not adopt this recommendation, then the Center recommends that:

2) The state should consider removal of the tax exemption for investor-managed hospitals. The N.C. Center's analysis of hospitals in North Carolina reveals that investor-managed hospitals engage in similar activities as do investor-owned hospitals and act more like for-profit entities than not-for-profits. Investor-*managed* hospitals, like investor-owned hospitals, often provide less indigent care and provide a somewhat narrower range of services. Unlike investor-*owned* hospitals, however, investor-managed facilities are not required to pay taxes. Each county with an investor-managed hospital should evaluate the hospital's mission statement and activities to determine whether they are carrying out their mission by providing community benefits substantial enough to justify a tax exemption.

3) The Center recommends that the state allow private not-for-profit and public hospitals to retain their tax exemptions. The state of Utah has adopted this same position, but with strict requirements, after a major public debate. The tax-exempt status should be retained for private not-for-profit and public hospitals (excluding not-for-profits *managed* by for-profit companies, which are covered by Recommendation #2 above) because the Center's study shows they shoulder a greater burden of indigent care. However constant re-evaluation of this data should be performed.

The N.C. Center also recommends that further study of tax-exempt hospitals be undertaken. The following questions should be investigated.

a) What restrictions (if any) are imposed on tax-exempt hospitals that are causing them to behave in a manner contrary to their mission?

b) What would be the likely effects of removals of the exemptions from federal, state, and local taxation on tax-exempt hospitals?

4) Counties receiving tax payments from investor-owned hospitals should earmark the revenues to provide indigent care for county residents. The Center's study, based on 1984 data, reveals that nine counties received $1 million in local property tax payments from investor-*owned* hospitals. Consistent with the recommendation in Chapter 2—which advocates that counties take a larger role in caring for indigent patients—the Center recommends that counties which receive local property tax payments from investor-owned hospitals earmark those tax payments for indigent care. In 1984, only 26 counties made appropriations to local hospitals for indigent care or other hospital-based services.

5) Finally, the Center recommends that the legislature not submit a constitutional amendment which would allow public hospitals to enter into joint ventures to the voters in 1989-90. Currently, public hospitals are not allowed to enter joint ventures. The legislature should first require hospitals to provide data on hospital performance on provision of indigent care and payment of taxes (see Recommendation #1 above) and then analyze that data before making a decision on the draft constitutional amendment. As in Illinois, if not-for-profit hospitals are allowed to go into joint ventures, the state of North Carolina could possibly get bogged down in hospital-by-hospi-

tal decisions on tax exemptions for every subsidiary of every hospital.

For the first time, tax-exemption challenges at federal, state, and local levels are forcing many hospitals to defend their role as charitable institutions. For-profit and not-for-profit health care providers are increasingly being viewed as the same. As the debate over the tax-exempt status of hospitals and other non-profit groups continues, not-for-profit hospitals will undergo a great deal of scrutiny. Hospitals are also being pressured to improve their financial viability in a competitive environment. Opponents of the tax-exempt status for not-for-profit hospitals will continue to cry foul and push for legislative and IRS rule changes. In light of all of these issues, all hospitals will be asked to demonstrate a high degree of excellence—through service to the community and accountability to the public.

FOOTNOTES

[1]Mark Baldwin, "Legislatures, agencies debating whether not-for-profit hospitals deserve their tax-exempt status," *Modern Healthcare*, May 22, 1987, p. 34.

[2]*Ibid.*

[3]*Ibid.*

[4]Jeffrey Finn, "Tax status of nonprofit ventures challenged: Interview with John Motley," *Hospitals*, January 5, 1987, pp. 46-47.

[5]Sec. 512-513, Internal Revenue Code.

[6]Sec. 3121(b)(8)(B), Internal Revenue Code.

[7]Kari Super Palm, "Hospitals losing tax status would pay in several ways," *Modern Healthcare*, June 3, 1988, p. 90.

[8]Bill Finger and Donald Horton, Jr. "Tax-Exempt Bonds for Manufacturers: How Effective in North Carolina?," *North Carolina Insight*, Vol. 9, No. 2, September 1986, pp. 4-5.

[9]Article V, Sec. 2(7), Constitution of North Carolina. "The General Assembly may enact laws whereby the state, any county, city, or town, and any other public corporation may contract with and appropriate money to any person, association, or corporation for the accomplishment of *public purposes* only."

[10]Chapter 738 (HB 1514) of the 1987 Session Laws.

[11]Chapter 830 (SB1252) of the 1987 Session Laws.

[12]"Non-profit hospitals branch out," *The News and Observer* (Raleigh, NC), June 13, 1987, p. 22A.

[13]Sec. 512-513, Internal Revenue Code.

[14]Jeffrey Finn, "IRS probes activities of tax-exempt groups: Interview with Edward Coleman," *Hospitals*, August 5, 1987, pp. 104-105.

[15]Steven Simpson and Robert L. Wilson Jr., Memorandum to the N.C. Center for Public Policy Research, March 28, 1988.

[16]As reported in Lynn Wagner, "Not-for-profit hospital executives defend tax-exempt status at committee hearings," *Modern Healthcare*, July 17, 1987, p. 18.

[17]"Congress to study income of tax-exempts' businesses," *Modern Healthcare*, February 27, 1987, p. 19.

[18]Cathy Tokarski, "Not-for-profit healthcare systems fear change in unrelated business income tax," *Modern Healthcare*, July 8, 1988, p. 26.

[19]Address by Robert Taylor, Duke University Medical Center Conference on Hospital Tax Exemptions, Durham, N.C., February 19, 1988.

[20]Lynn Wagner, "Not-for-profit hospital executives defend tax-exempt status at committee hearings," *Modern Healthcare*, July 17, 1987, pp. 18-19.

[21]John Leech, "Current unrelated business income taxation rules deserve preservation," *Trustee*, August 1987, p. 20.

[22]Remarks by Dan Bourque, Duke University Medical Center Conference on Hospital Tax Exemptions, Durham, N.C., February 19, 1988.

[23]"1988 State Legislative Forecast: The Leading Health Issues," *Federation of American Health Systems Review*, September/October 1987, pp. 22-23.

[24]Opinion of the Attorney General, State of California, Opinion No. 87-502, March 30, 1988.

[25]"Profits don't jeopardize hospital's tax exemption," *Modern Healthcare*, April 15, 1988, p. 9.

[26]Kari E. Super, "Fla. service tax will fund indigent care, aid hospitals," *Modern Healthcare*, June 19, 1987, p. 72.

[27]Marilyn Marks, "Florida Ends Tax on Services, Raises Sales Tax," *Governing*, January 1988, p. 57.

[28]Baldwin, p. 37.

[29]"Not-for-profit groups should pay some taxes," *Modern Healthcare*, July 29, 1988, p. 8.

[30]Baldwin, p. 37.

[31]"Pennsylvania Proposes Tax on Not-for-Profits," *Hospitals*, December 5, 1986, p. 22.

[32]HB 2344, 1988 Session of the General Assembly of Pennsylvania.

[33]Baldwin, p. 37.

[34]Jay Greene, "10 not-for-profit providers denied tax exemptions," *Modern Healthcare*, November 20, 1987, p. 11. See also "Salt Lake County Commissioners rule on tax exempt status for IHC hospitals," *Insights*, (Salt Lake City, UT: Intermountain Health Care Inc.), November 15, 1987, p. 1.

[35]"Utah will impose property taxes on non-profit hospitals," *State Legislatures*, January 1987, p. 9.

[36]Baldwin, p. 37.

[37]*Ibid.*

[38]Palm, p. 90.

[39]"News at Deadline," *Hospitals*, February 5, 1987, p. 4.

[40]Baldwin, p. 37.

[41]"Public hospitals seek amendment," *The News and Observer* (Raleigh, NC), May 9, 1987, p. 1A.

[42]Article V, Sec. 2(1), Constitution of North Carolina. "The power of taxation shall be exercised in a just and equitable manner, for *public purposes* only and shall never be surrendered, suspended, or contracted away."

[43]Address by Raymond Champ, Public Hospital Study Commission Meeting, Raleigh, N.C., December 15, 1987.

[44]"Illinois denies tax exemptions to subsidiaries," *Hospitals*, June 5, 1988, p. 57.

[45]Address by J. Phil Carlton, Public Hospital Study Commission Meeting, Raleigh, N.C., December 15, 1987.

[46]"Public hospitals seek amendment," p. 1A.

[47]Steven Simpson and Robert L. Wilson Jr., Memoran-

THE TAX REFORM ACT—WHAT DOES THE FUTURE HOLD FOR TAX-EXEMPT BOND FINANCINGS?

by Lori Ann Harris

TAX-EXEMPT BOND FINANCING offers many advantages to hospitals and investors. However, the concept of tax-exempt bonds has come under scrutiny by Congress. The federal Tax Reform Act of 1986 imposed new requirements and restrictions affecting most tax-exempt financing for not-for-profit hospitals. The tax reform act threatens, in the future, to classify not-for-profit hospital financing in the same category as funding for investor-owned companies and other private purposes.[1]

A landmark decision by the U.S. Supreme Court has fueled arguments to end continued tax exemption for municipal bonds. In *South Carolina v. Baker*[2], the state and the National Governors' Association challenged the government's authority to require federal registration of municipal bonds. The registration requirement was passed by Congress in 1982. The National Governors' Association argued that registration of municipal bonds is a tax on states. The Supreme Court ruled that the constitution does not restrain the power of Congress to tax interest on municipal bonds, and that Congress, "if it chooses, may end the federal tax exemption for state and local bonds." The decision overturned the 1895 precedent, *Pollack v. Farmer's Loan & Trust Co.*[3], and opens the way for taxing all municipal bonds.[4]

Congress is considering further limits on tax-exempt financing. In the 1987-88 Congress, there was a proposal to put a cap on the amount of all 501(c)(3) bonds, including hospitals bonds. The Congressional Budget Office has proposed direct subsidies for 501(c)(3) issuers in lieu of tax-exempt financing. With a direct subsidy, the borrower would receive all benefits, rather than sharing the benefits with investors in tax-exempt bonds.[5]

The future is uncertain for hospital bond issues as the attack on tax-exempt financing continues. Higher interest rates have greatly depressed the dollar volume of tax-exempt health care bonds and downgrading of hospital credit ratings continue to outpace upgradings. Hospitals are increasingly cautious about refunding outstanding debt. If anything, Congress will be looking for ways to raise more revenues and that means another round of debate over proposals affecting the tax-exempt bond market.

[1]Robert A. Cenci, "Not-for-profit capital financing faces new challenges after tax reform," *Trustee*, April 1987, pp. 29-30.

[2]108 S. Ct. 1355.

[3]157 U.S. 429 and 158 U.S. 601.

[4]Al Kamen and Anne Swardson, "High Court Rules Congress May Lift Tax Exemption on State, Local Bonds," *The Washington Post* (Washington, D.C.), April 21, 1988, p. A4.

[5]M.R. Traska, "Bond Battle: It isn't over yet, experts say," *Hospitals*, June 5, 1988, p. 32-33.

dum to the N.C. Center for Public Policy Research, March 28, 1988.

[48]Address by Susan Valauri, Public Hospital Study Commission Meeting, Raleigh, N.C., January 27, 1988.

[49]Address by Dan Pellegrini, Duke University Medical Center Conference on Hospital Tax Exemptions, Durham, N.C., February 19, 1988.

[50]Jay Greene, "Pittsburgh hospital appeals city's denial of tax exemption," *Modern Healthcare*, January 15, 1988, p. 38. See also Dean Mayer, "Pittsburgh non-profits skirt tax issue, pay fee," *Healthweek*, March 28, 1988, p. 1.

[51]Andy Sher, "Judge rules local hospital to keep tax-exempt status," *The Chattanooga Times* (Chattanooga, TN), February 6, 1988.

[52]"Nashville not-for-profits challenge property tax plan," *AHA News*, January 18, 1988, p. 3. See also Angela Cannon, "Appeal planned in hospital tax suit by metro," *Nashville Business Journal*, June 27, 1988. See also Jay Greene, "Tax man unmoved by not-for-profit hospital's charity case," *Modern Healthcare*, July 29, 1988, p. 28.

[53]"Vermont City Seeks to Tax A Non-Profit Hospital," *Governing*, December 1987, p. 12. See also Emily Friedman, "Interview with James Taylor," *Hospitals*, January 20, 1988, pp. 58-60.

[54]Lewin and Associates, Inc. *A Study of Investor-Owned Hospitals*, Health Services Foundation, Chicago, Illinois, 1976. Lewin and Associates, Inc. *Investor-Owned and Not-for-Profit Hospitals - A Second Look at Economic Performance*, Washington, D.C., 1984, p. 48.

[55]Frank Sloan and Robert Vraciu, "Investor-Owned and Not-for-Profit Hospitals: Addressing Some Issues," *Health Affairs*, Spring 1983, Vol. 2, No. 1.

[56]Regina Herzlinger and William Krasker, "Who profits from nonprofits?," *Harvard Business Review*, January/February 1987, pp. 93-105.

[57]"Access to Care and Investor-Owned Providers," *For-Profit Enterprise in Health Care* (Washington, DC: Institute of Medicine, National Academy Press, 1986), p. 114.

[58]*Ibid.*

[59]*Ibid.*

[60]Interview with Bradford Gray, May 18, 1988.

[61]Address by David Falcone, Duke University Medical Center Conference on Hospital Tax Exemptions, Durham, N.C., February 19, 1988.

[62]"Mission Matters" is the first chapter of the book, *In Sickness and in Health: The Mission of Voluntary Health Care Institutions*. (New York, NY: The United Hospital Fund of New York, 1987), p. 11.

[63]*Giving USA: The Annual Report on Philanthropy for the Year 1987*, American Association of Fund-Raising Counsel (AAFRC) Trust for Philanthropy, 1987, p. 16-17, 23, 43, 61. See also "Charitable Donations in U.S. Reach New High of $93.68 Billion," *The Grantsmanship Center Whole Nonprofit Catalog*, Summer 1988, p. 4.

[64]"News at Deadline," *Hospitals*, July 5, 1988, p. 12.

[65]As reported in Maureen Metz Charhut, "Trends in hospital philanthropy," *Hospitals*, March 16, 1984, pp. 73-74.

[66]*Ibid.*

[67]Anita Gunn Shirley, *Grantseeking in North Carolina: A Guide to Foundation and Corporate Giving*, (Raleigh, NC: North Carolina Center for Public Policy Research, 1985), p. 9.

[68]*Ibid.*

[69]*1982 Annual Report*, The Duke Endowment, pp. 71-82.

[70]*1986 Annual Report*, The Duke Endowment, pp. 53-60. Also Billy McCall, Deputy Executive Director, The Duke Endowment, personal communication, February 16, 1988.

APPENDIX A

The following tables list the amount of uncompensated care provided by North Carolina hospitals in 1984. The information in the tables has been taken from the Survey of Chief Executive Officers of North Carolina General Acute Care Hospitals.

Appendix A

Table A-1: Uncompensated Care Provided by Investor-Owned and Investor-Managed Hospitals in North Carolina Responding to N.C. Center's Survey (For Fiscal Year 1984)

Investor-Owned and Investor-Managed Hospitals	Indigent/ Charity Care Provided	Medicare/Medicaid Contractual Adjustments	Amount of Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Gross Patient Revenues	GPR	Uncompensated Care Per Bed	Number of Beds	Uncompensated Care Per Inpatient Admission	Number of Inpatient Admissions	Uncompensated Care Per Total Admissions	Number of Total Admissions
1. Ashe Memorial(IM)	$ 72,918	$ 949,188	$ 187,766	$ 260,684	4.6	$ 5,714,980	$ 3,430	76	$ 130	2,013	$ 28	9,258
2. Blue Ridge Hosp. System(IM)*	113,047	1,019,332	462,949	575,996	8.2	7,005,424	6,261	92	220	2,616	51	11,202
3. Cape Fear Valley Medical Center(IM)	NA	NA	7,065,563	7,065,563	10.3	68,597,699	14,361	492	362	19,510	69	102,363
4. Central Carolina(IO)	NA	NA	1,222,133	1,222,133	6.7	18,240,791	8,607	142	231	5,281	46	26,778
5. Davis Community(IO)	NA	1,032,675	746,604	746,604	5.4	13,913,199	5,011	149	135	5,510	38	19,408
6. Frye Regional Medical Center(IO)	NA	NA	2,086,000	2,086,000	6.0	34,766,667	7,585	275	248	8,413	42	49,708
7. Highsmith-Rainey(IO)	NA	684,000	808,081	808,081	4.6	17,635,969	5,387	150	197	4,102	50	16,062
8. Johnston Mem.(IM)	133,140	1,483,097	1,753,498	1,886,638	14.2	13,272,019	10,481	180	386	4,888	93	20,335
9. McDowell Hosp.(IM)	12,716	869,243	517,068	529,784	7.7	6,900,000	8,151	65	164	3,235	35	15,154
10. Medical Park(IO)	NA	489,295	148,889	148,889	1.2	12,400,000	1,095	136	21	6,989	9	15,731
11. Raleigh Community(IO)	NA	1,607,847	928,288	928,288	4.1	22,878,586	6,631	140	141	6,599	25	37,152

NA = Not Available

* The Blue Ridge Hospital System includes Burnsville Hospital and Spruce Pine Community Hospital.

Table A-2: Uncompensated Care Provided by Private Not-For-Profit and Public Hospitals in North Carolina Responding to N.C. Center Survey (For Fiscal Year 1984)

Not-For-Profit and Public Hospitals	Indigent/ Charity Care Provided	Medicare/Medicaid Contractual Adjustments	Amount of Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Gross Patient Revenues	GPR	Uncompensated Care Per Bed	Number of Beds	Uncompensated Care Per Inpatient Admission	Number of Inpatient Admissions	Uncompensated Care Per Total Admissions	Number of Total Admissions
1. Memorial Hospital of Alamance	$ 184,100	$ 1,418,011	$ 767,051	$ 951,151	6.2	$ 15,303,815	$ 4,284	222	$ 180	5,275	$ 42	22,448
2. Albemarle	274,234	3,361,081	1,320,858	1,595,092	8.2	19,426,664	7,743	206	269	5,935	65	24,634
3. Alleghany Co.	31,650	59,231	98,314	129,964	6.1	2,124,958	2,825	46	98	1,322	27	4,866
4. Annie Penn	298,356	2,360,518	1,150,059	1,448,415	10.7	13,600,000	9,529	152	308	4,699	43	33,558
5. Anson County	100,503	1,849,452	578,256	678,759	7.9	8,568,540	7,070	96	328	2,072	52	12,969
6. Bladen County	54,108	1,109,020	440,355	494,463	7.9	6,257,000	7,975	62	210	2,360	57	8,662
7. Cabarrus Memorial	NA	224,088	3,346,479	3,346,479	8.8	37,889,138	7,323	457	181	18,496	34	99,535
8. Caldwell Memorial	NA	2,154,702	1,743,007	1,743,007	10.2	17,079,160	13,408	130	315	5,528	78	22,379
9. Cape Fear Memorial	NA	2,038,495	526,840	526,840	3.8	13,765,756	3,710	142	130	4,056	30	17,388
10. Carteret General	254,816	1,945,396	1,477,510	1,732,326	11.7	14,828,074	14,557	119	340	5093	51	33,896
11. Catawba Memorial	673,163	2,754,592	2,017,363	2,690,526	10.3	26,063,347	10,348	260	307	8,769	69	38,714
12. C. Cannon Memorial	83,339	343,961	354,277	437,616	11.6	3,764,456	5,539	79	260	1,685	67	6,564
13. Charlotte Memorial	NA	11,217,000	3,436,157	3,436,157	2.4	142,618,000	4,028	853	121	28,431	17	197,189
14. Chatham Hospital	72,495	1,050,270	577,438	649,933	10.5	6,170,845	9,558	68	277	2,347	51	12,788
15. Chowan Hospital	110,971	1,400,007	628,720	739,691	8.6	8,564,227	6,786	109	316	2,343	62	12,008
16. C. J. Harris	95,137	1,523,533	557,943	653,080	7.0	9,301,588	8,164	80	166	3,930	56	11,630
17. Cleveland Mem.	485,357	1,495,770	2,328,121	2,813,478	10.6	26,649,118	9,378	300	250	11,259	37	75,334
18. Columbus County	NA	2,383,220	1,391,455	1,391,455	7.5	18,547,947	8,382	166	161	8,635	39	35,841
19. Community General of Thomasville	175,000	1,112,476	748,012	923,012	6.4	14,460,753	6,593	140	172	5,362	43	21,641
20. Craven Co. Hospital	NA	4,802,240	3,013,348	3,013,348	8.0	37,666,846	11,864	254	278	10,839	60	50,223
21. Davie Co. Hospital	NA	101,816	393,515	393,515	7.3	5,400,000	5,465	72	161	2,447	47	8,369
22. Duplin General	NA	801,819	749,747	749,747	12.0	6,231,771	9,372	80	283	2,651	63	11,984

NA = Not Available

Table A-2 (cont.): Uncompensated Care Provided by Private Not-For-Profit and Public Hospitals in North Carolina Responding to N.C. Center Survey (For Fiscal Year 1984)

Not-For-Profit and Public Hospitals	Indigent/ Charity Care Provided	Medicare/Medicaid Contractual Adjustments	Amount of Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Gross Patient Revenues	GPR	Uncompensated Care Per Bed	Number of Beds	Uncompensated Care Per Inpatient Admission	Number of Inpatient Admissions	Uncompensated Care Per Total Admissions	Number of Total Admissions
23. Durham County	$ 720,163	$ 5,207,020	$ 2,751,261	$ 3,471,424	5.7	$ 61,121,212	$ 7,293	476	$ 218	15,945	$ 73	47,806
24. Forsyth Mem.	1,522,646	8,412,710	3,376,247	4,898,893	5.7	85,790,036	6,429	762	156	31,308	39	124,058
25. Gaston Memorial	435,311	6,738,411	3,498,662	3,933,973	8.4	46,763,182	9,128	431	227	17,332	40	98,609
26. Good Hope	820,780	1,000,078	NA	820,780	11.3	7,245,000	11,399	72	331	3,023	47	21,062
27 Grace Hospital	363,513	1,546,553	1,419,294	1,782,807	9.3	19,203,925	11,073	161	240	7,425	46	38,301
28. Granville Hosp.	108,596	747,194	338,867	447,463	8.2	5,450,000	6,580	68	259	1,730	30	14,707
29. Halifax Memorial	404,200	3,242,738	994,012	1,398,212	8.0	17,513,939	7,359	190	177	7,903	49	28,462
30. Hamlet Hospital	NA	999,643	452,262	452,262	8.5	5,295,000	7,538	60	269	1,684	51	8,927
31. Haywood County	NA	1,004,509	1,242,728	1,242,728	7.4	16,764,302	6,214	200	180	6,911	30	42,026
32. High Point Regional	545,134	2,497,505	3,112,623	3,657,757	10.7	34,290,832	12,971	282	272	13,448	76	48,371
33. Iredell Memorial	264,431	2,497,362	952,435	1,216,866	5.7	21,443,776	6,686	182	149	8,191	36	33,837
34. J. Arthur Dosher	NA	615,959	569,632	569,632	11.7	4,867,787	14,241	40	355	1,605	82	6,911
35. Kings Mountain*	NA	1,326,138	NA	1,326,138	22.7	5,853,000	13,001	102	495	2,679	103	12,863
36. Lenoir Memorial	737,055	2,188,794	2,284,093	3,021,148	10.3	29,404,135	10,751	281	269	11,240	76	39,751
37. Lexington Mem.	NA	947,000	1,505,700	1,505,700	11.6	13,025,000	16,018	94	322	4,672	48	31,631
38. Lincoln County	106,320	226,691	745,579	851,899	13.0	6,529,485	7,745	110	239	3,570	50	16,978
39. Martin General	74,417	453,906	474,617	549,034	15.6	3,511,884	11,205	49	371	1,480	78	7,042
40. Memorial Mission	883,417	3,194,102	5,550,523	6,433,940	9.1	70,634,367	14,791	435	335	19,234	99	64,898
41. Montgomery Mem.	83,107	NA	665,207	748,314	11.9	6,300,000	13,128	57	259	2,886	39	19,402
42. Moses Cone	986,319	6,439,963	5,921,691	6,908,010	9.0	76,893,944	14,761	468	370	18,688	77	89,758
43. Mountain Park (now District Mem.)	37,380	NA	213,193	250,573	8.1	3,080,307	4,108	61	187	1,337	49	5,090
44. Murphy Medical*	NA	1,057,066	NA	1,057,066	18.7	5,659,083	6,218	170	546	1,937	115	9,180

NA = Not available

* Data was not included in Chapter 2's analysis; Center obtained data for this table at later date.

Table A-2 (cont.): Uncompensated Care Provided by Private Not-For-Profit and Public Hospitals in North Carolina Responding to N.C. Center Survey (For Fiscal Year 1984)

Not-For-Profit and Public Hospitals	Indigent/ Charity Care Provided	Medicare/Medicaid Contractual Adjustments	Amount of Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Gross Patient Revenues	GPR	Uncompensated Care Per Bed	Number of Beds	Uncompensated Care Per Inpatient Admission	Number of Inpatient Admissions	Uncompensated Care Per Total Admissions	Number of Total Admissions
45. N.C. Baptist	$ 2,354,000	$ 7,231,000	$ 4,282,000	$ 6,636,000	5.4	$ 122,821,303	$ 9,466	701	$ 264	25,140	$ 75	88,361
46. N.C. Memorial**	18,421,039	7,781,931	3,474,005	21,895,044	16.9	129,330,443	36,675	597	1,109	19,736	68	322,540
47. New Hanover Mem.	487,241	5,096,477	5,501,954	5,989,195	9.4	63,692,958	13,192	454	298	20,128	68	88,002
48. Northern Hospital of Surry County	60,000	1,000,000	600,000	660,000	4.8	13,772,146	6,111	108	126	5,243	19	34,131
48. Park Ridge	101,608	390,666	471,131	572,739	8.2	6,996,964	5,561	103	215	2,670	62	9,267
50. Pender Memorial	NA	689,765	355,731	355,731	8.8	4,056,675	8,085	44	233	1,527	41	8,773
51. Pitt Co. Mem.	264,581	8,602,314	6,743,715	7,008,296	8.7	80,386,112	13,027	538	366	19,143	100	70,395
52. Presbyterian	668,307	5,428,625	1,140,213	1,808,520	2.4	75,900,000	3,331	543	65	27,805	21	84,640
53. Rex Hospital	39,790	2,684,633	2,485,765	2,525,555	4.0	62,600,000	6,410	394	140	18,063	46	55,391
54. Richmond Mem.	NA	1,254,841	1,208,729	1,208,729	10.3	11,689,126	9,908	122	321	3,771	42	29,052
55. Roanoke-Chowan	186,740	1,964,772	882,868	1,069,608	9.2	11,660,344	8,913	120	215	4,986	69	15,546
56. Rowan Memorial	24,426	1,251,733	1,892,873	1,917,299	7.4	25,917,673	5,918	324	160	11,977	45	42,631
57. Scotland Memorial	91,610	1,937,911	1,541,193	1,632,803	9.8	16,600,000	9,896	165	290	5623	48	33,877
58. Sea Level	NA	511,235	81,025	81,025	2.2	3,656,689	1,125	72	108	752	40	2,038
59. Sloop Memorial	NA	371,141	416,080	416,080	10.7	3,897,672	10,949	38	228	1,826	81	5,122
60. Southeastern Gen'l	NA	5,400,000	3,354,000	3,354,000	8.9	37,500,000	9,448	355	299	11,211	77	43,576
61. Stanly Memorial	20,820	466,043	738,492	759,312	7.3	10,400,000	5,841	130	176	4,304	46	16,595
62. St. Luke's Hosp.	58,596	320,359	177,348	235,944	5.4	4,400,000	3,188	74	133	1,779	34	6,911
63. Stokes-Reynolds	NA	1,218,746	330,808	330,808	5.8	5,709,513	3,308	100	173	1,911	43	7,678
64. Valdese General	37,387	1,081,136	520,121	557,508	5.2	10,690,000	4,161	134	149	3,736	51	11,033
65. Wake Medical	1,086,764	8,754,973	7,576,507	8,663,271	8.9	97,638,321	16,533	524	431	20,079	82	105,243
66. Wayne Memorial	414,608	3,373,846	2,238,354	2,652,962	8.8	30,036,382	7,780	341	234	11,343	81	32,721
67. Wilkes General	305,870	2,151,191	1,622,648	1,928,518	12.9	14,960,000	14,500	133	287	6,729	43	45,170

NA = Not Available

** Data not included in Chapter 2's analysis because hospital is state-owned.

APPENDIX B

Survey of Chief Executive Officers of North Carolina General Acute Care Hospitals

North Carolina Center for Public Policy Research

Survey of Chief Executive Officers of North Carolina General, Acute-Care Hospitals

Date _____

Name of Hospital _____
Mailing Address _____
_____
_____
Number of Acute-Care Beds in Use _____

Is this hospital currently owned, leased, or managed by a multi-institutional hospital management company (for example, Hospital Corporation of America or SunHealth)?

Owned (Y or N) _____ Name of company _____
Leased (Y or N)_____ Name of company _____
Managed(Y or N)_____ Name of company _____

Name of Chief Executive Officer _____
When did he or she begin working at this hospital _____
How long has he or she worked with this hospital management company (if applicable) _____
Hospital's fiscal year begins _____ and ends _____
Month/Day Month/Day

Taxes

1. Please list the types and amounts of taxes your hospital paid to all levels of government in fiscal year 1984. The list below is provided as a suggestion only and is not intended to be exhaustive.

Type of Tax	Amount ($)	Paid to (√) Federal	State	Local
Real property				
Personal property				
Inventory				
Intangibles				
Sales				
Social Security				
Unemployment				
State income				
Federal income				
Other (please specify)				
_____				
_____				
_____				
_____				

N. C. Center for Public Policy Research
Hospital Chief Executive Officer Survey
November 25, 1985

Services

2. The N. C. Center seeks to learn of the types of services provided at general hospitals in North Carolina. Using the area below, please check (✓) the appropriate column to indicate
whether this hospital **offers** (or previously offered) the listed service;
whether the service has been **added** or **discontinued** and if so, when;
or whether the level of the service has been **reduced**.

Use fiscal year 1980 as the beginning date. *If this hospital has undergone a change in ownership or management since 1980,* ***please list the date(s) of the management change(s) at the bottom of this page.*** **If you require more room for additional services or reasons, please attach another sheet of paper.**

Name of Service	Offered in 1980	Added	Date	Discontinued	Date	Reduced	Reason
Inpatient:							
General Medicine							
Intensive Care Unit							
Cardiac ICU							
Pediatrics							
Psychiatry							
General Surgery							
Neurosurgery							
Thoracic Surgery							
Gynecology							
Eye, Ear, Nose & Throat							
Urology							
Orthopedics							
Obstetrics							
Abortions							
Nursery							
Neonatal ICU							
Pharmacy							
Physical Therapy							
Other_____							
_____							
_____							
_____							
Outpatient:							
Surgery							
Emergency Room							
Clinic							
Other_____							
_____							
_____							
_____							

Indigent Care

3. Does this hospital provide free care to indigent patients? Please do not include any contractual adjustments for Medicare and Medicaid in your answer. (Y or N)_____

a. If yes, how do you describe this expenditure on your financial records? Please define each as used in your hospital accounting.

_____as Charity care?
_____as Indigent care?
_____as Bad Debt?
_____Other (please explain)

4. For the hospital's fiscal year ending in 1984, please provide the following:

	Amount Budgeted	Amount Actually Provided	How Much as a Percentage of Gross Revenues
Free indigent care			
Charity care			
Medicare			
Medicaid			
Bad Debt (if different from the above)			

5. Do you require a deposit or proof of insurance coverage before admitting a patient? (Y or N) _____
If yes on the deposit, how much? _____

6. Does your hospital have a responsibility to provide free care under the federal Hill-Burton legislation? (Y or N) _____
If yes, what amount were you required to provide during the fiscal year that ended in 1984?_____

Thank you for your assistance. Please return the completed survey form to
Ms. Lacy Maddox
Research Coordinator
N. C. Center for Public Policy Research
Post Office Box 430
Raleigh, N. C. 27602 using the enclosed envelope.

If you have any questions or comments about the survey, please direct them to Ms. Maddox at the above address or at (919) 832-2839.

In case we have questions of you after receiving this survey, please tell us how to get in touch with you, the responding hospital representative.
Name _____
Title _____
Telephone Number _____

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