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The Changing American Hospital in the Twenty-first Century

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THE 14TH ANNUAL
HERBERT LOURIE MEMORIAL LECTURE ON HEALTH POLICY
**The Changing American Hospital
in the Twenty-first Century**

Ralph W. Muller

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From 1985 to 2001, **Ralph W. Muller**, Managing Director of Stockamp & Associates, Inc., was President and CEO of the University of Chicago Hospitals and Health Systems, a regional medical system serving a major portion of the greater Chicago area and adjacent parts of Indiana and Michigan. As deputy dean of the University of Chicago's Pritzker School of Medicine in 1985-1986, he guided the creation of the UCHHS as a corporation separate from the university, where he had been budget director. Mr. Muller received his B.A. in economics from Syracuse University and M.A. in government from Harvard University.

The Herbert Lourie Memorial Lecture on Health Policy, sponsored by the Maxwell School of Citizenship and Public Affairs of Syracuse University and the Central New York Community Foundation, Inc., honors the memory of Herbert Lourie, M.D., a distinguished Syracuse neurosurgeon, professor, and community leader for nearly 30 years. Generous contributions from his family, friends, colleagues, and former patients have endowed this series.

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Policy Brief

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The Changing American Hospital in the Twenty-first Century

One is always hesitant to speak about the future. A famous philosopher from New York, Yogi Berra, said “Making predictions is difficult, especially about the future,” and I have some trepidation about doing so now. There is also the difficulty of understanding what really has happened in the past. I recall the Bolshevik general in 1917 who said, “The future is clear, but the past is very murky.” We anticipate the future with more clarity than is justified, even as we disagree on what is happening right now or what happened before. In that vein, I will describe the role of the American hospital in our health care system, and the challenges it must meet, reviewing first the murky past by summarizing trends that have made hospitals what they are today.

Historical Background

The so-called health care “system” in the United States has always been two-tiered: public charity for the poor and private care for everyone else. Hospitals in this country began not as scientifically based medical centers but as philanthropic responses to a social need. The first hospitals were part of municipal almshouses; they received private donations and local government funds to house and feed the destitute, elderly, mentally ill, and orphans of the community, some of whom required health care. The first hospital opened in 1658 in a small poorhouse supported by a church in New Amsterdam; it was the forerunner of Bellevue Hospital (New York City).

No self-respecting person would voluntarily enter such a hospital for treatment, unless he fell ill while traveling. Most working class, middle class, and wealthy people were nursed and cared for by relatives at home. There was little health care that could not be provided at home anyway; most of it was palliative and long-term, while the disease ran its course.

Lourie Lecture Policy Brief

In 1754, the first general hospital opened specifically to care for the sick, Pennsylvania Hospital in Philadelphia. It was co-founded by Benjamin Franklin, a pivotal figure in the history of the American hospital. When attempts to raise money by private voluntary donations proved insufficient, Franklin devised a public-private matching grant scheme to finance the building. As Miller (1996) observes:

It is essential to understand Franklin's chameleon-like nature and leadership style since much of American health care falls under his shadow. His pragmatic character and actions generated the ambivalent versatility...of America's voluntary health care institutions. These versatile institutions combine and recombine the good and bad aspects of ideology and utopia. The methods for creating decision-making networks that were mobilized to form the physician-community coalitions necessary to build local hospitals in the 200 years that followed Franklin's founding of Pennsylvania Hospital...were first spelled out in Franklin's widely read *Autobiography*.... There he described how he catalyzed the formation of America's first community, not-for-profit hospital. The curious chameleon-like ability of the twentieth-century American hospital to reinvent itself to meet shifting social needs...had its origins in Franklin's invention and immediate re-invention of Pennsylvania Hospital...[H]e undogmatically moved the proposed hospital from being a private, nonprofit institution to being largely private, but with public financing—that is, a hybrid. He had thereby reinvented the American community hospital even before it was built. A chameleonlike genius thereby created the chameleonlike voluntary hospital, an institution that by its origin and nature could be continually reinvented—repositioned along a public/private continuum—to get a changing community task done.

Thereafter, unlike in Canada or Great Britain, where a single hospital system supports virtually all sectors of society, two types of

Ralph W. Muller

hospitals developed in the United States side by side: municipal hospitals for the poor and those chronically or incurably ill, dangerous, or morally undeserving patients who were excluded from the private facilities, and voluntary charitable hospitals for the rest (Boychuk 1999).

A flood of immigrants in the mid-1800s, combined with internal migration from rural, agricultural, family-centered communities to urban centers—both of which separated people from their roots—increased the demand for private hospitals for working and middle class patients. The second phase of hospital development in this same period witnessed the growth of specialized facilities for certain diseases, denominational or ethnic hospitals (reflecting the influx of large numbers of Catholic and Jewish immigrants), and hospitals for categories of patients, such as women or children. Many of these, such as Jew’s Hospital (later Mount Sinai) became important cultural and social centers within their ethnic communities.

In the late 1800s and early 1900s there was a large increase in the number of proprietary hospitals owned and operated by physicians for the benefit of their patients recovering after surgery. Up to this point, hospitals and medical practice had relatively little to do with each other, and there was still little effective treatment for diseases of the time. Harvard Professor Lawrence J. Henderson is credited with identifying the year 1910 as the “Great Divide” in United States medical care, when

for the first time in human history, a random patient with a random disease consulting a doctor chosen at random stood better than a 50-50 chance of benefiting from the encounter. (as quoted in Curran et al. 2002)

Lewis Thomas trained at Harvard Medical School in the mid-1930s, just before antibiotics were introduced. In his autobiography he wrote:

As early as 1937, medicine was changing into a technology based on genuine science. The signs of change were there, hard to see because of the overwhelming numbers of patients for whom we could

Lourie Lecture Policy Brief

do nothing but stand by, but unmistakably there all the same....I can recall only three or four patients for whom the diagnosis resulted in the possibility of doing something to change the course of the illness, and each of these involved calling in the surgeons to do the something—removal of a thyroid nodule, a gallbladder, an adrenal tumor. For the majority, the disease had to be left to run its own course, for better or worse.

War, and the need to care for large numbers of ill and injured soldiers after the fighting had ended, prompted construction of state homes for veterans, followed eventually by a broader national response. At the federal level, the Veterans Administration was established in 1930; today VA hospitals comprise the single largest hospital system in the United States. To upgrade the quality of these facilities, many of them established relationships with nearby medical schools for clinical research, much of which was funded by the newly established National Institutes of Health (NIH).

In 1946, in response to a perceived shortage of hospital beds, Congress passed the Hospital Survey and Construction Act (known as the Hill-Burton Act), which provided federal funds to construct new hospitals. The act imposed an uncompensated care obligation on these new hospitals, which required them to provide a certain dollar amount of free or discounted care following the completion of any construction project using Hill-Burton funding, and a community services obligation to make their services available to anyone living within the facility's service area who had some ability to pay. But rather than create a nationwide network of federally-administered hospitals for public use, these federal funds were specifically targeted to nongovernmental community hospitals. Many smaller proprietary hospitals could no longer compete for access to capital and closed, or converted to "community" hospitals. Hill-Burton was terminated in 1974, when it began to look like excess capacity had replaced shortages, and was replaced with federal and state policies oriented toward cost containment that continue through today.

Today we are experiencing an era of consolidation. The traditional freestanding general hospital is giving way to larger multi-hospital

Ralph W. Muller

systems, accompanied by establishment of for-profit multi-hospital chains formed by the acquisition of former non-profit or public hospitals. Whereas in 1945 there were 6,500 hospitals in the United States, today there are about 5,800, including 3,000 non-government, not-for-profit community hospitals, 1,160 state and local government community hospitals, and 750 investor-owned (for-profit) community hospitals (AHA Resource Center 2002).

The hospital, as we now know it, is an institution of medical science rather than social welfare.

Increased Third-Party Funding of Health Care

David Lawrence, who recently retired as CEO of Kaiser Permanente Foundation Health Plan, described the early roots of prepaid health insurance in his Lourie Lecture Policy Brief.

The first example of a fully integrated system was in Oklahoma. [In 1927] a Syrian immigrant named Michael Shadid reacted to an experience he had with a colleague. A fee-for-service surgeon who needed money performed three unnecessary surgeries on three patients in one night and all three died. Michael Shadid was apparently so incensed that he began to search for an alternative way to organize care. He organized the first real cooperative of its sort in the United States as an integrated, prepaid health care system in Elk City, Oklahoma. The Cooperative Hospital of Elk City is now Great Plains Regional Medical Center; it converted from cooperative status in 1965.

At the start of the Depression, in the early 1930s, only 2 percent of the U.S. population was covered by health insurance, and hospitals were losing money on patients who could not pay their bills. Dr. Rufus Rorem conceived of Blue Cross as local, community-based service agencies to “promote hospital group prepayment” within “unique local settings” (Miller 1996). “Of the 39 Blue Cross plans started in the 1930s about half got their start-up funds exclusively from hospitals, half from a variety of local community sources.” He deliberately opposed merging local Blue Cross Plans into statewide

Lourie Lecture Policy Brief

organizations. World War II spawned the growth of employer-subsidized commercial health insurance for workers, as a way to increase work incentives while complying with wage controls.

In 1965, Congress passed legislation to provide basic public insurance coverage for the elderly (Medicare) and the poor (Medicaid). These programs were never intended to cover all medical expenses, but to pay for basic hospital and doctor care.

Americans on average pay only about 3 percent of their hospital expenditures directly out-of-pocket, well below the 17 percent out-of-pocket average for all personal health care expenditures. Nearly all the rest is covered by private and public health insurance, 33.7 percent and 58.3 percent respectively (Centers for Medicare and Medicaid Services 2001). Thus, there is a major disconnect between the sources of payment and the beneficiaries of hospital services, which may have resulted in unrealistic demands for more services.

The U.S. spends more than any other countries on health care, over \$5,000 per person. Canada spends roughly about \$2,500, and Britain less than \$2,000. Yet the clear preference of voters and employees is to get more and more health care, whether it's access to pharmaceuticals or hospital care. And the demand for new technology—imaging scans, PSA tests, early detection screening for breast cancer—keeps increasing, even as objective research is sometimes skeptical of the benefits. The public wants access, and in a democratic system they are going to keep demanding access to new services as they are produced.

Hospitals Policy Reflects Community Desires

In 1973 Peter Drucker wrote “The hospital... has grown from a marginal institution to which the poor went to die...into one of the most complex social institutions around.” Hospitals provide care for people when they are most vulnerable, in settings that require the coordination of many professionals and other care givers, supported by an array of services usually seen separately in hotels, schools, insurance companies, community agencies, and retail stores. The care received can often require the largest financial expenditure made by a family in a year or, except for housing, a lifetime. One of

Ralph W. Muller

my themes is that a central dilemma of hospitals is how to balance the public's desire for more access to medical care with the public's willingness to pay for it. The hospital is a focal point where these decisions get made in American society, because the other settings in which those choices can be made, such as the Congress, are not taking that responsibility. By default, hospitals become the venue for these tradeoffs.

I recently came back from England, where I studied the British health system. By contrast with the British system, the American system doesn't have a central place in which to decide health policy. The British system centralizes health policy and delivery through the government. By contrast, the health care choices of the American public are made locally, often in hospitals.

Challenges in the 21st Century

In 2002 a survey of 45 hospital executives identified the major challenges facing hospitals in this country, ranked by how often they were mentioned and how concerned the hospital executives were about them. The American Hospital Association issued a report in August 2002, *Cracks in the Foundation: Averting a Crisis in America's Hospitals*, that documented those challenges.

1. Inadequate Reimbursement Levels

Reductions in Government Payments

Even with all the added cost pressures, spending by the largest program, Medicare, has not been equal to inflation. In 13 of the last 15 years, hospitals did not receive a payment rate increase from Medicare equal to inflation. The cumulative effect is a 21 percent gap for large hospitals (the category for most teaching hospitals) in that period, versus an inflationary increase. As a result, 58 percent of the hospitals in the country lost money on Medicare in 2000. Seventy-three percent lost money on Medicaid as state policies were adopted to reduce public spending.

Due to these protracted measures to force hospitals to absorb the increased costs of care, on average Medicare now pays roughly cost, Medicaid about 5 percent below cost, and private insurers pay 12

Lourie Lecture Policy Brief

percent above cost. Therefore in hospitals, payments made for the employed insured help cover Medicare and Medicaid shortfalls. This cross-subsidy of publicly funded care by private insurance purchasers is becoming less and less acceptable, as employers and workers resist the double-digit growth of their premiums. As the percentage of hospital costs that are being covered through private payer payments declines, hospitals need governmental payers to come closer to paying the costs of care.

When government payments increase, private payers reduce payments to hospitals. And when the government reduces its payments, hospitals negotiate with private insurers for higher payments. The biggest employee purchasing coalition in the country, Calpers in California, just required a 25 percent rate increase from its members. As increases of this magnitude are not sustainable, a major cutback is likely.

2. Uninsured and Underinsured Patients

The number of uninsured people, which dropped as a result of the strong economy of the 1990s, is now up to 41 million, or 14 percent of the population. And underinsurance resulting from caps on Medicaid coverage (see Danzon and Soumerai's *Lourie Lecture Policy Brief 2002*) is more likely to occur as the states go deeper into the red and struggle to cut their expenses.

Many hospitals are required by federal law to care for the uninsured. In 2000 they provided \$21.6 billion of uncompensated care. The Medicare Disproportionate Share Hospital payments (discussed below) compensate hospitals for indigent care, but these cover Medicaid shortfalls, not charity care, and it falls substantially below need. Other subsidies are provided by state and local governments. Yet the AHA report states that in 2000, hospitals received only 82 cents for every dollar spent caring for Medicaid and charity care patients.

3. Severe Workforce Shortages

The AHA (2002) wrote "Health care is about people caring for people, but we face a severe shortage of caregivers and other

Ralph W. Muller

workers.” Nationwide, in 2001 the vacancy rate for registered nurses was 13 percent, for imaging technicians 15.3 percent, for billing/coders 8.5 percent, and even housekeeping and maintenance had difficulty filling all its positions. Hospitals report that they are less able to provide needed services as a result.

About 60 percent of all RNs working in nursing are employed in hospitals. Aiken (2001) reports that

Hospital nurses as a group are among the least satisfied workers in the nation. A 1999 survey revealed that more than 40 percent of hospital nurses were dissatisfied with their jobs....Moreover, job dissatisfaction among nurses is highest among those employed in hospitals, even higher than nurses employed in long-term care settings.

Employment alternatives for women have grown in recent years. Salary levels for nurses, in real noninflated dollars, have remained flat in the last decade. There is no federal standard, nor even a consensus, for what constitutes “enough” nurses to do the work required. And there’s a growing dissatisfaction with mandatory overtime and the increased deskwork, leading to the loss of patient contact and hands-on caregiving that attracted many women to nursing in the first place.

Demographically, as the overall population ages, the nursing workforce is getting older as well. The average age of RNs working in nursing is now about 43 years. Significantly, the percentage of RNs under age 35 dropped by about half between over the last twenty years, from 40 to 18 percent.

4. Unwieldy Regulatory Requirements

Hospitals are highly regulated from a health provision perspective at the state level, by the federal government as a condition of participating in Medicare, and by the Joint Commission on Accreditation of HealthCare Organizations, and by various other government agencies that oversee workplace safety, environmental protection, and other aspects of business firms in general. The AHA

report contains a chart showing nearly 40 specific agencies and categories of regulatory bodies that have a role in the oversight and regulation of hospitals, at federal, state, and local levels. The report states:

Confusing, contradictory and cumbersome regulations force caregivers to spend more time on paperwork and less on patient care....Paperwork requires at least 30 minutes—often as much as an hour—for every hour of patient care provided.... Excessive paperwork not only shortchanges the patient, it also makes the job of the health care professional less rewarding—a key issue in making the health care field attractive to future workers.

5. Rapidly Changing Patient Demands

As use for hospital services increased, shortages, diversions and other measures of the imbalance between demand and supply have appeared in the last two or three years. There is little relief in sight. The proportion of the population over 65 will rise the most of any age grouping in the coming decades. As hospitalization for complex medical problems is highest for those over 65, the demographic projections imply even greater demands on the hospital and, because the payment systems tend to underpay for medical rather than surgical admissions, greater financial stress.

6. Constrained Capacity, Decreased Access to Capital

The demand for hospital services is going up again, and not just for inpatient care. Outpatient care has increased by 5 to 8 percent a year for 20 years. And emergency room activity is up sharply as well.

As a result, admissions into hospitals are getting backed up and held inside the emergency room: in a sample month in 2001, 56 percent of urban hospitals in the country reported that they had at some point been “on diversion,” or not taking emergency patients.

For a patient, it is distressing to go to the hospital and find that the hospital can't take you. “The inn is full” is not a good sign for the hospital to have up, as the public trust and support for hospitals

Ralph W. Muller

depends on care being available to those who are sick and highly vulnerable.

Why are these hospitals not taking patients at times inside the emergency room? Lack of critical care beds was the major reason. Critical care beds are those with monitors and intensive care capacity, the type of beds that hold patients in urgent need. While some patients could be held elsewhere, in cases of heart failure or accident, for example, the monitored bed is needed and if the hospital doesn't have enough monitored or critical care beds, critically ill patients are turned away .

And hospitals are aging physical plants. The median age of a hospital plant has risen from 7.9 years in 1990 to 9.3 years a decade later. Yet hospital borrowing capacity is diminished by low operating margins and mounting bad debts, both of which have a negative effect on bond marketability. In 2001, the bond ratings of 10 non-profit hospitals were upgraded, while 60 were downgraded. The difference between AAA and BB, the upper and lower bounds of marketability, is the higher interest rate that a less creditworthy hospital must pay to attract an investor. Hospitals in recent years are demonstrating increasingly aggressive bill collection behavior. They have begun to turn unpaid bills over to third-party collectors after only 30 to 60 days. Certainly they need the money, but they also need to qualify for a higher rating on the bond market (Access Project 2003). A 7 percent profit margin is required to qualify for a AA rating, but most hospitals run well below that.

7. Rapidly Rising Costs

The costs of the inputs, the elements that together make up units of hospital care, are rising rapidly, beyond the general rates of inflation.

Labor: One effect of fewer workers to draw from is that labor costs, which are hospitals' single biggest expense, are rising more than 50 percent faster than those of other service industries (AHA 2002).

Pharmaceuticals: Patricia Danzon and Stephen Soumerai discussed pharmaceuticals in their Lourie Lecture Policy Brief. Drug costs

Lourie Lecture Policy Brief

make up less than 10 percent of total health care expenditures but their rate of growth is much more rapid (17 percent in 2000) than expenditures for hospitals or physicians. In 2001, according to the AHA, the cost of a pint of blood increased an average of 31 percent.

Professional Liability: Hospital costs also reflect enormous increases in the price of malpractice insurance. In 2002, nearly 90 percent of hospitals reported substantial increases in their professional liability premiums; one-third reported premium increases of 100 percent or more.

Post September 11 Disaster Readiness: Hospitals are now charged with firstline response to any nuclear, chemical, or biological attacks on their communities.

Teaching Hospitals: National Resources That Require Greater Support

The 125 academic medical centers in the United States perform missions that provide benefits for society as a whole. They bear primary responsibility for training the next generation of health professionals, for conducting biomedical research to improve the quality and effectiveness of medical care, for providing highly specialized health care, as well as care to indigent and uninsured patients. For example, while teaching hospitals comprise one-fifth of all hospitals in the country, 68 percent of burn care units, 65 percent of transplant units, 62 percent of pediatric ICUs, 59 percent of neonatal ICUs, 58 percent of open-heart surgeries, 53 percent of PETs, and 52 percent of level I and II trauma centers are in teaching hospitals. Most major advanced specialized services are located, disproportionately, inside the teaching hospital.

Teaching hospitals are centers for community services, such as crisis prevention, AIDS, geriatric services, substance abuse, and outpatient services. As an illustration, 75 percent of major teaching hospitals have geriatric units, whereas only about 35 percent of non-teaching hospitals do. Thus while the major university hospitals are considered specialty centers, they also are centers of community-based and outpatient care, particularly for the poor with little or no third party coverage.

Ralph W. Muller

Major teaching hospitals provide 40 percent of the hospital-based charity care in the country. These mission-related costs represent nearly 30 percent of total costs.

In 1983 Medicare began paying hospitals prospectively, by diagnosis-related group (DRG) for each admission, which threatened to reduce disproportionately the level of compensation to teaching hospitals. In recognition of their contributions to the public, the Medicare program introduced “indirect medical education (IME)” payments as an add-on to reflect that teaching hospital patients are on average, sicker; that these teaching hospitals provide specialized programs; and that there are additional costs associated with the teaching of residents. In 1998, teaching hospitals received an average of \$24,000 per eligible resident toward the direct costs of residency training, plus \$48,000 per eligible resident to cover such indirect training expenses as additional diagnostic services, decreased productivity of nurses and other staff who help teach residents, and increased use of medical technology for research and educational purposes. Another Medicare payment, the Disproportionate Share Hospital (DSH) program, was begun in 1986 to offset the costs of hospitals that serve the indigent. Currently 38 percent of general acute care hospitals, including 63 percent of teaching hospitals, receive DSH payments (Nicholson 2002).

As a result, teaching hospitals have considerable stake in these supplemental payments. Originally the DRG payment was increased, with an IME adjustment, by 11.6 percent for every 10 percent increase in the number of residents per hospital bed. In 1997, Congress passed the Balanced Budget Act (BBA), which proposed to substantially reduce IME payments by almost 30 percent over four years. Relief legislation passed in 1999 and 2000 delayed the BBA reductions and froze the IME adjustment at 6.5 percent (per 10 percent increase in the resident-to-bed ratio) in 2001 and 2002, but lowering it to 5.5 percent in 2003. Nevertheless, inflation-adjusted spending on teaching hospitals is still less in 2002 than it was in 1997. These Medicare reductions have contributed to the lowering of the operating margins of the average teaching hospital to about 2 percent a year, compared to 4 percent for non-teaching hospitals.

Health Care Policies Are Rooted in the Community

As noted earlier, hospitals were started as institutions based in the community reflecting religious, university, and community purposes. Today, 85 percent of U.S. hospitals are not-for-profit organizations. The hospital is and will likely continue to be a setting where health policy choices get made by doctors and nurses on a daily basis in interaction with the patient. The United States does not have a health policy that says “you can get access to an MRI, you can get access to PSA screening, or you get access to an intensive care bed.” On a local basis in hospitals, doctors and nurses together with the patient make these choices. While their choices are somewhat influenced by health insurance coverage, 85 percent of people are well insured. For this population, what they decide in consultation with their doctor and nurse is what level of care they receive. In this country, that choice exists in a decentralized, local process, at the level of doctor and nurse, unlike more centralized control systems, for example, in the U.K. and Canada.

The support for one effort to have a major public policy change in the health care system ten years ago by President and Mrs. Clinton was fatally eroded as its specifics became known. In the same way as Medicare, when it was proposed in 1948, was not enacted for another eighteen years, we’re at least ten years away from any other major change in the health care system in this country. As a result of the failure of the Clinton plan, proposals for sweeping change will be avoided because of the political fallout. Instead, change will occur on a local, incremental basis. In 2000 Lynn Etheredge (2001) neatly summarized the current situation in his assessment of national health care policy over the past quarter century:

The status of the health system today represents no particular individual’s or group’s grand design, intention, or prediction. All paradigms tried and implemented thus far have fallen short of their proponents’ high aspirations.

Hospitals have grown up in the U.S. in a public policy framework that has markedly separated the financing and delivery of services for the poor and for the self-supporting. Public hospitals and public

Ralph W. Muller

payors (Medicaid and Medicare) have assumed a safety net role, caring for and financing services for individuals who are not positioned to cover the cost of their health care through employment related health coverage or with other private means. Private hospitals have evolved into two parallel tracks. A system of non-profit representative organizations that reflect the diversity of the community and are governed by boards that reflect the civic leadership of the community has grown up side by side with a system of for-profit organizations, established to generate a margin for the investor/owners.

Private hospitals serve the insured patients, those with private or public sources of funding. However, private funding subsidizes those public payors whose rates of payment do not cover costs. As the economy slows and as more individuals become eligible for public programs such as Medicare and Medicaid, it is not likely that the public purse will be opened further to cover the costs of increasing demand for the fruits of the biotechnology revolution, the great discoveries that are being made in the medical labs and being marketed by pharmaceutical companies, that are often provided in the hospital setting. Private payors, employers, are likely to push back as the cost of health insurance continues to rise and their ability to compete in an increasingly global economy is compromised. Part of this push back will probably result in decreases in health insurance coverage for both current employees and for retirees, increasing the already large number of uninsured and underinsured Americans.

It is in this context that hospitals will be asked to respond to increasing demand for services. Yet, how hospitals respond to that demand will be tempered by financial realities. In a balanced system, with good community and physician leadership and extensive involvement in the local community, hospitals should be able to make these choices and tradeoffs about access in a democratic, decentralized way. However, we do not have a balanced system. We have a system that developed without any centralized planning or with a mechanism to share the risks associated with caring for a community. As public payors and potentially public providers bow to financial pressure and shirk responsibility, and as for-profit providers adapt their businesses to achieve profitability

goals, it is left to the non-profit sector to care for the community. These non-profit hospitals are indeed powerful institutions that reflect that community and will continue to be major centers for care. How well they are able to meet their missions will be shaped by the pressures surrounding them.

Conclusion

The U.S. has a hospital system that is under stress because it's being asked to take care of more people who want the fruits of the biotechnology revolution, who want access to the great discoveries that are being made in the medical labs and marketed by pharmaceutical companies. They want access to outpatient care, which is less intrusive than inpatient care, and new diagnostic and medical procedures. The hospital and its doctors are being asked to make choices as to who gets what, under what constraints. The government pays them less than it costs to provide that care and leaves them to make these choices. Is this a fair way of doing things? It's more acceptable within the political system than the alternative system, a more centrally controlled system at the state or national level.

Hospitals will continue to be under great stress as demand for services continues to increase. With good community and physician leadership, and extensive involvement in the local community, hospitals will continue to be able to make these choices and tradeoffs about access in a democratic, decentralized way. This process is very consistent with our political culture. Hospitals will continue to be major centers of the community because they provide a service that people want, they do it in a way that's locally controlled, and the services that are being created and developed every day by our scientists will continue to be made available by our hospitals.

For More Information

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Lourie Lecture Policy Brief

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Ralph W. Muller

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