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A comparative and longitudinal study of the for-profit hospital sector in four Western countries

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Jeurissen, Patrick
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## Commerciële Ziekenhuizen
**Een vergelijkende en longitudinale studie naar de commerciële ziekenhuissector in vier westerse landen**

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*Voor Hanna en Lucas*

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# List of abbreviations

| | |
|---|---|
| AHA | American Hospital Association |
| AHR | Agency of Hospital Remuneration (the Netherlands) |
| AMA | American Medical Association |
| AMBAC | American Municipal Bond Assurance Corporation |
| AMI | American Medical International |
| ASC | Ambulatory surgery center |
| BDPK | Federal For-Profit Hospital Association (Germany) |
| BMA | British Medical Association |
| BMJ | British Medical Journal |
| BUPA | British United Provident Associations |
| CDC | Center for Disease Control (US) |
| CDU | Christian Democratic Union (Germany) |
| CMS | Centers Medicare and Medicaid Services (US) |
| CON | Certificate-of-need |
| CSU | Christian Social Union (Germany) |
| DHA | District Health Authority (UK) |
| DHSS | Department of Health and Social Services (UK) |
| DM | German Mark |
| DRG | Diagnostic-related-group |
| DTC | Diagnosis treatment combination |
| EMTALA | Emergency Medical Treatment and Active Labor Act |
| FASB | Financial Accounting Standard Board (US) |
| FDP | Free Democratic Party (Germany) |
| GAO | General Accounting Office (US) |
| GDP | Gross domestic product |
| GP | General practitioner |
| HCA | Health Corporation of America |
| HCSA | Health Care Structure Act (Germany) |
| HFA | Hospital Finance Act (Germany) |
| HHS | Department of Health and Human services (US) |
| HMA | Health Management Associates |
| HMFA | Health Management Finance Association (US) |
| HMO | Health Maintenance Organization |
| HMSO | Her Majesty's Stationery Office (UK) |
| HRA | Hospital Restructuring Act (Germany) |

| | |
|---|---|
| IGZ | Health Care Inspectorate (the Netherlands) |
| IOM | Institute of Medicine (US) |
| IRS | Internal Revenue Service (US) |
| MCO | Managed Care Organization |
| NAO | National Audit Office (UK) |
| nHFA | new Hospital Finance Act (Germany) |
| NHS | National Health Service (UK) |
| NME | National Medical Enterprises |
| OECD | Organization of Economic Cooperation and Development |
| PFI | Private finance initiative (UK) |
| PMI | Private medical insurance (UK) |
| POS | Point of Service |
| PPO | Preferred Provider Organization |
| PPP | Private Patients Plan (UK) |
| PPS | Prospective Payment Scheme |
| RWI | Economic Institute of North Rhine-Westphalia (Germany) |
| SCP | Social Conduct Performance Paradigm |
| SGBV | Social law book V, health insurance (Germany) |
| SPD | Social-democratic Party Germany (Germany) |
| WPA | West Provident Association (UK) |
| WZV | Hospital Facilities Act (the Netherlands) |

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# 1 Introduction and framework of study

## 1.1 Aim of this work and central questions

Many now argue that for-profit hospital ownership is on the rise because of the retrenchment of public entitlements and – often more importantly in health care – pro-market reforms in the delivery of these services[1]. Most theoretical notions assume that for-profit hospitals are more efficient than nonprofit and public hospitals[2]. It is thought that the inclusion of for-profits in the mainstream health care delivery system may increase efficiency or lower costs[3]. Issues and ideas around ownership are central in the public arena and for-profit hospital care has thus become the subject of fierce debate. Much of this discourse centers on the question whether health care differs fundamentally from other services, and should thus be sheltered from market forces[4]. Opponents of for-profit hospitals fear restricted access for those unable to pay, lower quality of care, cherry-picking of profitable services and patients, and excessive management interference in clinical autonomy. Proponents, on the other hand, believe that for-profits can bring about higher levels of efficiency and are more responsive to patient demands.

The claims surrounding for-profit hospital care have already been examined thoroughly, but primarily in the US. A broad body of literature exists which seeks to compare the performance of for-profit hospitals with nonprofit and public hospitals. A possible superior performance of for-profit hospitals compared to their public and nonprofit competitors may encourage their growth. However, differences regarding costs, charges, the quality of the care provided, as well as the access available to those in need to hospitals, have varied across these studies.

A meta-review by Mark Schlesinger and Bradford Gray (2006) found a nonprofit advantage or no significant performance differences in 179 out of 220 comparisons[5]. Wörz (2008) concludes that there is no definitive proof that for-profit hospitals in the US are more cost-efficient, but there is proof that they do often charge higher rates to payers, raising significant political questions. However, there still seem to be some methodological problems to be resolved. Wörz found only seventeen studies that contained adjustments for case-mix, chain-ownership, and the level of competition (market share): nine studies showed no significant differences between for-profits and nonprofits, for-profits turned out to be more efficient in five studies and nonprofits in three[6]. These conclusions may be applicable to other countries as well.[7] Appendix 1.1 provides a more detailed empirical overview of

the effects of ownership on hospital performance. On the basis of these reviews, the academic case for for-profit ownership would seem limited.

Economic calculation of costs and benefits, gains and losses, and trade-offs provides no direct answers if one wishes to explore and explain the growth (and variations in the growth) of for-profit hospitals. To discover which factors actually foster or hinder the development of the for-profit hospital sector requires a different approach. A quick glance at the available statistics tells us that: 1) the actual market share of for-profit hospitals varies greatly between Western countries; 2) the market share of for-profit hospitals has increased in certain countries over the last few decades; and, 3) in many countries for-profit providers have existed for some considerable time. A longitudinal and historical perspective is thus required in order to understand this subject fully.

The central purpose of this study is to provide an international comparison and historical explanation of the development of for-profit hospital care. I will seek to answer the following questions. 1) How did for-profit hospital ownership actually develop within the context of different Western health care systems? 2) How can one understand and explain growth (and decline) in for-profit hospitals over the long term? 3) Why does the development of the for-profit hospital sector differ between Western countries? This research will look for plausible answers to these three questions and provide hypotheses for future study. Such work is still uncommon and limited to shorter periods or tends to be somewhat polemical in nature[8].

Scholarly efforts have concentrated on the development of the much larger nonprofit and public hospital sectors or have sought to provide more general overviews[9]. A comparative perspective on the development of for-profit hospitals is – with the exception of explorative work of Henry Burdett in the nineteenth century (1895) – still lacking to my knowledge. A specific theory concerning (the development of) for-profit hospitals is similarly lacking, excluding standard theories of the firm. Paul Feldstein elaborates a standard profit-maximizing model of hospital behavior, but concludes that the behavior observed clearly diverges from this model[10]. This would seem to indicate the existence of strong constraints in the hospital sector. Although nonprofit hospitals have been studied in depth, a broadly accepted theory concerning their existence and behavior has also yet to be developed[11].

The remainder of this chapter deals with the framework used for this study. First, a working definition of for-profit ownership in hospital care is presented. What is a for-profit hospital and how should we interpret ownership rights? This section also includes an overview of the different terms that I use in this study (section 1.2). Section 1.3 contains a short introduction of the various theories regarding

hospital ownership. Section 1.4 sets out the method of analysis and justifies the choice of an inductive research methodology. I also discuss how I organized and structured the different empirical data and their analyses. Then, I will discuss the selection of the countries that are studied, the kind of hospitals included in this work, and the time period covered (section 1.5). The chapter ends with a summary of the structure and organization of this book (section 1.6).

## 1.2 For-profit ownership in hospital care

This section summarizes the different terminologies that are used in the empirical chapters, their connotations and the importance of the actual enforcement of ownership rights. As a general rule, essential ownership rights do not change over time, but it is important to note that such rights are not absolute. The degree to which ownership rights can be exercised depends on a variety of constraints. To illustrate this point, the fact that one owns all the shares of a hospital does not mean that one can ignore professional ethics, disobey regulations governing hygiene, or avoid paying property taxes. The actual discretionary powers of ownership are, in reality, somewhat limited. In other words, there is a difference between the formal control and effective control of hospitals. Ultimately, the one with the 'broadest bundle of enforceable rights' can be seen as the material owner,[12] but the precise scope of such a bundle of enforceable rights may fluctuate over time, depending on changes in constraints. As a result, a for-profit hospital may act very much like a nonprofit clinic in some cases, or nonprofit hospitals may resemble for-profits in disguise.

*For-profit, nonprofit, and public hospital ownership: formal definitions and categorizations*

The ownership of the classic for-profit firm, and thus of the for-profit hospital, can be defined by the possession of 'a bundle of proprietary rights' that represents *formal* control of the firm. These proprietary rights include: 1) the right to receive the residual, after all other payments to which the firm is contractually committed, such as wages, interest payments, and prices for supplies (residual claimancy); 2) the right, however qualified, to terminate or revise the ownership of the firm; and 3) the right to sell the rights specified in the preceding two points[13]. It is beyond the scope of this study to take account of all the subtleties of corporate law that may differ between individual countries or over time. However, such differences seem to have diminished over time: 'most of corporate law has achieved a high degree of uniformity across developed market jurisdictions, and continuing convergence toward a single, standard model is likely'[14].

The main rationale behind proprietary rights is that owners are motivated to seek profits, which can be distributed between them according to their stake in the firm. Note that an owner's stake need not – and frequently does not – be related to each owner's share of capital investment. The standard business corporation can be typified as a capital cooperative with one-share-one-vote as the general rule. However, in many other cooperatives (dairy or mutual insurance companies, for example), the rule is one-member-one-vote, with no adjustments for the volume of patronage of the individual members[15]. In health care, it is often the case that physicians who form partnerships or share commonly owned medical facilities do not share ownership rights and revenues according to the amount of capital invested. In for-profit hospital ownership too, there is a variety of models. On the one hand there are small stand-alone facilities that are owned and managed by their founders in a trading partnership and may, or may not, seek to obtain maximum profits. There are also companies with limited liability that shield the owners from personal insolvency risks, as well as large incorporated hospital chains that aggressively try to maximize profits and sell stock on the exchanges.

Nonprofit firms, in contrast to their for-profit counterparts, do not have formal owners. Their defining characteristic is that those who control the nonprofit organization – including its members, directors, and officers – are forbidden from receiving the organization's net earnings. Nonprofit firms are allowed to use retained earnings (profits) if they choose to, but the distribution of such profits to controlling persons is forbidden (non-distribution constraint)[16]. Nonprofits may also own for-profit subsidiaries, and in hospital care increasingly do so for a variety of reasons such as 'commercialization' or 'autonomization'[17], or simply to keep their physicians 'happy'. However, the returns of such for-profit subsidiaries go to the trust according to its stake. The non-distribution constraint implies that no clear governance structure exists. The central thread that draws this somewhat disparate group together is that these institutions are community-based and are mission-driven (as opposed to profit-driven)[18]. In contrast to most grassroots movements, they also have a legal status. Unlike public authorities, nonprofits cannot force people to become members of their organization[19]. Due to their weak governance structure and the specific interests of those whom they employ, nonprofits often develop into organizations that resemble workers' cooperatives[20]. In addition, Hansmann points out the difference between 'donative' organizations and 'service-oriented' or 'commercial' nonprofits[21]. The donators often sit on the hospital board and influence its day-to-day operations. At the other end of the spectrum, 'commercial' nonprofits may run many for-profit subsidiaries and effectively act as for-profits in disguise.

Public ownership implies that the government is the formal owner of the hospital. Public organizations, like nonprofits, are bound by the non-distribution constraint[22]. However, how the available proprietary rights are used depends on the outcome of a political process. Since public hospitals are often owned by local authorities, this means local – not national – politics[23]. Public hospital ownership ranges from government bureaus, in which the government is responsible for most day-to-day operations and is a form of organization still common in military hospitals, towards public corporations, where government involvement is limited to a majority shareholder stake[24].

It is important to note that the specific language and terminology used often tells us something of the specific characteristics of a certain ownership type. This becomes more obvious if one looks over a longer period-of-time. Proprietary hospitals become for-profit hospitals, and these may then be called investor-owned to further emphasize their focus on profit-maximization. On the other hand, voluntary hospitals become nonprofit facilities to underscore their evolution from charitable institutions into more service-oriented organizations. Religiously affiliated nonprofits have different objectives and governance structures to secular nonprofit hospitals. The specific language for such ownership typologies might differ between countries and over time. The terminology surrounding ownership typologies that is used in the different empirical chapters in this book is summarized in box 1.1.

*Ownership: formal and effective control*

The literature on ownership indicates that, although owners hold formal control rights, they do not necessarily (also) exercise effective control[25]. The difference between formal and effective control indicates the existence of agency problems, costs of contracting, and all kinds of legal, political, and social constraints. Formal ownership rights are not generally as absolute as the way in which they are formulated would suggest, but are constrained through other institutions[26]. Therefore, the preferred ownership status of a firm depends partially on the actual difference between formal and effective control. To gain the benefits of formal control, one also has to possess, or be able to contract, effective control. If the constraints on effective control are excessive, or if the costs of executing ownership rights are high, for-profit ownership might not be the preferred mode of organization. In those cases, the costs of controlling and contracting might simply exceed any benefits.

The constraints that limit or expand effective control do change over time, as is normal with social constructions that are being redefined more or less continuously[27]. Sometimes these changes in constraints may be enough to warrant different terminology[28]. For example, ownership in investor-owned firms often becomes so

**Box 1.1 Commonly used terminology regarding hospital ownership in this study**

1. *For-profit hospitals* operate for a profit or a return on investment. They can be stand-alone hospitals or form a part of a multi-hospital system. The owners have the residual claimancy and the right to terminate or revise their ownership rights (all countries).
2. *Nonprofit hospitals* are hospitals that do not seek an investment profit and cannot distribute any formal dividends (non-distribution constraint). They are owned by religious or other charities and can also be part of a multi-hospital system. Nonprofit hospitals may be commercially aware and can focus heavily on trading activities and otherwise use a business model resembling that of the for-profit providers (all countries).
3. *Public hospitals* are (for the main part) owned by municipalities or counties. Some hospitals are state property (US, Germany). UK public hospitals have been owned by the central government since the creation of the National Health Service (NHS).
4. *Proprietary or private hospitals* are not owned by a government or charity and are characterized by the direct involvement of the owners – often physicians – in daily management and operations. They are usually, but not always, for-profit-oriented and tend to be small and locally controlled with a straightforward and simple accountability structure (all countries).
5. *Investor-owned or corporate hospital chains* are organizations that own multiple facilities whose owners are connected with these facilities only by virtue of holding shares in the parent company. Profit making is deeply embedded in the management of these organizations and in how they maintain access to capital (all countries).
6. *Voluntary or charity hospitals* refer to nonprofit hospitals with a primary focus on charity (all countries).
7. *Open-staff hospitals (Belegkrankenhäuser)* are small (for-profit) hospitals, which generally operate in rural surroundings. They do not employ physicians but form a platform for ambulatory specialists for surgery and treatment (Germany). For-profit hospitals are almost totally open-staff organizations in the US and the UK.
8. *Included hospitals (Geförderter* or *Plankrankenhäuser)* own a certificate-of-need license. They fall under the hospital plans of German states and have formal access to public capital (Germany).
9. *Speciality hospitals (Fachkrankenhäuser)* specialize in certain procedures and illnesses. They are mainly owned by physicians, who see business opportunities. They often concentrate on the most lucrative services. For-profit facilities dominate in this category.
10. *Independent hospital* is a term that is only used in the UK; it refers to hospitals, which do not form part (are independent) of the NHS. Independent hospitals can be either nonprofit or for-profit facilities.

attenuated that those firms come close to being, and behaving like, firms that are formally nonprofit[29]. This has led Evans to suggest labeling proprietary hospitals as 'not-only-for-profit' firms, because their reliance on physicians compels them also to pursue non-pecuniary goals that are important to professionals. If governments provide benefits to nonprofits, for-profits will have incentives to 'disguise' themselves as nonprofit firms[30]. The consequences of the differences between

formal and effective control of the firm are at the heart of many ownership-related theories. This is the subject of the next section.

## 1.3 Theoretical explanations of the prevalence and development of for-profit hospitals

The goal of this section is to summarize the main theories regarding hospital ownership. This will help to interpret the empirical work of the next chapters. Although a general theory on the development of hospital ownership does not exist – and the many market failures and institutional constraints in health care seem to prevent a straightforward application of the standard theory-of-the-firm – several theories can go some way to explaining the prevalence of for-profit and nonprofit hospitals.

The section starts with an introduction of the explanations for the viability and growth of for-profit hospitals (section 1.3.1). Next comes the question of why nonprofits exist (section 1.3.2). This section ends with the possible deductions we can make concerning the development of for-profit hospitals. Because a generally accepted theory of the nonprofit hospital, the for-profit hospital and the market mix of various types of provider is lacking, these approaches and their deductions help primarily to explore and interpret the development of for-profit hospital sectors (section 1.3.3).

### 1.3.1 Explanations for the viability and growth of for-profit hospitals

The growth of the for-profit hospital sector is based at least partly on the assumption that making a 'decent' profit over a long time-period is generally possible (although in more mature and declining capital intensive industries, there are lock-in effects and exit barriers that 'force' unprofitable firms to stay in business). A 'decent' profit means a 'decent' return on invested capital. Thus, a crucial precondition for the viability of for-profit hospitals is that investors expect a long-term positive return on their investment that will cover at least the cost of the necessary capital[31]. For investors, the attractiveness of for-profit hospital care depends on the expected profit margin (prices minus average costs). This profit margin depends on the prices a hospital can charge and on its average production costs.

For-profit hospitals can charge higher prices when they have greater market power. The level of this market power depends on the structural characteristics of the markets in question. There are a number of important factors in securing a high level of market power; these include a concentrated market (due to high entrance barriers, for example), high levels of information asymmetry in favor

of the hospital (which brings about opportunities for supplier-induced demand and up-coding[32]), and a lack of price-sensitivity on the part of buyers,[33] (which depends on a well-funded payer system with small levels of uncompensated care). Accepted wisdom holds that market failures push up prices and the cost of contracting for many stakeholders, particularly patients, governments, and other payers.

For-profit hospitals can reduce their production costs by being more efficient or improving access to relatively scarce production factors (capital, labor, technology). Higher efficiency in for-profit hospitals might be expected on the basis of the property-rights theory. Property-rights enable owners to enjoy the yields of their property[34]. The property-rights approach centers on the impact of these rights on agent behavior,[35] and states that an increase in property rights usually improves efficiency. People with more property rights take better care of their assets, which increases future revenues. For example, homeowners maintain their dwellings better than tenants do. For-profit hospitals are based on more property rights, most notably the residual claimancy (see section 1.2), than public or nonprofit hospitals, which are bound by non-distribution constraints; for-profit hospitals should thus be more efficient. The property-rights school provided much of the intellectual impetus for the first phase of welfare state reforms[36]. Property-right theorists defended outright privatizations and the conversion of public services to for-profit ownership. Many property-rights theorists were also critical of other alternatives, such as the quasi-market approach, since residual claimancy rights were often lacking or constrained[37]. In such cases, society may even be worse off: 'you have to introduce more private property-rights to make markets work the way you think they should work. Unless you do, you will find that the market allocation will also seem to be perverse or deficient'[38].

We can split funded hospital capital into equity (stock, venture capital, philanthropy, and proprietary investments) and debt capital (bank loans, bonds etc.). To gain access to debt capital, a minimal profit margin is necessary to pay off the debt as well as to gain credibility from the lenders. Private investors demand a higher return on equity than the interest costs on debt capital or treasury bonds. From the perspective of a regulator, the price of investor capital to for-profit hospitals is generally higher than the costs of mutual bonds or other publicly backed capital (see box 1.2). According to property-rights theorists, it is exactly these higher capital costs that induce for-profit hospitals to behave more efficiently. This (higher) price can be attributed directly to actual risks and thus enhance the efficiency of hospital operations. Additionally, constraints on public budgets might limit access to 'cheaper' public capital; such access might also be difficult to obtain, since the number of altruists and taxpayers prepared to provide this kind of capital seems limited, while for-profit capital is more readily available[39]. To sum up, property-

**Box 1.2 Why hospitals need equity and why for-profit capital is most expensive?**

For hospitals, there are serious costs involved in obtaining all the capital they need through debt financing. In such cases, hospital administrators seeking returns have both the incentive and, because of asymmetric information, the opportunities to divert a share of the sums borrowed to themselves. The high asset-specificities of hospital investment create incentives for the opportunistic exploitation of the lenders, and do not constitute a marketable security.

How can these problems be overcome? The key is a contribution from equity capital as a share of the investment costs. According to Hansmann, a substantial contribution from equity capital avoids costly negotiations between debt holders and the hospital owners in the event of insolvency pressures. This is why banks force owners to provide a substantial amount of the capital required to get access to loans.

How can hospitals raise equity capital? For-profit hospitals turn to commercial equity markets; nonprofit hospitals raise capital from endowments and voluntary sources; and public hospitals rely on tax appropriations. All ownership types may also use retained earnings. How can hospitals raise equity capital under the most favorable terms? Capital prices are normally substantially higher for investor equity – investors demand a higher return on investments because such capital sources constitute the greatest risks in the event of insolvency. Nonprofits can access to tax-exempt debt, voluntary sources, and endowments. Public hospitals can also borrow at low cost and are shielded by public guarantees.

This implies that investor equity is normally more expensive than public or nonprofit equity sources, if available. In certain cases, investor financing might be more readily available and less cumbersome to manage than debt financing. Higher capital costs also form a strong incentive for for-profit hospitals to increase their efficiency since otherwise they will lose out in the competition with their public and nonprofit counterparts.

rights theorists state that for-profits have stronger incentives to strive for efficiency and will secure the additional capital required to meet the growing demand for hospital care if a profitable return can be made.

What does this imply about the presence of the for-profit hospital sector? Hansmann states that if we observe that a particular form of ownership is dominant – as public and nonprofit hospitals clearly are in health care – this can be perceived as a strong indication that these forms are less costly than other forms of ownership in that sector[40]. Indeed, in essence much of the validity of the property-rights approach seems to rely upon the existence of perfect competition conditions[41]. However, these conditions typically do not apply to the hospital market. Asymmetric information and the presence of insurance lead to major failures in market mechanisms; a sophisticated regulatory environment to correct such failures might be lacking. Prices can be raised above competitive levels, which is often an easier and better strategy for maximizing profits than enhancing efficiency[42].

Nonprofit hospitals may be 'forced' to mimic such strategies[43] or, as Lawton Burns calls it, change from 'institutions' towards organizations while becoming corporate rationalizers[44]. If for-profit hospitals take the most profitable patients, nonprofits will be bound to lose money and have to move into services that are more profitable in order to minimize their losses. As a consequence, nonprofits will be induced to behave more like profit seekers in markets with mixed ownership types[45]. Among other reasons, this might lead governments to step into the market and use planning, reimbursement, and tax regulation to favor other types of ownership over for-profit hospitals. Such policies may be softened if the level of information asymmetry decreases, for example as a result of healthcare reforms aiming at quality assurance[46].

The presence of (substantial) investment-seeking capital in the health care sector is not logical *a priori*. Institutions regulate and constrain the rationale and the amount of investor-supplied capital, and such institutions change over time. Depending on the specific institutional configuration, entrepreneurs may choose not to enter this market at all. In hospital care, the difference between formal and effective control (see section 1.2) is often fairly large. Many patients receive treatment even if they are unable to pay for it because, regardless of the ownership-type, not providing care is socially unacceptable[47]. This stems from the widely held view that health care is a matter of right, not privilege[48].

Physicians control large parts of the hospital's operations, have a decisive edge on essential medical information and control the referral of patients. All this makes them by far the most influential stakeholders in the hospital sector. With regard to the physicians, it is important to note that while 'external' asymmetric information may be in the interest of for-profit owners, 'internal' asymmetric information often is not. The costs involved in monitoring hospital managers and professionals are a clear restriction on the applicability of the property-rights paradigm in this sector. Agency costs are high because medical professionals are very influential and pursue their own goals. Owners face substantial transaction costs to enforce their targets, and the higher these costs are, the less feasible a for-profit ownership structure will be.

### 1.3.2 Explanations for the presence and dominance of nonprofit hospitals

Various theories account for the presence or dominance of nonprofit hospitals. Historically, charity care was considered an important goal of the nonprofit hospital sector. Max Weber saw voluntary organizations as unstable but highly adaptable entities which try to balance the 'value-rationality' of religious or political organizations with the technocratic 'means-rationality' of business and public

agencies[49]. Burton Weisbrod (1975) states that citizens in heterogeneous societies hold different preferences, and that this increases the need for nonprofits versus public organizations, since governments will only satisfy the needs of the average voter[50].

Both public and nonprofit providers may form an alternative to for-profit hospitals since they are less likely to capitalize on any of the market failures mentioned in the previous section. Kenneth Arrow (1963) saw the dominance of nonprofit hospital ownership as the logical outcome of the attempt to resolve the persisting information-asymmetries between providers and patients in an efficient way. Patients might fear suffering as a result of the opportunistic behavior of for-profit providers. This creates demand for the services of nonprofit organizations, which are assumed to be trustworthy. Arrow thus laid the groundwork for trust-related ownership theories[51].

Hansmann (1980) points out that it is the non-distribution constraint that serves to demonstrate the trustworthiness of nonprofit organizations. He states that nonprofit firms commonly arise where: 1) customers are in a poor position to determine, with reasonable effort, the quality and the quantity of the services provided; or 2) there is at least one significant class of patrons for whom both the costs of contracting and the costs of ownership are quite high. Patients are in the main poorly placed to determine the quality and quantity of the hospital services they receive, and physicians are the patrons who face significant costs from the contracting or ownership of hospital services.

Stakeholder approaches emphasize that nonprofit ownership serves all interested parties the best, since they often allow stakeholders to maximize control[52]. Indeed, a great deal of the literature points out the fact that nonprofit organizations are bound by weak external enforcement mechanisms[53]. Nonprofit law is primarily enabling law and tends to be poorly enforced: 'Compared to many other areas of law, not-for-profit law is imprecise. It is poorly developed relative to corporate law, has been weakened over the past few decades, and is often not enforced. Not-for-profit directors, for example, are no longer held to stringent fiduciaries found in trust law, but instead are governed by the looser duties of corporate directors that authorize considerable management leeway[54]'. James points out that many legal systems have only mild penalties for violations of the non-distribution constraint[55]. The legal conditions for tax exemption are weakly enforced and – in health care – becoming a nonprofit seems relatively easy.

Who might benefit most from such a situation? Medical staff are clearly among the most powerful and interested stakeholders in the hospital sector and face significant costs if they have to contract or own hospital facilities themselves.

Pauly and Redisch (1973) have stated that nonprofit hospitals act as physicians' cooperatives[56]. They assume that physicians, rather than trustees or administrators hold effective control of the nonprofit hospital, and that they use these powers primarily to maximize their net incomes. In other words, nonprofits are attractive for physicians because physicians do not have to bear any capital risks or share rents with shareholders. According to Pauly and Redisch, nonprofits only promote higher quality because this is synonymous with the use of non-physician labor and capital in physician-income enhancing ways. The fundamental idea seems to be that nonprofit hospitals are effectively for-profits in disguise[57].

Pauly and Redisch developed this hypothesis at a time when US for-profit hospital ownership had been in decline for many decades and nonprofits had become the dominant form of ownership, and this might have been seen as some kind of empirical proof for their ideas. If, on the other hand, such a trend is reversed and for-profits grow, new questions arise – if physician control over nonprofit hospitals has decreased compared to for-profits, or if for-profit hospitals pay higher rents to physicians than nonprofits do, for example. At least one recent study has found that physicians in for-profit hospitals are more involved at the level of the board and may therefore wield greater influence in these settings[58].

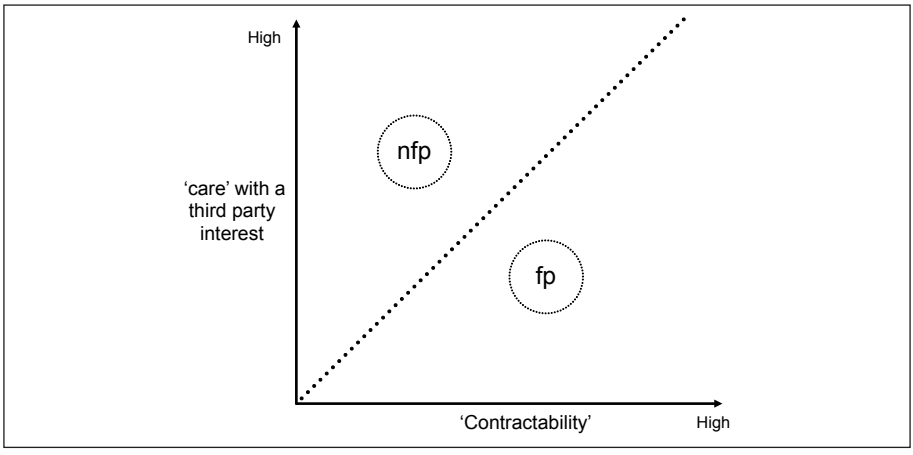
Nevertheless, nonprofit hospital care seems to fit perfectly with Hansmann's conditions. It is hard to ensure the quality and quantity of hospital services in an objective way and for-profit ownership may imply considerable costs for such powerful patrons as the physicians. The natural solution to this dilemma is to create an organization without owners, such as a hospital whose managers hold it in trust for its stakeholders, who – theoretically – have no opportunistic incentives, and where the benefits of full ownership are abandoned for stricter fiduciary constraints on its management[59]. The benefits of the non-distribution constraint have to be weighed against the disadvantages of the nonprofit form of ownership, such as a limited access to capital markets and fewer incentives for efficiency. Note that, the more markets and agents are able to develop enforceable, sophisticated contracts, the less rationale there is for the non-distribution constraint[60]. On the other hand, the higher the monitoring costs and the stronger the incentives for moral hazard, the higher the cost of contracting the services. The latter implies a better rationale for nonprofit ownership. It also implies that for-profit organizations will often be found in markets with 'contractable' services[61].

Governments can make for-profits comply too all kinds of regulations to reduce the chances of opportunistic behavior. Political and administrative policies, like certificate-of-need programs and reimbursement schedules can be used to constrain for-profit ownership[62]. This (implicitly) supports the development and

presence of the nonprofit sector. Lester Salomon states that the presence of an effective and complementary[63] partnership between the state and nonprofits is one of the best predictors of the scale and scope of nonprofit activities[64]. In most cases, the distinction between nonprofits and the rest of the public sector is not great and a significant proportion of their funding actually comes from government sources. It often seems more accurate to think of nonprofits as 'third-party government', a means by which nongovernmental entities carry out governmental purposes with a substantial degree of discretion[65]. In such a configuration, governments can be a great help in overcoming specific voluntary weaknesses, such as a lack of resources, a focus on particular subgroups, paternalism, and philanthropic amateurism. Governments can ensure a more stable flow of resources, discourage paternalism by regulations and universal access, and improve the quality of care by setting benchmarks and standards[66]. In other words, the more complementarity there is between government and the nonprofit sector, the more constraints there are to the growth of the for-profit hospital sector.

Some scholars state that a lack of 'contractability' cannot explain the breakdown of ownership entirely[67]. For-profit firms may also rely on reputation to solve 'contractability' problems, as is common among consultancy firms and IT companies. Francois suggests that nonprofit dominance, in addition to 'contractability' problems, is also driven by a broader notion of 'care' or altruistic preferences, especially when third parties have a stake in the quality and delivery of such services (figure 1.1). The delivery of 'care' is dependent on some kind of solidarity in society, which hinders profit maximization. Others suggest that 'care' is a form of pro-social motivation that attracts altruistic employees[68]. Underlying factors such as religious

**Figure 1.1: Archetypical ownership breakdown: 'care' and 'contractability'[73]**



duties and evangelism may also be important for worker motivation, and indeed most nonprofits started out as religious hospitals[69].

Workers with such pro-social motivations contribute additional effort, but only to improve outcomes, not to raise profits[70]. Nonprofit status can provide credible proof of the commitment of those who hold particular altruistic goals or preferences for 'non-contractible' aspects of quality[71]. This pro-social motivation can lead to important competitive advantages on the market place for nonprofit hospitals[72]. They can calculate lower prices since a much smaller mark-up (profit margin) is required. They can also operate with lower costs due to access to a certain amount of cheap capital (voluntary donations, charity) and cheap labor (religious or voluntary workers). Finally, lower costs may also result from favorable government regulation such as planning requirements and tax exemptions, depending on the degree of institutional complementarity.

To summarize, the market share of nonprofit hospitals is likely to be linked to the lack of 'contractability' of hospital services, the interests and market power of physicians within hospitals, the strength of the voluntary movement and professional ethics, and the extent of competitive advantages that may result from better access to cheap capital and labor or from favorable government regulations.

### 1.3.3 Conclusions

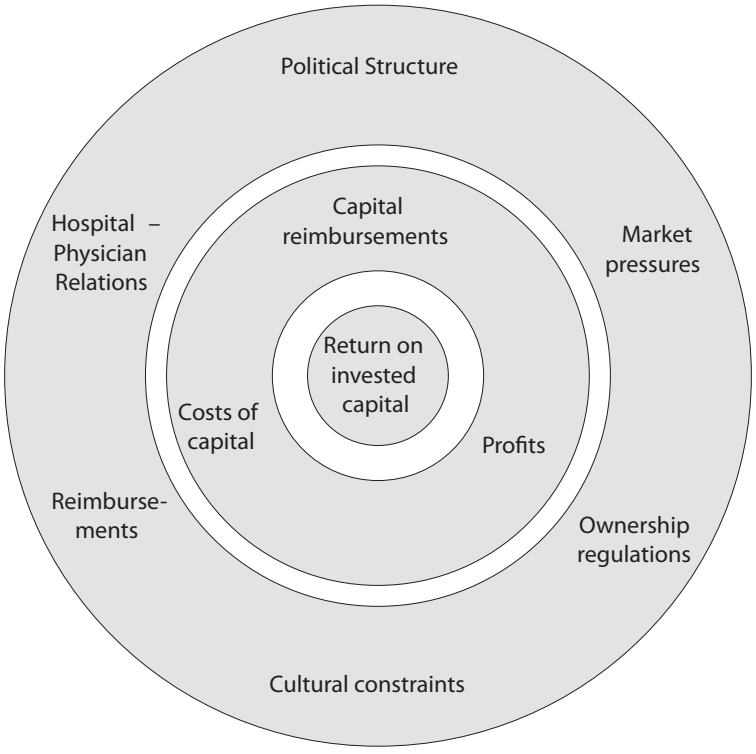
The growth of the for-profit hospital sector depends on a long-term positive return on capital, without which the sector will be unable to access equity capital. Return on capital investment is a crucial precondition for the development of for-profit hospital care. This depends directly on there being a profit margin and on the efficient use of capital (low costs and/or high reimbursements). The business case for for-profit ownership depends either on market powers or on lower production costs due to greater efficiency or better access to capital. It is widely held that maximizing proprietary rights in contestable markets and a sufficient level of equity capital are factors which serve as strong incentives to greater efficiency, innovation and consumer responsiveness. If these conditions are not present, this may be a major reason for a low share of for-profits in the hospital sector, because of government, community, or market constrains.

It is often supposed that nonprofit hospitals are preferred over for-profit hospitals because nonprofits offer higher levels of 'unobservable' quality, and because they take the interests of stakeholders into consideration to a greater extent. Note that this implies that for-profits are thought to deliver less unobservable quality and serve the interests of their shareholders more that those of their stakeholders. Since patients value the quality of care but find it hard to determine the precise level

of this quality, and since physicians hold high stakeholder interests in hospitals but hospital ownership involves high transaction costs, there may be significant demand for nonprofit ownership types. In addition, nonprofits may dominate if they are favored by public regulations, community support or competitive cost advantages (charity, no need for profit margins).

To conclude, the presence of for-profit hospitals may increase for at least two reasons. 1) Economic theory suggests that the development of a for-profit hospital sector is stimulated by an increase in 'contractability'. Higher 'contractability' acts as a trade-off for trust and 'care'. 2) Institutional approaches suggest that for-profits may prosper if there is less complementarity between the government and the nonprofit hospital sectors – for example, as a result of 'level-playing-field' policies. It seems important to study the impact of both economic and broader institutional constraints, which are represented in figure 1.2. Such constraints may often change over time and this may induce changes in ownership types. It is necessary to study the constraints on ownership-types across countries and over time in order to generate meaningful statements on the reasons that underlie the development of

**Figure 1.2: Constraints on the for-profit hospital sector**



for-profit hospital sectors. The empirical chapters of this study will all deal with these issues in depth.

## 1.4 The methodology of this research

This study is structured around four longitudinal case studies. Its purpose is to explore, as objectively as possible, the reasons for the patterns of for-profit hospital development that can be observed in different health care systems. Environment, or context, is essential to understanding the development of the for-profit hospital sector (figure 1.2)[74]. In such circumstances, case studies are the most rational method of research. Case studies are empirical inquiries that investigate a phenomenon within its real life context, in which the boundaries between that phenomenon and its context are not always clear and in which multiple sources of evidence are used[75]. Case studies are among the few research strategies that leave room for questions about historically, culturally, or geographically defined social phenomena[76].

I adopt a comparative perspective to investigate which factors are likely to be significant drivers in the development of for-profit hospitals. Further, as Ellen Immergut observes, the comparative perspective brings to the fore the institutional framework within which much of the developments to be studied take place: 'comparisons with other countries show that the factors that might be overpowering in one nation – such as the peculiarities of its liberal tradition, the attitude of the medical profession, or the strength of its labor movement – have resulted in quite different outcomes in other nations'[77]. She states that less 'case-embedded' approaches – involving elements such as the possible convergent forces of the economy, medical technology, professional autonomy, or the divergent forces of political ideology and class-based politics – simply fail to explain national health insurance politics in three Western European countries[78]. Victor Fuchs also points out the relevance of an institutional and historical approach in health care services research[79].

*An inductive approach*

I will not approach this research with a set of deterministic causal propositions to structure the evidence. To my knowledge at this point in time, no common analytically framework exists which includes all context-dependent aspects of the different cases, a precondition for causal statements[80]. The sparse research available on the development of the for-profit hospital sector lacks a well-specified framework that includes the relevant institutional context. It is difficult, without any empirical material, to specify the most likely conditions for the development

of for-profit hospitals. A pilot-study, conducted previously to this work, produced thirty-three possible conditions and constraints based on institutional, micro-economic and political-actorist approaches. Most of these could not be tested empirically because of a lack of comparable and testable (longitudinal) data or mutual interference problems[81].

In short, an approach that tries to include all possible causal variables and rests largely on induction and interpretation seems the most appropriate for this research[82]. As Henry Hansmann states: 'In studying any given organizational form, I have generally followed the simple practice of first examining the range of situations in which that form is found and then looking for theories that can explain the observed pattern'[83]. Paul Starr points out the fact that we – as a general rule – cannot derive current institutional health care arrangements from purely abstract analysis; it requires an analysis that is both structural and historical to explain the specific form taken by these departures[84]. Such approaches are likely to generate a better understanding of the development of the for-profit hospital sector.

In addition, the examination of longitudinal as well as comparative facts may aid the development of testable propositions. This study does not use a rigorous theoretical framework, which is subsequently tested against the data gathered. However, this does not mean that social science theories are absent, although it is unlikely that a single explanatory theory will be able to account for all developments in any one country, let alone across several countries with diverse cultures, histories, institutions, and interest groups[85]. Theoretical notions can increase our familiarity with the subject (see section 1.3). In fact, they can be useful analytical tools with which to structure and interpret the empirical evidence[86]. In addition, appendix 1.1 presents the available conclusions from the large number of empirical studies that address the performance of the various forms of hospital ownership. This further increases our understanding of the subject, but also underscores the relevance of the comparative and historical approach of this work.

*Methods of investigation*

I examined key-texts and secondary sources to describe how for-profit hospitals have developed in four health care systems. Each case is based on extensive scholarly, and, wherever available, statistical sources. In addition, I interviewed relevant experts from the various countries included in this study. I order and assess the complexity of the comparative and historical records by interpreting the significant phenomena and determining their causes[87]. The composition of the empirical findings is – to some extent – similar in the different cases. In each case, the relative share of for-profit hospital care is quantified as accurately as possible. I then investigate the available specific knowledge on the observed trends and

describe the major relevant developments in the health care system in question. The cases are structured around the relevant critical junctures I have found.

At a deeper level, the descriptions are structured according to two implicit questions. 1) How can a for-profit hospital make a profit? This leads us to a focus on remuneration structures, hospital strategies, market structures, and the demand for hospital services (both amenities and clinical treatment). 2) Who or what, in the broader health care system, has had a functional or ideological interest in – or was sympathetic or unsympathetic towards – for-profit hospitals? For example, private health care insurers seeking provider access or amenities for their clientele[88]; physicians seeking access to hospitals or additional rents; governments seeking investor capital to build new facilities; consumers seeking additional hospital services that differed from the current referral agents[89].

Ideally, comparative work will proceed simultaneously at two levels – at the level of systems (or the macro social level) and within-systems[90]. Both are studied in this work. First, an analysis of the findings is conducted for each case individually. We aim to develop plausible explanations for the growth or decline of for-profit hospitals over time. Then, another – historical comparative – analysis is conducted to explain if and why this process differs between the countries. The combination of both the longitudinal and comparative perspectives enhances the validity of the overall analysis.

## 1.5 Study objects: hospitals, countries, and time-period

This study focuses on the hospital sector. The acute hospital sector is at the center of health care delivery systems – especially when one takes a view of a longer period. Most capital investments concentrate on hospital assets. The fact that it is relatively easy to make cross-national comparison between hospitals is another consideration for their being the focus of this study. Finally, hospital developments are the best documented, an issue of importance for research that largely has to be based on secondary sources.

The total for-profit hospital sector, rather than individual for-profit hospitals, forms the subject of this research. This also implies a case-oriented research strategy, in contrast to studying (quantitative) variables or factors that are at work across countries[91]. What constitutes a for-profit hospital sector? This includes, of course, the number of for-profit hospitals and their attributes, such as the number of hospital beds, the specific (medical) specialties present in these hospitals, turnover and profit figures, the number of employees and physician status (on salaried or self-employed positions). It also includes the interest groups, which

surround them, any possible nonprofit subsidiaries and other (related) services, which cannot always be separated from their main activities.

I characterize hospitals as institutions that operate inpatient beds and deliver or facilitate acute health care services. Hospitals often offer a broad range of medical services, but they can also specialize in certain procedures or specialties. Hospitals provide inpatient treatment and may, but do not necessarily need to, offer outpatient treatment. This study does not therefore include the development of for-profit ambulatory surgery centers (ASCs).

It is important to note that both provision and institutional constraints are often more compelling in hospital care than in most other health care services. Institutions – human rules – often did bound hospitals more than other health care providers. Common institutional constraints are certificate-of-need regulations, reimbursement regulations, and quality requirements.

Hospitals are generally also bound by stronger non-social constraints or provision characteristics such as infrastructural or technical requirements. As a result, in hospitals there is less intra-industry variety than in other health care sectors. In general, inpatient care involves stronger constraints than outpatient care (figure 1.3).

**Figure 1.3: Provision and institutional constraints in health care services[92]**

| | | Institutional constraints (human rules) | |
|---|---|---|---|
| | | Strong | Weak |
| Provision constraints (non-human rules) | Strong | General hospitals, specialty hospitals | ASCs, outpatient clinics, dialysis clinics |
| | Weak | Mental health facilities, long-term care providers, social care facilities | Wellness clinics, rehabilitation facilities, case management companies |

I will also investigate how for-profit hospital development relates to the nonprofit and public hospital sectors. Hansmann states: 'to look at investor-owned firms in isolation, as the existing literature has largely done, is often misleading. We learn much more about them by comparing them with other forms of enterprise.'

*Countries*

For-profit hospital care is studied in the United Kingdom, Germany, the United States, and the Netherlands. Four cases may seem a small number from which to generalize, but this is defensible because an in-depth, historical, and contextual understanding is required to study the questions put forward. Due to the research strategy and the small number of cases, results cannot be generalized across other countries.

The development of for-profit hospital care will be investigated in various contexts and (institutional) environments, a diverse cases design[93]. Since this research is primarily explorative and longitudinal, this seems to be a better approach than selecting those health care systems that are most similar in terms of certain critical variables (assuming that these exist at all) in order to isolate for possible causal explanations[94]: the presence of more than one common causal variable makes it impossible for J.S. Mill's method of agreement to determine the actual cause[95]. Thus, I have sought countries that: 1) differ (a variation-finding strategy) in important aspects of their health care systems and the ways health care is governed, as well as in their political and constitutional environment; and 2) can provide enough accessible and comparable data with which to build a case.

Tables 1.1 and 1.2 provide an overview of the main features of the current political, economic, and hospital environment in the selected countries. There are significant differences between these countries. 1) The constitutional environment is not the same, especially along the unitary and federalist dimensions. This partially determines the governance of the health care system since federal countries allow discretionary powers to the states regarding (the planning and funding of) the hospital sector. 2) Executive dominance may also be relevant. The UK's Westminster model of democracy is the archetypical majority system with supposedly high levels of executive dominance and agenda control; by contrast, such aspects are very weakly developed in the Netherlands[96]. 3) Different scholars proposed adjustments to Esping-Andersen's typology of welfare regimes that are more specific about secondary characteristics[97]. It then becomes clear that health welfare regimes do differ substantially in these four countries. 4) The presence of an effective partnership between the state and the nonprofit sector is often assumed to be one of the best predictors of the scale and scope of nonprofit activities in a country, and thus may be negatively correlated with the viability of the for-profit sector (see section 1.3.2)[98].

Our selected countries also need to provide variety in the features of their hospital sectors[102]. Table 1.2 presents the central characteristics of the four hospital sectors. 1) The selected cases comprise the complete spectrum from no for-profit beds at all (the Netherlands) to comparatively high numbers (the United States and Germany). 2) The activities of the hospital sector may have a broad scale and scope (large general hospital facilities), or a smaller scale and scope of activities (smaller and more specialized facilities). 3) Physicians may be salaried, self-employed, or both: the four countries, once again, operate different models. 4) Hospital planning procedures differ according to whether the country is unitary or federalist. In the two federal countries the states are responsible, while some sort of central planning body exists in the two other countries.

**Table 1.1: Current country characteristics: political and economic systems**

| | United Kingdom | Germany | United States | The Netherlands |
|---|---|---|---|---|
| Constitution | Unitary | Federalist | Federalist | Decentralized unitary |
| Executive dominance and agenda control[99] | Very high | Low | N/a | Very low |
| Health welfare system[100] | Liberal-universalist[101] | Continental corporatism | Liberal residualism | Liberal-corporatism |
| State nonprofit partnership | Weaker, supplementary | Stronger, subsidiary | Stronger, associationalism | Stronger, subsidiary |

**Table 1.2: Current country characteristics: the hospital sector**

| | United Kingdom | Germany | United States | The Netherlands[103] |
|---|---|---|---|---|
| Share of for-profit beds | Five percent | Fifteen percent | Thirteen percent | None |
| Scale and scope of hospital sector | Broad (large general clinics) | More narrow (inpatient) | More narrow (diversified) | Broad (large general clinics) |
| Physician status | Salaried | Mainly salaried | Mainly self-employed | Self employed group practices |
| Hospital planning | Central body | State-level | State-level | Central body |

*Time-period*

Although the research questions do not necessitate a clearly defined time-period, it is important to choose a broad timeframe since I am interested in the whole for-profit hospital sector and a broader timeframe will allow us to investigate the appropriate preconditions and critical junctures for changes in a certain phenomenon. This research analyzes the cases by piecing the evidence together in a chronological manner. It seeks to offer limited historical generalizations that are objectifiable and where the enabling conditions seem reasonable[104].

What does this imply about the time-period? One important milestone in health care history was the arrival of the welfare state. This created an environment with 'universal' hospital access and much greater financial stability, as well as the potential for links between forms of hospital ownership and welfare state politics and policies. These welfare systems eventually became supplemented with cost-containment strategies and market reforms[105]. The focus of my research will be on this period, which coincides roughly with the post-Second World War period.

Remarkably, the welfare state also seems to mark a change in the characteristics of the for-profit hospital sector. It coincides with the beginning of a transformation from stand-alone proprietary facilities towards investor-owned hospital chains.

However, I will also, insofar as the available secondary sources allow, describe the development of the for-profit hospital sector during the prelude to the welfare state. Most overviews of the development of the general acute-care hospital sector as a whole take the beginning of the twentieth century as their starting point. It was during that period that hospitals became 'modern': they began to focus more on treatment, and to use x-rays, anesthesia, and antiseptics. For the first time, hospitals attracted a wealthier patient base; physicians became eager to gain access to these facilities. Here lie the roots of proprietary hospital care. This broad timeframe helps create a more comprehensive picture of the comparative development and dynamics of for-profit hospital care in Western health care systems.

## 1.6 Organization of the book

The composition of the remainder of this book is fairly straightforward. I start with the empirical chapters. They consist of country-specific descriptions as well as an analysis of the development of for-profit hospital care. The analytical sections explain why the for-profit sector developed in the way that it did. Chapter 2 describes and analyses the development of for-profit hospital care in the US. In absolute numbers, the US has the largest for-profit hospital sector in the world. Even more important may be the fact that this for-profit sector has been around for so long. This enables us to study the factors that have stimulated its growth and caused its decline over a long period. Chapter 3 examines the UK. The UK for-profit hospital sector and the National Health Service seem worlds apart. The particular dynamic between these two divided sectors is at the forefront of this analysis. Chapter 4 describes the German case. In Germany, the completely different funding models for capital and operational expenses have been crucial to the development of the for-profit hospital sector. Germany also provides a unique insight into how the restructuring of an entire nation's health care sector after the country's reunification affected the for-profit hospital sector. The Netherlands (Chapter 5) is unique in yet another way. It only operates nonprofit hospitals. Which factors were so 'powerful' that no for-profit hospital sector has developed at all? On the basis of questions that structure the empirical evidence, Chapter 6 is the final analytical exercise of this study. Using a comparative approach, I investigate whether and how the country-specific analyses can be integrated to create a broader understanding of the developments of for-profit hospital care. In fact, I seek to infer the conditions

that are crucial to for-profit hospital development. The aim of this chapter is to identify the key determinants of for-profit growth or decline.

## Appendix 1.1 Overview of empirical studies on the effect of ownership on hospital performance

The past decades have witnessed the emergence of a large number of, mainly, but not exclusively, US-based studies that have addressed the effect of ownership on hospital performance. The majority of these studies have employed cross-sectional research approaches and been based on any available quantitative variables. They have thus approached issues of efficiency and responsiveness, quality and outcome of care, and community benefits. Community benefits are socially valued goods, such as indigent care, public health programs, and occupational training.

This appendix provides a short but comprehensive overview of these research findings. However, it is important to note that in such studies intra-sector variety is often much greater than the variety between the different forms of ownership. I first present an overview of the most important studies from the US. This appendix ends with the evidence available from Germany, the only other country that to my knowledge has generated substantial research on the effects of ownership on hospital performance.

*For-profit hospital performance: efficiency, costs and responsiveness*

Most popular appeals for for-profit hospitals rely on their perceived superior efficiency. However, there is little academic work to support such a proposition. In fact, studies suggest that total adjusted cost per unit-of-service does not differ widely between for-profit hospitals and their nonprofit and public competitors. Most studies show that nonprofit and for-profit hospitals operate with about the same level of cost-efficiency (see table 1.3). There is also little significant cost-difference between stand-alone and chain-owned facilities[106]. However, most studies show that for-profit and nonprofit hospitals do have a different cost-structure: for-profits have lower salary costs, with the notable exception of managerial compensation[107] and the medical staff, but spend more in other expenditure categories (overhead, capital)[108]. Relative performance also depends on which ownership category for-profits are compared to: for example, religious hospitals have substantially lower cost than secular nonprofit hospitals[109].

Regarding the revenues, or the cost to the purchasers, the picture is very consistent: for-profits charge a substantially higher rate than public or nonprofit hospitals. These surcharges, of up to twenty percent, guarantee much higher margins for for-profit hospitals. How can this be explained? Research shows that hospitals rely primarily on revenue-generating strategies, in contrast to nursing homes where cost-containment strategies tend to dominate[110]. For-profit hospitals are most responsive to any financial incentives[111]. Recently Shen found that, responding to an increase of (for-profit) HMO penetration, the hazard of shutting down safety

**Table 1.3: Academic meta-reviews on ownership differences (US)[129]**

| | Efficiency and responsiveness | Quality of care and outcomes | Community benefits |
|---|---|---|---|
| Sloan (2000) | No significant cost-differences; for-profits have lower costs for personnel but score higher on other expenditure categories. | Different outcomes. | Regions with high for-profit share provide less uncompensated care; public hospitals provide most uncompensated care. |
| Deveraux et al. (2002b, 2004) | For-profit hospitals charge nineteen percent more than nonprofit hospitals on average | Higher mortality risk in for-profit hospitals (fifteen studies) | |
| Vaillancourt Rosenau (2003) | Nonprofit hospitals (23) more cost-efficient than for-profits (5); nine studies found no difference. | Nonprofit hospitals (12) deliver higher quality of care than for-profits (3); nine studies found no difference. | Nonprofits deliver more uncompensated care than for-profit hospitals; eight studies found no difference. |
| Currie, Donaldson, and Lu (2003) | For-profits charge higher prices; most studies show no cost-differences or a slightly worse performance by for-profits. | Nonprofit hospitals (4) deliver higher quality of care; seven studies found no difference. | |
| Hollingsworth (2003) | DEA-analysis: publics most efficient (0,95), nonprofits (0,82) slightly more efficient than for-profits (0,8). | | |
| Eggleston et al. (2006 and 2008) | | Highest mortality rates among public providers; for-profits have higher mortality rates than nonprofits; no differences found on individual patient levels; high variety. | |
| Schlesinger and Gray (2006) | Nonprofits have less overhead and less total costs per admission (13), than for-profits score (8); 11 studies showed no difference. | Nonprofits (8) have better mortality rates than for-profits (1), 16 studies show no differences; nonprofits (10) score better on other adverse outcomes and process indicators, than for-profits (3). | Nonprofit hospitals provide more uncompensated care, treat more Medicaid patients and, provide more unprofitable services and practices affecting the indigent. |
| Wörz (2008) | Nonprofit and for-profits are equally cost-efficient (9); for-profits are more cost-efficient (5); nonprofits are more cost-efficient (3). | | |

net services is the highest in for-profit hospitals and the lowest in government hospitals[112].

Hansmann, Kessler, and McClellan found that for-profit hospitals were the most responsive to reductions in demand, followed by public and religiously affiliated nonprofit hospitals, while secular nonprofits were the least responsive: a one percent decrease in population leads to a decline of 0.15 percent of for-profit bed capacity, 0.11 for public and religious facilities, but only 0.04 for secular nonprofit hospitals. They concluded that nonprofit ownership leads to capital traps, in which capital remains inefficiently embedded over long periods because of a lack of ownership incentives. This seems to apply less to religiously affiliated hospitals, which, like for-profits, have an owner in a functional sense with substantial control over the facility[113]. Stronger for-profit responsiveness to incentives might also explain why they encounter greater compliance problems (up-coding)[114]. For-profits are also more likely to offer profitable services; government hospitals are most likely to offer unprofitable services; nonprofit hospitals generally fall in the middle. This might be partly explained by tax-exemption requirements.

Although most work has been based on a cross-sectional perspective, some studies have taken a more dynamic approach. Hultman and Potter show that prospective payment systems had a converging effect on the reimbursement of different types of hospital ownership[115]. Others state that the entrance of for-profit hospitals increases competition and thus forces nonprofits to lower costs: for example, costs for coronary heart diseases are somewhat lower in regions where many for-profit providers are active[116]. Herr points to the fact that even if for-profits are less efficient, they may actually increase efficiency in the health care market if they acquire inefficient public or nonprofit hospitals, a major strategy for their growth[117].

To sum up, for-profits do not have a major cost advantage. However, they usually pay lower wages and use more capital. For-profits also charge much higher rates to payers. My conclusion is that such findings demonstrate above all that the conversion from nonprofit to for-profit ownership implies a transfer of the available monetary means to investors and physicians, rather than any increase in cost-efficiency. This implies that such decisions have a strong political component.

*For-profit hospitals: quality of care and medical outcomes*

Studies addressing quality of care and medical outcome encounter major measurement and conceptualization problems. Variations in quality seem at least as large among hospitals of the same ownership type as they are between different ownership types, and 'policymakers and researchers seeking to interpret the literature on hospital ownership and quality of care should be aware that findings differ significantly according to the analytic methods of individual studies'[118]. Thus, a

significant number of studies – not least the more sophisticated ones – concentrate on a narrow range of medical procedures such as coronary bypass surgery[119], dialysis[120], or caesarean sections[121].

Table 1.3 shows that, overall, nonprofits have somewhat lower mortality rates and score better on other adverse outcomes and process indicators. Public facilities seem to perform worst[122], while for-profit hospitals are in the middle. Note that quite some studies do not find a statistically significant difference between for-profits and other ownership types on mortality or other adverse advents[123]. I conclude that for-profits do not appear to deliver better quality of care than nonprofits – maybe as a result of more incentives to supply-induced demand – but may perform better than public hospitals. This implies that there could be a greater rationale for for-profit hospitals co-existing alongside public facilities, than alongside nonprofit providers.

*For-profit hospitals: community benefits*

Community benefits include a variety of services such as uncompensated care for the needy, professional education programs, unprofitable medical services[124], public health programs, and non-reimbursed medical research. Most studies show that public hospitals deliver the most uncompensated care, followed by the nonprofit providers (table 1.3). Notwithstanding the fact that for-profit hospitals are often located in states with many uninsured[125], US for-profit hospitals deliver the least uncompensated care. Such results may give rise to concerns over the impact of additional for-profit market share on uncompensated care and other community benefits[126].

However, for-profit hospitals pay taxes and public and nonprofit facilities do not. This implies the existence of a virtual benchmark for tax-exempted hospitals to deliver the amount of community benefits that equals such tax-breaks plus the amount of community benefits delivered by for-profit providers[127]. If we use such a benchmark, the evidence is less clear-cut, although it still seems to favor public and nonprofit hospitals, especially if we include 'non-measurable' variables like trust and regulatory compliance. For-profit community benefits may also be inflated because many studies do not adjust for the complicating factor of bad debt for uncompensated care. Research among Californian facilities suggests that the majority, but not all, of nonprofit hospitals do deliver enough community benefits to cover their tax-breaks[128].

*Evidence from other countries*

The empirical literature on the effect of ownership on hospital performance deals to a large extent with the US situation. However, although somewhat less sophisticated techniques are often used, the evidence from other countries does not paint

a very different picture. Two Australian inquiries, based on average length of stay and administrative costs suggest somewhat lower costs for for-profit hospitals, save in the field of obstetrics[130]. A French study on mortality rates tells that by choosing a for-profit hospital, patients have on average a lower instantaneous probability of dying, but can be less sure of the actual quality of care because of the much greater variety in the for-profit sector[131].

A great deal of the non-US research regarding ownership differences focuses on Germany and concentrates on efficiency issues. Table 1.4 presents the results for the main work that has been done. There seems to be support for four general conclusions. 1) The studies on differences in efficiency between for-profit and

**Table 1.4: Academic research on ownership differences in Germany[134]**

| | |
|---|---|
| Breyer et. al., 1987 | Nonprofits are more cost-efficient than for-profits (not significant); public hospitals are least efficient. |
| Simon, 1996 | For-profit hospitals tend to transfer unprofitable patients to other providers (cherry-picking). |
| Karl, 1999 | For-profit hospitals are more cost-efficient than public facilities. |
| Reichsthaler, 2001 | For-profit hospitals are slightly more cost-efficient than other ownership types. |
| Helmig and Lapsley, 2001 | Public and nonprofit hospitals are more cost-efficient than for-profit hospitals. |
| Lauterbach and Lüngen, 2002 | Nonprofit hospitals have the lowest per-case salary costs; public hospitals have the highest per-case salary costs. |
| Stock, 2002 | No significant ownership differences on *per diem* rates, profitability, solvency, and share of costs in turnover. |
| Gerste 2003, | Public hospitals have the highest costs (bed, *per diem*, and case); for-profits deliver the most nursing days per FTE. |
| Berhanu et. al., 2004 | Nonprofit hospitals have the best cost-efficiency; public hospitals have the worst cost-efficiency. |
| Werblow and Robra, 2007 | For-profit hospitals are the most efficient (except: Baden-Württemberg, Bavaria, Bremen, Rhineland-Palatinate, and Thuringia). |
| Wörz, 2008 | For-profit chain hospitals have clearly the highest case-adjusted revenues, although there is great variety. |
| Herr, 2008 | For-profit hospitals perform worst on cost and technical efficiency, partly as a result of their longer length of stay and their lower rate of inclusion in hospital planning. |
| Tiemann and Schreyögg, 2009 | Public hospitals perform significantly better on operational efficiency than for-profit and nonprofits, with the exception of for-profits with over a thousand beds. For-profit hospitals provide a somewhat higher quality of care in comparison to other ownership types. |

nonprofit hospitals show a divergent picture, which would seem to indicate that such differences are not very large. 2) For-profit hospital chains calculate the highest rates to the purchasers; they (formerly) had the highest average length of stay under per diem reimbursement and (currently) the highest case-mix under the current prospective payment system. This indicates that for-profits may seek to maximize their profits by maximizing revenues instead of minimizing inputs at a given output. 3) Quite a number of earlier studies show that public hospitals perform the worst on cost-efficiency. However, recent and more sophisticated research indicates that it is in fact the for-profits that have the lowest operational efficiency[132]. 4) A recent study found that for-profits provide a somewhat higher quality of care, probably as a result of a declining information asymmetry (mandatory publication of quality reports) over the years[133].

# 2 United States: the ups and downs of the largest for-profit sector

## 2.1 Introduction

The US health care system differs significantly from the health care systems of most other Western countries. The US health care system is, both in absolute and relative terms, very expensive, and although it provides first-class hospital care for the well-insured, large sections of the population are uninsured or underinsured. There are significant health disparities among the population and access to health care is unequal. The government operates public funding programs for the elderly (Medicare) and for low-income groups (Medicaid). Private employer-based insurance is available for most other Americans, but does not result in universally available coverage.

This chapter focuses on the origins, development and current state of the US for-profit hospital sector. How did the world's largest for-profit hospital sector develop? Which factors have stimulated or held up this development? The first section of this chapter part consists of a chronological description of the history of the for-profit hospital sector (section 2.2). I begin by describing the origins of the proprietary hospitals and its early growth (section 2.2.1). This period is followed by the decline of the sector until World War II (section 2.2.2). I then investigate how the sector maintained itself from the end of World War II until the start of the public programs covering the elderly and the poor (section 2.2.3). Section 2.2.4 describes the impact of Medicare (1965) and Medicaid (1966) on for-profit hospitals and how subsequent cost-containment policies affected the sector. Section 2.2.5 describes the emergence and growth of for-profit hospital chains and how they correspond to other ownership types. Section 2.2.6 describes the academic and public discussion concerning the appropriateness of for-profit hospitals, which reached its height with the publication of a report by the Institute of Medicine (IOM) in 1986. This is followed by a description of the development of the for-profit sector during the 1980s (section 2.2.7). Section 2.2.8 investigates the major drivers that are shaping the current for-profit hospital landscape.

The second part of this chapter (section 2.3) presents my analysis of the development of for-profit hospital care in the US. This analysis follows the historical sequence of events. Section 2.3.1 concentrates on proprietary hospitals (ca. 1910–1965). The two decades following the implementation of Medicare and its

effects are analyzed in section 2.3.2. Section 2.3.3 considers the dynamics of the modern for-profit hospital sector. The chapter ends with my main conclusions (section 2.3.4).

## 2.2 Developing for-profit hospital care

### 2.2.1 The origins of proprietary hospital care

Hospitals were originally philanthropic institutions. Few dollars actually changed hands, but to some extent, the system worked for those who participated in it[1]. The antebellum hospital was not very capital-intensive and the sector as a whole was small. In 1873, the first national survey counted only 178 hospitals and in total these contained less than fifty thousand beds[2]. The numbers of proprietary clinics were negligible: a few surgical hospitals in the large cities and a couple of mental health asylums for the prosperous[3]. However, the number of hospitals grew quickly between 1870 and 1920, the period in which the hospital sector, according to Rosenberg and Stevens, assumed many of its modern characteristics[4]. A general survey in the early 1920s already revealed almost five thousand hospitals[5], while the American Medical Association (AMA) registered 6,852 hospitals in 1928[6].

There is no single straightforward reason for this explosion in growth. Scholars have stressed various explanations: 1) mass immigration led to sustained demand for new hospital capacity, also along religious (i.e. Catholic[7]) and ethnic (i.e. German and Jewish) lines; 2) the rise of clinical technology and the promise of surgery stimulated the demand for inpatient care[8]; 3) the need for additional hospital wards as medical classrooms; 4) the trend from living in private houses to living in apartments hampered care in people's own homes[9]; and, 5) an increase in the average number of family members increased total household incomes. In general, there was a growing belief that the hospital was the best place for a sick person, rather than his own home; this increased people's willingness to seek hospital treatment[10].

Proprietary facilities accounted for a considerable share in the wider growth of the hospital sector. Statistics must be employed tentatively here, since official government figures did not include proprietary facilities, but their numbers may have equaled the numbers of non-proprietary facilities, and can be estimated at 1,500 to 2,000 (1904)[11]. Another investigation (1911) found a smaller, but still significant proportion of proprietary clinics[12]. Thus, although they were sometimes no more than a few beds in a physician's home, a large proportion of the many hospitals that were founded in the late-nineteenth and early-twentieth centuries seemed to be proprietary, notably in the South and West. How can we explain this development?

*Paying patients*

Larger numbers of paying patients was the most significant difference between America's nonprofit and proprietary hospitals and their European counterparts[13]. In 1875, no American hospital had an endowed income sufficient to underwrite free medical care for its community[14]. Another constant had been the difficulty of forcing local and county governments to underwrite the full cost of caring for indigent patients at private institutions[15]. In 1904, tax subsidies made up no more than around ten percent of hospital revenues[16].

Henry Burdett, the British hospital expert and proponent of private payments (see next chapter), proclaimed that the US was the true home of the pay system[17]. By 1904, patients paid for forty-five percent of the revenues of private nonproprietary hospitals, and this figure was seventy-one percent for private ecclesiastical hospitals[18]. In Western states, hospitals drew seventy percent or more of their operating income from patients (1903)[19]. The growth of pay-patients was spectacular: at Union Protestant Infirmary in Baltimore, pay-patients increased from sixty-seven percent (1905) to eighty-eight percent (1915) and at Touron Infirmary (New Orleans) from forty-nine percent (1900) to seventy-nine percent in 1914[20]. By the early 1920s, patient revenues already made up two-thirds of the income of all general hospitals[21]. Such large numbers of self-pay patients stimulated a rise in private and semiprivate accommodation in voluntary hospitals, in contrast to Europe where large patient wards were much more common[22].

Proprietary hospitals competed for fee-paying patients[23]. Comfort and convenience were a strategy to attract paying patients and thus proprietary hospitals contained many single rooms. Proprietary clinics also featured the use of new effective technologies, particularly surgery. Growth in the volume of surgical work allowed expansion and greater profits. Hospitals concentrated on obstetrical deliveries, appendectomies, and tonsillectomies and adenoidectomies, which together accounted for more than half of all admissions[24]. In the suburbs and small towns, doctors built hospitals under proprietary ownership. Surgical treatments made hospital care more profitable and enabled physicians to open new institutions without upper-class sponsorship and legitimacy. The disproportionate prominence of a few procedures in their operations – most notably appendectomies – indicates the activist enthusiasm of surgeons, and their willingness to solve diagnostic problems with their scalpels[25]. The broad acceptance of private patient income not only allowed larger inner city hospitals to maintain their role of caring for the poor, but it also allowed many smaller (proprietary) institutions to exist on the market.

*Physicians seeking hospital access*

It was not common for physicians to hold paid positions in hospitals. The advantages of place were seen as a fair substitute for salary until the final years of the nineteenth century. Many hospitals used a closed-staff model and each year physicians served for a couple of months on the hospital's staff (under a system of revolving appointments), before returning to their private practices. Less than two percent of doctors held hospital privileges (1870)[26].

However, as hospitals moved from the periphery to the centre of medical practice, control over and access to these facilities became a strategic basis for income and power. By the time of the First World War, hospital admission privileges were already so important that a city's medical practitioners were sometimes divided between the 'haves' and bitter 'have-nots' – between those with staff privileges and those without[27].

Competition was fierce: there were far more physicians in the US than in any of the major European countries[28]. Many public and nonprofit hospitals only gradually opened their doors to larger numbers of practitioners. Some physicians who were unable to obtain admission privileges at a hospital began their own proprietary hospitals, sometimes in shared ownership with colleagues. Hospital access was one problem, from a physicians' perspective. Another was the right to charge the patient a separate bill for the physicians' services, a practice that was not common in public hospitals or the larger traditional voluntary institutions. Although only thirteen percent (1913) of the sick were admitted to hospitals, the treatment of inpatients had become promising, and to some physicians this represented a significant source of income[29]. Thus, many doctors in the Massachusetts General Hospital routinely steered private patients to other hospitals, where they enjoyed admission privileges and where additional fees could be charged[30]. A more radical option was to start up a proprietary clinic.

There was a second reason for physicians to establish proprietary facilities. Although we now tend too see the hospital as an institution structured by medical priorities and defined by medical needs, this conception would have been inappropriate throughout most of the nineteenth century[31]. The board and their administrators held most powers. However, this traditional model of governance was hindered by increasing principal-agent problems resulting from new scientific discoveries that implied more clinical autonomy and a greater role for the physician in the hospital administration. Lay boards and hospital administrators lacked the necessary medical experience and education. The rationale for including physicians at the top of the hospital authority structure increased rapidly. The traditional policy of excluding physicians from hospital governing boards now seemed indefensible to most doctors, especially when combined with a policy of appointing only lay

superintendents[32]. To sum up, 'Oddly enough, proprietary hospitals were one of the main ways of resisting corporate domination and establishing professional control. Surgeons for treating their own patients founded some proprietary hospitals; others were joint ventures. To supply enough patients to make the hospitals profitable, competing doctors often had to combine their efforts'[33].

Ambitious physicians who wanted their own hospital could follow two strategies that were likely to succeed: 1) specialization in the most lucrative activities, which was often limited to the metropolitan areas; 2) founding a general clinic in (rural) areas, where other competitors were absent. Specialization had first attained maturity in the German-speaking countries, and did not become established in the English-speaking world until the 1890s. Private patients found the services of specialized proprietary hospitals less stigmatizing and easier to accept than admission to a larger general hospital. Many urban working people turned to the reassuring authority embodied in a 'professor' at a specialized outpatient clinic or dispensary[34].

Many proprietary hospitals were also established where there was less competition from nonprofit hospitals. Most of these hospitals were in the South and West, and in the smaller towns throughout the country. The South and West had less access to philanthropic capital and thus relied more on proprietary capital. For example, of the seventy-eight hospitals founded in North Carolina between 1890 and 1910, thirty-seven were proprietary. Generally they were owned and operated by individual surgeons[35]. The famous Mayo clinic (1887) also started out as a proprietary hospital, but was turned into a nonprofit foundation in 1923 by the founding Mayo brothers[36]. Judging from contemporary accounts, proprietary hospitals played a pioneering role in the industry, bringing medical services to areas where they would not otherwise have been available because the public spirit to support hospitals was too weak[37].

### 2.2.2 Proprietary hospitals in the interbellum

In 1928, Rufus Rorem was the first to provide a deeper insight into the economic position of the proprietary hospital sector. Tables 2.1 and 2.2 show that public and nonprofit hospitals were already dominant by the late 1920s, but that there were still many smaller proprietary facilities. Many of these proprietary clinics were losing money[38]. Nevertheless, in rural surroundings they often remained necessary from a medical point of view: due to lack of voluntary or public resources, proprietary clinics were often the only place to treat patients who could not be treated at home[39].

**Table 2.1: Acute care hospitals (1928)[42]**

| | Facilities | Beds | % Beds | Capital / bed | % Capital |
|---|---|---|---|---|---|
| Public | 772 | 115,037 | 31 | $ 3,613 | 22 |
| Voluntary | 1,889 | 197,407 | 53 | $ 6,202 | 66 |
| Proprietary, individually | 1,272 | 27,972 | 8 | $ 2,919 | 4 |
| Proprietary, corporate | 448 | 23,150 | 6 | $ 4,407 | 6 |
| Proprietary, industrial | 157 | 7,047 | 1 | $ 3,565 | 1 |

**Table 2.2: Specialty hospitals (1928)[43]**

| | Facilities | Beds | % Beds | Capital / bed | % Capital |
|---|---|---|---|---|---|
| Public | 127 | 12,335 | 29 | $ 3,520 | 26 |
| Voluntary | 333 | 23,324 | 55 | $ 4,288 | 60 |
| Proprietary, individually | 213 | 4,479 | 10 | $ 3,201 | 9 |
| Proprietary, corporate | 46 | 2,650 | 6 | $ 3,660 | 6 |
| Proprietary, industrial | - | - | - | - | - |

How can we characterize the proprietary sector during the years of the interbellum? Most of the proprietary facilities were owned directly by physicians. Many had a dual structure: a clinic comprising the medical practitioners and a property corporation that owned the plant and equipment. The clinic then leased the facilities from the property corporation. This split made it possible to divide earnings in a way that reflected the partners' varying contributions of labor and capital to the venture[40]. Many physician-owned hospitals were, in effect, annexes to the offices of private practitioners. But there were also some five hundred corporate hospitals, either privately held or publically traded (tables 2.1 and 2.2). Most hospital companies were located in the Western states. Patient payments were most common in the West[41] and the primary motive for this corporate group of hospitals was profit-seeking.

The medical staff usually held an ownership stake in proprietary facilities. Other investors were often hesitant about providing funds, realizing that it would be necessary to secure both public and physician support (i.e. they had to overcome major agency problems) if earnings on their investment were to be assured. Finally, some large corporations (mostly railway companies) owned proprietary hospitals, predominantly to treat their employees. It was not unusual for these industrial hospitals to be supported by the enterprise at little or no cost to the employees. Thus, these facilities were only 'for-profit' operations in a more formal sense.

Proprietary hospitals relied on equity capital, business loans, and patient fees to meet their commitments. In contrast to other ownership types, they generally

received no allowances from government, no voluntary contributions, and were not exempt from taxation. The overwhelming majority of the proprietary beds were intended for full-pay patients. Fees were high enough to cover both fixed and operating costs. However, these hospitals could not reject all patients (i.e. emergency cases), and patients were sometimes unable to pay the charges. Sometimes proprietary clinics adjusted fees downwards, but only if patients could prove inability to pay[44]. Their two primary business strategies – attracting the prosperous and providing high volume surgery – both needed substantial capital investments. At that point in time, doctors had to invest an entire year's practice earnings to add just two or three hospital beds[45].

The need to improve facilities, add outpatient services, and add new diagnostic and therapeutic equipment meant that the demand for capital increased continuously[46]. Hospital construction boomed during the 1920s, buoyed up by successful charitable fund-raising efforts and by an increasing number of bequests. In fact, the real value of hospital construction in the late 1920s was not reached again until the 1950s[47]. Since the capital needs of public and nonprofit hospitals were essentially met for free, they did not have to charge for capital depreciation[48]. Public hospitals delivered most of their services free of charge: in 1927, only 5.5 percent of their operating costs were recovered through charges[49].

How did local communities ensure the necessary support for their hospitals? Their efforts were focused on current hospital deficits, rather than future financial health: 'Community chests have uniformly taken the stand that amounts gathered currently from public subscription should be applied to current needs of the community. They have argued that obligations from the past (such as repayment of debt) and needs of the future (such as replacement or expansion of plant and equipment) should be met by other methods and under other auspices'[50]. Support to public hospitals was thus formally limited to the recovery of the operating costs. In practice, interest expenses, replacement investments, and occasionally building depreciation sometimes received support, especially if the hospital would otherwise have been unable to balance its cash budget.

Tables 2.1 and 2.2 show that nonprofit hospitals invested the most capital per bed and this enhanced their competitive position. Neither did nonprofit hospitals charge their patients for any capital costs. These were provided for almost entirely through charitable contributions. In addition, nonprofit hospitals could use a certain amount of endowment capital to cover operating expenses (i.e. for the indigent populations)[51]. Current costs were also kept down because religious nursing orders contributed a substantial amount of free labor. It was common practice that voluntary hospitals charged for most of the remaining costs.

Although the nonprofit hospitals were clearly the most successful in obtaining capital, voluntary means were spread unevenly throughout the country. In 1928, per capita hospital investment was lowest in the South ($6) in comparison with the Central Northwest ($14), the Central West ($16), the Far West ($19), and the North and North Atlantic regions ($25)[52]. As a result, Southern states had the largest proportion of proprietary hospitals since they had less access to philanthropic means.

*The decline of the proprietary hospital sector*

In 1910, proprietary clinics represented fifty-six percent of the total number of hospitals, but this had declined to thirty-six percent by 1928. In 1934, when official statistics began, proprietary hospitals were operating six percent of beds and this slipped to less than three percent a decade later[53]. The percentage of proprietary admissions also decreased dramatically – from thirteen percent (1935) to nine percent (1941) and eight percent in 1952[54].

Why was the proprietary hospital sector reduced so rapidly to a marginal status? One reason was that these hospitals were usually very small, and thus their rate of institutional survival was also rather low. Between 1928 and 1938, a remarkable forty-three percent of proprietary individuals and partnerships closed their business, a closure rate that was about three times as high as that among nonprofit and public facilities[55]. Like other small business they opened and closed with the vicissitudes of personal fortune and the life span of the owner.

More importantly, their proprietary status made them vulnerable to the economic downturn of the Great Depression. They lacked the institutional support of public and voluntary patrons and were confronted with a severe increase in bad debt. In contrast to other ownership types, the funding for proprietary clinics depended entirely on their ability to charge patients at full cost. However, in the first year after the stock-market crash (1929), hospital receipts per person fell from $236 to $59 and average deficits rose from fifteen to twenty-one percent of disbursements[56]. Rosemary Stevens tells us that: 'Small profit-making hospitals were particularly hard hit. The number of hospitals owned by individuals or partnerships dropped from 1,600 in 1929, to 1,400 in 1933, to 1,200 in 1939; and their occupancy levels were consistently lower than those of other types of institutions. Many of the proprietary clinics were small, inefficient urban institutions, which were already generally outdated. Also for-profit hospitals were much more likely than private nonprofit hospitals to enter the Depression with outstanding debts. [...] As their clientele of paying patients fell away, they ran a serious risk of bankruptcy. Nor were state legislatures or city governments eager to save them. The proprietary hospitals had the fewest friends[57].'

**Table 2.3: Hospital investment, funding sources and, occupancy rates during the years of the Great Depression[61]**

| | Investment ($ million) | | Change (%) | Estimated income (1935) | | Occupancy rate (1935) |
|---|---|---|---|---|---|---|
| | 1928 | 1935 | | Patients | Public sources | |
| Federal | 123 | 226 | 83.7 | 7.5 | 92.4 | 75.0 |
| Other public | 293 | 401 | 36.9 | 16.7 | 81.1 | 90.2 |
| Nonprofit | 1,224 | 1,369 | 11.8 | 70.8 | 10.2 | 55.4 |
| Proprietary | 209 | 113 | −45.9 | 91.4 | 4.1 | 41.2 |

Indeed, the average daily census in proprietary hospitals decreased by thirty-three percent between 1929 and 1933, sixteen percent in voluntary hospitals, while it increased by twenty-one percent in low-charging public hospitals[58]. In sharp contrast to public and voluntary institutions, capital investment made by proprietary hospitals halved (table 2.3). Physician incomes also dropped severely, since patients paid a lower proportion of doctors' bills than of hospitals' bills for hospitalized illness[59] and private practitioners had lost half of their 1929 incomes by 1933[60].

The growing influence of the physicians on health care and their preference for working in the prospering nonprofit hospital sector is a more fundamental explanation for the decline of proprietary hospitals. It is important to remember that an initial reason for establishing proprietary hospitals was the closed-staff model of many public and nonprofit hospitals. However, this model was abandoned after 1910 and by 1933 five out of six physicians were affiliated with one or more hospitals[62]. The legitimization of the proprietary hospital as an alternative for some physicians for hospital access vanished.

Physician interest groups now became suspicious of corporate hospitals. This was partly a consequence of their professional ethics, but physicians also believed that any profit belonged to the doctor and not to a lay corporation or supplier of capital: the full return on physician labor should go to the doctors. If capital was required over and above what doctors could not provide themselves, it would have to be contributed 'gratis' by the community rather than by investors seeking a profit.

The physicians were successful in their lobbying. The development of an investor-owned hospital sector was limited by a series of legal decisions. Between 1905 and 1917, several state courts ruled that corporations could not engage in the practice of medicine and that corporate for-profit hospitals violated 'sound public policy'[63]. Further growth of corporate hospitals was blocked, although there were

some legal exemptions in Western states where the most existed. According to both public opinion and professional ethics, everyone in need had the right to be treated at a hospital, which implied that hospital care could not be treated as a normal commodity.

From a physician's perspective, the voluntary open-staff model emerged as the preferred place for treatment[64]. As one author put it in 1932: 'the legal ownership (…) of the great bulk of capital invested in the practice of medicine lies with the lay public, but the medical profession exercises a pervasive and in most instances a determining influence over the utilization of this capital'[65]. Market conditions for nonprofit ownership types improved. Voluntary leaders became better organized, more visible, and more articulate during the Depression. Nonprofit hospitals could make the most of their religious affiliations, donations to them were tax-deductible, they had charitable immunity from malpractice liability[66], and – in contrast to public clinics – nonprofits were largely exempt from growing government regulations[67].

We have already seen that nonprofits had the best access to increasingly needed capital. Doctors incurred no risks from these investments, but they did hold effective control over the hospital due to severe and increasing agency problems[68]. This control was further reinforced because physicians were in a position to cut off the flow of paying patients, a very important source of revenue[69]. Nonprofit hospitals increasingly disassociated themselves from proprietary and for-profit hospitals, and joined together under the banner of voluntarism[70]. The AMA (1934) made a significant revision in its statistics, and classified proprietary hospitals as a separate sector, a statement that was meant to legitimize the existence of a voluntary hospital sector, occupying the middle ground between tax-supported institutions and profit-making institutions[71].

*The absence of (compulsory) third-party payers*

In most European countries, forms of compulsory insurance developed as early as the late nineteenth century. These schemes covered physician benefits and provided some income protection in the event of sickness or funeral costs. In the US, the middle classes were the dominant political force, while the working classes were much less of a threat to political stability than in Europe. The US middle class could turn to a well-developed life insurance sector for income protection and funeral money. Physicians' fees could be paid from comparatively high wages. The life insurance lobby played a key role in the defeat of the first attempt to introduce compulsory insurance just after World War I[72]. Consumer clubs and the health insurance sector were relatively weak while employer benefits were limited to larger corporations in the railways, mining and lumber industries.

More importantly, doctors were firmly opposed to any party coming between them and their patients[73]. They were not only suspicious of corporate hospitals, but also of closed-staff hospitals and third-party payers. They succeeded in killing off all attempts to introduce compulsory insurance and in limiting voluntary insurance until the Great Depression, when physicians began to need insurance money. In a world without third-party payers, the balance of supply and demand were, during those recession years, not favorable to proprietary hospitals, which were confronted with lower utilization and higher levels of bad debt.

During the 1920s, hospital costs increased due to increased volumes and higher unit costs. In addition, the variation in medical costs increased, heightening the risk of personal failures. The Committee on the Costs of Medical Care, a self-declared independent body, started to research health care costs. The Committee published twenty-seven reports between 1927 and 1932, which were highly influential at the time. The Committee opposed compulsory insurance, but the majority of the members approved prepaid group practice plans on a nonprofit basis (Blue Cross and Blue Shield). The new Democrat President Roosevelt, facing mass unemployment and increasing membership of voluntary and indemnity health insurance, chose not to seek to introduce a compulsory health insurance scheme, but to concentrate on other social issues[74].

The new nonprofit Blue Cross plans became regional monopolies while a majority of their directors represented the major nonprofit hospitals. The nonprofit hospitals were thus much better positioned within the boards of the Blues than the proprietary facilities. Blue Cross negotiated reimbursement rates that were often lower for proprietary hospitals than for their nonprofit counterparts[75]. Indeed, in Minneapolis and St. Paul, explicit standards meant that hospitals had to be nonprofit if they wanted to be reimbursed by Blue Cross schemes: the number of proprietary hospitals declined from eight-five (1934) to sixty-one (1940), and twenty-six (1950). Most Blue Cross schemes confirmed the right of all physicians to have hospital appointments, breaking down any remnants of the system of closed-staff hospitals[76].

The Blue Cross plans were popular among middle class Americans. The termination of sliding fees and community rating meant that, for the middle and upper classes, pre-paid hospital costs remained a modest percentage of their income. Initially, there was only limited competition for the Blues from commercial indemnity insurers, which imposed no controls on proprietary hospitals but received no tax-exemptions and only operated in the group market. In 1940, commercial insurance companies insured 3.7 million people, while the Blues covered over 6 million and by 1945, the Blues counted 19 million subscribers, about three-quarters of the market[77]. By that time, the US had established some sort of a health

insurance system, although only twenty percent of the population was protected against excessive hospital costs.

### 2.2.3 Reaching the bottom: proprietary hospitals before Medicare

The policies that followed World War II provided an ideal environment for the nonprofit hospital sector[78]. Meanwhile, the proprietary hospital sector declined even further, especially in the 1950s, but reached a bottom during the early 1960s (table 2.4). During this period, hospitals often passed through a proprietary stage before converting permanently to non-profit status[79]. Proprietary hospitals held a large share of the hospital base in the South and in the West. In 1950, eight southern states reported more for-profit than nonprofit hospitals: Alabama, Arkansas, Georgia, Louisiana, Oklahoma, Tennessee, Texas, and West Virginia[80].

The share of for-profit hospitals and beds declined in all areas of the country, but this was most marked in the Northern central areas and in the South. In 1970, the West passed the South as the region with the largest share of for-profit hospital beds. In the South, new Hill-Burton funds financed the construction of many new nonprofit and public hospitals (table 2.5).

Three factors seem important to the changing fortunes of the proprietary sector and these will be discussed in the remainder of this section[81]. 1) The Hill-Burton

**Table 2.4: Non-federal short-term and special hospitals by ownership (1946–1965)[83]**

| | Nonprofit | Public | Proprietary | Total | Total number of hospitals |
|---|---|---|---|---|---|
| 1946 total | 2,584 | 785 | 1,076 | 4,445 | 4,445 |
| Net gain or loss | | | | | |
| 1946–1950 | + 287 | + 157 | + 142 | + 586 | 5,031 |
| 1950–1955 | + 226 | + 178 | − 198 | + 206 | 5,237 |
| 1955–1960 | + 194 | + 140 | − 164 | + 170 | 5,407 |
| 1960–1965 | + 135 | + 193 | + 1 | + 329 | 5,736 |

**Table 2.5: Percentage of for-profit hospitals and beds in different regions[84]**

| | Northeast | | North Central | | South | | West | |
|---|---|---|---|---|---|---|---|---|
| | Hospitals | Beds | Hospitals | Beds | Hospitals | Beds | Hospitals | Beds |
| 1940 | 14 | 5 | 24 | 6 | 50 | 20 | 36 | 13 |
| 1950 | 10 | 4 | 14 | 4 | 41 | 18 | 26 | 9 |
| 1960 | 7 | 4 | 6 | 2 | 31 | 11 | 17 | 8 |
| 1970 | 9 | 5 | 2 | 1 | 21 | 10 | 19 | 11 |

program supported the nonprofit hospital sector, which continued to grow until the enactment of the Medicare/Medicaid legislation. 2) Research supports the hypothesis that the growth of health insurance stimulated the prevalence of proprietary clinics due to the better prospect of making a profit[82]. 3) The relative position of the proprietary hospital sector versus the nonprofit hospitals weakened.

*Financing new nonprofit infrastructure: The Hill-Burton program*

The Lanham Act (1941–1946), a program of public works for the creation of a community infrastructure in defense areas, established the important precedent of allowing federal aid to nonprofit as well as local government institutions. The House bill left open the possibility of grants to for-profit hospitals, but profit-making institutions were excluded at the conference stage between House and Senate[85]. This laid the foundations for postwar hospital planning, which arrived comparatively early in the US and predated 'universal' insurance coverage. The federal government limited its financial activity in the health care sector to the expansion of medical research funding and the construction of new hospitals.

The Hospital Survey and Construction Act (1946), more popularly known as the Hill-Burton Act, was a large program of public works to build new hospitals. This was considered necessary because of the growing demand and declining capital plant that resulted from low levels of investment during the depression years and World War II. The American Hospital Association[86] had already recommended a huge program of hospital construction during the war and there was broad political support for such a proposal. Hill-Burton would continue until 1975 and invested over four billion dollars in new hospital construction[87].

What were the important features of the program? 1) The states, not the federal government, decided on the distribution of the money. 2) The states were allocated federal funding on the basis of their population and per capita income[88]. This measure favored low-income Southern states where large numbers of proprietary hospitals were operating and where there was a recognized lack of adequate hospitals. In the South, the number of beds now grew gradually to match the national average[89]. 3) The Hill-Burton program provided for matching funds. Initially, communities had to raise two-thirds of the construction costs themselves. 4) The final constraint of central importance to this book was that proprietary hospitals were ineligible for Hill Burton funds.

The Hill-Burton program met the capital needs of nonprofit hospitals and construction spending rose above ten percent of total health care expenditure[90]. Hill-Burton, administered by its own administrative agency, was a major help for the nonprofit hospital sector. Feshbach states: 'the Bureau of Hospitals (a public planning agency[91]) acted to protect the economic position of voluntary

hospitals more effectively than the industry or individual hospitals could do themselves'[92].

Hill-Burton funds were distributed as 'loans', which would be repaid by the provision of a reasonable amount of free care to people who otherwise would have ended up as the responsibility of the government[93]. However, there was minimal enforcement of this condition, if any at all, since the underlying expectation was that nonprofit and public hospitals could be trusted to further the public good. Uncollectibles represented only 3.5 percent of the charges of nonprofit hospitals (1953), but 5.9 percent for proprietary hospitals, and 6.2 percent for public hospitals[94]. In 1972, the 'official' standard for indigent care became the lower of a) three percent of operating expenses minus any Medicare and Medicaid costs on free care, or b) ten percent of inflation-adjusted federal capital assistance[95]. The federal government also required that the remaining useful life and value of the Hill-Burton assets be repaid when a nonprofit was purchased by a for-profit hospital. Thus, there were few conversions from nonprofit status to for-profit status[96].

Because of Hill-Burton, nonprofits had much better access to capital than for-profit hospitals. In essence, the government was supplying the additional capital that philanthropy was no longer able to provide. Hill-Burton meant that nonprofit hospitals paid a (much) lower price for capital than for-profit hospitals and, as a result, were able to operate with an excessively high capital-labor ratio[97]. Michael Davis, a well-known scholar at the time, observed that: 'the predominance of social capital has continued. Proprietary hospitals have diminished in absolute and relative importance (…). More capital per physician is required than formerly'[98].

Since for-profit hospitals were not eligible for Hill-Burton funds, they had no legal obligations to provide free care to the poor [99]. Some for-profit hospitals converted to nonprofit status to obtain access to Hill-Burton funds, which led Lave and Lave (1974) to suggest that Hill-Burton may have contributed to the decline of for-profit hospitals. This is reflected by the trend to replace for-profit hospitals with nonprofits or public facilities in smaller communities and rural areas[100]. The rapid decline of the proprietary hospital share in Southern states underscores such reasoning (table 2.5). Nevertheless, in some areas capital spending by nonprofits triggered a competitive dynamic, which led ineligible for-profit hospitals to undertake construction work. In such cases, for-profit hospitals used Hill-Burton planning documents, which showed the extent of local need within states, to secure private financing for their projects[101]. However, the consequences were often not appreciated.

Between 1954 and 1957, New York state for-profit hospital beds increased at a rate of 32.6 percent while all other hospital beds increased at the much lower rate of 5.1 percent[102]. In response, state and local planning agencies[103] sought to eliminate

'unfair competition' from 'fly by night' proprietary hospitals. The perceived lack of quality of the care provided by for-profits was an important issue in such discussions. In 1960, only fifteen out of forty proprietary hospitals in New York were accredited, while seventy percent of Blue Cross payments going to unaccredited facilities went to proprietary hospitals[104]. Such critical indicators were underlined by the widespread idea that: 'everybody knew that for-profit motivation was a menace to the health of patients and the finances of payers'[105]. A view that was supported by a renowned expert such as Milton Roemer: 'there can be no doubt of the corrupting influence of profit-making in American health service. The unnecessary surgery (…), the entrepreneurialism of substandard nursing homes and proprietary hospitals – these and other problems are real'[106]. What happened was that additional licensing and fire-and-safety regulations forced many small proprietary hospitals to close[107].

*Voluntary coverage for health insurance*

The number of Americans with health insurance coverage increased during the decade following World War II. In 1949, Blue Cross had thirty-one million subscribers; commercial indemnity insurers added an additional twenty-eight million enrollees; and independent plans (including direct-service organizations) covered four million. The strength of commercial indemnity insurance increased. By 1953, these carriers provided hospital insurance for twenty-nine percent of Americans, Blue Cross for twenty-seven percent, and independent plans for seven percent[108]. For the sick poor without health insurance, Congress approved a system of 'vendor payments' – federal grants to states for direct third-party payments to hospitals and physicians[109].

The government supported the private insurance system by exempting employers' contributions from taxes. Besides, unions were given the right to bargain collectively for health benefits[110]. This stimulated the development of an employer-based insurance system; by 1950, employers were paying thirty-seven percent of workers' net health care costs, up from ten percent in 1945[111]. Although unions preferred these to commercial indemnity insurance, provider-organized Blue Cross plans began to lose some of their dominance. Employers often favored the more flexible indemnity insurance policies[112]. Where hospitals were primarily proprietary or government-owned, indemnity insurance often dominated[113]. This was partly caused by the traditional ties between Blue Cross and local nonprofit hospitals. On the other hand, in such areas, indemnity insurers bore less cost shifting, since proprietary hospitals delivered less free care and public hospitals relied on tax sources to serve the indigent.

The increase in insurance coverage benefited the entire hospital sector. Now, most of the money for hospital bills was taken out of employees' paychecks in the form of payroll deductions of insurance premiums. Hospital bad debt eased and their business model improved. The climate for hospitals was further enhanced by another development. Due to improved medicine and better incomes, a change occurred in the public's attitude towards paying for hospital services. The better prospects for the hospitals can be summarized by an interesting citation from Rufus Rorem, one of the founders of Blue Cross, in a 1950 article[114]: 'Hospital patients are paying more money, with less complaint, than ever before. When private hospital bills averaged $5 a day, only a small percentage of patients paid full costs. Now, when ward hospital bills averaged $12 a day, most patients expect to pay their hospital bill, or present a good reason for not doing so. A generation ago, people didn't bother to complain about the costs. They merely accepted the services free and complained about the food. Why this change in point of view? In my opinion it rests in the basic change in the public's attitude toward hospitalization. Thirty years ago, hospital service was essentially a charitable function provided by one group of the population for the benefit of another group, through taxation or voluntary philanthropy. The people who supported the hospitals financially were not the people who utilized their services. [...] The situation has changed. Now, almost anyone may be a hospital patient. On the average, each family will provide a hospital case every two or three years. This greater frequency of use was accompanied by a rising price level for wages and supplies, without a proportionate increase in endowment income, voluntary contributions, or tax appropriations. The hospital gradually had been transformed from a charitable service for the poor to a self-supporting service for the entire population. The people who pay the bills are now the same people as the ones who receive the service'[115].

*Proprietary hospitals on the market: decreasing profits*

The difficult position of the proprietary hospital sector was reflected in its profitability. Between 1946 and 1965, the margins of proprietary hospitals decreased steadily. Nonprofit and public hospitals caught up with proprietary clinics in terms of patient income as a percentage of total income, thus stabilizing their revenue base. In comparison with nonprofit hospitals, the profit margin of for-profits declined more rapidly (see table 2.6).

In many aspects the 1950s represented the heyday of the voluntary sector. They benefited from a great deal of free labor: in 1961, there were thought to be 1.2 million members of hospital auxiliaries, a number not far short of the total number of paid employees. In the northeast, where the most nonprofit hospitals were located, unpaid labor was highest, while it was lowest in the southeastern states where many proprietary clinics existed[116]. Nonprofit hospitals were specifically

**Table 2.6: Finances of non-federal short-term hospitals, 1946–1965[118]**

| | 1946 | 1955 | 1965 |
|---|---|---|---|
| Expense per patient day ($) | | | |
| Nonprofit hospitals | 10.04 | 23.12 | 44.48 |
| Public hospitals | 7.39 | 20.62 | 41.84 |
| Proprietary hospitals | 10.13 | 21.25 | 43.74 |
| Patient income as percent of total income | | | |
| Nonprofit hospitals | 83.5 | 91.4 | 93.6 |
| Public hospitals | 57.1 | n/a | n/a |
| Proprietary hospitals | 96.9 | 96.9 | 96.1 |
| Percentage difference between revenues and expenses | | | |
| Nonprofit hospitals | + 4.4 | + 1.5 | + 3.4 |
| Proprietary hospitals | + 12.5 | + 10.6 | + 8.3 |

exempted from the Taft-Harley Act (1947) on the grounds of their public role, allowing them the privilege of not recognizing collective bargain agents and firing union sympathizers at will. In these respects, workers in voluntary hospitals lacked the job protection of workers in profit-making hospitals[117].

Physicians might actually have encountered more constraints in proprietary clinics than in nonprofit hospitals, both financially and in terms of operational control. Nonprofit hospitals were seen as ideal workshops for physicians: they enjoyed excellent remuneration, maximum control over most aspects of their workplace, and no financial risk. During the decades that followed World War II, most developments and public policies favored the nonprofit hospital sector; the proprietary sector contracted or, at best, stood still.

### 2.2.4 Medicare/Medicaid: for-profit hospitals set for a new start

Hospitals suffered from significant levels of bad debt from elderly patients who could not afford to pay hospital bills out-of-pocket. Because of their high-risk profile, elders could not afford or were denied private health insurance, and the scale of this problem only increased until by the late 1950s, competition from commercial carriers, who offered experience-rated plans, forced the Blues to abandon community rating, eliminating the subsidies that it implied for high-risk groups[119].

The intention of Medicare and Medicaid was to extend the existing social security system to which it was modelled, so that the elderly could be sure that their savings and pensions would not be wiped out by costly, and at their age unavoidable, hos-

pitalization. The poor would also have access to care. After slow economic growth in the 1950s, momentum increased in the early 1960s and between 1961 and 1965, the real economy grew twenty-five percent[120]. Political support for reforms also increased and President Lyndon Johnson, who was very committed to expanding health care insurance, announced an unconditional war on poverty in America. He stands alone as the most effective health care president in American history[121].

The problems of the elderly rose to the top of the policy agenda. In 1965, Medicare brought in compulsory hospital insurance for all those over sixty-five years of age, while the Medicaid program expanded federal assistance to the states for medical care for the poor, replacing more limited programs[122]. Medicare was financed from employer and employee payroll taxes paid into an earmarked trust fund. The federal government was to become a major stakeholder through Medicare, and thus a potentially powerful source of regulation[123].

However, in an effort to implement the program as quickly as possible, the government did not, and could not, opt for an intermediating role for itself. Medicare's benefits, reimbursement mechanisms, administration and structure of insurance all reflected prevailing practices in the American private sector. Existing third-party payers, which were needed to implement the program, were given significant discretionary powers such as provider reimbursement, claims processing, and auditing. Hospitals were free to choose their own intermediary for the new federal funds, and ninety percent chose Blue Cross[124]. Blue Cross was generally sympathetic to the interests of the hospitals and Medicare broadly replicated existing private fee-for-service paying practices. By any measure, Medicare and Medicaid represented a watershed for hospital funding. I will first describe the direct impact of these programs on the proprietary hospital sector. I will then proceed to discuss how they pre-structured the 'unavoidable' cost-containment policies of the 1970s.

*The impact of Medicare and Medicaid on the for-profit hospital sector: much improved investment opportunities*

Between 1965 and 1973, health expenditure rose from 4.4 to 11.3 percent of the federal budget. Primarily, these funds contributed to massive hospital payroll and non-payroll expenses – including profits – and far less to increases in utilization. In 1972 Medicare included end-stage renal disease as an additional benefit. For-profits quickly and totally dominated the provision in this specific disease category. Medicare worked to the advantage of new for-profit hospital chains, covering what for them had previously been bad debt. For-profit hospitals captured additional market share: their assets increased from a negligible $243 million, or two percent of total hospital assets (1960), towards $ 3.5 billion, or six percent of hospital assets (1977)[125].

Medicare's reimbursement procedures favored the hospital sector as a whole. In essence, hospitals were reimbursed for whatever charges they billed without direct administrative supervision by the federal government[126]. Hospitals were paid according to their costs, including depreciation on assets, and a return on supplied capital. Such a cost-based reimbursement covered most costs, thus reducing insolvency risks as well as efficiency incentives. It is important to bear in mind that costs often do not equal actual hospital expenses, and that a favorable calculation of hospital costs generally induces profits. Medicare provided the most capital to the hospitals with the newest and most expensive facilities, without any review of their actual needs. Investors that built new hospitals could pass the bill on to federal government and thus a 'medical arms race' developed[127]. In the absence of strong federal ground rules, Blue Cross intermediaries had a fair degree of discretionary power; when the interests of the federal government and the hospitals conflicted, Blue Cross favor the latter[128].

The actual remuneration of capital is critical in the choices investors make. Medicare did not control the future direction of the hospital system by controlling capital expenditure; its main focus was protecting the incomes of the elderly[129]. This created major business opportunities and it is important to discuss these in some detail. 1) Medicare payments for patient care included allowances for the estimated replacement costs of hospital plant and equipment[130]: depreciation costs were defined on a current base; the habit of historical depreciation and up-front payments came to an end. 2) Hospitals were paid another two percent for the future improvement of assets on top of this depreciation. 3) Interest expenses were also reimbursed and providing for-profit hospitals with an additional return on invested capital[131]. 4) The latter was an important advantage to for-profit hospitals versus other ownership-types. The rationale being that if for-profits were reimbursed on a strictly cost basis, thus without an additional allowance for the cost of equity financing, the supply of such funds would not provide any investment return and that source of funding would dry up[132]. The calculated returns were generous: prior to 1982 the allowance was set at 1.5 times the rate of return earned by Medicare's Hospital Insurance Trust Fund. Then, legislation reduced the amount to the same rate as the fund; this was still the equivalent of forty percent of all Medicare capital payments, a disproportionately larger share in relation to the size of the for-profit hospital sector[133]. 5) Medicare also contributed to the purchase price of a hospital by recognizing additional depreciation expenses in relation to the purchase price. How did this come about? The purchaser usually paid more for the acquired hospital than its depreciated book value. Thus, although the acquired assets themselves were the same, depreciation expenses rose, and were generally covered by Medicare[134]. 6) Another for-profit advantage came through corporate

tax law, which permitted owners of hospital buildings to use accelerated depreciation over a fifteen-year period. Thus, a hospital building that would normally have an estimated useful life of forty years could be written off in fifteen years. From a corporate tax perspective, it could also have paid to change ownership every six or seven years because, by that time, more than half of the facility's depreciation could be taken. Interests on loans obtained to finance the acquisition as well as accelerated depreciation on the hospital's newly established value were deductible from income. 7) Purchasers of hospital assets could also qualify for an investment tax credit on at least some of the equipment acquired[135]. 8) Finally, as a result of the inclusion of capital costs in third party reimbursements, nonprofit hospitals also had to contend with the phasing out of the Hill-Burton program, which ended the head start they had enjoyed from this source of funding *vis-à-vis* for-profit hospitals[136].

The combination of the above factors meant that for-profit hospitals now bore only a minor risk on their capital investments. This could explain why they were much more indebted than their nonprofit or governmental counterparts. In 1982, for-profit hospital chains had a total debt-to-equity ratio of 1.25 compared to 0.79 for all hospitals[137]. For-profits were helped most by Medicare, but nonprofit hospitals retained one important advantage. In 1963, the Internal Revenue Service (IRS) issued a ruling that permitted a county or municipality to issue tax-exempt bonds for the benefit of nonprofit hospitals[138]. The majority of states passed enabling legislation permitting nonprofit hospitals to benefit from tax-exempt bonds[139]. Tax-exempt bonds became the backbone of capital funding for this type of hospital and were used so frequently that they were allocated a separate category in debt-financing statistics. Section 242 of the National Housing Act (1968) allowed hospitals to 'insure' their default risk, which further lowered the cost of borrowing[140]. The importance of philanthropy and public grants diminished, while dependence on debt financing grew (see table 2.7).

For-profit hospitals were able to fund a considerable share of their capital needs through commercial equity[141]. Stock issues became popular as hospital stock prices grew rapidly during the late 1970s and early 1980s. Between 1978 and 1983, new stock issues frequently accounted for more then fifty percent of the increase in the equity of the companies involved[142]. On the other hand, the financing of the nonprofit hospitals was threatened by efforts to restrict tax-exemption instruments as well as by the steep rise in interest rates[143]. Together with lavish capital reimbursement policies, the favorable environment provided by the financial markets increased the financial power of the for-profit hospital companies. The ability of for-profit chains to gain capital and modernize public or nonprofit hospitals was a major factor in the willingness of the owners to sell off these facilities. Most

**Table 2.7: Trends in Funding for Hospital Construction 1973–1981 (percent of total)[145]**

| | 1968 | 1973 | 1978 | 1981 |
|---|---|---|---|---|
| Governmental grants and appropriations | 23 | 21 | 16 | 12 |
| Philanthropy | 21 | 10 | 6 | 4 |
| Hospital reserves | 16 | 15 | 17 | 15 |
| Debt | 38 | 54 | 61 | 69 |

for-profit chains modernized the newly acquired facilities, while simultaneously substantially increasing charges for ancillary services and increasing reimbursable costs for capital, return-on-equity, and overhead expenses[144].

*Cost containment through government intervention: no impact on the for-profit hospital sector*

In 1968 and 1969, Medicare costs rose at an average annual rate of fort percent. Russel Long, chairman of the Senate Finance Committee, warned that Medicare had become a runaway program. President Richard Nixon proclaimed the first 'fiscal health care crisis'[146]. Importantly, the government had to create cost-containment mechanisms from scratch. The Nixon Administration imposed a general wage-price freeze in August 1971 and increases remained limited until 1974. Such a bold instrument illustrates how few options were open to the federal government to reduce hospital costs at that point[147]. This encouraged policymakers to look for other mechanisms, particularly market-based competition[148].

Health Maintenance Organizations (HMOs), a new variant of the old direct-service plans, were proposed as a new method of promoting efficiency. HMOs, which finally took off many years later, were different to the old direct-service plans in one important respect. The Nixon administration, and later more especially the Reagan administration, welcomed profit-making corporations as part of the HMO sector[149]. Market forces were seen as an important way of improving efficiency. This was stipulated by a new set of definitions: the AHA now categorized proprietary hospitals as for-profit or investor-owned; voluntary hospitals became not-for-profit; surpluses were seen as indications of effective management[150], although early researchers remained skeptical of the appropriateness of for profit hospitals[151].

Confronted with spiraling Medicaid costs, states sought a more pragmatic approach to cost containment. In 1964, New York required all hospitals to obtain state approval for expansion or new construction work. By the end of 1972, twenty states had introduced a requirement for hospitals to obtain state approval for construction projects and large capital investments, known as certificate-of-need

programs (CON). In some of the more liberal states, consumer representatives formed alliances with the local government officials responsible for enforcing CON regulations in order to target the unpopular for-profits[152]. Note that such 'planning' was often more holding meetings, consulting and communication instead of analysis of empirical data to foster alternative policy decisions[153]. In New York the for-profits were effectively phased out (see section 2.2.3). The federal government reinforced the impact of state policies and in 1974 denied the full reimbursement of capital in the Medicare program unless planning agencies had approved the investment for which reimbursement was being sought[154]. Rate-setting was another way of containing costs. Again, the states led the way. By 1976, six states – Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington – had adopted mandatory rate-setting programs for hospitals. Eventually, discounts by rate-setting would lead to significant cost-shifts to private insurers[155].

*Physicians: a change of view towards for-profit ownership*

The AMA was an important organization in health care for much of the twentieth century and was also the primary defender of physician autonomy (and corporatism[156]) as a way to maximize income[157]. For a long time, this meant defending fee-for-service medicine and rejecting corporate ownership: physicians had a natural 'right' to any profits (see section 2.2.2). However, from the mid-1960s onwards, AMA dominance was increasingly challenged by government regulation, large for-profit and nonprofit hospital chains, giant health insurance corporations, and salary-paying HMOs[158].

Entrepreneurism and activism on the part of physicians was also encouraged. For-profit hospitals developed a habit of soliciting and 'selling' stock in proprietary hospitals to local doctors[159]. Nonprofit hospitals' effort to become comprehensive community medical centers induces conflict between medical profession and hospital management[160]. Often the medical staff wants the hospital to remain a private doctor's workshop, which sometimes seemed to be better guaranteed in a for-profit context.

The internal cohesion of the AMA on such issues began to break down as more physicians became entrepreneurs themselves and the membership of the association gradually fell from seventy percent of all US physicians to forty percent by the early 1990s[161]. In 1984, fifty-two percent of physicians already believed that hospitals could be properly operated on a for-profit basis[162] and investor-owned hospitals began to be built with the explicit support of discontented physicians[163]. As physicians came to derive more of their revenues from testing done in their own laboratories and from the services of the nurse practitioners they employed, the AMA (1980) changed its ethical guideline that a physician's professional income should be derived solely from medical services personally delivered to patients. In

1984, the AMA stated that: 'physician ownership interest in a commercial venture with the potential for abuses is not in itself unethical if the physician took certain precautions such as full disclosure to patients'[164].

### 2.2.5 The take-off of the for-profit hospital sector (1965–1983)

Before Medicare and Medicaid, the proprietary hospital sector was dominated by three categories of ownership: individuals, partnerships, and corporations (see table 2.2). These entities usually owned perhaps one or, at most, a few hospitals. The primary goal of profit making was the continued existence of the hospital. For-profit hospital chains that focused on expansion and maximizing profits did not yet exist. However, the generous way that Medicare reimbursed (equity) capital and the less hostile opinions of the doctors brought about an environment that was conducive to a different kind of for-profit hospital sector (section 2.2.4). The argument that for-profit companies were simply uninterested in delivering hospital services vanished, and with it the argument that voluntary hospitals were essential[165]. While economic development remained lackluster during much of the 1970s and 1980s, hospitals turned into a very profitable sector.

*The emergence of for-profit hospital chains*

The ownership of multiple hospitals by public corporations dates back to 1960, when American Medical International (AMI) purchased two hospitals[166]. In the same year, the Health Corporation of America (HCA) opened Park View Hospital[167]. However, it was not until the late 1960s that significant growth began[168]. When HCA went public in 1969, stocks were priced at $18, but by the end of the day had soared to $46[169]. Investors clearly thought hospitals were a good investment. In 1969, twenty-one percent of all for-profit hospitals belonged to a hospital chain[170]. Old state laws against the corporate practice of medicine (see section 2.2.2) were no major barriers[171], although they precluded the direct employment of physicians by investor-owned companies[172].

For-profit chains invested in new hospital plant as well as acquiring existing stand-alone proprietary clinics. Physicians controlled many older proprietary clinics that were actually not that different from nonprofit hospitals, which were also dominated by their medical staff[173]. Many of such proprietary facilities were by now being purchased by hospital chains because they had limited access to capital, lacked the skills to exploit reimbursement loopholes, and were unable to navigate the red tape of the new planning laws.

The entrance of the for-profit hospital companies onto the market was a major change, but they were joined by hybrid organizations that combined profit and nonprofit elements – nonprofit contract management by for-profit firms[174]and

nonprofits with for-profit subsidiaries[175]. The growth of the for-profit chains was huge: 'after their emergence […], the profit making chains grew faster in the 1970s than the computer industry. In 1970 the largest for-profit chain controlled twenty-three hospitals; by 1980 the same company, Hospital Corporation of America (HCA), owned or managed more than three hundred hospitals with 40,000 beds. In 1981 the for-profit making chains owned or managed hospitals with 121,741 beds, up sixty-eight percent over the total of 72,282 beds they had five years earlier'[176]. Table 2.8 summarizes the growth of hospital chains, which is much faster than the growth of the for-profit sector as a whole. In 1982, chains operated sixty-five percent of all for-profit hospitals and eighty percent of all for-profit beds[177]. Investor-owned systems grew largely through the acquisition of (proprietary) hospitals in financial difficulty – an inventory by the General Accounting Office (GAO) of eleven acquired hospitals (1981) showed that nine were running severe operating losses[178].

For-profit hospital chains proved very profitable. During the 1970s and early 1980s, stock returns for five large for-profit hospital companies were almost three times as large as returns in other sectors[181]. In 1982, for-profit hospital chains had

**Table 2.8: Investor-owned hospitals[179] and beds: chains versus the total for-profit sector[180]**

| | Chain-owned for-profit hospitals | Percent of total hospitals | Percent of total beds | Stand-alone for-profit hospitals |
|---|---|---|---|---|
| 1975 | 378 | 6.3 | 5.3 | 682 |
| 1980 | 531 | 9.0 | 7.5 | n/a |
| 1982 | 682 | 11.6 | 8.9 | 330 |
| 1983 | 767 | 13.1 | 9.8 | n/a |
| 1984 | 878 | n/a | n/a | 303 |

**Table 2.9: Profitability by ownership and chain status, 1982 (percent)[184]**

| | Return on Equity | Return on Assets | Total Margin |
|---|---|---|---|
| All hospitals | 7.5 | 4.2 | 4.3 |
| Government, independent | 5.6 | 3.7 | 3.8 |
| Government, chain | –1.6 | –0.9 | –0.7 |
| Nonprofit, independent | 7.1 | 3.9 | 4.2 |
| Nonprofit, chain | 9.8 | 5.0 | 5.2 |
| For-profit, independent | 35.1 | 10.8 | 7.1 |
| For-profit, chain | 26.4 | 11.7 | 9.2 |

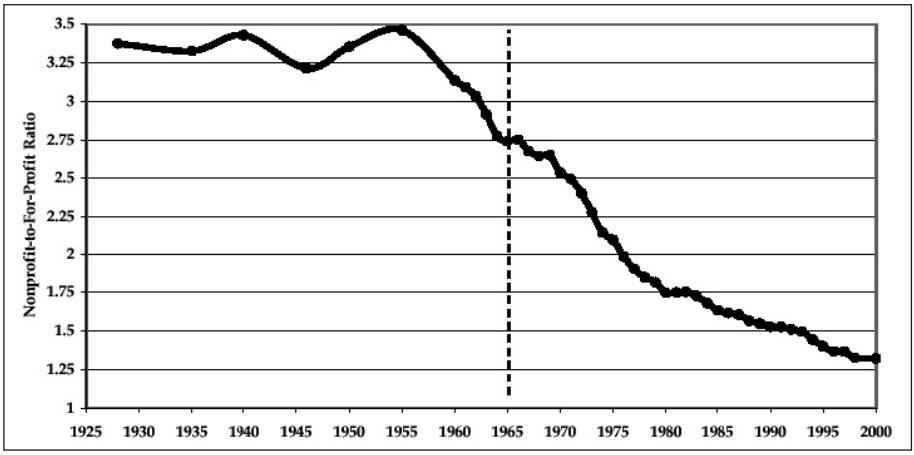
a return on equity of twenty-six percent; return on capital was twelve percent, while the total margin was still nine percent. These were much better figures than the profitability of public and nonprofit hospitals (see table 2.9). Scholars argue that a higher return on equity among for-profit hospitals was only natural because of their higher risk-premium[182]. For-profit capital seems to have been complementary to (increasing the lack of) public and nonprofit capital: 'Where there is a strong philanthropic tradition, and demand for hospital care is not large (or not growing), the price [of capital PJ] can be quite low, since all needed capital is furnished with cheap, voluntarily donated capital. Where demand is large and the philanthropic tradition weak, then it is efficient to have for-profit firms, a high price for not-for-profit output, and an even higher price for for-profit firms'[183].

How can we characterize the typical for-profit chain hospital? Many chain hospitals were located in the South, Southwest, and West[185]. They were medium-sized (with 100–200 beds) with no residency programs. For-profit market share grew most rapidly in states with the greatest increases of per capita income and population and where for-profits had already held a significant market share[186]. Legal restraints, such as certificate-of-need procedures, were important, but there is little evidence that the nonprofit sector 'captured' such regulations as a competitive weapon against for-profit hospitals[187]. However, virtually none of the for-profit chain hospitals was located in rate-setting states[188]. Nashville became the epicenter of the for-profit health services industry. Eventually, the city would be home to more than 450 healthcare companies and support firms, many of which sprang from Nashville-based HCA[189]. The for-profit hospital industry now employs more than 300,000 employees in the region.

*For-profit hospital chains: more similarity with public and nonprofit hospitals?*
For-profit hospital chains differed in a number of ways from their nonprofit counterparts. They included many more hospitals than the competing nonprofit chains; a few large companies that operated on a national scene dominated the for-profit hospital sector. For-profit hospitals rarely operated residency programs or affiliated with medical schools. They were also more focused on inpatient treatment. Nonprofit hospitals held more outpatient and emergency departments, more home care programs, and more nurseries for premature deliveries[190]. Physicians in for-profit chains seem least likely to have been involved in a salaried relationship and were the most satisfied with the responsiveness of the hospital towards their needs[191].

On other characteristics, for-profit and nonprofit hospitals seem to have converged[192]. With the phasing-out of Hill-Burton and the decline of charitable contributions, capital requirements were met mainly through retained earnings and debt[193]. Net nonprofit operating margins on patient treatments, which had

**Figure 2.1: Convergence in average nonprofit-to-for-profit bed ratio[199]**




traditionally often been negative, now became positive[194]. Another trend was the emergence of for-profit/nonprofit hybrids. For-profit chains managed nonprofit and public hospitals, while some nonprofit hospitals established for-profit subsidiaries, such as ambulatory surgery centers[195]. However, converging characteristics were the most obvious in the scale and scope of the for-profit hospital sector. This is illustrated by the convergence in the average number of hospital beds. Nonprofit hospitals had operated on a much larger scale than for-profits until the early 1960s but by 2000, the average nonprofit hospital was only thirty percent larger than the typical for-profit hospital (figure 2.1).

David calculated the reasons behind this development. Between 1970 and 1978, this trend primarily reflected the creation of larger for-profit hospitals (construction) and the gradual disappearance of small proprietary hospitals, the latter being a trend that continued into the early 1990s. Ownership conversions from nonprofit to for-profit played a much smaller role. Between 1978 and 1986, large newly built for-profit facilities were no longer contributing to this convergence in scale. Nevertheless, the trend continued due to the continuing exit of small proprietary facilities and because nonprofit hospitals were downsizing. The conversion of small nonprofit and, more notably, public hospitals into for-profit ownership only mitigated this trend partially[196]. In the 1990s, mergers, acquisitions of nonprofit hospitals, and divestitures became the most important factors[197]. During this period, the convergence trend began to slow: between 2000 and 2005, there was a downward trend in the average number of beds in for-profit hospitals, while average nonprofit bed numbers remained stable[198].

### 2.2.6 The IOM's report on for-profit health care

In 1980, Ronald Reagan entered the White House with a strongly conservative agenda. The new emphasis on markets and deeply felt mistrust of the public sector strongly influenced the political climate. The new government had no reservations about the appropriateness of for-profit medicine. For health care, this natural corollary of this change in the *Zeitgeist* was more for-profit ownership and market competition. Nevertheless, the strong growth of the for-profit hospital corporations led to uneasiness in many quarters. The mainstream health care community resented the success of the large for-profit hospital chains[200]. Arnold Relman, editor of the New England Journal of Medicine, was among the first to criticize the emergence of a 'new medical-industrial complex'[201]. He was supported by the American Public Health Association[202]. Some independent reports were also critical: the General Accounting Office documented sharp increases in Medicare charges after nonprofit or public hospitals converted to for-profit ownership[203]. Given the vast growth of for-profit hospital chains, some even wondered whether the nonprofit sector might eventually disappear[204].

*A Committee in Implications of For-Profit Enterprise in Health Care*

Large-scale research into the issue of for-profit hospital care, 'was stimulated by concerns among members of the Institute of Medicine and others that health services, already heavily dependent on monetary transactions through prepayment and insurance, will become excessively commercialized, with growing ownership by stockholders'[205]. The Committee on the Implications of For-Profit Enterprise in Health Care was chaired by Walter McNerney and consisted of twenty-two members, including some from for-profit hospital corporations. After two years of research, they issued their report in 1986.

The Committee carried out its work against the backdrop of concern that for the first time, there was a serious possibility that the New Deal legacy may be dismantled. However, it was unable to come up with a way of resolving the issue, an indication of broader public discord[206]. Discussing the growth of private capital investment and reliance on market mechanisms, Relman concluded that: 'no political decision has been made to rely on this method of financing health care – or that the implications of such a decision have even been explored or publicly discussed [...] the public has not given its approval of that trend, and many people have not even thought about it'[207]. The Committee could not devise a solution unilaterally: 'the report should be viewed as a benchmark and not the final answer to the issues addressed. Its essence lies in an illumination of the issues, not in their resolution'[208]. Nevertheless, the Committee agreed that ownership was an important variable that affected the entire health care system.

The Committee's focus on ownership also meant that the (conceptual) relationships between for-profit organizations and the constraints of the market place had not been worked out. However, the Committee did not entirely neglect the impact of a changing environment and of new policy incentives on the endogenous constraints on the various types of hospital ownership. They discussed the significant problems surrounding the distinction between for-profit and nonprofit ownership, as well as the fact that a sharpening of the competitive environment and the diminishing differences in access to capital may lead towards decreasing ownership related differences[209].

However, at the same time, the Committee did not accept that public policy should aim to create a level playing field between the different types of ownership; substantive goals regarding costs, access, and quality were thought more appropriate[210]. The IOM did take a position in the growing discussion of the tax-exempt status of nonprofit hospitals[211]: 'the Committee strongly believes in the importance of a not-for-profit sector in health care, and that it is imperative that tax-exempt financing be maintained'[212]. Nonprofit hospitals kept their tax-exempt status, but in 1986, the federal government revoked the tax-exempt status of nonprofit Blue Cross plans[213]. Nevertheless, the idea of a special tax-status for nonprofits came to be challenged increasingly after Robert Clark (1980) proposed neutrality between nonprofit and for-profit hospitals: favoring nonprofits was considered to be unfair because they had no demonstrable public function that distinguished them from for-profits (see section 2.2.8)[214].

Much of the empirical research carried out by the Committee targeted questions on what difference the form of ownership made. The Committee found that for-profit and nonprofit hospitals had about the same costs per case (adjusted for case-mix), but that investor-owned hospitals had significantly higher administrative costs and deployed fewer employees per occupied bed; these employees were paid more than in nonprofit surroundings[215]. For-profits were not found to operate with lower quality of care[216], but it was concluded that for-profits were more responsive to economic incentives than nonprofit hospitals[217]. This resulted in significantly higher charges to payers and higher levels of capital investment[218]. On the other hand, nonprofit hospitals were found to provide only slightly higher levels of uncompensated care[219]. From a public policy point of view, the major advantage of for-profit organizations was thought to be their supposed better access to equity capital, the innovations they made in service delivery, and their greater responsiveness to consumers as well as to incentives in general. According to the Committee, the evidence available on the differences between nonprofit and for-profit hospitals was insufficient to justify a public policy that either opposed or supported investor ownership[220].

It is important to note that since ownership distinctions represent powerful ideas in society that transcends their history[221], the value question was never far from the IOM's analysis. A deep division concerning values underlies and affects any discussion of the implications of a growing investor-owned health care sector, which in effect seems to come down to a distinction between health care as an economic good or as a social good. For-profit hospitals, it is claimed, exacerbate the problem of access, provide unfair competition to nonprofits, treat health care as a commodity instead of the right of every citizen, damage the physician-patient relationship, undermine medical education, and lead to new, strong political regulations[222]. The Committee sought to evaluate such objections, but seven of the twenty-two members signed a supplementary statement rejecting for-profit medicine.

The Committee was particularly interested in how for-profit hospital corporations could affect the values of the physicians. They strongly agreed that physicians held fiduciary responsibilities towards their patients and that they should play a role in assuring the quality of care. The Committee was concerned that for-profit hospital ownership might, over time, permit considerations of economic self-interest to invade the hitherto rather protected sphere of the physician-patient relationship[223]. Direct physician investment in hospital assets and bonus incentive arrangements were important issues in this discussion. In the 1970s, entrepreneurial physicians started new hospital facilities or provided traditional services in new settings. HMOs and (for-profit) hospitals started to give physicians a direct economic incentive to contribute to the 'well-being' of the institution. The Committee was highly critical of such developments, which some saw as detrimental to the credibility and moral standing of the entire medical profession. They wanted them terminated or codified in rules, which to a certain extent, would be what happened a few years later.

The concern generated by the rise of for-profit hospital chains brought about a broad debate, but did not produce a coalition that was able to block the growth of for-profit hospital chains – although the combined power of skeptical physicians, voluntary institutions, Blue Cross organizations, and liberal politicians probably could have achieved this. Ironically, the Reagan Administration itself temporarily put a stop to the growth of the for-profit corporations. This was a consequence of the introduction of a prospective payment system to contain Medicare costs as well as more restricted reimbursement procedures for capital. According to some scholars, few ongoing changes in American medicine have provoked so much controversy yet so little direct response from policymakers[224].

### 2.2.7 The 1980s: less favorable for-profit reimbursement and increasing countervailing powers

The 1980s started with critical discussions about the appropriateness of for-profit health care (section 2.2.6). However, this dispute had vanished by the late 1980s and, ironically, was replaced by skepticism about the legitimacy of tax-exemptions by nonprofit hospitals[225]. Following the Intermountain case of 1985, courts looked to the provision of actual community benefits to determine whether a nonprofit hospital qualified for tax-exempt status[226]. Nevertheless, despite this pressure on nonprofits, for-profit hospitals seem to encounter greater difficulty still.

The growth of the for-profit hospital sector began to slow in the mid-1980s. The number of for-profit hospitals decreased slowly, while the number of for-profit beds hovered at around a hundred thousand[227]. As occupancy levels fell, it became clear that greater use of outpatient facilities and a general trend towards declining lengths of stay had created a surplus of hospital beds. However, the share of for-profit hospitals in the total number of community hospitals, community beds, hospital admissions, and hospital expenses continued to increase, though at a more modest pace (table 2.10). This growth now became more cyclical. Years of substantial growth were succeeded by years of lower or even negative growth. The next two sections will explore the patterns of this cyclical growth.

*Changing reimbursements and protection of the uninsured*
Changes in Medicare reimbursement procedures, often also adopted by Medicaid and private insurance, impacted on the for-profit business model.

**Table 2.10: For-profit share (percent) in the total community hospital sector (1980–2002)[228]**

| | Hospitals | Beds | Admissions | Outpatient visits | FTE's | Expenses |
|---|---|---|---|---|---|---|
| 1980 | 12.5 | 8.8 | 8.8 | 4.8 | 6.6 | 7.6 |
| 1985 | 14.0 | 10.4 | 9.7 | 5.7 | 7.4 | 8.8 |
| 1990 | 13.9 | 10.9 | 9.8 | 6.7 | 8.0 | 9.2 |
| 1995 | 14.5 | 12.1 | 11.1 | 7.7 | 9.2 | 9.3 |
| 2000 | 15.2 | 13.3 | 12.5 | 8.3 | 9.7 | 9.8 |
| 2002 | 15.5 | 13.2 | 12.7 | 8.1 | 9.3 | 9.6 |
| 2004 | 16.9 | 13.9 | 13.1 | 7.9 | 9.8 | 10.2 |
| 2006 | 18.0 | 14.4 | 13.3 | 7.3 | 9.7 | 10.0 |
| 2007 | 17.8 | 14.5 | 13.1 | 7.3 | 9.7 | 9.6 |

1) In 1983, Medicare introduced a prospective payment scheme (PPS), based on 467 diagnostic-related groups (DRGs) for inpatient treatments. Cost-based reimbursement was phased out. Hospitals now were reimbursed with a fixed payment per patient, regardless of the actual costs incurred and dependent on the diagnosis of the patient at the time of admission[229]. This new reimbursement system was strongly supported by the for-profit hospital chains, since more efficient producers would be rewarded with higher profits. However, the PPS was primarily designed to contain costs. Over time, since rates were not fully updated for inflation, the PPS effectively became a mechanism to limit spending. More importantly, hospital margins became an explicit policy concern in a way they had not been before: 'reports of initially high profit margins among hospitals were an invitation for the federal government to adjust payment levels accordingly, and annual payment rates increases thereafter trailed inflation. Thus, the thirty to forty percent of revenues from Medicare that were once seen as a highly secure source of income for the hospital industry became a problem with which hospitals had to cope'[230].

2) For-profit hospitals received less guaranteed return-on-capital payments. In 1982, return-on-equity payments were cut from 1.5 times the return of Medicare's Hospital Insurance Trust Fund towards the same return (see section 2.2.4).

3) The method of calculating depreciation expenses when a hospital was sold to a new owner was also changed. Normally, depreciation could be calculated on the basis of the purchase price[231]. However, in the aftermath of HCA's acquisition of Hospital Affiliates International (1981), the GAO found that the deal had raised Medicare's interest and depreciation expenses in the first year by $71 million for the same services and facilities. This was possible because Hospital Affiliates International's book value increased by $272 million to $530 million. In the opinion of the GAO, HCA was allocating debt towards Medicare in a way not allowed by the rules of the program[232]; it also assigned inaccurate values to the assets acquired[233]. It was decided that Medicare would, from now on, only pay once for the depreciation of an asset, no matter how many times it changed hands. The Deficit Reduction Act (1984) set limits on Medicare's allowances for interest, depreciation, and, if applicable, return on equity for hospitals changing ownership after July 18, 1984[234]. The stock market began to evaluate for-profit hospitals more critically. On November 1, 1983, a rumor circulated about the forthcoming GAO report and panic selling of HCA's stock was triggered by speculation about the negative effect of this report on profits. The price per share plummeted and HCA requested the New York Stock Exchange to suspend trading in its stock temporarily. The value recovered, but the incident demonstrated how brutally the market could treat a company whose earnings were threatened[235].

4) After a sick patient was refused admission to a hospital and died in a hospital parking lot due to perceived lack of ability to pay, the government tried to secure

hospital access for the growing number of uninsured. In 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA) stipulated that hospitals that wanted to treat Medicare patients were forbidden to 'dump' medically unstable patients on financial grounds. In other words, hospitals were obliged to provide emergency screening to any patient who attended an emergency room and to stabilize any emergency condition, regardless of the patient's ability to pay. Since the share of workers who received insurance from their own employers started to fell, this was a serious problem. The EMTALA signaled that the growing number of uninsured could result in rising bad debt and thus reduce hospital profits.

*Countervailing powers*

During the 1980s, health care costs started to become a large burden on corporate profits. Health care costs, which had been equivalent to less than nine percent of company profits in 1965, increased to more than fifty percent of corporate profits in the mid-1980s[236]. Employers took the issue of rising health care costs very seriously. In 1990, more than half of the workers who went on strike did so over health benefit issues[237]. Growing concern over health care costs encouraged the growth of HMOs, which used aggressive strategies to contain costs. Enrolments in HMOs increased from 9.1 million (1980) to 33.6 million (1990), and their cost-reduction strategies included discount bargaining, selective contracting, utilization reviews, and patient steering towards outpatient care. In November 1986, the end of Blue Cross' favorable federal tax treatment stimulated the growth of their competitors, mainly commercial HMOs.

In the aftermath of the PPS, the number of ambulatory treatments, which were not subject to this scheme, grew rapidly. In response to increasing competition from ambulatory surgery centers, joint ventures involving physicians and hospitals became more common. By creating a for-profit subsidiary that could pay partners a proportion of its revenues, and was backed by hospital assets and access to capital, the hospital could strengthen its ties with physicians. Physicians, meanwhile, wanted the hospital to prosper for their own interest[238]. Research carried out by the Office of the Inspector General showed that physicians more often referred patients to freestanding facilities in which they had an ownership interest[239]. This provoked a political response.

In 1989, Congressman Stark amended the Omnibus Budget Reconciliation Act. These were provisions that prohibited physician-entrepreneurs from referring Medicare patients to clinical labs in which they held a direct or indirect financial interest. As a result, the numbers of joint ventures between hospitals and physicians declined[240]. In 1993, this provision was broadened to include eleven other medical services. However, a notable exception to these regulations was the 'whole hospital' exception, which allowed physicians who had an ownership interest in

an entire hospital, and who were authorized to perform services there, to refer patients to that hospital[241]. This implied that for-profit hospital chains could continue attracting the loyalty of the physicians by awarding them stock bonuses.

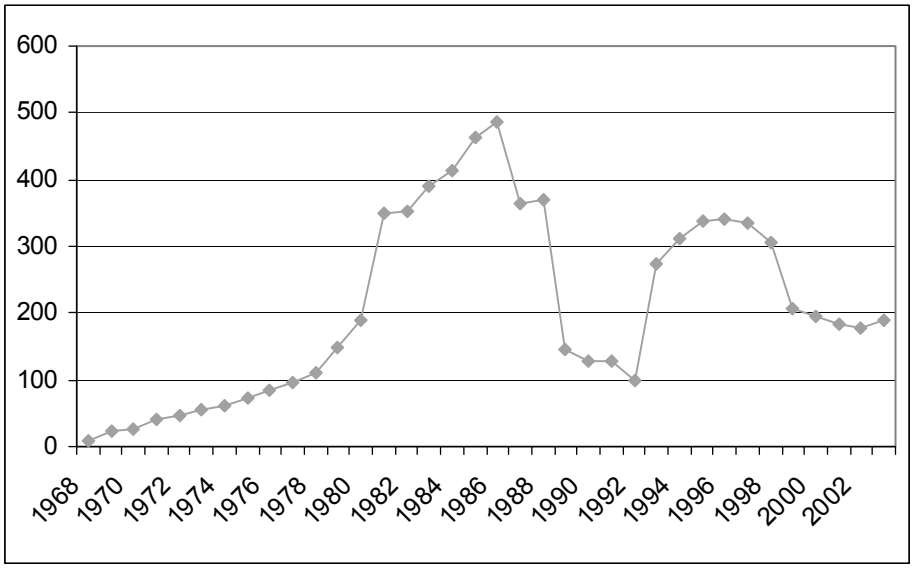
*The response of the for-profit groups*

By the mid-1980s, it was becoming clear that a successful business model was under pressure and for the first time, many for-profit hospital chains were lowering their expectations. In 1985, after a day of panic selling due to the downward revision of earnings estimates by HCA, the industry leader, the market value of the for-profit sector fell by more than $1.5 billion[242]. For-profit groups intensified their administrative efforts. For-profit providers submitted more appeals to Medicare's Provider Reimbursement Review Board than other types of ownership[243]; for-profit hospitals were also more involved in health planning lawsuits; and finally, for-profit hospitals increased their political lobbying activities and by 1985, for-profit providers[244] accounted for thirty-six percent of the total expenditure on hospital lobbying. With regard to direct contributions to political candidates, for-profit hospitals funded thirty percent of hospital sector contributions, while their trade associations contributed another twenty-five percent[245].

For-profit hospitals were pressured to adjust their business model in a more fundamental way. They began to sell hospitals and, when they made new acquisitions, they became more interested in nonprofit facilities. Large for-profit hospital chains began to sell hospitals to smaller and newer companies or nonprofit chains. This is illustrated by the number of hospital facilities that HCA were operating, which shows large dips in the late 1980s and then again in the late 1990s (figure 2.2). HCA 'transferred' many hospitals to new employee-owned companies[246]. Other companies also trimmed their facilities: six hospital chains that owned 519 hospitals in the early 1980s, owned only 320 by late 1987[247]. During the late 1980s, private investors bought HCA, NME, and AMI.

The other response to worsening prospects was a shift into new lines of business such as mental health, nursing homes, or ambulatory care[248]. Psychiatric care appeared especially appealing. In the 1980s, psychiatric care in many states became a required benefit in health insurance policies sold commercially within the state, and psychiatric care was still exempt from the PPS. However, diversification into mental health or long-term care did not prove a successful long-term strategy. NME was even fined $379 million after criminal proceedings because its psychiatric hospitals paid for referrals and kept patients incarcerated until their insurance had expired[249]. Some for-profit hospital groups also started insurance subsidiaries. However, the success of the hospital business came at the expense of the insurance business or *vice versa*[250]. HCA ran into difficulties with its insurance business and in 1987 sold 104 of its hospitals to HealthTrust, a newly created company.

**Figure 2.2: Number of HCA hospitals (1968–2003)**[252]




Humana became the only lasting success although it, too, experienced problems with its hospital business, which was spun off to a new company that was bought by Columbia/HCA in 1993[251].

### 2.2.8 Ups and downs in the 1990s and thereafter

By the late 1980s, the for-profit hospital sector had matured and challenges were increasing in importance. 1) Employers ended their reliance on traditional indemnity insurance, increasing cost pressures from new third-party payers. 2) Governmental powers introduced prospective capital payments and introduced rate-setting policies. 3) Entrepreneurial physicians challenged the hospital sector with ambulatory surgery centers and specialized hospitals. Although other types of ownership were also confronted with such challenges, their business models were less susceptible.

Nonprofits were subject to increasing monitoring concerning whether they were delivering reasonable community benefits in return for their tax-exempt status. In this section, I will explore the consequences of these constraints on the for-profit hospital sector. I then discuss the developing debate on tax exemption, since this affected the competitive position of the for-profit sector. I end with an overview of strategies employed by the for-profit sector to deal with this new set of challenges.

*The employers: the end of traditional indemnity insurance and growing pressures from third-party payers*

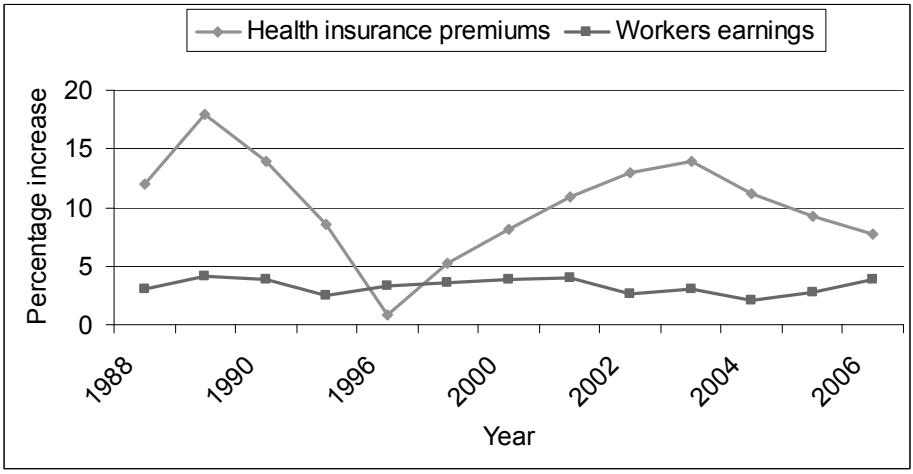
Private insurance coverage was already down from a peak of more than eighty percent of the population in the 1970s. Between 1979 and 1998 the share of workers who received health insurance from their own employer fell from sixty-six towards fifty-four percent. This would add to the bad debt pressures of the entire hospital sector[253]. However, there was more. The 1990s saw the end of indemnity insurance with its generous reimbursement policies. The number of workers covered by such plans declined from seventy-three percent (1988) towards only three percent in 2006[254]. Employers sharply reduced coverage both through conventional indemnity insurance and for their retired employees[255]. Quite some (large) firms entered into self-insurance to contain their health care costs. Under this type of set-up, managed care organizations (MCOs) delivered administrative services to the company, while the companies themselves bore the underwriting risk. An important effect of self-insurance was that the situation of smaller employers to pool the risk of their employers was worsened. This added to the number of uninsured[256]. MCOs not only replaced private indemnity insurance plans, but also grew under the Medicaid program[257]. Academic studies indicate that MCOs were able to reduce costs without reducing quality of care[258].

Managed care was also the central plank of President Clinton's Health Security Act (1992), an effort to implement universal coverage, which failed due to lack of support from the elderly and resistance from traditional insurers and small employers[259]. This failure, and the fact that Republicans took control of both the Senate and the House for the first time since 1954, reinforced market-based efforts to contain costs and stakeholders now felt free to act without taking any political and regulatory risks[260]. For-profit MCOs had the most success. In 1993, both for-profit and nonprofit plans had about the same enrollment, but by 2001, for-profit plans had 50 million enrollees, while nonprofit plans covered 30 million[261]. Although price reductions had more effect than lowering utilization, MCOs contributed to excess hospital capacity[262]. Some researchers stipulated that MCOs primarily reduced non-recurrent X-inefficiencies[263].

The restrictive MCO standards did not gain the trust of the American people[264]. In response to a patient backlash in the late 1990s, MCOs started to ease restrictions. Preferred Provider Organizations (PPOs), which allowed enrollees to receive full-reimbursement if they received their care from within the network, became the most popular form of managed care[265].

The increase in managed care penetration did not help the for-profit hospitals. On the contrary, it was the for-profit hospital sector, which was the first to begin renegotiating contracts with MCOs, that demanded more 'appropriate reimburse-

**Figure 2.3: Increases in health premiums compared to earnings 1988–2006**[267]




ment'. The Wall Street Journal reported that 'big insurance companies held the upper hand in the struggle over prices charged by hospitals [...] In a little known power shift since the late 1990s, HCA and other major hospital chains have reshaped themselves into local oligopolies with the muscle to enforce much higher prices. For-profit hospital chains told MCOs that they could not just contract one of their hospitals, but had to give the same price to all of the chains' hospitals in a particular state'. Well-positioned hospital networks achieved solid rate increases. Health insurance premiums advanced and the increased out-of-pocket payments and risks of PPOs were shifted to the insured (figure 2.3). The long-term trend of increasing insurance protection weakened and the number of uninsured grew as premiums increased[266]. The result was an increase in hospital bad debt.

*The government: prospective capital payments and more rate-setting policies*
Capital costs were 'passed through' under PPS. They were not used when computing the maximum amount payable or in establishing the prospective rate and were paid to the facility on a reasonable cost basis. In the mid-1980s, Congress started to discuss the elimination of the explicit return-on-equity payments, as well as the separate cost-based payments for interest and depreciation expenses. The report of the IOM (1986) favored including capital costs under the PPS[268]. This sometimes hurt for-profit hospitals, which had much higher reimbursable capital costs: 'in the short run investor owned hospitals would be less advantaged by a payment system that included capital as a fixed-percentage add-on to the DRG-rates. Investor owned hospitals might be disadvantaged over the long run as well, unless their higher capital costs in fact show the financing of more future costs'[269].

GAO figures stipulate that the ratio of capital to operating costs (including for a return-on-equity) among for-profit hospitals was about double that of public and nonprofit hospitals[270]. This was a result of their higher leverage, lower occupancy levels[271], and the lower average age of their plant[272]. However, it is important to note that since nonprofits use slower depreciation trends, the higher capital costs of for-profits can be distorted. Nevertheless, even if we adjust for these differing accounting methods, for-profit hospitals are still generally more capital intensive than their nonprofit counterparts[273].

In 1986, the GAO issued a report reviewing the different proposals on the future of capital reimbursement. Most proposals converged on a fixed percentage add-on to the PPS, although the idea of the length of the transition period differed between the health department and the hospital association[274]. The add-on percentage varied according to the types of capital costs covered and the base period used to compute the payment rates. The GAO recognized that hospitals with large uncompensated care loads were not always able to accumulate the capital needed to finance replacement assets[275]. This resulted in a longer transition period for implementing prospective capital rates.

In 1992, Medicare's capital costs moved from cost reimbursement to prospective payments. Because risk increased, borrowing costs increased and many hospitals started to postpone construction projects and substitute equity for debt as the relative cost of debt grew[276]. Excess capacity also weakened construction projects[277] and over the course of the 1990s, the median average age of hospital plant increased from eight to ten years[278]. Capital spending declined toward less than seven percent of operating expenses[279]. The amount of capital accessed from traditional sources, especially commercial banks, dropped[280] because many banks were less willing to supply loans to the hospital sector[281]. In 1998, the Allegheny Health Education and Research Foundation defaulted on $1.3 billion of debt, sending a shock through the financial markets. Hospital interest spreads widened from 0.3 percent to 1.2 percent, reflecting the increased risk perceived by investors[282].

For-profit hospitals had no access to the tax-exempt bond market, meaning that the decline in commercial loans hit them hard. For-profit hospitals were also heavily leveraged and, by now, few had broad access to capital (table 2.11). Between 1997 and 2001, more than half of all for-profit hospitals did not invest enough to keep up with depreciation on their fixed assets[283]. This suggests that the for-profit sector did not see much prospect of making future investments[284]. It was possible that the importance of broad access to capital would diminish once the hospital sector had moved from being a mature industry to a declining industry. With no need for equity capital, for-profit hospitals could have used retained earnings and asset-based debt to fund investment, and they could even have exited the stock

**Table 2.11: Relative capital access and five-ear capital spending (1997–2001) per bed[286]**

| | Broad Access | Limited Access | Total | $ (1,000) per bed |
|---|---|---|---|---|
| Governmental | 28% | 19% | 26% | $ 230.9 |
| For-profit | 5% | 22% | 15% | $ 143.7 |
| Nonprofit religious | 15% | 15% | 14% | $ 243.1 |
| Nonprofit | 52% | 45% | 46% | $ 222.0 |

market altogether via a leveraged buy-out[285]. Indeed, in 2006, HCA was taken from the stock market in a highly publicized $33 billion leveraged buy-out.

The hospital sector also had to contend with severe cost-containment measures. Medicare rates are adjusted annually on the basis of statutory cost factors in a market basket. Congress – medicare policymaking often resembles 'congressional government'[287] – typically sets the update rates at a discount. Medicare's median update rate between 1988 and 2003 was 62.2 percent of the market basket update[288]. The 1995 Republican budget plan sought for $ 270 billion of cuts in Medicare spending[289]. Indeed, after Congress adopted the Balanced Budget Act (1997), the discounts on the annual PPS adjustments were very steep. Substantial budget cuts of $ 115 billion over a five-year period were sought for. In 1998, Medicare rates were frozen, and in 1999 the increase was no more than half a percent. The Balanced Budget Act also introduced an expanded market of private insurance into Medicare (the program's first major adjustment known as Medicare + Choice); to some extent, and with support of the Democrats, Medicare now could become part of the managed care movement[290].

The for-profit hospital chains responded to the Balanced Budget Act by massive cost cutting and divesting ancillary businesses such as home health agencies, ambulatory surgery facilities, and physician practices. The sector split into companies that focused on the more competitive urban markets (HCA, Tenet) and those that focused on the more monopolistic rural markets (HMA, Community Health Systems, and Lifepoint). At $ 31 billion, the expenses of the for-profit hospital sector remained flat for three years in a row between 1997 and 1999. Hospital acquisition values fell from a median price of about $ 250.000 per bed in 1997 to about $ 170.000 by 1999[291]. For-profit chains lost much of their profitability and initiated grassroots campaigns in an attempt to correct this. They succeeded. In 1999, Congress passed the Balanced Budget Refinement Act, which reduced further Medicare cuts, as well as the Benefit Improvement and Protection Act, which helped compensate the extensive reductions[292]. In 2001, hospitals received an increase in Medicare payment rates that was equal to the market basket[293].

*Entrepreneurial physicians: more competition from ambulatory surgery centers and specialty hospitals*

As inpatient treatment became less central to the process of care, hospitals encountered additional competitors. Fuelled by new technological possibilities, outpatient revenues increased[294]. This opened up many opportunities and a wave of entrepreneurism swept doctors. Physicians competed with hospitals by referring patients to their own facilities. Although federal law generally prohibits these self-referrals, there are some significant exceptions. Physicians may refer patients to specialized or general hospitals in which they have an ownership interest (the 'whole-hospital' exception)[295]. Another important exception allows physicians to refer patients to ambulatory surgery centers in which they have an ownership interest, because such facilities are expected to deliver care more efficiently and at lower prices than hospitals[296]. Nevertheless, as recent research found, physicians at physician-owned facilities are more likely than other physicians to refer well-insured patients to their facilities and route Medicaid patients to hospital outpatient clinics[297].

For-profit hospitals sought to harmonize the conflicting interests of their physicians and their hospital systems. Columbia/HCA often gave physicians an economic stake in its local ventures or offered other inducements (i.e. cheap office rents) in an effort to stop physicians splitting their admissions with other hospitals[298]. This action was legal because of another exception to the Stark laws covering public hospital companies worth at least $50 million[299].

During the early 1980s, hospitals had dominated the market for outpatient surgeries, but, in the 1990s, physicians effectively competed for this lucrative market (figure 2.4). The number of ambulatory surgery centers, diagnostic testing facilities, and specialty hospitals[301] increased rapidly (table 2.12). Between 2002 and 2008, the largest increases in capital spending were in outpatient departments (12.1 percent), followed by ASCs (11.2 percent), while the growth of investment in inpatient services was estimated at only 6.2 percent[302]. Competition from physician-owned ambulatory surgery centers and specialty hospitals reduced the volume of hospital admissions and average length of stay. Also, as less severely ill patients began to be treated elsewhere, hospitals were left with a less profitable case mix. In 2003, HCA attributed one third of its lower-than-expected first-quarter earnings to the increase in competition from physician-owned specialty hospitals and ASCs[303].

Research showed that the emergence of specialty hospitals or ASCs was leading to lower patient volumes for the existing hospitals[304]. Specialty hospitals presented the greatest threat because they provided high revenue services and were receiving many patient referrals. ASCs operated as specialized factories and were praised for maximizing efficient practice[305]. The GAO found that such hospitals were mainly

**Figure 2.4: Market of outpatient surgeries by facility type 1981–2003[300]**

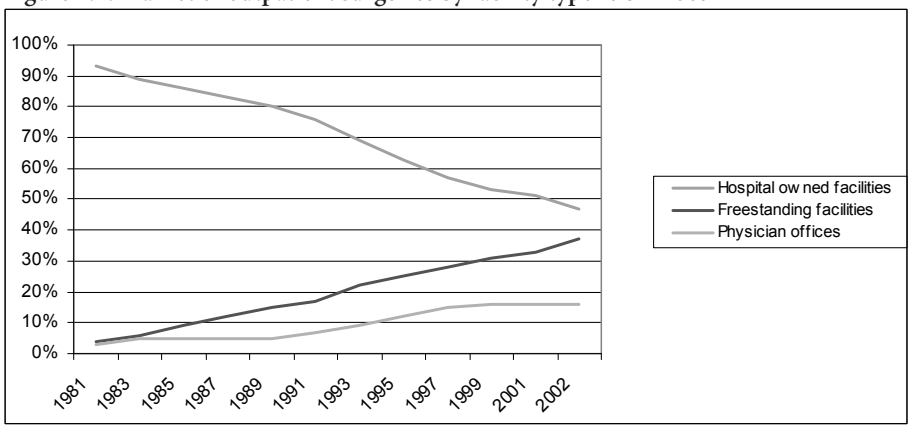



**Table 2.12: Technology is moving care away from hospitals (by number of facilities)[310]**

| | Ambulatory surgery centers | Diagnostic testing facilities | Specialty hospitals |
|---|---|---|---|
| 1997 | 2,462 | n/a | 31 |
| 1999 | 2,786 | n/a | 49 |
| 2001 | 3,371 | 2,012 | 67 |
| 2002 | 3,597 | 2,403 | 86 |
| 2003 | 3,735 | n/a | 113 |

for-profit and physician-owned, and they were concentrated in seven states, which did not operate CON programs (Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas)[306]. Since these states were also home to many for-profit hospitals, the for-profit sector was sometimes hit disproportionately by competition from specialty hospitals. Although specialized hospitals were fiercely criticized by both nonprofit and for-profit hospitals for cherry picking, the AMA voted in 2004 to oppose efforts to extend a moratorium on specialty clinics[307]. Nevertheless, after intense lobbying from hospital interest groups and several critical reports from the GAO, Congress did establish a moratorium, which temporarily halted further development of physician-owned specialty hospitals[308]. The moratorium expired in June 2005, but then was again reimposed[309].

*Pressure on nonprofit hospitals: community benefits*

The debate on community benefits was fuelled by academic arguments that nonprofit hospitals resembled the for-profit sector because of conversions, joint ventures, and the growing importance of market constraints. Growth in the

number of uninsured – a result of the decline in employment-based insurance protection especially for low-income workers – made tax-exemption an important issue. The number of uninsured rose from thirty-five million in 1990 to forty-four million in 2002. Medicaid enrollees, often paid for beneath actual costs, grew even faster and this number surpassed the number of uninsured in the late 1990s[311]. These numbers put pressure on the entire hospital sector, since, as Rosemary Stevens states, hospitals – not insurers – form America's *de facto* national health system[312].

Ownership is central in US laws on tax obligations. In contrast to many other countries, such as Germany, for-profit hospitals in the US bear a high tax-burden. The tax advantages of nonprofit hospitals were increasingly disputed, because it was suspected that they did not always provide equivalent community benefits to compensate for these advantages. Others argued that this was part of the steady, long-term erosion of the special tax status afforded to nonprofit organizations[313]. Nevertheless, the dispute on the future of the tax-exempt status of nonprofit hospitals intensified. For-profits complained that these tax-breaks gave nonprofits an unfair advantage. Some firms challenged the tax-exempt status of nonprofits by sponsoring research that concluded that in fact for-profit firms provided more community benefits than nonprofits[314].

In 1990, the GAO argued for clearer standards for the tax-exemption of nonprofit hospitals[315]. They reported that a significant percentage of nonprofit hospitals in five states provided fewer community benefits than the tax-breaks they received, and in some cases they actually provided less uncompensated care than for-profit hospitals. The nonprofit hospitals with the highest margins (and, therefore, the greatest ability to provide charity care) often had the lowest rates of uncompensated care. After the GAO study, an academic and public debate ensued over the appropriateness of nonprofit tax exemptions[316]. National data showed that there was little difference between nonprofit and for-profit hospitals in the overall rates of uncompensated care and indicated an aggregate value of $7.8 billion in tax relief[317]. Benefits varied widely at the level of individual hospitals, depending on the profitability of the nonprofit hospital[318]. Although some argued that the justification for tax-exemptions is more a matter of values, theory, and politics than of the actual monetary numbers involved[319] and that there are serious problems with the concept of uncompensated care[320], the new consensus was that it was reasonable to expect nonprofits to provide community benefits and that these should at least equal those provided by for-profit hospitals plus their tax breaks[321].

In 2005, the GAO concluded that although nonprofit hospitals devoted more resources to uncompensated care than for-profits, the differences were small. Uncompensated care tended to be concentrated in a small number of large public

hospitals. The GAO stated once again that if Congress wished to encourage nonprofits to provide charity care for the poor, it should consider revising the criteria for tax exemption[322]. The media, politicians, and governmental agencies challenged hospitals to justify their tax exemptions. Now, many states asked hospitals for mandatory and voluntary community benefit reports[323]. Some states, ranging from conservative Texas to liberal Massachusetts, enacted legislation that required nonprofit hospitals to deliver a fixed percentage of community benefits[324]. From 2001 onwards, reported uncompensated care levels increased significantly[325].

*For-profit strategies: increasing consolidations and 'maximization' of reimbursement*

Consolidation was the natural response to increasing managed care[326]. Consolidated hospitals had more leverage in negotiations and could achieve economies of scale by spreading fixed costs over a larger number of beds[327]. A core strategy of for-profit Columbia/HCA[328] was to buy several hospitals in a local market, close the weaker ones, and bolster the stronger hospitals with rerouted admissions. In 1993, Colombia and HCA formed a chain with 190 hospitals and 42,000 beds[329]. The new firm immediately acquired or formed joint ventures with 32 nonprofit hospitals and at that point operated about half of all for-profit beds[330].

Continuing difficulties at many nonprofit hospitals fuelled between twenty-five and fifty acquisitions and mergers annually. In 2003, HCA bought Health Midwest, a nonprofit network in Kansas City, for $1.1 billion[331]. For-profit hospital corporations were in competition with large, emerging nonprofit hospital systems. Anti-trust regulations were less severe for nonprofits – for example, a judge ruling on a merger between two large nonprofit hospitals in Grand Rapids (Michigan) accepted the claim that nonprofits were (more) unlikely (than for-profit hospitals) to act in a way that would be costly to their communities.

For-profit hospital chains came increasingly to rely on the conversion of nonprofit clinics to for-profit status. Case studies suggest that financial considerations and the culture of the nonprofit hospital both influenced for-profit conversions[332]. Physicians often favored these conversions because it allowed them to have an ownership share in the new entity[333]. However, nonprofit to for-profit conversions were also associated with decreases in the staff-to-patient ratio, which explains why local unions opposed such efforts[334]. The local authorities usually approved conversions, which brought in additional capital for the community because of the new endowments filled with the money from the deal[335]. Some, but not all, of these endowments returned funds to the hospital sector[336]. The terms negotiated for the conversions often included charity care and service provisions[337].

There was a considerable debate over whether for-profit hospitals were offering to pay a fair value for the nonprofit hospital[338]. Investment bankers often value nonprofit hospitals as being worth much less than the financial markets value their for-profit counterparts. For-profit chains may be able to purchase a nonprofit facility at one price, but that same hospital is valued with a much higher price-earnings multiple after its acquisition. If the for-profit chain uses the differential to purchase another nonprofit facility, this circle continues[339].

In most states, the attorney general is responsible for monitoring hospital conversions. Prior to 1990, few had paid attention to this role and many state attorneys, especially those from jurisdictions in fiscal difficulties, saw conversions as beneficial since tax-exempt institutions would become tax-paying ones[340]. Allegations of insider dealing and the undervaluation of charitable assets led to more scrutiny by attorney generals[341]. During the mid 1990s, many states enacted legislation to require attorney generals to determine whether a fair market value had been established, advance notification, and community involvement[342]. The actual enforcement of these laws varied[343]. In liberal states, particularly Rhode Island, Massachusetts, Ohio, and Michigan, the state attorney tried to block the entry of Columbia/HCA into local markets[344]. In Tennessee with its large stock of for-profit hospitals, on the other hand, the state attorney took little action[345].

For-profit hospital companies were repeatedly investigated for (Medicare) fraud due to their aggressive reimbursement strategies. During the 1980s, there was already much unease about the way for-profit hospitals were interpreting the possibilities for capital reimbursement (section 2.2.7). In 1993, the GAO pointed out unacceptable or questionable costs charged to Medicare by HCA and other corporations[346]. In 1997, Columbia/HCA was accused of Medicare fraud (i.e. routine up-coding) after a highly publicized federal raid on their hospitals in seven states. After a long lawsuit, Colombia/HCA reached an agreement with the Justice Department in which it paid $745 million to settle civil fraud allegations. It also paid $95 million in penalties and fines relating to a criminal probe. In 2002, it paid another $631 million as a final settlement for the remaining outstanding issues relating to cost reports and physician relations[347]. In another scandal, Tenet Healthcare, agreed to pay $100 million to former patients who charged that the company had illegally interned them in psychiatric hospitals against their will to obtain their insurance benefits[348]. In 2002, Tenet was also accused of overbilling Medicare for cardiac surgery and was fined for its billing practices[349]. Research has revealed suspicions of up-coding – Cutler and Sheiner, among others, found that areas with more for-profit hospitals have higher levels of Medicare reimbursement[350].

## 2.3 Analysis

In this section I will try to explain the forces that have shaped US for-profit hospital care from a chronological perspective. I will first explain the long decline of the proprietary hospital sector. This period lasts from the early twentieth century until the mid 1960s (section 2.3.1). Medicare (1965) and Medicaid (1966) form a watershed in the development of the for-profit hospital sector. I focus next on the rapid growth of the for-profit hospital sector, as well as its metamorphosis from (stand-alone) proprietary facilities to investor-owned hospital chains. This period lasts roughly from the mid 1960s until the mid 1980s (section 2.3.2). I will then explain developments in the US for-profit hospital sector since the mid 1980s. Section 2.3.3 focuses on the changing configuration of constraints and inducements in a more mature hospital industry. This chapter ends with my main conclusions (section 2.3.4).

### 2.3.1 Proprietary hospitals: lack of competitive powers

In the early twentieth century, many proprietary hospitals were founded. They were a result of physicians seeking hospital access in an otherwise closed-staff hospital sector, combined with a comparatively high percentage of paying patients. However, these proprietary clinics were – as a general rule – not particularly profitable. Proprietary hospitals were much smaller than their public and nonprofit counterparts, and were also less capital-intensive. In the late 1920s, proprietary clinics required around twelve percent of total capital, which declined to only two percent by the mid- and late 1960s. Nevertheless, with the exception of the period during the Great Depression, the number of proprietary beds did not decline substantially, although the number of proprietary facilities did. It was rather that other ownership types were growing strongly, especially nonprofit providers.

Proprietary hospitals suffered from low profitability and returns on capital investments were meager. There were three major reasons for this. 1) Nonprofit and public hospitals had increasingly better access to relatively cheap capital. The price of proprietary capital was considerably higher. 2) A lack of buyers with sufficient purchasing power and less favorable coverage by Blue-Cross plans produced volatile revenues and investment risks. 3) Nonprofit hospitals became increasingly attractive to physicians, who could appropriate any surplus (nonprofit as a physician's cooperative). For these three reasons, nonprofit hospitals obtained an increasing competitive advantage, which diminished for-profits' prospects of a sufficient return on investment.

*1) The relatively high price of proprietary capital*

In the period 1900–1945, voluntary capital and charity sources were available in large parts of the US, especially in the northeastern and central regions. Nonprofit hospitals could tap these capital sources and relied on comparatively high numbers of paying patients. They could also rely on religious or ethnic bonds with their patient base. They were thus highly competitive relative to other types of hospitals. Philanthropic capital was cheap and in plentiful supply. This is underscored by the fact that nonprofit hospitals saw strong growth and that the level of capital invested per bed was much higher than the amount invested by proprietary hospitals and – to a lesser extent – by the public sector. Most proprietary hospitals were located in the southern and western parts of the country, where less voluntary capital was available. In those regions, proprietary hospitals were more competitive, although public hospitals had the largest share of the market. However, public hospitals were stigmatized as poor houses and found it hard to attract the paying patients of the middle classes. This constellation survived until after World War II.

Through the new Hill-Burton program (1946), the government started to supply large amounts of capital to the hospital sector. The supply of free philanthropic capital, alone, was no longer enough to meet the nation's increasing demand for hospital care. However, because of Hill-Burton sufficient capital remained available on attractive terms. The Hill-Burton program supplied the capital necessary to construct and renovate nonprofit and public hospitals, especially in the economically less developed South with its large stock of proprietary hospitals.

Proprietary hospitals were not eligible for Hill-Burton funds, meaning that the relative price of for-profit capital increased. The numbers of proprietary beds continued to decline until the mid-1960s, especially in the South, which received more funds because Hill-Burton's allocation formula favored states with lower per capita incomes. Formally, the Hill-Burton money was a gift that hospitals 'repaid' by the delivery of charity care and community benefits. Consequently, the cheap price of Hill-Burton capital was far more attractive than any equity that private investors could offer.

One result of Hill-Burton was a significant role for the states in hospital policy. States and local authorities had to provide matching funds for construction or renovation projects. They also had to endorse hospital applications as part of a state hospital plan. The result was variety in state hospital policies. This pre-structured more restrictive policies on for-profit providers in some states and more liberal policies in others. For example, New York effectively phased out for-profit hospitals during the late 1950s and early 1960s. Although for-profits converted to nonprofit status, conversions in the opposite direction were not attractive. If nonprofit hospitals converted to for-profit ownership, the Hill-Burton funds had to be repaid minus depreciation, though this rule was not well enforced.

To sum up, the relative price of investor capital was substantially higher than capital supplied by voluntary sources or by Hill-Burton funds. Neither state governments nor philanthropic donors asked for many provisions in return. Together with other charity sources like religious labor, the competitive position of nonprofit providers, and to a lesser extent public hospitals, was substantially better than that of the proprietary hospital sector.

*2) The Great Depression increases uncompensated care; the answer – Blue Cross – favored nonprofits*

In the US, paying patients were common and this constituted one of the main factors behind the development of a significant proprietary hospital sector. Intermediaries and underwriters were of little importance. However, the combination of high out-of-pocket payments and few third-party payers made the proprietary sector vulnerable to economic problems, a fact that was confirmed during the Great Depression.

The Great Depression decreased the number of patients with sufficient purchasing power and pushed up hospitals' levels of bad debt as a result of non-paying patients. The proprietary hospital sector was unable, due to ethical reasons, to avoid its responsibility for uncompensated care completely. However, even a small percentage of bad debt substantially reduced hospital margins. The Great Depression also reduced the service levels of the proprietary clinics, which added to their vulnerability.

Proprietary hospitals often co-existed alongside public hospitals with much lower or no charges, which enjoyed continuing funding from state legislatures and local government. Daily census figures show that the attractiveness of public hospitals versus proprietary hospitals increased considerably (section 2.2.2). During the depression, levels of bad debt rocketed and many proprietary clinics went out of business, never to return. More and more, niche strategies were necessary to survive and obtain a positive return on proprietary investments.

The level of uncompensated care declined gradually after the mid 1930s. This was a consequence of the marginally better economic conditions and the wider availability of hospital insurance. In response to the financial problems, the hospital sector started Blue Cross – prepaid group insurance plans to cover hospital costs. Although these new insurance plans mitigated the financial problems of the hospital sector, they were tailored to voluntary providers. Blue Cross often negotiated reimbursements that were (much) higher for nonprofit hospitals; some Blue Cross plans even declined reimbursement coverage to proprietary clinics. Initially, there was not much competition for Blue Cross schemes from commercial indemnity plans; they were often local monopolists. After World War II, these commercial plans became stronger competitors and were favored by many employers.

*3) The gradual evolution of nonprofit hospitals as physicians' cooperatives*
The need of doctors for access to inpatient treatment in a mainly closed-staff hospital sector was another major reason for the emergence of a proprietary hospital sector. This gradually became a less important factor during the first decades of the twentieth century, because the AMA, Blue Cross, and also many nonprofit hospitals came to prefer open-staff hospitals. The improving professional status of physicians strengthened their market power within hospitals as well as the influence of the AMA as the major health care interest group. Often, proprietary hospitals were no longer necessary to help doctors to get patient access.

Nonprofit hospitals were the most attractive to physicians. Technological developments, improved physician status and shortages of physicians created agency problems that shifted effective control of the hospitals to the medical staff. It was the physician, not the hospital, who became the effective residual claimant of surpluses on either physician or hospital services.

The AMA successfully rejected the status of physician-employees in proprietary hospitals owned by laymen. AMA guidelines were redefined and stated that all 'profits' belonged to physicians as compensation for professional labor. The preferred model was the open-staff voluntary hospital in which physicians held effective control. Most states, with the exception of a few in the far west, outlawed the corporate practice of medicine by non-physicians, implying that any remaining proprietary hospitals had to be physician-owned. Proprietary hospitals therefore came to be heavily reliant on physicians' savings for their investment and had limited access to other sources of equity. If physicians affiliated with nonprofit hospitals, capital was much more broadly available while their dominant status guaranteed their control over investment and daily operations as well as giving them equally generous income opportunities. Any physician who wanted to start a hospital business would face very high transaction costs and a comparatively low prospect of any adequate reward for such high risks.

### 2.3.2 Changing trends and the rise of for-profit hospital chains

The share of for-profit hospital beds rose rapidly from the mid 1960s until the mid 1980s. In retrospect, this was the golden age of the for-profit hospital chain with average yearly investment returns at almost thirty percent. The institutional configuration described in the previous section changed radically. 1) The introduction of Medicare offered the prospect of generous reimbursements for for-profit hospitals; Medicare, Medicaid, and expanding employer-based private health insurance reduced the problem of uncompensated care. 2) Due to the declining role of voluntary capital and Hill-Burton funds, nonprofit hospitals lost most of their advantage in terms of access to cheap capital. 3) For-profit hospitals

became increasingly attractive to physicians – the substantial returns on investments, made it possible to offer physicians favorable financial conditions as well as access to new technologies.

*1) Medicare, Medicaid and their impact on the for-profit business model*
Medicare, and to a lesser extent Medicaid, represented a turning point for the for-profit hospital sector. Overnight, significant positive equity returns became possible for most for-profit hospitals. This attracted a major inflow of investor capital. In essence, Medicare 'guaranteed' substantial investment returns for for-profit hospitals, but not for nonprofit and public facilities. Both programs substantially reduced the amount of uncompensated care and bad debt; now, many (but not all) of the poor and high medical cost patients qualified for insurance coverage.

Investment risks in for-profit hospitals declined. The generous, cost-based reimbursement policies of the Medicare program were the icing on the cake. In addition, Medicare paid for equity, interest, and depreciation on a cost-plus basis. Such payments were substantially higher for for-profit hospitals than for other ownership-types and were copied by other third-party payers. The new money was used to construct new plant and to consolidate the proprietary sector. Many small proprietary hospitals became available for take-over. Moreover, a large proportion of the cost of buying other hospitals was actually reimbursed by Medicare. Such funding for hospital consolidation became increasingly common, but did not become controversial until the early 1980s. By then, a few large firms with listings on the stock market were dominating the for-profit hospital sector.

*2) Diminishing access to cheap capital for nonprofit hospitals*
On the other hand, the capital supply from voluntary sources and the Hill-Burton program was diminishing. Voluntary capital could no longer match the growth in demand that Medicare had created. Medicare's capital payments, which were replicated by other third-party payers, made it possible to terminate the Hill-Burton program. In other words, the competitive advantage of the nonprofit hospitals was gradually eroded. In 1974, Hill-Burton was formally scrapped and these funds were no longer a way for nonprofits to raise capital. Nonprofit hospitals had to fall back on retained earnings and the debt markets. By way of compensation, a tax-exempt bond market became available to nonprofit hospitals. The termination of Hill-Burton also implied that the conversions of nonprofit hospitals to for-profit status became easier (section 2.2.3).

To conclude, 'free' sources of capital were drying up for nonprofit and public owners, while for-profits could 'guarantee' investment returns. Through these

changes in the capital institutions, risk was transferred from the for-profit to the nonprofit and public hospital sectors.

*3) For-profit hospitals become increasingly appealing to physicians*
The dominant and disciplining force of the AMA and the opposition of the physicians to corporate medicine gradually weakened. The new for-profit hospital chains linked the financial interests of physicians with those of their hospitals using financial incentives. Physician remuneration in for-profit hospitals caught up with or exceeded the level in nonprofit hospitals. For-profit hospitals became much more capital intensive and could offer physicians opportunities for innovative medical practice that had formerly been reserved for public and nonprofit hospitals. For physicians, the attraction of working in an open-staff voluntary hospital declined.

The AMA's traditional opposition to corporate ownership vanished. More physicians began to hold some kind of financial interest in the for-profit hospital where they also had staff privileges; now, such involvements came to be viewed as appropriate. In contrast to the 1920s, when physicians needed to supply investor capital and had to take severe risks, they now enjoyed a very real chance of accumulating capital under favorable conditions by affiliating themselves with one of the for-profit hospital chains. Physicians were increasingly willing to work in such clinics. For-profit hospitals built larger facilities, bought new equipment, and maintained these investments. They could afford to acquire nonprofit and public hospitals. As a result, for-profit and nonprofit hospitals began to converge in scale, patient mix, and capital appropriations.

### 2.3.3 The dynamics of a mature for-profit hospital sector

The for-profit hospital sector was well established by the early 1980s, with both high growth and high investment returns. Critics began to talk of a new industrial-medical complex. However, the growth of the sector slowed as for-profits encountered new constraints. Growth became more modest and cyclical as the sector encountered more competition on the supply-side and more countervailing pressures on the demand-side.

Since for-profits did not seem to be able to operate much more efficiently than their competitors, growth stagnated in the for-profit hospital industry. There are four major explanations for this. 1) The termination of Medicare's generous capital reimbursement rules. 2) The increasing price-sensitiveness of payers. 3) The increasing relevance of uncompensated care for the profit margins of the for-profit providers. 4) Increasing competition due to excess capacity and new

entrants (ASCs) and specialty hospitals). Nonprofit hospitals, on the other hand, saw their tax-exempt status questioned, but not terminated.

*1) The gradual termination of for-profit access to capital under more favorable terms*

New regulations put an end to the favored position of for-profit hospitals in capital reimbursement. The Republican administration brought the distorted capital reimbursements of for-profit providers into line with the other ownership types, which eventually increased relative for-profit capital costs. In the early 1980s, Medicare's loophole of increasing book values to calculate higher post-acquisition depreciation reimbursements was closed and payments for return on equity to for-profits were lowered. In 1992, they were phased out altogether because of the introduction of prospective capital rates for the entire hospital industry. A kind of level playing field – with the exception of nonprofit access to tax-exempt bonds – developed in capital reimbursement. Because they operated newer facilities, for-profit chains sometimes struggled to secure adequate compensation to cover their higher depreciation costs. The consequence of this level playing field was that all types of ownership were now relatively exposed to the pressures of the market. Payers wanted lower costs and until the late 1990s government regulations and MCO penetration tempered cost increases.

*2) Increasingly price-sensitive buyers reduce potential profit margins*

Health care costs increased steeply, leading to increased price sensitiveness on the part of the payers. In 1983, the new Prospective Payment System made it possible to cut prices for hospital care to Medicare patients and the margins on these patients fell. To counteract the threat of cross-subsidization, private indemnity plans were transformed into cost-conscious MCOs that won over much of the employer-based insurance market in the early 1990s. Increasing MCO penetration reinforced the price-sensitivity of the private payers still further. Indemnity insurers were replaced by MCOs, which sought and received large discounts and squeezed cross-subsidization from private insurance. HMOs dominated this market until the late 1990s, when PPOs – a less restrictive model – became more popular. The result of managed care was a decline in the demand for inpatient capacity and a reduction of hospital margins.

The PPS (1983) set the standard for other third-party payers. It allowed efficient hospitals to be more profitable and obtain higher margins. Many saw this as an advantage for for-profit hospitals. However, it turned out that it was guaranteed returns on equity, and not so much a higher efficiency level, that was driving the for-profit business model. This was confirmed by most research that showed no large differences between the costs of for-profit and nonprofits[351]. In response to

these developments, for-profit hospital chains reallocated capital to other sectors of healthcare, such as mental health or nursing homes, which did not fell under the scope of the PPS. However, the PPS did not stop at acute care and was gradually extended to cover other healthcare sectors. After a few years these new business lines were often divested. The for-profit hospital sector enjoyed limited success in its search for alternative business opportunities.

An unanticipated consequence of the PPS was that it made hospital Medicare margins more transparent and they became a political issue in Congress. This was possible because for all of PPS's complexity, each system has crude budgetary instruments that can be manipulated without much expertise. In the case of Medicare, moving the annual update factor up or down controls the overall level of program payments[352]. Many state legislatures reduced Medicaid rates, which were already lower than the rates of other third-party payers. Cutting the regular market basket updates was legitimized on the grounds of higher hospital margins; this also made funds available for other health needs.

Medicare and Medicaid, which had been the original driving force behind the success of for-profit hospital chains, now increasingly became a burden for for-profits because their margins lagged behind and were sometimes even negative. In 1997, the Balanced Budget Act, which froze Medicare reimbursement rates, imposed the strongest constraints. For-profit hospitals responded by fierce cost cutting and their expenses remained flat during 1997, 1998, and 1999. For-profits were at the forefront of successful lobbying that had broken these margin-related cuts by the start of the new century.

*3) Increasing levels of uncompensated care*

The cost-containment strategies described above led to reduced revenue and higher levels of uncompensated care. To maintain their investment returns, charges to indemnity insurers and private patients were increased, and employers shifted part of this rising bill to their employees. Combined with the impact of slow economic growth and rising premiums[353] on purchasing power, the relative price of insurance coverage rose. This pushed up the number of the uninsured. The federal government sought to fix the problems caused by a rising indigent population through regulations (EMTALA), which forced all hospitals to provide any necessary medical emergency care regardless of patients' ability to pay.

Uncompensated care and rising levels of bad debt came to dominate the management agenda of for-profit hospital companies. The level of uncompensated care became one of the biggest threats to hospital margins. During the 1990s, strict managed care strategies made cross-subsidization to the indigent less feasible until more expensive PPO policies became more widespread. Up-coding and overtreatment were strategies that could be severely penalized. The two largest for-profit

chains (Columbia/HCA and Tenet Healthcare) were successfully prosecuted for legal irregularities and forced to divest many facilities.

*4) Increasing competition due to excess capacity and physician-owned new entrants*

By the early 1990s, the hospital sector had reached maturity as an industry. Due to the worsening growth prospects of the for-profit hospital sector, stock market valuations decreased. Excess capacity increased as managed care induced fewer hospital admissions and prospective capital payments increased the level of risk on supplied capital. Capital needs stabilized or even declined and access to investor-owned capital was less valuable than before. These were favorable conditions for private equity and, in 2006, HCA – by far the largest listed for-profit hospital chain – became private and some smaller hospital companies followed.

Better access to capital was no longer the driving force behind the growth of the for-profit hospital sector. However, troubled individual hospitals sometimes still needed investor capital and affiliation to a (for-profit) hospital chain was a natural way to obtain such resources. Consolidation became the main strategy of for-profit hospital groups to deal with this more challenging environment, and rural hospital operators with local monopolies seemed to employ it the most successfully. The large for-profit hospital chains were well positioned for acquisitions. However, there was competition from new nonprofit hospital chains that also pursued mergers and were less dependent on lucrative acquisition deals. More and more states and communities therefore disputed whether for-profit chains were paying a fair price for local hospital assets.

There was another force that increased competition. The entrance barriers to elective acute care decreased because of technological developments, which shifted the focus toward ASCs and specialty hospitals, which required less capital. This opened up a promising business model for entrepreneurial physicians. They now had well-paying alternatives to working in a hospital, and this shifted the balance of power in their favor. Hospitals had to play defense. During the 1980s, for-profit and nonprofit hospitals set up subsidiaries that allowed additional compensation for their affiliated physicians. Hospitals hoped that these certain losses might be compensated for by additional patient admissions. This strategy seemed fairly effective at first, but did not last.

ASCs and specialty hospitals did not operate emergency departments and were therefore less affected by increases in bad debt, giving them a more favorable risk profile and boosting their profits. The market favored outpatient and focused facilities, which were considered more efficient. In the 1990s and thereafter, physician-owned ASCs and specialty hospitals began to pose a significant threat to the hospital sector, especially in metropolitan areas. Since most of these com-

panies were concentrated in the same states as the for-profit hospitals, these were threatened the most. They sought to influence Congress and the state legislatures to redress 'unfair competition' from physician-owned facilities. In the case of specialty hospitals, they partly succeeded. Increasingly, for-profit hospitals had to navigate their way through a more competitive environment in which low costs were more important than access to additional investor capital.

### 2.3.4 Conclusions

There are three factors that, over a longer period of time, are key to understanding the development of the US for-profit hospital sector. The first factor is access to capital. This analysis has shown three periods in terms of capital reimbursement. In the first period, capital reimbursement favored nonprofits: for-profits had no access to voluntary and public funds, which were available and cheap (ca. 1900–1965). The second period was favorable to for-profits: Medicare regulations 'guaranteed' investment returns to for-profits, but not to other ownership types (1965–1985). Finally, a sort of level playing field was created that also reduced the need for equity capital (the PPS). Since equity capital is most expensive, and since, in the US, there is little evidence that it is earned back by higher efficiency, the need for investor capital as a supplementary source declined.

Physician remuneration is a second important factor. This analysis has shown that the interests of physicians can encourage as well as hinder for-profit hospital growth. The birth of the proprietary sector was a result of the physicians' lack of hospital access to other ownership-types (ca. 1880–1920). Once this problem was solved, physicians turned against proprietary hospitals that tried to capture a share of the surpluses. Physician remuneration was most favorable in the open-staff voluntary hospital (ca. 1920–1970). Since 1970, for-profit ownership types have increasingly outcompeted nonprofits in keeping their 'physicians happy' (i.e. remuneration, access to technology, fringe benefits). For-profit hospitals have seemed better able to solve agency problems thanks to generous reimbursements and to involving physicians in helping them make additional profits. However, this position is currently being challenged due to physician-owned ASCs and specialty clinics that make even better remuneration possible (1995 and onwards).

Finally, in the US, the number of uninsured patients matters. Since hospitals have both high fixed costs and ethical or legal duties to deliver necessary medical care, too much uncompensated care threatens the ability to earn profits. This first became a problem during the Great Depression. At that time, it hurt the proprietary sector that was dependent on charging paying patients at full costs the most (1929–1940). Medicare and Medicaid substantially reduced the amount of bad debt. Together with favorable capital reimbursement policies, this benefited the

for-profit sector the most (1965–1985). Since the mid-1980s, cost-containment policies have cut the margins on Medicare and Medicaid payments severely. This has represented a continuing challenge to the for-profit hospital sector, accompanied by other challenges such as the increasing number of uninsured and legal requirements to treat them, and more effective cost control by third parties. High levels of uncompensated care have limited the business opportunities of the for-profit hospital sector.

To conclude this chapter, it appears that a new area of growth for the for-profit hospital sector depends on large additional demand for (equity) capital – to invest in new technologies, for example, which may again induce inpatient care – and the establishment of some kind of (private) universal health insurance system which may reduce the level of bad debt, maybe partly paid by the abandonment of nonprofit tax exemptions. The latter is important in structurally improving the competitive position of the for-profit hospital sector *vis-à-vis* other forms of ownership.

# 3 United Kingdom: for-profit hospitals outside the mainstream system

## 3.1 Introduction

This chapter deals with the development of for-profit acute hospital care in the UK. Section 3.2 presents a historical description of the development of the for-profit hospital sector and is split into nine chronological sections. I begin with the status of the voluntary and pay hospitals before World War I (section 3.2.1) and World War II (section 3.2.2). Then follows the start of the NHS (section 3.2.3) and its immediate impact on private and voluntary hospital care (section 3.2.4). The next sections describe hospital care outside the NHS (the independent sector). These sections address the period until 1970 (section 3.2.5), the politicization of independent hospital care during the 1970s (section 3.2.6) and 1980s (section 3.2.7), the years of the internal NHS market until 1997 (section 3.2.8), as well as the more recent developments (section 3.2.9).

The second part of the chapter analyzes this historical sequence of events. Factors that shaped how and how much for-profit hospital care was delivered are analyzed. I first analyze the growth and decline of proprietary hospitals (section 3.3.1). This section is followed by an analysis of the way in which the NHS shaped relations with the independent hospital sector for decades to come (section 3.3.2). Section 3.3.3 analyzes the rapid expansion of for-profit hospital chains during the 1970s and 1980s. I explore current dynamics, such as the efforts to open up the NHS to the independent sector, in section 3.3.4. The chapter then ends with my main conclusions (section 3.3.5).

## 3.2 The development of for-profit hospital care

### 3.2.1 Pay hospitals and paying wards before World War I

In the nineteenth and early twentieth century, illness was generally endured at home. The fellows and licentiates of the Royal Colleges of Physicians were the elite of the medical practitioners. They were consulted by the rich and often held honorary positions in (university) voluntary hospitals. Medicine was a highly competitive field and there were many demarcation disputes between general

practitioners (GPs) and consultants. Generally, hospitals worked with a closed list of consultants, meaning that many (general) practitioners had no hospital access and feared that consultants would 'steal' their patients if they sent them to a hospital.

The profession sought to solve such tensions over remuneration through a system of referral: 'the need has arisen for a class of men who will practice as consultants in the strictest acceptance of the term, who will see patients only by the intermediary of their ordinal medical attendant, and who, consequently, could never be the cause of the latter losing his patient[1]. In 1911, a national insurance scheme for general practitioner, pharmaceutical, and tuberculosis services was based on these principles[2]. Patients were to be accompanied with a letter of recommendation from their GP when seeking consultant care. Since GPs were paid capitation fees, they had an incentive to move seriously ill patients to the hospital.

The UK hospital sector consisted mainly of voluntary facilities, supplemented with public institutions for the poor, and some cottage facilities in the rural areas. Most hospitals were controlled by laymen and staffed by honorary physicians[3]. How were hospitals funded? Public facilities depended on tax-money and did not meet the standards of the middle classes. Larger voluntary hospitals could sometimes support themselves through their endowment incomes. As a matter of fact, charity contributions were very significant and the scale of donations indicated a tremendous sense of social duty and responsibility[4]. Many voluntary hospitals depended on annual subscriptions[5], private donations, and church or union collections.

The nursing reform movement – begun by Florence Nightingale who, in 1860, founded a school – gradually raised the cost of treatment, which increased incentives to make provisions for those who could afford to pay[6]. However, in sharp contrast to the US (see chapter 2), direct payments by patients remained negligible in voluntary clinics: in 1910, after many years of attempting to attract more paying patients, they only received about 2.5 percent of their revenue from such payments[7]. There were three reasons for this lack of paying patients. 1) Most patients lacked the necessary means. 2) It was strongly believed that introducing payments for treatment would harm appeals for charity funds[8]. 3) GPs wanted hospitals to be 'free'[9]. Nevertheless, some large voluntary clinics – despite the opposition of physicians – formed paying wards[10] and under pressure from GPs, such wings became open to all doctors[11].

Quite some physician-controlled cottage hospitals formed an exception to these rules. They were the pioneers in the movement of patient payments. In 1895, there were some 300 cottage hospitals[12]. Henry Burdett (1892) calculated that patients' payments accounted for about eight percent of the income of a sample of 183 cottage hospitals, a much higher percentage than in other types of hospital[13]. Many

of these cottage hospitals were still charities, but significant proportions had been formally founded as proprietary facilities. Nevertheless, in the UK pay hospitals and pay wards developed comparatively late.

In 1877, Henry Burdett[14], the founder of the pay-hospitals movement, 'advocated the formation of an association for the purpose of founding a hospital replete with every comfort and provision for the privacy and proper treatment of the well-to-do patients to which admission should be by payment alone'[15]. The medical profession gave its lukewarm approval, but – importantly – came out strongly against pay wards attached to general hospitals: paying patients should be treated in separate institutions. Burdett's home hospital, intended for those whose homes are ill adapted for the successful treatment of serious illness, was established in 1880; by 1902 1,476 doctors had treated 5,376 patients[16].

During the 1880s and 1890s, many nursing homes and pay hospitals were founded by GPs or by ladies with or without a nursing qualification. In 1900, there were at least fifty nursing homes in London. The British Medical Journal remained dubious about this trend: 'it is on the whole better that neither physicians nor surgeons should be pecuniarily interested in running such homes'[17]. Indeed, quite a number of homes seemed to be of a dubious nature. They offered unusual treatments such as 'fresh air cures' and 'vegetarian diets', or 'massages' for men who were not really ill. Calls for inspection grew, but no further regulations were enforced. By 1914, virtually all such homes were run on business principles and patients had to pay substantially above costs. However, besides the cottage hospitals where patients usually paid less than actual costs, there were very few pay beds in the general hospital sector[18].

### 3.2.2 Pay hospitals, paying wards, and pay beds before World War II

After World War I, the voluntary hospitals faced grave financial pressure. This was a result of the decrease in their *per diem* payments for the wounded servicemen and increasing inflation. Now, many hospitals abandoned their tradition of not charging patients and increased their numbers of pay beds. It became clear that charity contributions could no longer be their principal source of income.

A Committee suggested the use of contributions and collections from wage earners to solve such problems, but rejected the idea of permanent support from public funds[22]. Provident and contribution savings schemes were set up in response[23]. Such schemes were unpopular with the profession because of their lower levels of reimbursement. However, the physicians were unsuccessful in their attempts to impose income limits on these schemes. One such scheme, the British Provident Association (later BUPA), had been organized to provide pre-insurance for the somewhat better off[24].

In 1936, the remaining legal restrictions on the ability of charitable hospitals to charge fees to private patients were lifted[25]. A high proportion of patients in voluntary hospitals now made some form of payment, which gave these hospitals the financial power to withstand the attractions of the modernizing public hospitals. There were now three classes of patients: 1) those that paid directly for treatment, 2) those that paid for insurance contributions, and 3) poorer patients for whom the community paid. Most poor patients were treated in municipal hospitals,[26] which started paying considerable salaries to their consultants. Specialists in voluntary hospitals still had to gain their income mainly from private practice and additional hospital fees charged to the better-off[27].

Well-to-do patients were gradually seeking more inpatient treatment as a result of changes in medical techniques and socio-economic conditions. Again, demands for the regulation of the expanding number of nursing homes increased. Many richer people still preferred the small nursing homes where they could be treated with a better class of patients. Ironically, the standard of care they received was limited (because of the small size of the institutions and their resources) and less good than they might have received in a public or voluntary hospital[28]. The bad quality of proprietary nursing homes did not go unnoticed – in Decline and Fall, Evelyn Waugh's 1928 satirical literary debut, he commented on the low standards and corruption in the private nursing home where Paul Pennyfeather, his hero, was sent to have his appendix removed[29]. It was estimated that one-third of the nursing homes had no operating theatre and in nearly every case there was no X-ray apparatus, no laboratory, and no resident doctor. In fact, nursing homes seemed grossly inadequate in comparison to other hospital types[30]. The College of Nurses was a vigorous proponent of the registration of nursing homes, but the British Medical Association continued to be reluctant to harm the interests of proprietary physicians. The Nursing Homes Registration Act (1927) set down some minimal standards: nursing homes had to be run by a 'fit' person in a 'fit' premise. Nevertheless, the number of these beds had dwindled to 22,500 by 1938, although this figure might be exaggerated due to changes of title to less regulated convalescent homes (table 3.1)[31].

**Table 3.1: Estimated hospital statistics (1800–1948)[19]**

| | 1800 | 1861 | 1891 | 1911 | 1921 | 1938 | 1948 |
|---|---|---|---|---|---|---|---|
| Voluntary beds | 4,000 | 11,000 | 39,000 | 43,000 | 57,000[20] | 87,000 | 90,000 |
| Public beds | n/a | 50,000 | 83,000 | 154,000 | 172,000 | 176,000 | 200,000 |
| Pay beds in pay homes[21] | n/a | n/a | 9,500 | 13,000 | 40,000 | 48,500 | n/a |
| of which nursing homes | n/a | n/a | n/a | n/a | 26,000 | 22,500 | n/a |

### 3.2.3 The National Health Service

In the 1930s, a broad consensus developed that changes in hospital care were needed. The idea of a national health service – which would address the problems and had been included in a 1920 ministerial report (The Dawson report) – gained ground. World War II accelerated these developments. By the end of World War II most voluntary hospitals were suffering from inadequate accommodation and shortages in and poor distribution of specialists, and the entire system lacked coordination[32]. Although, during the war, voluntary hospitals had added more than £10 million to their reserves, this did not mean that they were in a stronger overall financial position. Voluntary hospitals became dependent on the government for their maintenance expenditure[33]. With low interest rates, these reserves could not contribute much towards operating costs and price levels had become much higher. If the higher standards of service that had been achieved during the war were to be maintained, much higher spending was needed. World War II brought a watershed in the approach to health care delivery. Mass mobilization was matched by a call for social justice, the abolition of privileges, a more equitable distribution of income and wealth, and drastic changes in the socio-economic life of the country[34].

In 1945, the Labour party won an unprecedented electoral victory, capturing more than sixty percent of the seats in the House of Commons. Labour had the political will to enact bold social changes and this provided a window of opportunity for major change. Nevertheless, it is widely believed that the political skills of Aneurin Bevan (a left-wing member of the Labour party) were at least partly responsible for reaching the ambitious goal of an almost totally nationalized health service[35].

To accomplish this goal, Bevan ensured that some private care was still possible within the NHS. In the debate in the House of Commons he stated that 'unless we permit some few paying patients in the public hospitals, there will be a rash of nursing homes all over the country. If people wish to pay for additional amenities, or something to which they attach value, like privacy in a single ward, we ought to aim at providing such facilities for everyone who wants them […] people will want to buy something more than the general health service is providing[36]'. He was thus able to secure the approval of the influential Royal Colleges that effectively represented the consultants, who were not averse to being paid for hospital work that they previously carried out for free, but want to retain some lucrative private practice. Only consultants and not the other doctors (associate specialists, registrars, and house officers) were allowed to treat private patients in NHS pay beds[37]. The number of such beds was about 1.3 percent of total NHS capacity. The government set maximum fees, but in the process of getting consultant sup-

port, some non-ceiling pay beds were also tolerated. Note that Bevan's policies produced interdependence between the public and private facets of consultants' total remuneration.

With the inclusion of some NHS private practice and attractive salaries, Bevan secured the support of the consultants, thereby splitting the common front between consultants and GPs[38]. He famously remarked to a friend: 'I stuffed their mouths with gold'[39]. However, Bevan also tried to deter the consultants from treating private patients in nursing homes or small clinics. This was less for ideological reasons, and was mainly because the quality of care was still believed to be inferior in small settings[40].

The NHS came into operation on the 5th of July 1948, after a relatively easy vote in parliament. From that point on, health services were free of charge at the point of delivery. After nationalization, the central government owned about ninety percent of the country's hospitals and inherited a waiting list of approximately half a million patients[41]. Hospital physicians were salaried. In England and Wales, hospitals fell under the responsibility of one of the fourteen Regional Hospital Boards. Consultants became key participants on these boards as well as on the local hospitals' management committees. From the outset, Bevan's accommodation with the consultants turned the NHS into a system of 'hierarchical corporatism', with effective veto rights for the medical profession at each level of the hierarchy[42].

### 3.2.4 The survival of a small independent hospital sector

NHS costs exploded because of much higher than expected use. Many hospitals were out-dated and the capital funds needed to modernize them were not available. During the first decade of the NHS, only £100 million was invested, while the BMA gave £500 million as the absolute minimum figure that was required.

Some hospitals decided to remain outside the NHS. They were mainly small, Roman Catholic facilities that received some contracts from the NHS[43]. However, their numbers declined rapidly due to terminations and delayed NHS inclusions. The remaining facilities formed the core of the independent hospital sector and in 1949 they were represented by the Association of Independent Hospitals and Kindred organizations.

The independent hospital sector consisted overwhelmingly of nonprofit organizations[44]. These hospitals were located disproportionately in the London area and other parts of the more affluent south. Labour took a permissive attitude to them, hoping that eventually these hospitals would become part of the NHS or go out of business. Minimal legislation was introduced to control their activities. Independent hospitals remained eligible for tax-exempt charity status even though there was a free public alternative. Consultants relied largely on NHS pay beds for

additional remuneration. The rates for such services were high; in comparison with their private income, the number of treated patients was small[45]. In 1955, part-time consultants working a maximum number of sessions in the NHS could earn as much as one seventh of their salary from pay beds.

Private insurance schemes were severely threatened by the introduction of the NHS and most of the old social contributory schemes went out of business[46]. Some 3.5 million people remained insured for minor additional services with one of the health plans that were ideologically close to the NHS[47]. However, some private insurers believed that demand for a 'comprehensive' health insurance package, as an alternative to the NHS, would continue. In an attempt to secure a basis for continued operations, eighty-nine local funds formed the British United Provident Association (BUPA). They covered 34,000 subscribers and their families, which at that time (1949) was around eighty-five percent of the private insurance market[48]. Their subscribers were different from the pre-war middle-class clientele, who did not fall under statutory insurance but could not, like the rich, bear the risk of medical cost by themselves. Now, the core clientele of private medical insurance (PMI) was overwhelmingly upper-middle class.

### 3.2.5 Moderate growth in independent hospitals

Independent hospitals grew at a moderate but steady pace until the beginning of the 1970s. They grew from a trivial percentage to about 3.5 percent of NHS expenditures[49]. Political attention was not on the independent hospitals, for which there was no agenda, but primarily on the NHS pay beds. Over time, many NHS contracts hold by independent providers were phased out. In 1956, the NHS strengthened its commitment to scale: a new hospital plan introduced the district general hospital, with an average of six- to eight hundred beds. As a result, capital investments increased slowly from 4.5 percent of total hospital expenditure (1961) to 6.5 percent (1970)[50]. However, the Treasury had long neglected NHS capital funds and in 1969 the average age of a hospital facility was seventy years.

During the same period, consultants' salaries could be set at a relatively low level because consultants could also engage in private practice. During the 1960s, consultant salaries rose less than sixty percent, while average GPs' net remuneration more than doubled. In the mid 1960s, private payments to consultants equaled fourteen percent of their salaries; it would have cost the Treasury a considerable amount to compensate consultants for the loss of private practice income[51]. Note that clinicians involved in private practice had to retain their positions in the NHS, otherwise the consultant was unlikely to attract referrals and hence less attractive to the owners of independent sector facilities.

*The payers of the independent sector*

PMI companies, the new third-party funders of the independent hospital sector, grew healthily after the creation of the NHS. They presented themselves as a responsible alternative to the NHS and they pointed to the family responsibilities of their subscribers, convenient appointments[52], no waiting lists, privacy, congenial surroundings, and more luxury care. PMI subscribers could make use of independent hospitals or NHS pay beds.

Although the charitable status of the provident associations, who dominated PMI, was terminated in 1960, the number of subscribers to the three dominant companies continued to grow (table 3.2)[53]. Initially, only individual insurance policies were sold, but in the mid 1960s, group plans came to dominate this market, reaching sixty-four percent of policies sold in 1969. The growth of PMI implied an additional flow of resources into the independent sector. Nevertheless, in the first decades of the independent hospital sector, out-of-pocket payments remained a much more important source of funding. Even as late as in 1975, forty percent of the bills were still paid directly out-of-pocket[54]. Overseas patients from Commonwealth and Arab countries seeking first-class medical treatment were supportive of this arrangement.

Private insurers copied the NHS regulations that only consultants could treat private patients as a way of proving their commitment to high-quality care and justifying their high fees. The business model of the private insurers also depended on the availability of enough private hospital beds, since the NHS was not always willing or able to deliver a sufficient number of pay beds. PMI companies monitored the availability of hospital capacity closely, since demand was growing. A BUPA survey in 1953 counted 8,045 NHS pay and amenity beds[56] and some 18,000 suitable beds within the independent sector[57]. The capacity of the indepen-

**Table 3.2: Persons insured, number of subscribers (BUPA, PPP, WPA) and claims 1950–1984[55]**

| Year | Persons insured as % UK population | Subscribers (thousands) | Claims as % subscriptions |
|---|---|---|---|
| 1950 | 0.2 | 56 | |
| 1955 | 1.2 | 274 | 84 |
| 1960 | 1.9 | 467 | 84 |
| 1965 | 2.7 | 680 | 88 |
| 1970 | 3.6 | 930 | 83 |
| 1975 | 4.1 | 1,087 | 73 |
| 1980 | 6.4 | 1,647 | 83 |
| 1984 | 7.8 | 2,010 | 82 |

dent sector remained stable during the 1950s and 1960s, but the number of NHS pay-beds declined[58]. Because of the abolition of caps on pay-bed fees, not much consultant resistance followed this decline.

Following its survey, BUPA decided to intervene in the hospital market itself. Many stand-alone independent hospitals had been integrated into the NHS or left the market. BUPA believed that more quality beds were necessary to guarantee that its clientele could get rapid access to (typically lower-technology) care in modern, pleasant and comfortable surroundings, and wanted to be less dependent on the NHS. In 1957, BUPA donated £100,000 to help start the Nuffield Homes Charitable Trust, which grew quickly by acquiring and building small hospitals. By 1967, Nuffield was operating thirteen hospitals, which grew to seventeen (493 beds) in 1970 and twenty-six (831 beds) in 1976. By that time it had become the biggest provider of independent hospital beds, treating 35,000 patients a year[59].

### 3.2.6 Politicization: the left and the birth of for-profit hospital care

In the early 1970s, the politicization of the issues of pay beds and the independent hospital sector began. During Labour's opposition (1970–1974), the party's left-wing dominated on health issues, paving the way for a more radical agenda. Such leftist viewpoints were supported by some other factors. Within the strong hierarchy of the medical professions, junior doctors sometimes felt exploited by senior colleagues, whom they relied on for references, and who were asking them to assist in their private practice without compensation.

In early 1971, the association of junior doctors sent an alarming open letter to the Health Secretary. The association demanded a public inquiry into the abuse of NHS facilities by 'unscrupulous' consultants who were engaging in private practice. Another suspicion was that, due to its weak administration, the NHS did not identify all private services for its charges. In 1972, the first broad investigation of NHS private practice, based on interviews and opinions among interested parties and persons, suggested that on balance the retention of private practice and pay beds was having a damaging effect on NHS patients[60]. However, the Conservative government decided to take no further action and maintained the status quo.

*The attack on private hospital care*

In February 1974, Labour returned to power and was anxious to curtail both independent hospitals and NHS pay beds. As they saw it, Bevan's legacy of free access to care according to medical need was being undermined. Barbara Castle, the new Secretary of State for Health, had a strong personal commitment to these issues. In society at large there seemed to be support for reforms.

At the time, some described the NHS as being in the grip of 'workers' syndicates[61]. Indeed, inn various parts of the country, NHS union members started actions to terminate private care in their facilities[62]. The BMA urged the government to intervene in the strikes but the government angrily refused to support the BMA's interests. It was not until July 1974 that the government made a hesitant and reluctant announcement and attempted to end the strikes, which for the time being was enough to normalize the situation[63].

However, relations between the consultants and the government had been undermined and in late 1974, they became even worse after new radical policy proposals, the fiercest reform effort since the beginning of the NHS[64]. The government sought for three major adjustments: 1) fewer NHS pay beds; 2) an increase in the attractiveness of full-time NHS positions to consultants in comparison with part-time contracts; and 3) common waiting lists for private and NHS patients, to prevent 'queue-jumping'.

Consultants thought that these proposals seriously undermined the treatment of private patients within the NHS. Rough estimates suggest that part-time consultants earned some twenty percent more than their full-time NHS colleagues[65]. In early 1975, they began a 'go-slow', only to find still stiffer government proposals in response. The government now intended to phase out all the NHS pay beds, while simultaneously curbing the independent hospital sector. A new license system would ensure that the total volume of independent care was frozen at 1974 levels. The government also stated that independent hospitals, which used NHS services for some of the treatments they delivered, must pay full economic costs, meaning a substantial rise in prices[66]. In addition, an administrative fee for the independent sector's use of freely donated blood was introduced.

The independent hospital sector and most consultants were outraged and massive strikes loomed; the uncertainties engendered by the pay-beds dispute seemed also responsible for (temporarily) arresting the growth of PMI[67]. The moderate Association of Independent Hospitals split in two. Under the lead of BUPA, a more radical and successful association was formed (the Independent Hospital Group). BUPA supplied most of the money to support this new trade association, which only focused on commercially aware hospitals, not long-term care providers or charity hospitals. The Independent Hospital Group was able to win the full and explicit support of almost all the medical profession. This produced a degree of unanimity almost without precedent in the history of the medical profession[68].

### *The failure of the governmental attacks leads to the commercial transformation of independent hospital care*

A compromise was needed and Prime Minister Harold Wilson intervened personally. He appointed Lord Goodman, who had close links to the independent

sector, as an intermediary[69]. The Government now no longer sought to terminate private care, but committed to maintaining it according to the needs of society. In December 1975, a compromise was reached to release a thousand NHS pay beds. An independent review board was to make decisions about any possible future reductions. To guide its decisions, this Health Services Board considered the demand for pay beds and the actual occupancy rates. The Health Services Board saw a fifty percent utilization rate as appropriate for pay beds; later sixty percent was considered appropriate.

The attack on pay beds had largely failed, but in response consultants were now much more willing to shift their patients to independent hospitals (see table 3.4). The Health Services Board required building permits for newly built independent hospitals with over seventy-five beds (in London a hundred beds). However, most independent hospitals were smaller than these thresholds and the Board was only allowed to test the impact of such facilities on the NHS marginally.

The number of NHS pay beds further declined (table 3.3). With waiting lists growing, independent hospitals started to fill the gap. Not only were the traditional (commercially aware) nonprofit operators (Nuffield) growing rapidly, new for-profit hospital companies were entering the market. American AMI opened its first clinic in 1970 and bought another one in 1977. In 1976, Humana, another US for-profit hospital chain, bought the large and prestigious 256-bed Wellington Hospital. In 1975, BUPA, in reaction to the threat that the government might phase out all NHS pay beds, founded BUPA Hospitals Ltd, a for-profit subsidiary[72], with more sophisticated facilities than the Nuffield nursing homes[73]. BUPA hospitals expanded rapidly. All for-profit hospital groups invested heavily in new facilities and equipment; as a result, the proportion of capital expenditure went up.

**Table 3.3: NHS pay-beds[70]**

| 1953 | 1956 | 1965 | 1976[71] | 1979 | 1980 | 1983 | 1986 |
|---|---|---|---|---|---|---|---|
| 8,045 | 7,188 | 6,239 | 4,859 | | | | |
| | | | 4,407 | 3,924 | 3,301 | 3,144 | 3,138 |

**Table 3.4: Value of private hospital care (turnover £ million) and percentage of pay beds [74]**

| | NHS pay beds | Independent hospitals | Percentage pay beds |
|---|---|---|---|
| 1970 | 20 | 20 | 50 |
| 1974 | 36 | 49 | 42 |
| 1980 | 46 | 173 | 21 |
| 1982 | 50 | 369 | 12 |
| 1984 | 58 | 525 | 10 |

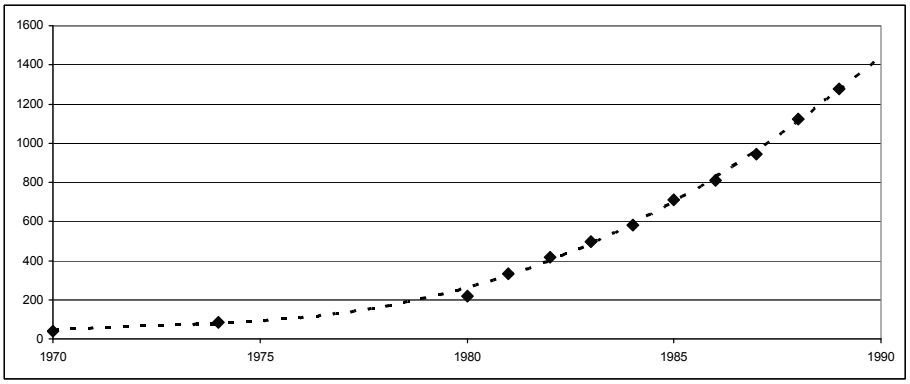
To sum up, private acute care was more or less equally divided between NHS pay beds and independent hospitals. In the 1970s, independent hospitals clearly outpaced the turnover of the NHS pay beds (table 3.4). The independent hospital sector became more sophisticated and capital-intensive. New for-profit chains entered the market, which transformed the traditional nonprofit character of the sector. Under the Labour government of the late 1970s, the independent hospital sector grew, particularly capital-intensive for-profit hospital providers.

### 3.2.7 Politicization: right-wing policies and the for-profit hospital boom

Ever since the creation of the NHS, the independent sector had continued to grow. Even during the hostile political climate of the 1970s. Still the Royal Commission on the NHS reported in 1979 that the independent sector was to small to make a significant impact on the NHS[75]. However, in May 1979, the coming to office of Margaret Thatcher's Conservative government marked a real watershed. Figure 3.1 shows that the growth path of the private sector climbed steeply. The new Conservative government constituted an ideological project, although not along the lines of a coherent and well-developed policy agenda[76]. The retrenchment of the public sector formed an essential part of this project. Between 1982 and 1994, the number of acute NHS beds dropped by twenty-five percent[77]. Public investment declined and obtaining new capital continued to be a problem[78]. In the late 1980s, the necessary capital was so hard to find that the government sought out private partners, under the private finance initiative (PFI)[79]. The other goal of the Conservative project was to induce the growth of private markets.

The independent hospital sector boomed. In 1979, it counted 6,578 beds, but by 1985 there were 10,155 beds[80]. Fifty new hospitals, generally for-profit facilities, opened their doors and almost half of all independent hospitals had been built

**Figure 3.1: Total spending (£ million) acute private health care[86]**



since 1975. Total spending on private acute care went up from £144 million (1979) to £1,490 million (1990)[81]. Between 1979 and 1985, for-profit hospital companies created fifty-four additional facilities and 3,500 beds; their market share in the total independent hospital sector grew from twenty-eight to fifty percent. The for-profit hospital sector was now firmly established.

US for-profit hospital chains were responsible for most capital investment. Supported by a historical high level of the dollar there has been a strong incentive to invest overseas[82]. These companies copied their own business models and built comparatively large facilities with modern and expensive equipment. In 1985, the average for-profit hospital owned by a US chain had a total of 85 beds; the average hospital owned by a British company counted 44 beds. The larger scale of the US chains was supposed to attract the consultants who brought the patients in. In such facilities, complex procedures such as cardiac surgery became more feasible[83]. On the other hand, for-profit chains also created niches where the NHS was less active, like day surgery, screening services, sports medicine, fertility services as well as acute mental health[84].

The entry of US hospital chains provoked animosity among British operators, who felt threatened by their aggressive expansion and explicit promotion of for-profit medicine. However, British chains like Nuffield and BUPA hospitals had better access to political influence and the media. In 1983, BUPA insurance decided that not all of their comprehensive insurance schemes would cover the full fees of some of the higher-charging US hospitals. BUPA now offered the choice of less expensive schemes that only permitted access to the (lower-charging) British hospitals. Eventually, most of the US hospital chains left the market. Britain did not turn out to be the springboard into continental Europe that they had hoped, there was some antagonism in the population and falling revenues in their US home market led them to trim their overseas operations[85].

### *The Conservative agenda: curtaining the NHS and stimulating independent hospital care*

The Conservative government was strongly committed to the free market. Polls financed by BUPA seemed to show that there was reasonable public support for some mix of private and public health care[87]. Nevertheless, the idea of free health care at the point of delivery, a strong symbol of fairness, was still cherished by a large majority of the population. Although some senior officials might have played with the idea of abolishing the NHS, this was not politically feasible[88]. As an alternative, tight budgetary measures limited NHS spending. During Thatcher's first two terms, the average annual rate of real NHS expenditure growth was only 1.25 percent, compared with 2.75 percent from 1976 through 1979, when Labour introduced global budgets; and, 6.5 percent for the 1970s as a whole[89].

Budgetary deprivation gradually damaged the image of the NHS. It resulted in long waiting lists, which grew even faster in the later part of the 1980s. In 1990, forty-seven percent of the public was generally dissatisfied with the NHS, compared with twenty-five percent in 1983[90]. Another survey found that patient satisfaction was much higher in the independent sector. Private patients always saw a consultant, compared to forty percent in the NHS[91]. However, such figures did not increase popular support for the independent sector. As a matter of fact, opposition to what was called the 'two-tier system' increased between 1983 and 1989. The general public seemed to prefer increasing spending on the NHS[92].

The Conservative government did not dare to challenge the existence of the NHS in any fundamental way, but it did take measures to stimulate the independent hospital sector. In 1980, the Health Services Act abolished the Health Services Board and thus the certificate-of-need regulations for both NHS pay beds and the independent hospital sector. Although, the government developed some alternative conditions for the delivery of private care in pay beds, these were not enforced[93]. The independent hospital sector tended to see NHS pay beds as unfair competition and argued that the NHS was in fact subsidizing them[94]. The government also eased the requirements for developing independent hospitals. Ministerial veto powers on the construction of new hospitals or on hospital conversions became much more limited[95]. Town and county planning legislation was weakened, making it easier for new for-profit hospitals to be approved regardless of their impact on the local community[96].

However, the most important changes were in the terms of employment of consultants. It became much more attractive for consultants to treat private patients. Full-time consultants were allowed to earn an additional ten percent of their gross salary from private work (whereas they had previously been allowed to earn nothing extra). Maximum part-timers had to forego one-eleventh (previously two-elevenths) of their salary, but now could undertake any amount of private practice[97]. Consultants could also be flexible about meeting their NHS commitments[98]. Such changes increased the willingness of consultants to become involved in private practice. It was estimated that in 1984 eighty-five percent of consultants did some private practice, the highest proportion since the NHS had come into being[99]. In 1987, average consultant income from private practice was £17,000[100].

The independent sector stated that they were in fact subsidizing the low wages that consultants were receiving from the NHS. Others were concerned that the NHS was subsidizing the independent sector because consultants were not always fulfilling all their NHS duties. Some seventy percent of surgery in the independent sector was carried out within regular office hours[101]. Beyond doubt is the fact that

the interdependence of the NHS and the independent sector strengthened since more consultants depended for their total income on a substantial private share.

Finally, the government sought to stimulate the number of contractual agreements between the NHS and the independent sector. The work, which the independent sector provided for the NHS, had been in decline ever since 1948[102]. In 1983, the Regional Health Authorities were directed to use independent hospitals as a way of reducing waiting lists for non-urgent cases and for those waiting over one year[103]. The Royal Institute for Public Administration (1984) found that only seven percent of District health authorities responded to contracting out some acute care to independent providers, without exception short term contracts to clear operation backlogs[104]. In 1989, the National Audit Office (NAO) estimated that such contractual arrangements were around £50 million, or less than five percent of total turnover of the independent sector. Only a small part of this money went to projects to reduce waiting lists; the remainder was still paid out for longstanding arrangements with nonprofit providers. This limited success was not surprising. The average marginal cost of contracting (for-profit) hospitals was almost double that of NHS hospitals. This raised questions about the value of independent hospitals in reducing waiting lists[105].

*A boom in private medical insurance*

The Conservative government was much more outspoken in its efforts to stimulate PMI and removed many obstacles to this. Employers who paid for PMI for their employees received new tax benefits[106]. In 1984, 4.4 million people were covered, up from 2.3 million in 1977. New commercial insurers had a significant share of this growth in subscriptions[107]. Combined with the dwindling number of non-British patients, this led to a decline in the share of out-of-pocket payments in the independent hospital sector[108]. In 1984, twenty-five percent of all hospital charges were patient-paid; in 1975 this number had been as high as forty percent[109]. As a consequence of tax benefits for companies, most growth was in company schemes that targeted the working population. The lengthening of the waiting lists also encouraged the growth of PMI[110]. Indeed, research indicated that waiting lists coincided with the purchase of PMI[111].

Gradually more working families were covered by PMI. Because of the larger number of claims filed by this lower-income group, the pay-out ratio went up. In combination with inflationary pressures on hospital costs and consultants' fees, the claim ratio increased to ninety-five percent. Private insurers were forced to raise premiums sharply and by the mid 1980s the PMI boom had ended.

The growth of PMI favored for-profit hospitals. Private insurers were not competing on price and exercised little direct influence on containing hospital costs. They were offering services whose marketing appeal was that they were 'better'

than the NHS. This made the private insurers natural allies of the independent providers who wished to charge more to demonstrate their perceived 'superiority'. At the end of the 1980s, it was clear that the independent hospital sector was a permanent player. It accounted for slightly over six percent of all the acute hospital beds in the UK. For-profit hospital chains held more than half of this lucrative market; nonprofit hospitals were obliged to modify their charity focus and imitate the strategies of the for-profits or take the risk of a buy-out or termination.

### 3.2.8 Internal market: the NHS contracting for-profit hospitals

At the end of the 1980s, the Royal Colleges triggered a debate on inadequate NHS funding. With waiting lists lengthening rapidly, the Conservatives prepared a new set of policies, with Mrs. Thatcher taking personal charge of these efforts. The remaining restrictions on the development of activity in the independent sector were ended[112]. People over sixty were awarded tax rebates for certain comprehensive PMI schemes[113]. On the other hand, the insurance tax on PMI increased from 2.5 to 4 percent. The growth of the number of people in PMI slowed[114].

However, the real fundamental policy reform, also for the independent hospital sector, was the effort to introduce markets into the NHS. Such a policy had already been chosen for public education. In an influential essay entitled 'Reflections on the National Health Services' (1985), Alan Enthoven, who developed the model of managed competition, proposed such a solution. Enthoven proposed that the District Health Authorities (DHA) would receive a needs-based global budget and be free to use either directly managed facilities, buy services from other authorities, or from the independent sector to cover the demands of their patients. The central idea was that providers would compete for contracts from DHAs – a purchaser-provider split[115]. The NHS and Community Care Act went into effect on 1 April 1991. In 1992, the PFI was enacted to minimize the impact of public funding restrictions on investments[116]. Nevertheless, hospital capital investments under this new program remained modest, with no major project launched until 1997. Obtaining capital remained a problem for the NHS[117].

*A purchaser-provider split to mimic market pressures*

The internal market represented the greatest change in the history of the NHS[118]. What were the main adjustments? A purchaser-provider split was introduced inside the NHS. The DHAs had to purchase hospital services and could chose block contracts, cost-and-volume contracts, or cost-per-case contracts. Initially, the DHAs were not allowed to roll over spare funds[119]. The hospitals were gradually organized into separate trusts. These hospital trusts, and by 1998 this included all NHS hospitals, only had limited freedom on financial affairs. The government

enforced a system of global budgets. Hospital trusts were required to pay the Treasury six percent (later 3.5 percent) charges for the use of capital, which was considered to be a 'free good' prior to the 1990s, to cover for interest and depreciation; trusts also were required to break even on their operational budgets. Hospital payments were regulated and hospital trusts were expected to price their services on the basis of average costs; they could not engage in marginal cost pricing.

What was the outcome of these reforms? Most scholars tend to view the evidence on efficiency, equity, choice, responsiveness, and accountability as inconclusive[120]. Competition among hospital trusts did not come into being, although this had been the cornerstone of the project. One reason for the limited amount of competition was the monopoly position of many hospital trusts. Another factor was the persistence of the relationships and patterns of activity that predated the purchaser-provider split. The internal market remained socially embedded in professional and managerial networks and institutions within the NHS hierarchy[121]. By 1997, waiting lists had risen to a record of 1.25 million persons. Waiting lists were worst for elective surgery, the principal activity of the independent hospital sector[122].

*NHS pay beds gain through the internal market*

It was the intention of the Conservative government that the independent hospital sector could tender for NHS work. Theoretically, this created the opportunity to increase the quantity of for-profit hospital services provided for the NHS[123]. However, for the independent sector as a whole, this remained a negligible possibility with mostly spot purchasing being used to reduce waiting lists and no long-term contracts[124]. Table 3.5 shows that during the 1990s the value of private acute medical care for the NHS increased only modestly.

During the period of Conservative government, NHS pay beds grew more rapidly. Some scholars think that the public NHS trusts proved to be more competitive than for-profit hospitals[125]. Indeed, charges for NHS pay beds were often much lower than the charges of the for-profit hospital companies. The growing autonomy of NHS trusts increased their interest in income from pay beds. In 1989, the Health and Medicine Act extended the freedom of hospitals to set rates for private patients. The Norwich Union estimated that in 1994 the NHS had earned a surplus of about £300 on each private patient. Only a few years earlier, the NHS had been losing about £90 million due to undercharging for private patients[126].

NHS trusts developed dedicated private patient units, entire wards or wings which were dedicated to treating private patients and similar to independent hospital surroundings, but had the advantage of providing NHS back-up services. These units typically offered single rooms with en-suite facilities and stand-alone catering[127]. By 1998, there were seventy-five NHS dedicated private patient units

**Table 3.5: Value of independent acute healthcare markets (1992–2006)[147]**

| | 1992 | 1996 | 2000 | 2002 | 2004 | 2006 |
|---|---|---|---|---|---|---|
| Total acute market (£ million) | 1,786 | 2,331 | 3,246 | 4,059 | 4,923 | 5,911 |
| % Private fees for medical specialists | 30.7 | 27.4 | 26.2 | 26.1 | 26 | 25.4 |
| % Private treatment in NHS hospitals | 9.2 | 10.7 | 10.3 | 9.6 | 8.1 | 7.3 |
| % Private acute medical care | 48 | 47.5 | 46.9 | 46.5 | 45.5 | 42.8 |
| % Private acute medical care for NHS | 2.9 | 3.8 | 4.2 | 4.7 | 5.2 | 7.3 |
| % Private acute psychiatric care | 5.4 | 7.5 | 4.2 | 3.5 | 2.2 | 2.3 |
| % Private acute psychiatric care for NHS | incl. | incl. | 5.0 | 6.5 | 9.9 | 12 |
| % Private care remaining | 3.8 | 3.3 | 3.2 | 3.1 | 3.1 | 2.9 |
| % Total | 100 | 100 | 100 | 100 | 100 | 100 |

that had transformed 1,400 of a total of about 3,000 pay beds. The growth of NHS dedicated patient units was seen as a threat to the independent hospital sector interests and dedicated patient units were strongly opposed by its representative body, which claimed that the NHS was in fact subsidizing its private activities to undercut independent hospitals[128]. For-profit hospital companies responded to this challenge by introducing fixed-price surgery for self-pay patients. PMI companies offered a choice of specific insurance benefit reductions by which premiums for private treatment could be reduced[129].

*Consultant remuneration leads to inefficiency in the independent hospital sector*
A new investigation concluded that private consultant fees were much higher than necessary to ensure the availability of an appropriate level and range of specialist skills. British private fees were also much higher (by up to five times) than medical fees in other countries[130]. NHS salaries were comparatively low and the supply of physicians to the independent hospital sector was limited to the high-earning consultants. In 1992, an average consultant earned £59,000 of which £17,000 came from private practice.

Private net income as a percentage of total consultant remuneration increased from 11–13 percent (1975) to 28–31 percent in 1992[131]. Although there were wide variations, private fees were substantial for all consultants[132]. The government refused compliance measures to check whether, due to their growing private practices, consultants were still fulfilling their NHS responsibilities[133]. This produced another long-term problem. Because consultants were working in private practice on a self-employed basis, often at low volumes, and with disproportionately high traveling times and other logistical costs, the general efficiency of independent hospitals was low.

The high level of private fees provoked some response; it was believed that PMI could contain these fees by monopsony power or by preferred provider networks. In 1993, BUPA, which had a widely used consultant fee schedule and had always been given the role of referee in the independent sector, became the sole *de facto* regulator of private consultant rates, because its competitors were allowed to follow this schedule and form a *de facto* monopsony[134]. From 1989 to 1993, the BMA published its own fee guidelines because its members were concerned that BUPA was holding fees down – it had not increased fees in the previous three years. In 1992, around 6,600 consultants were following the BUPA benefit maxima and 3,400 were following the BMA guidelines[135].

However, an important report by the Monopolies and Mergers Commission was highly critical of the BMA schedule. The Commission stated that private hospital services were a 'complex monopoly'. In such a situation the countervailing power of the private medical insurers was seen as crucially important. The BUPA schedule was deemed to be in the public interest because the Commission thought that these guidelines put downward pressure on consultant fees. Considering the BMA guidelines they thought that this was primarily a way of closing the market, leading to high prices and suppressing competition. The BMA schedule was prohibited. The reaction of most private insurers to the report was to adopt stronger cost-containment measures. Private consultant fees rose at a more moderate pace in the years after this ruling.

### 3.2.9 Labour: new business models to the for-profit hospitals

In May 1997, after eighteen years of Conservative rule, Labour was elected by a landslide victory[136]. The new government was less radical than its predecessors of the 1970s, although Frank Dobson, the first Secretary of State for Health (1997–1999) and a left-winger, emphasized cooperation as an alternative to the internal market. Trusts changed short-term DHA contracts into long-term service agreements for which 'commissioning' became the new terminology; the GP-fundholder program, the source of a small amount of independent sector revenues, was abolished[137]. 'The New NHS', the first white paper on the subject, made no mention of the independent hospital sector[138].

The government started an ambitious NHS expansion program with almost five percent in annual real monetary increases. The Conservative PFI program was revived, being seen as a useful way to provide a rapid injection of capital investment into new hospital plant without breaching public borrowing limits[139]. Under PFI, hospitals typically pay annual charges averaging between eight and eleven percent of their income to private consortiums, covering the costs of leasing and of procuring non-clinical services[140].

The steep increase in NHS spending was the main reason that the share of the independent sector (acute and long-term care) in total health care expenditure decreased from twenty percent (1997) towards seventeen percent (2006)[141]. Apart from the fact that purchasing independent hospital care was restricted to last-resort cases, the new government did not envisage any restrictions on NHS pay beds, nor on the independent hospital sector. Nevertheless, arguments on this subject continued in the background[142]. Private medical insurance companies were affected by some factors that constrained demand. 1) Tax relief for individually paid PMI-premiums was terminated for those over sixty. 2) In 1999, non-life insurance premium taxes (which also applied to PMI) were increased by one percent. 3) A loophole used by a few employers to avoid paying this tax was closed.

This section describes how the huge amounts of new funding for the NHS affected the business model of the for-profit hospital groups. Note that it thereby concentrates on England. In 1999, the government handled over NHS discretionary responsibilities towards the different 'countries' forming the UK (devolution). The reform path adopted by England is different from that being followed in Wales and Scotland, especially in respect of its more favorable adoption of market-style incentives[143].

The NHS became a more attractive option for both patients and consultants, which affected the position of the for-profit hospital groups as a 'better' alternative. Eventually, the for-profit sector got 'access' to a part of these additional NHS funds. Alan Milburn, Frank Dobson's centrist successor, introduced patient choice policies. Milburn enacted the 'New Labour' agenda, in fact a continuation of the internal market policies: 'Reflecting (…) on his experience in reforming the NHS, at a time when New Labour was busy reintroducing market forces into health care having spent its first few years insisting it had abolished them, Enthoven notes that New Labour, while claiming to do something different, in fact built on and extended Thatcher reforms'[144].

Patient choice paved the way for more cooperation between the NHS and the independent hospital sector. Table 3.5 shows that for-profit groups were more successful in providing acute psychiatric care for the NHS than in providing acute medical care. This success was driven by NHS outsourcing and bed reductions in mental health[145]. However, there is a strict separation between for-profit acute care and for-profit mental health care providers. Only Capio has a small interest in the independent mental health sector[146]. The growth of commissioned mental health services therefore did not benefit the for-profit hospital sector.

*Additional patient choice through 'including' independent hospitals*

During a political health care crisis in the winter of 1999/2000, the government changed direction. Despite significant monetary increases, severe capacity con-

straints meant that long waiting lists were only decreasing very slowly. Real annual budgetary expenses increased to as much as 7.5 percent. However, it now was also recognized that the help of the independent hospital sector might be required to achieve the promised service levels set for the NHS. This brought about a rather sudden change in the stance of the government.

In 2000, the government began to 'encourage' the use of the independent sector by the NHS[148]. A 'Concordat' between the NHS and the Independent Hospital Association was established and signed on national television[149]. The purpose was said to be to pave the way for more long-term relationships between the NHS and the independent hospital sector. On the other hand, the government thinks that this could also drive down prices in the independent hospital sector[150]. Thus, value-for-money became an important criterion in the commissioning of independent hospital services.

The primary impact of the 'Concordat' was political, as is illustrated by qualitative research indicating that NHS organizations do not yet view the development of public/private partnerships as a high priority[151]. Indeed, private medical services commissioned for the NHS were picking up only gradually (table 3.5). Nevertheless, NHS purchasing of for-profit hospital services became easier. Before the 'Concordat', District Health Authorities had to use all of their local capacity before they were allowed to purchase any for-profit services. The independent hospital sector also had to fulfill all NHS quality standards and complaints procedures[152]. This now became feasible, since the Care Standards Act (2000) set national minimum quality standards for the delivery of independent hospital care[153]. Previously, the sector had been subject to little external regulation[154]. Since the larger (for-profit) groups were already compliant and public recognition of such compliance would make business with the NHS easier, the sector welcomed these regulations[155].

In 2001, the Department of Health started a program of diagnostic and treatment centers. Such centers offered fast-track surgery, separated from emergency cases. Treatment centers were intended to reduce waiting lists, particularly for elective surgery, and primarily in orthopedics and ophthalmology. Initially, these centers were publicly owned. However, as the program expanded, it was decided that the independent hospital sector would deliver 100,000 of the 280,000 procedures that were to be completed by 2006[156]. A second wave (2005–2010) was foreseen to include up to 250,000 additional procedures.

From the perspective of the for-profit hospital groups, the government set its prices very low. NHS and independent sector were reimbursed by the same prospective payment rates (payment-by-results). As a result, for-profits began to restructure and are reviewing their cost and price structures, which can be up to forty percent

higher than NHS costs[157]. Between 2002 and 2006, the average cost of outsourced care in the independent sector decreased by twenty percent per episode, partly due to transformations from high-cost spot purchasing to fixed volume block purchasing[158]. The independent sector has not much further to go to match for unadjusted NHS costs[159]. Some dispute the fact that the NHS and the independent sector got the same reimbursement. Pointing to the higher value added tax independent providers pay on certain contracted-out services; higher registration and reporting requirements; and, higher costs for insurance against clinical negligence as well as IT services. Besides independent providers seek for a much higher return on capital than NHS trusts, which further increases their costs (see box 1.2). On the other hand independent providers are not obliged to provide a full range of services and may benefit from a better case mix and no or less costs for emergency care, research and development as well as teaching and training expenses[160].

The government saw 'additional' medical staff – one reason for resorting to the private sector was to avoid dependence on the monopoly position enjoyed by NHS consultants[161] – as another condition for contracting independent sector treatment centers. This means that the independent sector is expected to employ 'additional' staff and not draw them away from the NHS[162]. As a result, most contracts went to (cheaper) non-British providers who were likely to employ foreign doctors[163]. This led to concern among both the British providers and the BMA; the Independent Hospital Association collapsed because some of its members gained a contract and left the trade-association[164]. Existing independent providers face a double challenge: the loss of their traditional clientele as waiting lists shrink, as well as the unfavorable conditions of new NHS contracts to compensate for this loss of business[165].

The government saw the increased competition as beneficial[166]. However, a report by the House of Commons Health Committee was critical of the results of the program, including its quality of care, and made a case for NHS alternatives[167]. On the other hand, for-profit hospital groups continued to struggle to comply with the pricing conditions of the program. In 2006, seven tranches of the program were cancelled; in 2007 another two schemes were terminated. At that point in time, Alan Johnson, the Secretary of State for Health, stated that better value for money was essential for the continuation of the independent sector treatment centers[168].

Initially, the government's commitment to patient choice did not stop with the independent sector treatment center program. In 2002, pilots started for the 'extending choice for patients' scheme. The purpose was to create treatment alternatives for patients on waiting lists. In late 2002, the government implemented a framework whereby funding followed patients. Patients could now obtain treatment in those for-profit hospitals that accepted the prices it specified. Starting

in 2006, patients were allowed to chose from at least four hospitals or treatment centers (choose-and-book).

Patient choice broadened access to for-profit hospital care and the government thought that the market share of independent treatment centers could increase substantially[169]. Indeed, the 'Concordat' led to additional NHS business, but it failed to produce the long-term contractual relationships that the for-profit hospital groups had been seeking. The historical separation between the NHS and the independent sector with few cooperative institutional structures still forms an obstacle to any such pact[170]. Besides, patients are in no hurry to choose independent hospitals for their treatment, which leads to budgets not being used[171].

Recently, independent hospitals have entered choppier waters. In 2006, growth was the lowest in a decade. The new Brown government seems to be cooler on moves towards more choice and competition in the NHS, which alarms the for-profit hospital sector[172]. Alan Johnson has promised an end to the permanent NHS revolution. The same day, September 25th 2007, the commercial advisory board of the NHS disbanded itself due to these political changes in direction[173].

*Increasing remuneration for NHS consultants*

Few Trusts took action against consultants on the grounds that private practice was affecting their NHS commitments, or collected information on the amount of private practice, or tried to regulate private practice[174]. Consultants went unchallenged and enjoyed a favored position within the NHS[175]. The only exception was that their salaries were comparatively low (see sections 3.2.5 and 3.2.8). Now, the large increases in funding made a change of policy possible on consultant remuneration.

The government reconsidered remuneration in order to reward those consultants who contributed most to the NHS. The goal was to increase the consultants' hours of work within the NHS[176]. The government also proposed a seven-year ban on private practice for newly qualified consultants. However, this ban failed due to fierce resistance from consultants[177].

The only feasible way to increase the hours that consultants devoted to the NHS was to increase their pay. The idea was that many consultants would have little incentive to consider private practice if the NHS made a more reasonable financial offer for their services[178]. The government raised consultant salaries considerably and introduced large bonuses for NHS work. Consultants have to work more hours for the NHS before becoming eligible for these higher salaries and bonuses[179]. The income gap between public and private work narrowed.

The government succeeded in its efforts to redirect consultants to their NHS duties. In 2006, the National Audit Office estimated that fifty-five percent of consultants were active in private practice, down from seventy percent in 1999[180].

Thus it becomes less attractive for consultants to align themselves with for-profit hospitals, putting their business model of keeping 'physicians happy' under pressure. Although private remuneration is still considerable[181], this development could curtail the supply of consultants active in the independent hospital sector in the future.

*PMI strategies predominantly hurt other ownership-types, not for-profit hospital groups*

Inflationary pressures on independent hospital rates gradually led PMI companies to intensify their cost-containment strategies. From the mid 1990s onwards, they began building preferred provider networks. Subscribers who choose such schemes agree that they will use a limited hospital network but pay lower premiums. Insurers obtain better prices from these in-network hospitals in exchange for the expectation of increased volume. However, the main strategy was not so much to increase competition in the market, but to split total overhead costs over fewer hospital facilities[182].

All the larger for-profit hospital chains tended to be included in these networks. These companies now formed the backbone of the independent hospital sector and were the only ones that could offer some sort of national provider network. It was also not in the interest of the insurers to hurt the for-profit hospital chains, which formed the only feasible alternative to the NHS. The preferred provider networks hit the other providers within the independent sector: 1) dedicated NHS private patient units (see table 3.5); 2) non-affiliated hospitals, especially stand-alone for-profits as well as some of the religious hospitals[183].

Real growth in claims payments, the most important source of income for independent hospitals, slowed markedly to less than one percent a year. These were by far the lowest increases of the past three decades. Other reasons behind these trends were an increase in the incidence of smaller claims, more effective cost management by insurers, and some impact by the restructuring of prices following the competition from the treatment centers[184].

In 2006, PMI funded sixty-three percent of the independent hospital sector. Subscription growth remained modest throughout the 1990s and has declined slightly in more recent years. During the end of the 1990s, self-insured company schemes grew; now third-party administrators were servicing some twenty-five percent of the insurance market[185]. Self-pay patients also grew, stimulated by the favorable economic climate, increasing demand for cosmetic surgery, and a sharp increase in critical illness policies[186]. However, self-pay patients eased again in recent years. Demand weakened in traditional areas where NHS waiting lists were now shrinking (table 3.6).

**Table 3.6: Percent self-pay patients in independent hospitals (England and Wales)[187]**

| | Total | Male | Female |
|---|---|---|---|
| 1981 | 28.0 | 24.9 | 30.8 |
| 1986 | 21.0 | 17.6 | 24.3 |
| 1992 | 12.9 | 11.0 | 14.2 |
| 1997 | 19.2 | 16.1 | 21.6 |
| 2002 | 22.5 | n/a | n/a |
| 2006 | 18.2 | n/a | n/a |

*Consequences for the independent hospital sector*

By 1995, the bed capacity of the independent sector had peaked. The network arrangements and the general trend towards outpatient treatments contributed to the downward pressure on the number of beds (table 3.7). Nevertheless, independent hospital care continued to grow. The main reason for this was the NHS's outsourcing of acute psychiatric and medical care (see table 3.5). In 2006, the turnover of the independent hospital sector reached almost six billion pounds. Because the share of NHS dedicated private patient units declined, the for-profit hospitals could continue their growth paths. As mentioned above, many of the dedicated private patient units were excluded from the preferred provider networks of the insurers. They were considered to be unduly expensive after the gradual elimination of traditional NHS cross-subsidy policies. Neither did the NHS form a cartel to increase the bargaining powers of their private business.

Due to capital requirements, economies of scale, access to information systems, and excess capacity, consolidation continued among independent hospitals (table 3.8). In response, mergers authorities are increasing their activities. In 2000, the Department of Trade and Industry blocked a takeover bid for Community Hospitals made by BUPA hospitals; in 2001, the Competition Commission blocked the possible purchase of the Heart Hospital in Central London by HCA; in 2007, as

**Table 3.7: Independent acute medical/surgical hospitals and beds[188]**

| | Hospitals | Beds |
|---|---|---|
| 1981 | 154 | 7,035 |
| 1985 | 200 | 10,067 |
| 1990 | 211 | 10,739 |
| 1995 | 227 | 11,681 |
| 2000 | 225 | 9,980 |
| 2007 | 209 | 9,572 |

**Table 3.8: Percent market share independent hospitals by medical revenue[196]**

| | 1997 | 1999 | 2001 | 2003 | 2005 | 2006 |
|---|---|---|---|---|---|---|
| Top 3 | 48.9 | 56.7 | 59.0 | 60.0 | 56.3 | 51.9 |
| No. 4–10 | 22.0 | 23.0 | 26.0 | 26.8 | 27.9 | 30.3 |
| Remaining | 29.1 | 20.3 | 15.0 | 13.2 | 15.8 | 17.8 |

a result of a review by the European Competition Commission, the Swedish firm Capio[189] sold its hospitals to Australian Ramsay Health Care[190].

The for-profit hospital chains continued to increase their share of the market. Despite their favorable tax status, nonprofits lost market-share[191]. In mid 2007, for-profits owned seventy-three percent of all independent hospitals and a slightly larger share in the number of beds and total revenues[192]. For-profits operated half of all hospitals in 1985 and twenty-eight percent in 1979. Nuffield remains the only large nonprofit hospital chain with 1,700 beds, but gains almost a hundred percent of its turnover from trading activities[193]. In 2007, Nuffield sold nine hospitals to the General Health Care group[194]. BUPA (2005) sold nine hospitals to Classic hospitals and the remainder of its facilities to a private equity company (2007)[195].

Elective surgery forms the bulk of independent hospital services. Surprisingly, the market share of the independent sector in elective surgery declined during the mid 1990s; by 1998 their market share had fallen back to the level of 1981[197]. The apparent reasons: 1) increased efforts to reduce NHS waiting lists; 2) high price inflation in the independent hospital sector; and 3) the independent hospital sector is highly dependent on the amount of time NHS consultants are willing to undertake private work and there may be natural limits to that, since the Royal Colleges have historically kept the number of training places low.

The independent sector focuses on a fairly narrow range of medical work, with a preponderance of minor or intermediate procedures. In the distribution of clinical activity, the number of abortions has clearly declined, while endoscopic investigations and the number of admissions without an operation have increased (table 3.9). Due to its focus on elective treatment, the independent hospital sector performs more and more operations in day surgery. The percentage of day surgery cases increased from twenty-three percent in 1986, to thirty-seven percent in 1993, and fifty-one percent in 1998. Nevertheless, the independent sector still lags behind the NHS in terms of private day surgeries[198]. In fields that resemble life-style medicine, such as cosmetic surgery and fertilization procedures, the independent sector has a high market share[199].

**Table 3.9: Percentage of clinical activity in private sector hospitals[200]**

| | 1981 | 1986 | 1992/93 | 1997/98 |
|---|---|---|---|---|
| No operation or procedure | 6.1 | 7.4 | 11.5 | 16.9 |
| Endoscopic investigations | 4.0 | 6.8 | 8.8 | 12.6 |
| Operations on lens | 1.4 | 1.8 | 2.3 | 4.1 |
| Heart operations | 0.2 | 1.0 | 1.7 | 2.9 |
| Joint replacements | 2.3 | 2.2 | 1.9 | 2.2 |
| Abdominal hernia repair | 3.4 | 3.4 | 2.5 | 2.7 |
| Abortion | 23.9 | 14.9 | 13.2 | 11.0 |
| Other elective surgery | 58.7 | 62.5 | 58.1 | 47.6 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

## 3.3 Analysis

I will now seek to explain the underlying forces that shaped the development of the UK's for-profit hospital sector. I will identify critical junctures to separate the different stages in the development of the independent hospital sector, focusing on the sub-sector of for-profit hospitals. I will first analyze the growth and decline of proprietary homes in relation to other types of ownership (section 3.3.1). The creation of the NHS was clearly the most important event in the history of the UK health care system and therefore merits separate attention.

Section 3.3.2 analyzes the impact of the NHS on those disclaimed hospitals that formed no part of it – the independent hospital sector. What shaped relations between NHS and independent hospital sector? Were they two worlds apart, or did they complement one another? How did such relations shape the development of the independent hospital sector?

Section 3.3.3 explores the take-off and growth of a for-profit sector within the independent hospital sector. The confrontation between the independent sector and a more hostile government agenda actually brought about growth in for-profit hospitals. I will also look for an explanation for the possible influence of gradually changing market conditions that favored for-profit ownership over nonprofit ownership in the independent hospital sector.

Section 3.3.4 analyzes the current stagnation of for-profit hospital growth. Internal market policies and NHS spending increases have created a delicate balance between opportunities and threats for the independent sector; the for-profit hospital sector is urged to deliver more value for money. This chapter ends with my main conclusions (section 3.3.5).

### 3.3.1 A small and stable fringe of proprietary hospitals (pay homes)

Proprietary hospitals developed comparatively late in the UK. The main reasons for this were a general lack of paying patients and the fact that most physicians had less need for hospital access. Proprietary hospitals were tolerated in some rural areas, where not enough voluntary or public sources were available. However, as a general rule these hospitals were not profitable and only tried to cover their own costs. The limited access of physicians to hospitals due to closed staff-facilities was resolved by a system of referral that limited the demand for hospital affiliations. Voluntary hospitals depended on comparatively high levels of charity income and were therefore hesitant to supply any pay services[201]. Free hospital care was also strongly supported by GPs, a newly formed profession. Free voluntary hospitals did not hinder their referral practices and allowed them to raise their fees for (additional) services. Public hospitals were to a large extent still almshouses.

The above meant that voluntary and public hospitals offered a limited number of treatment possibilities for the small and exclusive group of potential well-to-do patients. This group wanted to be cared for in separate facilities with more amenities and among their own class. In the 1880s and 1890s, this led to the establishment of a new group of pay homes whose clientele was limited to those that were able to pay substantially above costs. These homes were clearly for-profit – that is they were run as small businesses.

Physician involvement in such facilities was limited. Physicians did not really need proprietary homes for patient access or as a source of income. The lack of physician involvement is illustrated by the terminology used. Until World War II, one spoke of nursing homes and convalescent homes. The owners were most often ladies who may or may not have held nursing qualifications, rather than physicians (although the latter may have been affiliated on a fee-for-service basis). The scale and scope of this sector was limited, but, in contrast to the rural proprietary hospitals, they were profitable.

After World War I, these pay homes encountered competition from nonprofit hospitals and the quality of nursing homes was disputed. Partly as a result of financial pressures, voluntary hospitals gradually accepted paying patients for which it developed separate wards. Proprietary hospitals now encountered more serious competition. Between 1921 and 1938, the number of voluntary beds increased by 30,000 while the number of beds in nursing homes (the most hospital-like for-profit institutions) declined by almost 4,000. Efforts to improve the medical quality of nursing homes through registration policies and more physician involvement could not counter this trend. Nevertheless, the sector continued to appeal to well-to-do patients who strongly favored amenities as well as the companionship of similar patients in small-scale surroundings.

### 3.3.2 The creation of the NHS brings about a 'two-tier' logic

In 1948, the NHS created a dichotomy between public and private hospital care. The NHS offered free care for all UK citizens, which severely restricted the group of potential buyers for private hospital care since they had to pay the full price for this. However, the independent sector did deliver amenities that is, as supported by recent research, often highly valued[202]. Private care was inefficient because many consultants were servicing only a few private beds.

Private hospital care accounted for less than two percent of all acute care beds. NHS pay beds dominated this market, although its market share had gradually slipped to fifty percent by the early 1970s. Due to the opportunity for treating private patients on pay beds, the NHS was also the most attractive facility for most consultants to treat their private patients. The remainder of private care was provided by 'independent hospitals'. Independent hospitals operated on a very small scale and the bulk of them were nonprofit, largely religiously based or charitable institutions. Initially, many were commissioned to provide services to the NHS. They supplemented this work by trading activities for paying patients. Private insurance was still in its infancy.

Initially, for-profit providers were a small minority within the independent sector. Precise figures are lacking, but in the late 1970s, after the entrance of the first for-profit groups, their share in terms of hospital beds was still no more than twenty-eight percent. This suggests that during the 1950s and 1960s, for-profits were well underneath twenty percent, and probably even lower than ten percent, of total independent hospital capacity. How was this possible?

Nonprofits had a few important advantages over their for-profit counterparts. 1) NHS-commissions guaranteed a certain volume to religious nonprofit hospitals. 2) Nonprofits had better access to cheap philanthropic capital and cheap labor from religious workers. 3) Nonprofits were legally eligible for tax-exempt charity status. 4) Finally, nonprofits had better access to consultants and physicians who shared their (religious) values.

For-profit hospitals lacked such advantages and were much more dependent on patients paying above full cost. As a consequence, many proprietary nursing homes simply went out of business or converted to nonprofit status. Despite their commercial orientation, in 1957 Nuffield hospitals began as a nonprofit organization. In search for a long-term strategy versus the NHS, most independent hospitals focused on providing choice, early access, consultant treatments, and comfort. Most were located in the more affluent south. The basic attraction of independent hospital providers was the growing demand for such care. The increasing penetration of private medical insurance decreased price sensitivity to private treatments; rich overseas patients from the Commonwealth also sought treatment.

*Consultant incomes increasingly supplemented by work in independent hospitals*

The total income of consultants – and this is a very important feature that accompanied the start of the NHS – was partially dependent on treating private patients. With private remuneration rising over time, consultants became more tied to the interests of the independent hospital sector. Since medical etiquette prevented consultants from starting treatment without a reference letter from a GP, it was practical for consultants to keep an NHS position.

Why were NHS consultants allowed to treat private patients? Historically, consultant incomes depended on the share of affluent private patients, who were reluctant to obtain treatment from large public (or nonprofit) hospitals. From a consultant's point of view, the NHS presented a risk in that these patients may not follow them. Consultants demanded facilities for such patients, either within or outside of the NHS. They got their way and were allowed to earn additional income under NHS part-time contracts. Three-quarters of consultants chose such contracts, demonstrating how important they were to them.

Nevertheless, this situation also worked from the government's point of view. 1) Private patients did not utilize public services very much, while their taxes continued to pay a considerable amount towards the cost of the NHS. 2) Many private patients were treated in NHS pay beds, further adding to NHS revenues. 3) Private consultant remuneration may lower salaries that the government had to pay. Consultant salaries could be held down because they could recoup lost income by their private practice. Indeed, during the 1960s consultants' salaries grew much more slowly than GPs' salaries.

*The interests of the private medical insurers and the independent hospital sector are closely linked*

After the creation of the NHS, the demand for private medical insurance gradually increased (section 3.2.5), adding to the demand for additional private beds. However, private insurers did not feel comfortable being dependent on a monopolistic provider system that was politically managed. They sought an alternative to NHS pay beds, which the independent hospital sector could provide.

Insurers had an interest in and were highly supportive of a stronger and more modern independent hospital sector. This was more important than their interest in low costs. The support of BUPA, which dominated PMI, was highly accommodating to the development of the independent hospital sector. In 1957, ideological positioning and an expected scarcity of pay beds led insurers (mainly BUPA) to establish Nuffield, the first not-for-profit hospital group, which concentrated on trading activities. At that point in time, the business case for for-profit hospitals in the independent sector was still weak (see beginning of this section).

*An inverse relationship: meager NHS funding stimulates a prospering independent hospital sector*

The dichotomy between the NHS and independent hospitals implies an inverse relationship between both sectors. As long as NHS performance remained below the expectations of the (upper) middle-classes, these people would increasingly be willing to pay for PMI and for services from the independent hospital sector[203]. Such a situation could happen if funds were lacking and indeed, the NHS was soon short on resources as a result of unanticipated demand.

The tax-based integrative health system made enforceable cost-containment policies quite easy. Strict budgetary limits were often put in place. In 1960, capital investments amounted to only 4.5 percent of hospital expenditure, which by the way also hit the updating of NHS pay beds (section 3.2.5). The slow but steady growth of waiting lists for elective procedures was another consequence of structural cost-containment policies. Both trends added to a gradual increase in willingness to pay for an alternative to NHS treatment, through either PMI or out-of-pocket payments. This became evident during the 1980s, when the deteriorating image of the NHS (severe increases in waiting lists and outdated capital plant) invigorated the independent hospital sector.

### 3.3.3 Political tensions fuel the rapid expansion of for-profit hospital chains

The underlying drivers of for-profit hospital development – the increasing importance of private remuneration for consultants, the common interests of PMI companies with the independent hospital providers, and meager NHS funding – came to the fore during the 1970s and 1980s. New for-profit hospital groups saw rapid growth, the result of the interaction of these three drivers with new ideological political agendas. 1) It became much more attractive for consultants to perform private services for the independent sector. 2) Within the independent hospital sector, the traditional advantages of nonprofit providers declined and investor capital became more valuable. 3) The expansion of private medical insurance accelerated, which increased the demand for private care and reduced the price sensitivity of patients. 4) Rapidly growing waiting lists led to increased demand for private hospital services. These were the consequences of left-wing policies of the 1970s of curbing pay beds and independent hospitals, and the right-wing efforts of the 1980s to expand the role of private markets.

*Labour induces an unintended commercial transformation of the independent hospital sector*

In the mid 1970s, the new Labour government tried to phase out NHS pay beds and freeze the capacity of the independent hospital sector. With the support of

the unions and the association of junior doctors, the ideology underpinning the NHS – free care at the point of service – was literally revitalized. However, the government underestimated the underlying logic of the system. The interests of the consultants were firmly bound to their private practices. A natural alliance between consultants, private indemnity insurers, the independent hospital sector, and large parts of the Conservative party was formed. This opposition was very energetic and was successful in stopping most of the policies of the government. With the exception of new certificate-of-need regulations for some larger independent hospitals and some 'paper' reductions in NHS pay beds, nothing substantial was implemented.

On the contrary, something unintentional happened to strengthen the independent hospital sector. In response to the policies of the government, consultants shifted many patients from NHS pay beds to independent hospitals. The consequence was that the dominant position of the NHS in private practice ended. This vaulted the independent hospital sector into the lead in private practice. New for-profit hospital companies (BUPA hospitals and some US chains) were willing and the best equipped to fill this gap. They had the access to investor capital that was necessary to build the hospital plant to take the place of pay beds.

Nonprofit hospitals could not react as quickly and their traditional advantages, commissioning by the NHS, access to cheap philanthropic capital, and access to cheap religious labor, dwindled or declined in importance. Increasingly, they became objects for consolidation. Stand-alone proprietary hospitals and nonprofit hospitals with low profit margins and reserves often went out of business or merged with the larger for-profit chains. Left-wing policies had brought about a larger share for the independent hospital sector within the total amount of private hospital care, and most of this additional share went to for-profit companies. By 1979, they held twenty-eight percent of this larger pie.

*The Conservatives bring about strong growth in for-profit hospitals*

In 1979, the Conservatives entered government with an ideologically pro-market agenda and the for-profit hospital sector boomed during the 1980s. Three changes of policy brought about such rapid growth. 1) New tax-benefits incentivized the purchase of private medical insurance, which intensified the trend toward growing private coverage. Thus, the demand for private care was stimulated because the availability of an important source of funding increased. Price-sensitivity decreased, partly as a result of the crowding out of self-pay business by PMI. This benefited the higher-charging for-profit hospital chains. 2) New employment conditions for consultants made private practice much more attractive to them. The importance of private practice for consultant income was further strengthened[204]. 3) The government severely curbed the amount of funding it provided to

the NHS. This led to major growth in waiting lists for elective care. More and more budgetary cuts and underfunding encouraged patients to seek hospital services in the independent sector. Note that none of these policy changes addressed the independent hospital sector directly. Indirectly, they positively influenced the demand for (additional) independent hospital services.

Regarding the balance between for-profit hospitals, nonprofit hospitals, and NHS pay beds, the dynamics of the 1970s continued during the 1980s. For-profit hospital groups met the additional demand, not nonprofit hospitals or NHS pay beds. Wrestling with budgetary pressures, the NHS was unable to meet the growing demand for private capacity. In the early 1990s, the market share of pay beds bottomed out. Nonprofits continued to be confronted with the long-term decline of their competitive advantages (see section 3.3.2).

Only the for-profit hospital groups had the necessary access to investor capital to invest in new plants and capitalize on first-mover advantages. US for-profit hospital chains, which were looking for attractive investments abroad, also entered the market. These hospitals were comparatively large and purchased more medical technology and were thus also attractive to consultants. Some of these companies started to leave the British market by the mid 1980s, but their facilities were simply taken over by for-profit UK hospital operators. In the late 1980s, due to large for-profit investments, some excess capacity had developed. However, it was not the for-profit chains (which did not earn as much as they had hoped for) that were hurt the most, but the stand-alone facilities and voluntary providers who lacked the financial strength to compete. In fact, consolidation favored the for-profit groups.

### 3.3.4 Internal market strategies induces higher demand for value-for-money

In 1991, the purchaser-provider split was designed to replicate market forces within the NHS. The establishment of an internal market became the goal of most NHS policy adjustments. This gradually affected the independent hospital sector, although not necessarily in a positive way. 1) NHS hospital trusts were rewarded for earning additional income and, with newly formed dedicated private patient units, increased their share of the private market. After the mid 1990s, the threat of these dedicated private patient units to the for-profit hospitals eased due to the fact that PMI companies did not include these units in their preferred provider networks. In 1997, the Labour government discouraged this kind of entrepreneurship in the NHS. 2) One of the Conservatives' intentions in creating the purchaser-provider split was that the (for-profit) hospital sector would obtain a larger share of the NHS's market. Although they gained some NHS business, this

was mostly spot purchasing to reduce NHS waiting lists rather than long-term contracts. NHS purchasers did not see any continuing advantage or found too many contractual complications to make use of independent hospitals (lack of cooperative institutions). 3) Since 1997, large increases in NHS spending by the new Labour government stopped the deterioration of the NHS's image. Many new public hospitals were built with a more pleasant environment and waiting lists were reduced substantially. As a result, the price-sensitivity of care seekers to private care increases. Consultants were given significantly higher rewards if they worked more hours in the NHS and if their involvement in private practice declined. They thus became less active in the independent hospital sector. Simultaneously, the policies of the internal market were doing as much to hinder as to encourage the structural growth of independent hospital care. These companies were in need of a different business model.

The Labour government was willing to let the independent sector participate in reducing NHS waiting lists and increasing patient choice. This less ideological stand implied that the independent sector could be involved as a subcontractor of NHS funds. In 2000, a 'Concordat' gave independent hospitals the opportunity to treat NHS clients. However, the NHS turned out to be a price-sensitive purchaser of hospital services and for-profit hospitals needed to provide value-for-money if they wanted work from the NHS. Conditions were strict: 1) for-profit providers must be able to make a case for an acceptable level of efficiency compared to NHS provision; 2) there were limitations on the use of NHS employees, which stimulated the employment of foreign doctors and companies.

The Labour government had created the most uncertain prospects for the for-profit hospital sector since the creation of the NHS. To be successful in gaining a share of the lavish NHS funding, the independent hospital sector needs to transform its traditional high-margin, low-volume model, into a low-margin, high-volume model. This is difficult since it also implies a fundamental change of its relations with the many self-employed consultants that treat only a few patients in a private session. In other words, they must either cut back on the number of consultants or they must tremendously improve logistical efficiency. However, the results of a recent study, sponsored by BUPA, might be an escape since they point to the fact that the NHS is probably unable to continue its current growth path and that raising revenues by other sources like PMI might be a necessity in the future[205].

Ever since the foundation of for-profit hospitals in the 1970s, their growth has depended on two strategies. 1) The acquisition of the remaining nonprofit hospitals in the independent sector. This strategy seems less feasible now, since the number of nonprofit hospitals available for take-over is minimal. 2) The fact that

the private market bears high prices. For many years, price inflation in the independent sector was substantially higher than the increases in NHS prices. Indeed, since 1980, independent market share in total elective treatments has remained the same, although the share in the financial turnover has increased significantly. This structural high cost-base is hindering the for-profit hospital sector in competing for NHS contracts. The threat of improving NHS performance seems to be greater than the opportunities of for-profits to gain a share of the additional NHS funding.

### 3.3.5 Conclusions

In the UK, the proprietary and for-profit hospital sectors have since their inception focused very much on providing services for a richer clientele. This can be explained not only by the fact that these were the only patients that were able to pay, but also that voluntary and later NHS hospitals were reluctant to treat these private patients. The creation of the NHS ended most, but not all, voluntary and proprietary acute health care.

However, at the same time, the NHS brought about the gradual consolidation of the remaining fragmented private forces into an independent sector. The independent hospital sector functions as a kind of alternative to the NHS[206] for those people who want treatment by a consultant, want to jump waiting lists, or seek more convenient appointments and amenities. The independent hospital sector complements – rather than substitutes – the public hospital system. Accordingly, the better the NHS performs according to the standards expected by the upper-middle classes, the less demand there is for independent hospital care.

The independent hospital sector also serves as an important means of supplementing the remuneration of NHS consultants. This not only explains part of its growth, it is critical in understanding the specific shape of the independent hospital sector. Many consultants perform only a few low-volume sessions in the independent sector, giving rise to low efficiency. For a long time, however, this low efficiency did not hinder its growth. Demand increased due to the curbing of NHS expenses and, additionally, an effective political 'iron triangle' protected and stimulated the independent hospital sector. This triangle consisted of consultants, private medical insurers and the Conservative party. BUPA acts as the natural coordinator of these interests.

Left-wing governments and their supporters have, hitherto, been unable to bring an end to or reduce independent and for-profit hospital care. The combined interests of the independent hospital sector and its 'iron triangle' have proved too strong to overcome. The 'iron triangle' was most successful during the decade of change (1975–1985), when it was able to defend independent hospital care successfully against left-wing ideological policies and speed up the development of

the independent hospital sector. It remained very successful in the following years, which resulted in the rapid expansion of the number of for-profit hospitals. This was helped by other factors that more gradually improved the business climate for for-profit hospitals *vis-à-vis* their nonprofit counterparts within the independent sector – declining nonprofit access to cheap capital and cheap labor and a fall in NHS commissioning. When opportunities arose in the mid and late 1970s, the better access to capital enjoyed by for-profit hospitals groups proved decisive.

The traditional business model of the independent hospital came under gradual pressure as investment in the NHS increased very rapidly after 1997. This reduced the demand for separate acute care services and facilities alongside those of the NHS. This implies that independent hospitals are now more dependent on access to NHS funds. However, unless independent hospitals are able to reform their business model radically, they cannot compete with regular hospital trusts for additional NHS business on a cost basis. Meanwhile the number of nonprofit hospitals available for acquisition has severely diminished. For-profit hospitals now account for some three-quarters of the total independent sector. This opportunity for further growth thus also seems less feasible. It will be a considerable challenge for for-profit hospital groups to adapt their business model to the new circumstances. Indeed, many traditional for-profit companies have recently left the market and sold their hospitals to new owners.

# 4 Germany: the impact of public capital subsidies on for-profit hospitals

## 4.1 Introduction

This chapter describes and discusses the development of for-profit hospital care in Germany. Until reunification in 1990, this chapter concerns West Germany, not the German Democratic Republic. The first part of the chapter describes the actual development of the for-profit hospital sector (section 4.2).

I start with an overview of the proprietary hospital sector until World War II (section 4.2.1). Section 4.2.2 describes the new political-institutional situation after the occupation of Germany by the Allied forces. The next section discusses the problem of building up the hospital sector with the scarce resources available (section 4.2.3)? Section 4.2.4 describes the immediate consequences of the Hospital Finance Act of 1972. Section 4.2.5 covers how West Germany, until reunification, brought about cost-containment and market-building policies in small incremental steps. In the new unified German republic, important institutional changes were made (section 4.2.6). This was also the period when the rapid growth of the for-profit hospital sector began (section 4.2.7). Finally, section 4.2.8 describes the dynamics of the development of the for-profit hospital sector in the current landscape. Since many for-profit hospital groups evolved from rehabilitation companies, appendix 4.1 gives a brief account of these developments.

Section 4.3 gives an analysis of the historical descriptions. I start with a historical interpretation of the specific structure of the proprietary hospital sector (section 4.3.1). I then explain the impact of scarce resources and the newly formed institutions on the development of the for-profit hospital sector (section 4.3.2). Section 4.3.3 analyzes how the impact of 'free' public capital hit the for-profit hospital sector. However, this policy proved unsustainable, and section 4.3.4 explains how the same institutions gradually evolved into a framework of incentives that actually stimulated for-profit hospital growth. The chapter ends with my conclusions (section 4.3.5).

## 4.2 Developing for-profit hospital care

### 4.2.1 Historical background

Small proprietary hospitals have existed since the mid-nineteenth century, especially in the northern part of Germany. The early development of liberal settlement legislations and other capitalist principles in these protestant regions were probably important factors in this[1], but other reasons were the growth of an educated middle class (*Burgertum*) and the growing urbanization (*städtischen Lebensform*)[2].

Proprietary clinics were often located next to the much larger public or nonprofit hospitals, situated mainly in the (major) cities and often specialized in particular disciplines or treatments[3]. Comparatively, such clinics attained high levels of quality; they contributed significantly to medical practice and scholarship. Medical doctors, who held senior positions at university hospitals, often ran the more important proprietary clinics[4]. Typically, a proprietary hospital consisted of up to thirty beds and also operated an outpatient department[5]. To set up a proprietary hospital, one had to be fairly affluent or have a wealthy sponsor (typically a family member or friend)[6]. Generally, proprietary clinics were owned by physicians who served affluent families. The numbers of small proprietary hospitals rose steeply in the last part of the nineteenth century. In Berlin, their numbers rose from eleven (1873) to seventy-three (ca. 1900)[7]. One explanation for this was the dramatic increase in the number of physicians; all these extra doctors needed hospital access and to a certain extent this pushed up the number of proprietary clinics.

In Germany, the level of hospital fees varied according to social class: first-class patients consisted of the educated people and officials with senior positions, who were used to a high level of consuming; second-class patients were (more senior) white-collar workers; the much lower third-class charges were for blue-collar workers and those who were used to hardship. Many of these third-class patients soon came to be covered by some sort of insurance. In an attempt by Chancellor Bismarck to counter the rapidly strengthening socialist party, the country was in 1883 the first nation in which a segment of the population received statutory insurance.

In 1910, membership of these sickness funds was already at just under twenty percent of the population[8]. A consequence of the early introduction of statutory insurance was that only a rather small private insurance sector developed[9]. The statutory health insurance scheme was executed through thousands of sickness funds[10]. Their comparatively small scale increased insolvency risks, making the reduction in the number of funds a policy goal for many decades to come. Obligatory entitlements included medical care, pharmaceuticals, sickness benefits (up to thirteen weeks)[11], and funeral coverage. The coverage of hospital care was left to

the decision of the funds on a case-by-case basis, but was mostly included. Workers paid for two-thirds of the contributions, which represented around 2.5 percent of their wages[12]. Sickness funds were allowed to contract any providers, including proprietary hospitals.

*Worsening conditions for the hospital sector*

Conditions for the (proprietary) hospitals deteriorated during the first decades of the twentieth century. World War I caused a sharp increase in general inflation. The government proclaimed a prohibition on any supplementary entitlements under the sickness funds[13]. Since hospital services were included as supplementary entitlement, this hit hospital finances. Due to a change of law during the revolutionary upheavals of 1919, the socialists and communists gained more powers on the boards of the funds[14]. Many sickness funds became more hostile towards proprietary hospitals. Only a few years later, in the early 1920s, hyperinflation crushed the financial reserves of the entire hospital sector. Many smaller proprietary clinics went out of business. After a few years of economic recovery, during the mid- and late 1920s, recession struck again.

In contrast to other countries, hospital access was less important for doctors in Germany. Why was that the case? Ambulatory doctors dominated physician interests. The Leipziger Union (later called Hartmann bund) became the most important physician interest group. By 1910, it already counted seventy-five percent of the doctors among its members[15]. The Hartmann bund won repeated victories over sickness funds, over other health professions, and over salaried hospital physicians.

Nevertheless, in 1927 the physician/patient ratio was twice as high as in 1887 and this put pressure on doctors' incomes. In an attempt to ease the tensions over physician reimbursements as well as the network policies of the sickness funds, which now insured almost sixty percent of the population, some enduring reforms were made. In 1931, ambulatory physicians were given a legal monopoly on all outpatient care. This makes the German outpatient larger than in many other countries[16]. Hospital services were strictly limited to inpatient care. The result of this unique reform was that the (potential) business of hospitals shrunk.

Hospital access became less important for the majority of ambulatory physicians. The hospital sector became the domain of the salaried physician; note that in the 1920s, the majority of hospital doctors were already employed full-time on a salary. Due to their (obligatory) care for the poor, local authorities were also involved in the hospital sector[17]. The split between outpatient and inpatient care resulted in structural inefficiencies because of the increasing duplication of (diagnostic) services.

**Table 4.1: Hospitals and beds (acute care, psychiatric, rehabilitation and other)[18]**

| # Hospitals | Public | Nonprofit | Proprietary |
|---|---|---|---|
| 1931 | 2,263 | 1,454 | 1,234 |
| 1937 | 2,076 | 1,552 | 1,117 |
| # Beds | | | |
| 1931 | 367,245 | 186,246 | 41,612 |
| 1937 | 390,189 | 201,213 | 37,282 |

**Table 4.2: Bed utility rate (percent) and average length of stay (days)[19]**

| | 1934 | 1957 |
|---|---|---|
| Bed Utility | | |
| Public | 80.3 | 91.2 |
| Nonprofit | 72.3 | 88.0 |
| Proprietary | 59.5 | 83.6 |
| Average Length of Stay | | |
| Public | 43.5 | 31.4 |
| Nonprofit | 37.4 | 26.7 |
| Proprietary | 24.5 | 25.5 |

The reform was also a setback for many proprietary hospitals since (generally) outpatient care was more lucrative. In deprived or rural surroundings, where it was not feasible to guarantee hospital access, some open-staff hospitals were still permitted (*Belegkrankenhäuser*). These open-staff clinics were mainly proprietary facilities, in which a combination of outpatient and inpatient care remained possible. Nevertheless, the market share of proprietary hospitals declined; utilization rates and average length-of-stay were much lower in those facilities (tables 4.1 and 4.2).

*The Nazi regime*

The Nazis did not fundamentally alter the structure of the health care system. However, the leadership principle (*Führerprinzip*) was carried over into the governance structure of the sickness funds. This implied that the National Socialist party effectively controlled the funds by appointing their leaders. Soon after the establishment of the regime in 1933, an economic recovery strengthened the finances of the funds. In contrast to many other countries, Germany was not hit particularly hard by the economic recession of the 1930s. Membership of the sickness funds rose, premiums fell, and co-payments were halved. The balance of power shifted further from the sickness funds towards the physicians.

The number of physicians decreased due to the racist policies of the regime: twelve percent of German doctors were of Jewish origin and, because of long standing Anti-Semitism, these were engaged disproportionately in private practice and physician-owned hospitals. In the mid 1930s, the principles of self-regulation were combined with central conditions regarding costs[20]. Regional physicians' associations obtained the right to negotiate remuneration contracts with the sickness funds and distribute these payments among their members.

Despite some indulgence regulations, hospital expenses were contained. Germany was one of the first countries to introduce rate-setting for the hospital sector. In 1936, the government froze per diem charges and these were not raised significantly until 1948. Consequently, many hospitals gradually came under budgetary pressure and required additional voluntary or public resources.

By the end of World War II, the entire hospital sector was bankrupt. Financial reserves were worthless and most of the infrastructure had been destroyed. Twenty percent of hospital beds had vanished and there was no money to upgrade the undamaged facilities that remained. It was, once again, the year zero (*Stunde Null*) for the hospital sector.

### 4.2.2 Old policies embedded in new institutions

Following the Allied occupation, West Germany became a federal republic. For health care, this eventually implied a constitutionally enshrined sharing of powers between the states and the federal government, with further powers delegated to nongovernmental corporatist bodies (self-regulation)[21]. The institutionalization of many countervailing powers implied that the policies of the middle way became firmly established[22].

Since election schedules are not synchronized, the lower (*Bundestag*) and higher (*Bundesrat*) assemblies often have different political majorities, further reinforcing the need to negotiate. As a general rule, stable political majorities only exist after the elections for the lower assembly. Thus if any health care reforms are to be made, they are implemented within one or two years of a general election[23]. The first post-war elections were won by the conservative CDU; Konrad Adenauer became West Germany's first Chancellor. The CDU dominated the federal government until 1969, when a left-wing coalition of social democrats (SPD) and liberals (FDP) took over.

Post-war German politics were characterized by the reflex to oppose any policy that the National Socialists had implemented. By 1955, the health care system, which had existed since the end of the Weimar republic, was restored within the new constitutional institutions[24]. In the first years of post-war Germany, health

policies were characterized by: 1) *ad hoc* public health interventions aimed at handling and preventing epidemics; 2) a fair and efficient distribution of the scarce health care resources.

For many years to come, the sickness funds increased their market share. Many sickness funds merged although they remained relatively small-scale[25]. Enrolment in the sickness funds grew because of the strong growth of the working population and various legislative measures[26]. By the mid 1970s, ninety percent of the population was covered via statutory insurance. The remaining people were covered through private insurance schemes, which also had a legal monopoly on the provision of supplementary insurance schemes. Private insurance calculates experience-rated premiums, although by law were forced to make some provision for claims during old age in the form of premiums paid while the insured are still young.

*A pluralist hospital system*

West Germany developed a social market system – the Rhineland model – for which there was broad political consensus and in which the principle of subsidiarity, taken from Catholic Social Teaching, was consistently applied. Hospital interest groups became heavily involved in the implementation of government policies. Sickness funds and physicians' associations have the status of public law bodies, which gave them a privileged legal status and a (near) monopoly on social welfare provision but, at the same time, constrained their freedom of action by requiring that they fulfill certain public functions[27].

The principle of subsidiarity meant that the government would only intervene in hospital care if there were no private alternatives; at the same time, the government could only retreat from supplying public hospital services if a private alternative existed. This promoted a pluralist hospital landscape that corresponded with the interests of nonprofit and proprietary hospitals[28]. The socialization of proprietary hospitals never became an important political issue[29]. The German hospital sector also differs in a number of ways from other countries. 1.) Inpatient and outpatient care are strictly separated. Hospitals are not involved in outpatient activities. 2) An influential role for physicians in hospital operations and management is provided for by law[30]. 3) There are large numbers of facilities that specialize in preventive medicine and rehabilitation. Appendix 4.1 describes this sector, which has always been dominated by for-profit facilities.

How can we characterize the various types of ownership? Public hospitals are large-scale facilities – owned by the federal government (army hospitals), the states (university clinics, state psychiatry clinics and the public hospitals in the city states), but mostly by local government (community hospitals). Such public hospitals can be governed in a very centralist way or at arms-length, where it has been

possible to accrue a certain amount of retained earnings[31]. Nonprofit hospitals were operated mainly by religious foundations but sometimes also by other charities. Until the 1970s, these hospitals were able to rely on considerable amounts of cheap religious labor, which gave them a considerable cost advantage of up to fifty percent over other ownership types. However, public hospitals could count on deficit funding by the municipalities, which was also necessary because of a lack of retained earnings. Some religious charities also supplied nurses to public hospitals at comparatively low rates[32]. The for-profit or private hospital sector consisted mainly of smaller specialized facilities (*Fachkrankenhäuser*) and, especially in the rural surroundings of the south[33], there were a number of open-staff hospitals which provided services for local ambulatory physicians. Often these doctors had an (indirect) interest in these hospitals. According to law, private hospital companies shared the profit-seeking motive as general goal. However, they also had to fulfill legal requirements on their trustworthiness and compliance with certain health legislation as well as inspections[34].

### 4.2.3 Scarce resources dominate hospital policies

After the war, the main policy priority of the federal government was to restore the solvency of the sickness funds. Together, the sickness funds had lost more than 14.5 billion *Reichmarks*[35]. According to the constitution, the federal government was responsible for any deficits in the statutory insurance schemes[36]. The schemes for both public pensions and unemployment insurance were linked with the sickness funds through the federal budget. These two social security schemes had to pay health insurance contributions, so any increases in health premiums had to be paid from the federal budget[37]. This explains why the ministry of social affairs was strongly opposed to easing the pricing caps on the hospital sector and, until the end of the 1960s, succeeded in accomplishing its goals against the more liberal ministry of economic affairs as well as the newly (1962) formed health department.

The federal government had a strong interest in holding down the growth of hospital rates. However, about 80,000 hospital beds had been destroyed during the war and eleven million refugees required an additional 100,000 beds[38]. It was estimated that 3.25 billion *Deutschmarks* (DM) were necessary to upgrade the hospitals to modern standards. There was no money for these additional beds. On the contrary, hospitals continued to struggle with deficits. Most hospitals did not get enough money to make the necessary investment in restoration, nor were charges sufficient to cover the remaining operating costs[39]. During the 1950s and 1960s, the scarcity of resources dominated hospital politics. Two political coalitions developed. On the one hand, the interest of the federal government and the sickness funds coincided. The same was true of the hospital providers and the states and

local communities that were the owners of the struggling public hospitals. These authorities had the ultimate responsibility for 'solving' their hospitals' financial difficulties.

*Tight reimbursement*

The federal authorities did not accept the rises in hospital charges that, to some extent, became possible in 1948. A freeze on hospital *per diem* rates was installed once more only a year later. The 'way out' of this underfunding by the sickness funds implied that the hospitals' owners should pay for at least part of any losses, as well as additional investments. However, losses were often significant and are likely to have been about thirty to forty percent of total hospital turnover[40].

How did the various types of ownership handle this situation? Nonprofit hospitals had some voluntary means from endowments, had access to cheap labor by religious orders, and could sometimes generate retained earnings. However, nonprofits also relied on funding through additional debt and on the willingness of state and local authorities to support them. The losses made by public hospitals became a considerable burden on local budgets, since these governments had to finance these deficits by law. The proprietary hospitals had the most problems. In principle, they could only rely on retained earnings and profitable patients (cherry-picking) to solve any financial problems. Any hypothetical large for-profit clinic would have needed to be close to fifty percent more efficient than a public hospital to make a decent return on investment, which was simply not possible.

Financial adjustments seemed necessary and the federal government increased its powers in the area of health care[41]. They did this on general jurisdiction, since until the constitutional reform of 1969 the states had the formal jurisdiction over hospital regulations[42]. These federal regulations determined the methodology of the *per diem* calculations; although the states held some discretionary powers since they set the actual rates in a bureaucratic procedure.

In 1954, the government issued a hospital reimbursement ordinance (*Pflegesatzverordnung*), which eased budgetary pressures somewhat, although the common practice that hospital owners shared in the financial burden was reiterated. In their *per diem* payments, the sickness funds did not allow for any calculated return on equity, interest payments, or reimbursement for repairing war damage. Acceptable depreciation costs were very low: one percent on the basis of historical calculations[43]. Besides, sickness funds could always reject *per diem* increases if they went beyond their economic means. Finally, the mean of all public contributions of the past five years were detracted from the rates[44]. This was important since it meant that states and local communities were forced to continue funding hospital deficits.

*Preparing a solution for scarce hospital resources*

In the early 1960s, forty percent of hospital beds predated 1916[45]. Technological developments led to an additional need for capital. In 1960, the federal government issued an interest-free loan of 150 million DM for building new nonprofit and for-profit plant. However, this was only a temporary remedy, since hospitals were already heavily in debt[46]. States were much more active in solving the problem of hospital capital shortages. Between 1950 and 1966, the states granted 4.3 billion DM for the construction of new hospitals[47]. Often all types of ownership were eligible for these funds. The states wanted the federal government to share the burden of these capital costs.

Financial difficulties were exacerbated by other developments too. Economic prosperity and labor shortages put pressure on wages. The large surplus of doctors turned into a shortage, especially for assistant physicians. Worse still, the substitution of religious nurses for secular personnel put additional pressure on nonprofit and public hospital costs[48]. As a consequence, many less educated nurses were employed to meet requirements.

In 1970, the hospital sector operated at a yearly loss of almost one billion DM[49]. Since total hospital equity was estimated at around thirty-five billion DM, this implied a continuing loss of assets[50]. There were only two ways out of this problem that were politically feasible: 1) *per diem* rates that included all hospital costs (monistic finance); or 2) separate remuneration of current and capital costs (dual finance). Under the latter option, the sickness funds would pay for the current costs and the public authorities for the capital costs. This option would reconfirm the existing situation of hospital funding. However, for-profit hospital providers would be best-off with the first option, which implied less risk for their access to public capital funds.

*Proprietary hospitals in a period of scarce resources*

During the 1950s and 1960s, a large-scale for-profit hospital business model was not feasible due to lack of funding. The two dominant modes of survival were specialization in profitable service lines and the delivery of hospital facilities to ambulatory physicians in rural areas. Any new models that would have enhanced efficiency, such as the integration of outpatient and inpatient care, were unsuccessful because ambulatory physicians resisted any such 'violation' of their monopoly on outpatient care[51].

How did proprietary clinics manage to stay in business when general resources were so scarce? The affluent and those who had private insurance provided a market niche for the sector. Private insurers patronized proprietary hospitals with their well-developed amenity structures[52]. It is important to note that private insurance rates were between 1.5 and two times the sickness fund rate[53]. This gave the pro-

**Table 4.3: Proprietary beds in selected specialties and increase/decrease (%)[56]**

| | 1959 | 1969 | Change (%) |
|---|---|---|---|
| Internal medicine | 3,309 | 2,795 | – 15.4 |
| Gynecology | 1,907 | 3,507 | 83.9 |
| Eye diseases | 252 | 709 | 181.3 |
| Surgery / Urology | 2,519 | 4,469 | 77.4 |
| Pediatrics | 328 | 492 | 50.0 |
| Orthopedics | 567 | 401 | – 29.3 |
| Other | 4,058 | 6,653 | 63.9 |

prietary sector a means of surviving and of making small profit margin. Secondly, proprietary hospitals often specialized in certain procedures, particularly elective surgery. Such clinics were often owned by renowned medical specialists[54].

In the late 1950s, proprietary clinics owned almost eight percent of planned acute care beds, but this had fallen to 4.25 percent by 1969[55]. This decline was primarily a result of the more rapid increase in public and nonprofit hospital beds, although the number of private beds also grew by forty-five percent. Growth seemed to be the strongest in the surgical disciplines and in obstetric care, where amenities are important. In internal medicine and orthopedics, there were absolute decreases in the number of the private beds (table 4.3).

Table 4.4 presents the number of all proprietary beds per 10,000 inhabitants until 1969. Note that with the exception of the last year (second bar), it was not possible

**Table 4.4: Proprietary beds per 10,000 inhabitants (acute care, rehabilitation, and other)[57]**

| | 1952 | 1956 | 1957 | 1961 | 1969 | 1969 |
|---|---|---|---|---|---|---|
| Schleswig-Holstein | 6 | 7 | 8 | 5 | 5 | 4 |
| Hamburg | 3 | 3 | 2 | 3 | 4 | 4 |
| Lower Saxony | 8 | 10 | 11 | 11 | 10 | 4 |
| Bremen | 5 | 5 | 5 | 5 | 6 | 5 |
| North Rhine-Westphalia | 2 | 2 | 2 | 2 | 2 | 1 |
| Hesse | 7 | 8 | 9 | 9 | 16 | 3 |
| Rhineland-Palatinate | 5 | 5 | 6 | 9 | 11 | 2 |
| Baden-Wuerttemberg | 9 | 11 | 12 | 13 | 17 | 5 |
| Bavaria | 6 | 9 | 9 | 11 | 14 | 4 |
| Saarland | n/a | n/a | 1 | 1 | 5 | 1 |
| West-Berlin | 12 | 13 | 13 | 14 | 13 | 7 |

to divide acute care from other proprietary beds. Proprietary hospitals had some market share in the more thinly populated areas, especially in parts of the south. Open-staff hospitals existed in Hesse, Bavaria, and Baden-Wuerttemberg. Specialized proprietary clinics operated in the more urban areas. On the other hand, the large state of North Rhine-Westphalia had mainly nonprofit hospitals and there were hardly any proprietary providers at all. In Bavaria, Baden-Wuerttemberg, Lower Saxony, Rhineland-Palatinate, and Hesse, the number of private beds for rehabilitation and other non-acute treatments increased rapidly. This is an important point since some of the current more successful for-profit hospital groups started as rehabilitation or preventive care clinics during the 1950s and 1960s (see appendix 4.1).

### 4.2.4 Initial consequences of the Hospital Finance Act

In 1970, the hospital sector experienced an annual loss of almost one billion DM. A major reform to clarify the financial responsibilities seemed necessary. What pre-structured this reform? After 1967, a strong economic upturn generated substantial revenue increases for the payers of hospital care. Additionally, after 1970 sickness funds no longer had to pay sick benefit for the first six weeks of sickness leave. In combination with threshold increases, this led to major improvements in the financial condition of the funds. In 1969, the CDU-SPD coalition did have a large enough majority to amend the constitution. The federal government was now given the jurisdiction to supplement state budgets with federal means to fund hospital capital. This was an important requirement by the states to support any major reforms[58].

In 1972, the new left-wing coalition of social democrats and liberals implemented the Hospital Finance Act (HFA). The HFA sought to fundamentally clarify the responsibilities of the states and the sickness funds. It opted for the principle of dual funding. Sickness funds paid for operational expenditure, while the states, with some federal assistance, were responsible for funding the capital costs[59]. With the exception of the hospital sector, which feared additional government influence, there was broad support among the major stakeholders involved in this reform[60]. The HFA focused more on enabling (capital) investment than on containing costs[61]. By law, communities were responsible for supporting the existence of an adequate local hospital infrastructure[62].

Cost containment was to achieved through efficient planning regulations. States had to draw up hospital plans and certificate-of-need procedures in order to quantify the number of facilities, medical specialties and hospital beds needed[63]. For equipment and smaller-scale investment, which had to be amortized between three and fifteen years, hospitals were given a budget. Once approved, the large-

**Table 4.5: Total hospital funding, percentages by payers[66]**

| | 1970 | 1975 | 1980 | 1985 | 1990 |
|---|---|---|---|---|---|
| Public[67] | 28.1 | 18.5 | 17.3 | 14.9 | 12.3 |
| Sickness funds | 51.6 | 63.6 | 65.0 | 67.1 | 68.4 |
| Private insurance | 7.7 | 6.5 | 6.7 | 7.3 | 8.1 |
| Other | 12.6 | 11.4 | 11.0 | 10.7 | 11.2 |

scale investment was funded in its entirety, generally in a lump sum, although due to the large budgetary impact of such supplements, the actual costs for the loan were eventually financed[64].

Initially, states had to finance two-thirds of all capital expenditure and the federal government financed the remaining one-third. States decided on the definitive *per diem* charges after regional negotiations between hospitals and statutory insurers. Generally, hospitals with losses were allowed to charge the remainder in the next year and hospitals with a surplus could charge less (retrospective cost coverage)[65]. Table 4.5 illustrates the main distributive consequences of the HFA. The funding of the hospital deficits was shifted to the insurers. States and communities focused on capital subsidies, and the burden of deficit financing eased.

Each state hospital plan consisted of a statement and an analysis of the hospital facilities necessary. Only hospitals that were included in a state hospital plan were eligible for public capital subsidies. In 1975, it was stated that sickness funds had to commission all hospitals that were included in a hospital plan[68]. Only under certain conditions could the sickness funds commission the services of hospitals, which were not included in state hospital plans[69].

Public hospitals with over five hundred beds were the main beneficiaries of the reform[70]. Hospitals with less than a hundred beds were only included if they were necessary for the long-term infrastructure needs of the region[71]. This attempt to decrease the number of small hospitals did not go entirely without discussion: 'It was against the interests of physicians to decrease the number of smaller hospitals in the state plans. The fact that 81.9 percent of all clinics with less than a hundred beds were proprietary hospitals with many private patients could have hit physicians' revenues. Although they got the support of the CDU/CSU, the effort to oppose the new arrangements failed. This was probably the case while it seemed clear to most that new technological developments induced larger hospitals'[72]. In response, many smaller hospitals closed[73].

From the perspective of (public and nonprofit) hospitals, the main consequence of the HFA was its guarantee of 'free' capital. For the states, on the other hand, it meant that the demand for capital, for which they bore the financial risk, was

'endless'. As a consequence, a large shortage of capital developed. In 1984, this shortage was estimated somewhere between six and fifteen billion DM[74]. By law, the actual availability of capital was dependent on the budgetary means of the federal and state governments. The states quickly reached their budgetary limits. Although deficit financing decreased from eleven percent (1973) to 4.5 percent of total hospital costs in 1976[75], some communities continued to support their hospitals through additional funding[76]. Nevertheless, the HFA paved the way for a massive growth in spending. Hospital expenditure increased by an annual real average of thirteen percent during the subsequent decade[77].

*Consequences of the Hospital Finance Act for for-profit hospitals*

The HFA alleviated the financial stress of the public and nonprofit hospital sector, but was less favorable for the for-profit hospital sector. The HFA prohibited public capital investment in for-profit hospitals[78]. There was not much discussion of this measure, nor was it explained in the parliamentary discussion of the act[79]. As a consequence, new (especially larger) for-profit hospitals were not feasible, while existing for-profit clinics became underrepresented in state capital expenditure. State hospital plans functioned as an effective barrier to new for-profit hospitals. Sickness funds were not required to reimburse clinics that were not included in a state hospital plan[80]. Since excluded hospitals also could not charge for higher per-diem rates than comparable included hospitals, it was hard to cover for any capital costs[81]. The cost-base of for-profits thus had to be significantly lower than of their included peers. This could only be achieved through specialization (efficiencies of scope) or through investment that generated savings[82]. Additional revenues were gained by treating private patients.

Their limited access to public capital did not seem to lead to a deterioration of the for-profit infrastructure.[83]. Also, such hospitals were better able to select profitable patients. Small for-profit clinics had significantly lower operating costs. This was primarily a result of lower salaries for employees, especially nurses, since food and administrative expenses were substantially above those in other ownership types[84]. Nevertheless, with the exception of Rhineland-Palatinate the share of for-profit beds fell sharply after the implementation of the HFA. Between 1969 and 1989, more than two hundred for-profit clinics closed their doors. For-profit market penetration only remained above five percent in Schleswig-Holstein, Bavaria, and Rhineland-Palatinate (table 4.6)[85].

The left-wing government also tried to implement another policy that curbed the business model of the for-profit hospital sector. In an effort to create 'classless' hospitals, payments by private insurers were regulated. Up to that point, private rates had been much higher than the payments by the sickness funds. The government's intention was that lower private rates would alter the historic preferences of

**Table 4.6: State percentages of for-profit hospital beds[87]**

| | 1969 | 1979 | 1989 |
|---|---|---|---|
| Schleswig-Holstein | 7.9 | 6.0 | 6.4 |
| Hamburg | 4.0 | 3.8 | 3.0 |
| Lower Saxony | 5.6 | 3.6 | 3.1 |
| Bremen | 5.0 | 4.5 | 3.9 |
| North Rhine-Westphalia | 1.0 | 0.6 | 0.5 |
| Hesse | 4.6 | 3.9 | 2.6 |
| Rhineland-Palatinate | 2.2 | 2.7 | 5.4 |
| Baden-Wurttemberg | 7.1 | 2.9 | 2.0 |
| Bavaria | 6.2 | 4.8 | 4.9 |
| Saarland | 1.2 | 2.3 | 0.5 |
| West-Berlin | 6.8 | 7.3 | 3.8 |

private patients. It implied a cost shift from private insurers to the sickness funds, since the rates for full private insurance were reduced[86]. Many for-profit hospitals treated a disproportionate share of private patients and were harmed.

In 1972, in response to the political climate that had led to these measures, eighteen private insurers founded the Association of Private Hospitals. Their goal was the creation of a counterweight to the 'classless hospital'. They founded Sana, which in 1976 became a hospital company and gradually started to acquire clinics. Like Nuffield hospitals in the UK, Sana formally became a nonprofit company, although it did seek investment returns. Sana was the country's first private hospital chain that relied solely on trading activities.

### 4.2.5 Cost containment policies and their impact for the for-profit sector

In the spring of 1974, the more moderate Helmut Schmidt succeeded Willy Brandt. During the aftermath of the oil shocks, general economic conditions worsened and public deficits increased massively between 1972 and 1986[88]. This forced the government into adopting more restrictive budgetary policies. In 1975, the federal government decreased its share in hospital investment costs[89]. The states were unable to supplement this budgetary hole and an attempt to allow the hospitals to charge these costs to the sickness funds also failed.

Animosity between the federal government and the states increased. A new Health Insurance Cost Containment Act failed because of resistance from the states. However, one important new proposal was the fiscal rule of thumb that workers' contributions to the sickness funds should be kept stable in terms of a percentage of their income (*Beitragssatzstabilität*)[90]. Eventually, in 1988, this was

enshrined in legislation; the government enforced this fiscal rule of thumb by pegging the spending of the sickness funds to their revenues, which in turn, are linked to the development of wages and employment[91].

In 1981, benefit reductions, co-payments, and lower physician remunerations were the most important elements of a new law that sought to contain costs. States were given greater control over the negotiation of *per diem* rates[92]. To ease pressure on state bureaucracies, smaller maintenance costs were included in the *per diem* rates[93]. However, these measures only contained health care cost inflation temporarily, if at all. Then, the ruling SPD-FDP coalition broke up after almost thirteen years in office, with the withdrawal of the liberal FDP ministers on October 1st, 1982. The dismal state of the economy had exacerbated political tensions.

New elections were held and the CDU/CSU became the largest party, with the FDP now becoming their junior coalition partner. The FDP, which always had been close to doctors' associations, provided the minister for health. Helmut Kohl (CDU) succeeded Schmidt to become the new Chancellor and was to retain this position until 1997. The new center-right government did not make radical changes in policy, as happened in the UK and the US, but opted for more gradual changes. The 'regulative embeddedness' of the health system also prevented any rapid major changes[94]. As a consequence, the for-profit hospital sector did not gain any new momentum.

*Pre-structuring a market paradigm*

The center-right government was more tolerant towards private health insurance and halted the expansion of the sickness fund scheme. When the economy recovered, membership of private insurance schemes increased rapidly. The number of people with supplementary insurance, partly driven by reductions in the statutory benefit scheme, also increased quickly. There was thus a larger patient base with access to for-profit hospitals[95].

On the provider side, gradual market reforms, devolution, and increasing prospective payments became key policies of the new government. This did not mean an immediate turnaround in the prospects of for-profit hospitals, but on a conceptual level it was definitely important and helped to pave the way for later for-profit growth. Reports and policy papers by important think tanks underpinned such pro-market viewpoints. The Robert-Bosch Foundation argued for an end to the principle of dual financing, the introduction of prospective payments and more decentralization of powers to insurers and providers[96]. The *Sachverständigenrat*, an independent advisory body, also favored market reforms[97].

In 1984, the new Hospital Finance Act (nHFA) curtailed federal responsibilities. The federal government stopped sharing in hospital capital costs and acquired

fewer discretionary powers over state hospital planning policies[98]. This once again increased the pressure on state capital budgets for investment in hospitals; it was estimated that by the late 1980s, there was an annual capital deficit of three billion DM[99]. Increases in capital subsidies did not keep up with the rising cost of investing in new beds[100]. It is also important to note that the estimated capital deficits were not uniform across all states. The richer states in the south were much better able to support their hospitals than the poorer city states[101]. Capitation fees, which also differed among the states, funded smaller investments[102]. In the years to come, small adjustments would not ease the general shortage of capital funds. For example, with the permission of the sickness funds it became possible to fund capital through additional *per diem* charges but only if such an investment implied lower current costs, less capacity, and could be amortized within seven years[103]; sickness funds remained reluctant to facilitate this possibility[104].

The nHFA stated explicitly that a plurality of hospital ownership types should be considered: 'The implementation of this law should involve hospital plurality. This implies that state regulations should specifically consider the economic base of nonprofit and for-profit hospitals. Thus, capital subsidies might not be linked to conditions that threaten the independence of hospitals above regular certificate-of-need-regulations or normal hospital management'[105]. This statement primarily addressed the for-profit hospital sector since nonprofit hospitals were generally included in state hospital plans.

The nHFA's main goal was a gradual policy adjustment, rather than encouraging the outright privatization of hospitals[106]. Nevertheless, it should be noted that the formal prohibition of the inclusion of for-profit hospitals was ended. A number of states gradually altered their hospital regulations to make it easier for for-profits to be included in their state hospital plan[107]. The nHFA also took a first step towards prospective payments, which were strongly favored by the for-profit hospital sector. Prospective *per diem* rates were calculated to cover the operating costs of a 'reasonably efficient' hospital. The new payment system included a correction for the level of utilization: hospitals received only twenty-five percent of the standard rates if they delivered more services than planned, and they were cut by twenty-five percent if the hospitals did not reach their target[108]. It also became possible to negotiate prospective payments for specific procedures but this was not made mandatory and not used much. In 1988, ninety-six percent of hospital turnover was still funded by *per diem* rates[109].

*Early conversions to for-profit hospital ownership*

The immediate impact of these reforms to the for-profit hospital sector was small, but the seeds for subsequent growth had been planted. The long-term decline of the for-profit sector seemed to have been halted by the late 1980s.

What did the for-profit hospital sector look like? In the mid 1980s, larger for-profit hospitals were rare. In 1985, there were twenty-nine for-profit hospitals with over a hundred beds. A significant part of these facilities were operating as open-staff hospitals for local ambulatory physicians. Most for-profit hospitals were small, specialty hospitals. For-profits accounted for around half of all specialty clinics and a quarter of all specialty beds. More than half of all for-profit beds were located in one of the three southern states. According to an initial but less sophisticated study, for-profit hospitals had lower costs than public and nonprofit hospitals[110].

Public hospitals, which had gained the most from the HFA, now felt the squeeze from the cost containment policies. Public hospitals were the most dependent on public capital and they also treated the most difficult case-mix. Furthermore, they are embedded in political structures that reduce their flexibility. Quite a number of public hospitals operated with deficits[111]. The public authorities funded these losses, but many public authorities were now indebted and increasingly short of funds.

Following a discussion that had begun as early as 1975 with a Treasury paper, hospital privatization was seen as a feasible alternative to balance these public deficits[112]. Privatization, though still controversial, became a possible alternative of easing the budgetary pressure on the municipalities[113]. Hürth was the first city that opted to privatize its hospital (box 4.1)[114].

However, the favorable economic conditions of the 1980s soon eased budgetary pressures and the number of privatizations remained limited[115]. But less radical solutions, which gave hospitals greater autonomy remained a trend. Many cities

**Box 4.1: The privatization of the city hospital in Hürth**

The hospital in the city of Hürth had major financial problems and was privatized in 1984 to Sana hospitals. At that time there were projected losses of 3.25 million DM for the period 1984–1988. The hospital also required an estimated five to seven million DM in capital investments. Sana, which is owned by most of the private insurance companies, sought a return on its capital but is formally a not-for-profit company. Sana got the site and buildings for free provided that it did not terminate its operations, in which case the city would get its property back. The city paid Sana 1.5 million DM to compensate for expected losses in 1984 and 1985. The city also paid an additional 4.25 million DM for capital investment. The city was did not retain any formal decision-making powers. In other words, Hürth paid Sana to take on the expected future losses, which it did not trust itself to handle. By 1993, the utilization rate had risen by sixteen percent while the average length-of-stay had decreased by thirty-three percent, the assets on the balance sheet had increased by almost 400 percent, the number of hospital employees had increased significantly and the hospital had new intensive care and emergency units.

and communities gradually converted their hospitals into public corporate bodies. Formal conversions to private company status, over which the public community held all ownership rights, also became a popular alternative, especially in Bavaria, Baden-Wuerttemberg, and Schleswig-Holstein[116]. The outsourcing of hospital management was another trend. Sana being the principal hospital company in this sector[117]. Placing the hospital at arms length from the public owner was often a prelude to material privatizations to for-profit providers[118].

### 4.2.6 Erosion of the dual funding of capital

Under social conservative Horst Seehofer (CSU), minister of health 1992–1998, and left-wing ministers (Green Party and SPD) thereafter, reform policies continued to be incremental in nature. However, the period started with one significant reform. In 1992, the Health Care Structure Act (HCSA) was an effort to tear down some of the long-standing divisions in the structure of the hospital system[119]. 1) The split between inpatient and outpatient care was partially lifted. The hospital sector was given the freedom to provide some ambulatory surgery and provide some outpatient care before and after certain inpatient treatments. The idea was that this would bring about greater efficiency. 2) Global budgets were introduced, in combination with an extension of the potential for prospective payments. 3) Although the principle of dual funding remained intact, it became possible to increase the amount of capital reimbursement in the (*per diem*) charges[120]. Prospective rates now reimbursed adequately for smaller building expenses[121]; under certain conditions, interest costs could also be included in the *per diem* rates[122]; capital costs related to ambulatory treatments were included in general charges. As a result of the HCSA, hospitals could broaden the scope of their activities. The number of ambulatory treatments performed in hospitals grew considerably[123]. As a result of the increase in prospective funding, all hospitals became more exposed to financial risk.

In 1997, the Hospital Restructuring Act (HRA) caused a further erosion of the principle of dual hospital funding. Dual funding only remained relevant for new hospital construction. All maintenance costs as well as investment costs for larger equipment were now included in the regular rates. Hospitals with a certificate-of-need license were permitted to increase their charges by 1.25 percent to fund these expenses[124]. In Bavaria, hospitals received between €1,750 and €3,000 per bed, depending on the scale of the hospital[125]. The states became responsible for the settlement of the prospective rates. Because of lower wages, these rates were lower in the Eastern part of the country. However, the rates for capital and material expenses were not lower in the new states[126]. It will shortly be illustrated why this is of importance.

Hospitals and sickness funds could adjust prospective rates by up to thirty percent. This implied additional potential for hospitals to cover their capital costs: 'Special circumstances might lead to higher fixed costs. In such cases, prospective rates should include their share of such costs. This is possible by adding a surcharge to the prospective rate. Special circumstances include for variations in assets, the security of medical quality, or the capital costs of hospitals that are not included or only partially included in a state hospital plan'[127]. The latter was still the case for many for-profit hospitals.

In 1998, the social democrats formed a new government with the junior green party. However, the in-coming left-wing coalition did not fundamentally alter the pro-market policies of the former coalition. The new government continued the movement towards more prospective payment reimbursement; they also refrained from enacting any new legislation that would curb the for-profit hospital sector, with the exception of lowering the reimbursements of the for-profit dominated open-staff hospitals.

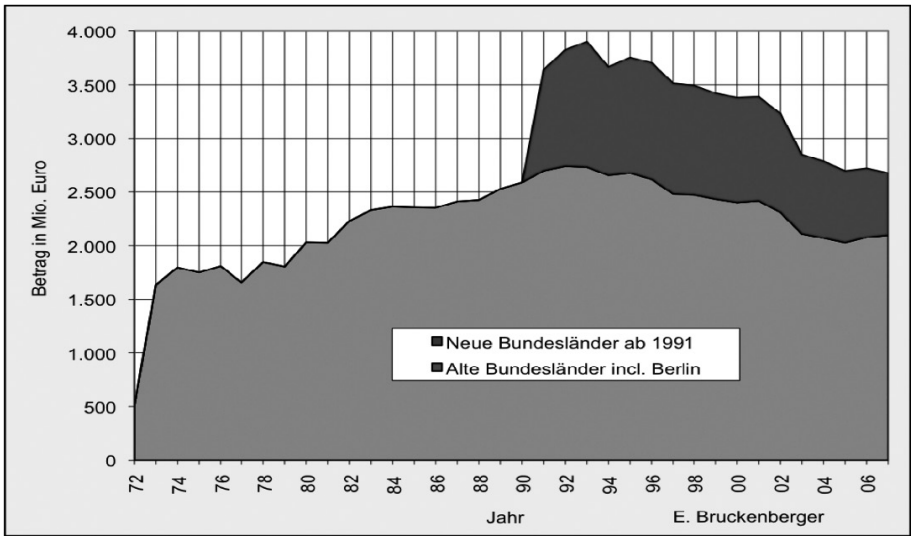
The agenda of the left-wing coalition concentrated on the insurance side of health care as well as on the quality of care legislation; the latter implied the introduction of an 'Institute for quality and efficiency in health care' that would increase the transparency of hospital quality[128]. In an effort to make it more difficult for individuals to switch from sickness funds to private health insurance, the government raised the threshold for the statutory insurance scheme[129]. In 1999, the sickness funds of the former West German states also had to pay 1.2 billion DM to strengthen the balance sheets of the sickness funds in the new former East German states.

*Changing comparative advantages in access to hospital capital*

Since the 1990s, the access of public and nonprofit hospitals to capital substantially declined in relation to their for-profit counterparts. Historically, public and nonprofit ownership types had held the edge due to their much better access to 'free' public capital. However, for-profit access to such funds gradually increased. More importantly, the relevance of such public capital subsidies to general competitiveness decreased.

Figure 4.1 shows that the amount of funding that the states had available for investment in hospitals declined, at least in the former West German states. Within western Germany, the southern states invested more capital than the other states due to their better economic and fiscal positions. Bavarian capital expenses were seen as the national benchmark[130]. The capital backlog appears highest in North Rhine-Westphalia, Lower Saxony, and Rhineland-Palatinate[131]. The total capital backlog is estimated at some €30 billion[132]. Figure 4.1 also shows that there

**Figure 4.1: Hospital Finance Act: state and federal subsidies (1972–2007)**[134]




is one major exception to these severe fiscal pressures. The federal government financed a large multi-year investment program to rebuild the outdated hospital infrastructure of the new eastern states. In the 1990s, the average hospital in the eastern states was able to spend an additional €70,000 per bed over and above the amount supplied to hospitals in the old states[133].

In 1972, as much as twenty-seven percent of total hospital turnover was used for capital investment; by 2001 this figure had decreased to around seven percent[135]. The actual availability of public capital was highly dependent on the state of the general economy as well as on the fiscal position of the state in question. From 1991 onwards, German GDP growth lagged significantly behind the OECD average. In real terms, annual capital subsidies to hospitals decreased by five percent between 1996 and 2003[136].

The effect was that a monistic funding of hospital capital was in fact gradually being implemented: 'In practice, there is monistic funding of capital in many states. Now, the public subsidies for capital are marginal. From a hospital's perspective, the fact that sickness funds are forced to contract hospitals included in a state plan is of much more importance than the actual entitlements to public capital subsidies'[137]. Between 1988 and 1992, hospital capital expenses still more or less equaled the public capital budgets. However, between 1993 and 1997, almost forty percent of capital expenses were funded by other means[138]. This also illustrates the growing involvement of for-profit hospital groups as a source of capital. In 2004, average capital expenses for for-profit hospitals were estimated at ten percent,

much higher than for other ownership types[139]. For-profit hospital groups often tapped the financial markets for capital[140].

Because of the erosion of the dual funding principle, the competitive advantages for for-profit hospitals increased. 1) The importance of for-profit access to the capital markets was encouraged through the large capital shortage of other ownership types. In fact, yearly capital costs are expected to increase by about €1.5 billion between 2004 and 2010, which will further increase their comparative advantage[141]. 2) For-profit hospitals had more opportunities to increase their access to public capital. The gradual inclusion of capital payments in regular charges worked to their advantage. This is becoming even more apparent now that the federal government, although against the will of the states that see their discretionary powers diminish[142], seems to want to abolish what remains of the dual funding principle and encourage capital to become fully included in regular hospital charges[143]. 3) The program to rebuild the hospital sector in the new states was open to for-profit hospital groups. It was also not uncommon for a for-profit hospital company that was acquiring a public hospital to received a once-only capital grant. In return, the for-profit hospital generally promised not to seek any additional public capital subsidies for a certain period[144].

There are significant differences between the capital structure of for-profit hospitals and other ownership types. For-profit hospitals are more dependent on equity as well as on commercial loans. They are able to fund such capital through their comparatively higher margins[145]. However, this also implies that their balance sheets are more loaded with debt[146]. Other ownership types use state subsidies, retained earnings (especially nonprofits), and low interest debt, often from their owners (table 4.7). The credit enhancement techniques of public and nonprofit hospitals are still poorly developed[147].

For-profit hospitals that make no appeal for public capital subsidies, which is less common than generally assumed[148], adopt three strategies to fund for their capital investments. They may gain a higher level of efficiency, choose more profit-

**Table 4.7: Average balance sheet of German hospitals (2003)[150]**

| | For-profit hospitals | Other hospitals |
|---|---|---|
| Total | €7.3 billion | €62.9 billion |
| % Equity | 25 | 15 |
| % Public means (HFA) | 25 | 46 |
| % Provisions | 5 | 11 |
| % Other debt | 10 | 17 |
| % Loans with interests | 35 | 11 |

able patients, and pursue specific revenue generating strategies: 'Such possibilities appear most in smaller hospitals that are sometimes badly managed. This gives opportunities for a quick and easy turnaround. It is disputable whether for-profit companies can also gain such advantages for large hospitals with large investment needs over a longer period'[149].

### 4.2.7 Rapid for-profit hospital growth

The for-profit hospital sector had been in decline for many years and had become a marginal phenomenon by the time of the German reunification. A few small hospital groups existed, of which one (Rhön-Klinikum) has been listed on the German stock exchange since 1989. Most of these companies had existed for many years; they often started as rehabilitation clinics (see appendix 4.1). Now, changes in planning and reimbursement regulations (see sections 4.2.5 and 4.2.6), together with the political consequences of German reunification brought about rapid growth among these for-profit health care companies.

Between 1991 and 1996, for-profit hospitals increased their monetary market share by fifty percent. The for-profit hospital sector also sharply increased its share of beds, the number of cases it treated, and the number of physicians it employed. The fastest growth was among for-profit hospitals that operated over two hundred beds. Table 4.8 illustrates that the number of for-profit hospital beds in the sector's traditional strongholds – open-staff clinics and facilities that did not form part

**Table 4.8: Trends in hospital ownership types from the 1990s onwards[151]**

| | 1992 | 1997 | 2002 | 2007 |
|---|---|---|---|---|
| Public hospital beds | 355,312 | 304,500 | 272,293 | 229,971 |
| Nonprofit hospital beds | 211,137 | 204,811 | 190,426 | 167,739 |
| For-profit hospital beds | 25,381 | 31,603 | 41,965 | 70,459 |
| of which in open-staff clinics | 14,130 | 9,991 | 9,667 | 5,551 |
| Beds not included in hospital plans | | | | |
| Public | 4,624 | 3,736 | 3,485 | 3,515 |
| Nonprofit | 5,103 | 2,763 | 2,278 | 2,044 |
| For-profit | 8,393 | 7,960 | 6,736 | 7,959 |
| # Day care patients | 99,128 | 192,665 | 575,294 | 1,638,911 |
| % in public hospitals | 78.75 | 79.5 | 55.75 | 47.5 |
| % in nonprofit hospitals | 11.75 | 13.75 | 30.75 | 36.25 |
| % in for-profit hospitals | 9.5 | 6.75 | 13.25 | 16.25 |

**Table 4.9: Share of for-profit hospital cost (%) and total capital subsidies per bed[165]**

| | 1992 (costs) | 1997 (costs) | 2001 (costs) | 2007 (costs) | 1972–2007 (HFA subsidies per bed) |
|---|---|---|---|---|---|
| Baden-Wuerttemberg | 3.7 | 5.2 | 6.7 | 9.1 | 196,400 |
| Bavaria | 6.7 | 7.8 | 8.4 | 11.7 | 267,700 |
| Berlin | 5.8 | 3.4 | 11.6 | 14.4 | 396,700 |
| Brandenburg | n/a | 14.8 | 10.8 | 27.8 | 184,600 |
| Hamburg | 2.2 | 1.5 | 1.5 | n/a | 219,000 |
| Hesse | 5.6 | 7.4 | 8.0 | 21.2 | 208,700 |
| Mecklenburg | n/a | n/a | 15.5 | 45.6 | 233,600 |
| Lower Saxony | 2.9 | 6.1 | 7.0 | 14.1 | 165,500 |
| North Rhine-Westphalia | 0.6 | 0.7 | 1.2 | 4.5 | 155,500 |
| Rhineland-Palatinate | 2.5 | 2.5 | 3.9 | 4.0 | 192,500 |
| Saxony | 1.9 | 7.8 | 20.2 | 23.4 | 182,000 |
| Saxony-Anhalt | n/a | n/a | 3.0 | 14.3 | 210,800 |
| Schleswig-Holstein | 8.9 | 13.3 | 18.8 | 24.1 | 175,700 |
| Thuringia | 6.3 | 17.3 | 22.2 | 35.7 | 225,800 |

of state hospital plans – was actually declining. On the other hand, the growth of for-profit hospitals that were included in a state hospital plan was rising rapidly. In the West German states, the number of for-profit hospitals increased most where the sector was historically rooted: Schleswig-Holstein, Bavaria, and Baden-Wuerttemberg. However, in Lower Saxony too, where the man who would later become Chancellor Gerhardt Schröder led a leftwing coalition, for-profit hospital ownership increased significantly (table 4.9).

Most for-profit hospital growth was driven by acquisitions. For-profit hospital companies were allowed to operate many of the former public hospitals in the eastern states and more and more also gradually made acquisitions in western Germany.

*New markets in the East*

In the post-communist era, support for neo-liberal policies was strong and most of the new eastern states were firmly in favor of for-profit hospitals. The German Hospital Association argued strongly for a pluralist landscape of ownership types in the new states[152]. The hospital stock in the new states included many outdated public facilities and there was an urgent need for new and upgraded hospitals. It was estimated that one-third of the hospitals needed replacing, one-third needed drastic upgrading, and only about one-third of buildings were adequate. The Ger-

man Hospital Association estimated that thirty-five billion DM was needed for the necessary investment[153].

The federal responsibility for investing in hospital construction became part of the reunification treaty[154]. The operating costs of the eastern hospitals were also allowed to increase very rapidly[155]. Figure 4.1 shows that the new states were able to invest approximately €1.5 billion in their hospitals annually, of which three-quarters came from special reunification funds[156]. Eventually, this massive injection of funding paid off. In 2000, the chairman of the Saxony Hospital Association stated that the differences between hospitals in Western and Eastern Germany had more or less vanished[157]. As validated by a recent study, these capital investments also paid off in another way: 'operational efficiency (…) was significantly greater than that of their western counterparts. This can be explained by the large investments made to modernize hospital infrastructure'[158].

Ninety percent of hospitals in the eastern states were under public ownership but it was initially anticipated that the small nonprofit sector in the new states would expand[159]. However, this did not happen since most voluntary movements in the new states lacked the necessary expertise and means. The existing nonprofit hospital groups in the Western states had a local or regional focus. In fact, it was only the for-profit hospital groups that were willing and able to become involved in the consolidation of the hospital sector in the new states – when the conditions were favorable, that is.

The German Hospital Association argued for the accommodation of private investment through more flexible (accounting) regulations[160]. The federal government favored the privatization of hospitals in the new states[161]. The pro-market ideologies of most of the new states were enshrined in their hospital regulations. For example, Saxony stated that new public hospitals were only allowed if no private alternative was available. Only in Saxony-Anhalt was it more difficult to change the corporate status of public hospitals. Under Saxony-Anhalt law, a public hospital should remain public if it can meet its goals in a reasonable way[162].

For-profit hospital groups easily passed the planning requirements in most new states, which gave them access to the public capital subsidies. This was important, because the federal government was at that time supporting the reconstruction of hospitals in the new states with significant funding. For example, in 1993 Rhön-Klinikum acquired the public hospital in Meiningen. The city financed the liquidation of the old public hospital. Rhön funded the new hospital but the state of Thuringia provided almost thirty percent of the necessary capital. In return, Rhön gave up most of its future claims to public capital payments[163].

Table 4.9 indicates that within a decade, for-profit hospital groups had grown from having no presence at all to a considerable market share in most new states.

Most acquisitions were made by one of the five large for-profit hospital groups[164]. An additional advantage for these groups was that, again on ideological grounds but with the exception of Brandenburg, the old East German system of ambulatory (specialist) group practices was dismantled. There was thus a lack of (outpatient) specialist care in many regions. For-profit hospitals filled this gap and built hospitals under less restrictive conditions.

*Privatization of public hospitals in the Western states*

The trend of hospital privatizations gradually spread to the old states of the west, too. Both the federal government (global budgets) and the states (decreasing capital subsidies) implemented ever-increasing expenditure controls. Many public hospitals, which saw their access to capital decrease, had increasing problems with annual deficits as well as outdated facilities[166]. Between 1996 and 2006, the number of hospital staff decreased by more than ten percent and the hospital sector now shows signs of underfunding[167]. According to the Economic Institute of North Rhine-Westphalia (RWI), currently many German hospitals bear insolvency risks[168]. The annual average probability of default is currently calculated at approximately 1.3 percent, much higher among public than among for for-profit facilities[169].

The RWI estimates the annual underfunding of the sector to be between one and two billion euro[170]. Since quite some public hospitals have low utilization levels, they have often not been able to cover fixed costs and the resulting deficits have sometimes been considerable. Facing additional fiscal pressures, the privatization of the public hospitals has become an ever more feasible option to ease these burdens. Privatization was usually perceived as a means of increasing efficiency, since public hospitals were thought to be highly inefficient. Indeed, privatization of an inefficient public hospital may reduce inefficiency compared with the counterfactual situation in which the particular hospital had not been privatized[171].

Much state-level hospital legislation – which traditionally prevented the privatization of public hospitals – had been changed during the late 1980s and early 1990s[172]. In the 1994 coalition agreement between the CDU/CSU and FDP, privatizations and a stricter use of the subsidiarity principle were high on the agenda. It is also important to note that tax-policies regarding different hospital ownership types were broadly although not entirely similar[173]. Hospitals with roughly forty percent sickness fund patients are seen as social companies and thus benefit from tax-breaks[174]. If they are also included in a state hospital plan, there is no discussion whatsoever of whether their work is in the public interest. A public hospital that converted to for-profit status was more or less automatically incorporated into the state hospital plan.

Initially, hospital privatizations became the subject of fierce public debate, in which labor rights were a significant issue[175]. Collective agreements between unions and employers in the public sector are less flexible and more expensive than those made in the private sector[176]. The Union of public workers opposed privatizations, not only for ideological reasons, but also because it would imply a reduction in union membership[177]. By the end of the 1990s, most unions had adopted a more pragmatic view, although the public union remained strongly in favor of securing employee benefits and its labor co-partnership rights[178]. The council of employees had to approve the material consequences of privatization such as lay-offs, changes in social security and education policies, and labor co-partnership rights. Employee representatives cannot block a privatization but they can influence the process significantly and delay it[179].

Management and the physicians are often attracted by the additional capital investment offered by the new owner. Currently investments as percentage of turnover are about thirty percent higher in for-profit clinics versus public hospitals[180]. Physician salaries are more flexible and also tend to be higher in the new for-profit settings, but physician autonomy might be more restricted due to the rationalization measures of the acquiring for-profit company. This affects coordinating senior doctors the most since they may lose part of their powers. Physicians might also benefit from equity participation and additional stock plans[181]. The Federal Chamber of Physicians supports the pluralist hospital landscape but is critical of for-profit involvement in education and research (university clinics); it also supports greater transparency on quality issues[182]. Nevertheless, most doctors seem to favor moves towards privatization.

A municipality that faces a decision on hospital privatization must consider a difficult mix of arguments. These include the impact of the privatization on the local economy; any possible efficiency gains and the effect on the public budget; the impact of privatization on employees and voters; the attitudes of the various interest groups involved; the possible impact on the patients; and many other kinds of personal and political goals[183]. In the Western states, political support for privatization often remained shaky until well into the 1990s[184]. However, fiscal support for struggling public hospitals becomes an increasing difficult option. The for-profit hospital sector sees this as incompatible with EU legislation. In 2003, Asklepios with the support of the federal for-profit hospital association filed a lawsuit at the European Court in an effort to prohibit deficit financing by German municipalities[185].

States seem still very reluctant to support the privatization of university clinics[186]. In 2006, there was an extensive public debate on the privatization of the university clinic in Marburg/Gießen[187]. However, over the years many local communities became less reluctant to privatize their hospitals. During the late 1990s

and the first years of the new century, the supply of public hospitals even began to exceed the demand from for-profit chains to buy them. Purchasing prices halved to fifty cents for each euro of revenue; many communities were disappointed by the price and the terms associated with these agreements[188].

### 4.2.8 The transformation of the scale and scope of for-profit hospitals

During the 1990s, the for-profit hospital sector not only rapidly increased its share of the market but it also changed the scale and scope of its activities. By now the sector consisted of more large-scale hospitals, which was a significant change from the small and specialized clinics that had previously formed its core. Now the large majority of for-profit hospitals were also included in state hospital plans, had contracts with the statutory insurance funds, and were eligible for public capital subsidies. By 2002, the average for-profit hospital had a hundred beds, up from seventy-five a decade earlier[189]. Specific policies contributed to this process: small open-staff clinics were hurt by higher deductions from their all-in rates, which was motivated by the fact that open-staff hospitals do not pay any physician's salaries.

During the 1990s, the for-profit hospital sector consolidated. Four large groups (Rhön, Helios, Asklepios, and Sana) came to dominate the market. By 2003, their estimated turnover was equal to almost sixty percent of the total for-profit hospital sector[190]. Some for-profit companies brand their hospitals under their own name (Asklepios, Helios), while others do not (Rhön). The large hospital groups focus heavily on acute care, while some smaller companies favor a model of integrative care and also operate rehabilitation and long-term care clinics (Mediclin, Damp). German hospital groups – with the exception of Asklepios, which owns a multi-hospital system in the Los Angeles area – are not active in foreign markets. Neither are foreign hospital operators very active in the German market, although some Swiss, Swedish, and US operators own a few clinics. According to some, the consolidation of the for-profit hospital chains has led to greater efficiency. This may imply that future capital requirements can be funded monistically. It could reduce the public capital subsidies required, which would make it possible to include capital in the DRG financing system. This would be a decisive step towards greater responsibility for resources and giving hospitals greater financial freedom[191].

*Converging patient mixes and cost bases*

The strong growth in larger for-profit hospitals implies that the case-mix among all ownership types becomes more comparable. Currently, for-profit hospitals report even higher patient case-mix than other ownership types[192]. The traditional overrepresentation of private patients in for-profit hospitals has also decreased, the workload of nurses seem to be converging. Nurses in for-profit hospitals still

**Table 4.10: Cost-base 1992–2007**[204]

| | 1992 (EUR) | 1997 (EUR) | 2001 (EUR) | 2007 (EUR) |
|---|---|---|---|---|
| Public hospitals | | | | |
| Costs FTE | 32,404 | 36,622 | 41,374 | 52,620 |
| Costs FTE physician | 57,386 | 61,460 | 66,594 | 90,288 |
| *Per diem* charges | 225 | 306 | 356 | n/a |
| Nonprofit hospitals | | | | |
| Costs FTE | 35,865 | 40,933 | 48,044 | 52,179 |
| Costs FTE physician | 70,143 | 73,569 | 82,231 | 91,542 |
| *Per diem* charges | 193 | 260 | 307 | n/a |
| For-profit hospitals | | | | |
| Costs FTE | 31,735 | 37,596 | 41,610 | 50,867 |
| Costs FTE physician | 63,755 | 71,410 | 72,674 | 92,093 |
| *Per diem* charges | 171 | 255 | 309 | n/a |

provide the most yearly nursing days, but these numbers are converging across ownership types[193]. Average length-of-stay is also tending to converge across different ownership types, although it remains somewhat longer in for-profit hospitals[194]. For-profit hospitals are also increasingly involved in educating nurses. Nevertheless, in 2002, the for-profit share in training nurses was still no more than three percent[195]. However, relative for-profit expenses for training and education kept increasing and now are not that far behind the expenses of other ownership types[196].

The rapidly growing number of intensive care units in for-profit hospitals as well demonstrates the fact that for-profits are treating sicker patients. Between 1992 and 2002, the number of intensive care beds in for-profit hospitals quadrupled; by the end of that period, the sector had 7.25 percent of all intensive care beds[197]. Table 4.10 shows that actual patient charges also converged during the 1990s. The practice of average lower charges among for-profit hospitals, due to their lower caseloads, has gradually ended. In 1999, the average *per diem* rate for an intensive care unit was 1,580 DM in for-profit hospitals, compared with 1,525 DM in public hospitals and 1,390 DM in nonprofit hospitals[198]. For-profit hospitals still pay somewhat lower wages to nurses, partly due to lower pension premiums[199]. For-profit hospitals pay physicians higher wages than public hospitals, although this difference has lessened (table 4.10).

*New competitors?*
German for-profit hospitals are comparatively well protected from competition from ambulatory surgery centers. After reunification outpatient care in the Eastern states was modeled after West Germany's ambulatory system with solo practitioners and few group practices[200]. Nevertheless, the separation between inpatient and outpatient care has gradually been eroded. The 2004 reform introduced the possibility to establish medical care centers, and the right for sickness funds and providers to enter into integrated care contracts[201].

Currently, a thousand medical centers exist, of which thirty-seven percent are owned by hospitals and the remainder by physician partnerships[202]. For-profit hospitals are also involved in this business[203]. Many patients are enrolled in outpatient disease management programs and in GP-centered care. Outpatient clinical centers are a clear threat to single ambulatory physicians. However, if their treatments begin to overlap more with the activities of hospitals, due to technological developments or further regulatory changes, they could also threaten the business model of (for-profit) hospitals. They may then attract more profitable patients. Physicians could become engaged with such centers and refer hospital patients to such centers.

## 4.3 Analysis

This section analyzes the development of for-profit hospital care in Germany. Section 4.3.1 explains which historic factors shaped Germany's proprietary hospital sector, and this period ends with World War II. In 1945, Germany was ravaged, divided into East and West, and a federal constitution was established in West Germany. Section 4.3.2 analyzes how the for-profit hospital sector was able to survive the following years of scarce resources, years when the reimbursement of hospitals was dissipated and dependent on supplements by hospital owners. I then analyze the consequences of the Hospital Finance Act. Section 4.3.3 discusses the impact of these new planning regulations on the for-profit hospital sector. Strong growth of the for-profit hospital sector started in the early 1990s. What pre-structured this sudden and radical change? Section 4.3.4 analyzes the causes of this rapid growth in for-profit hospitals. The chapter ends with my concluding statements in section 4.3.5.

### 4.3.1 Constraints on the scale and scope of a declining proprietary sector

Proprietary hospitals have existed in Germany since the mid-nineteenth century and supplemented the services of other ownership types. They treated private

patients in search of specialized services and luxury care. These patients were able to pay the comparatively high charges. In some rural areas, there were insufficient public and voluntary funds available to fund a hospital. In such regions, local physicians helped to found open-staff proprietary hospitals that served a broader range of patients.

Germany stands out as having the first system of sickness funds, which also generally covered hospital treatment in public and nonprofit hospitals. This improved the access of these hospitals to (adequate) funding. It also worsened the competitive position of proprietary hospitals. Nonprofits also had access to cheap philanthropic capital and charity work from religious orders. Both were amply available in the industrial areas along the river Rhine in the Western part of the country. Indeed, the market penetration of nonprofit hospitals was the highest in North Rhine-Westphalia and Rhineland-Palatinate.

The relatively well-funded hospital sector was probably one reason why many physicians in public and nonprofit hospitals were on salaried positions as early as the 1920s. Lack of hospital access was less critical in determining physician remuneration and, in comparison to other countries, founding a proprietary hospital was a less feasible alternative. Nevertheless, there was the dormant threat that hospital physicians may threaten the income of ambulatory physicians by becoming active in those markets.

In 1932, remuneration disputes between doctors were resolved by the establishment of a legal monopoly of self-employed ambulatory physicians active in outpatient care. How did this split between inpatient and outpatient care affect the scale and scope of the proprietary hospital sector? The split created structural inefficiencies because of the duplication of activities by outpatient and inpatient providers. Ambulatory physicians did not need the same amount of hospital access that physicians in other countries needed to secure their remuneration. Due to their legal monopoly, ambulatory physicians, where the medical situation allows this, were also able to keep the more profitable patients and refer less financially attractive patients to hospital. They could perform additional tests that were also likely to be done once the patient is admitted to the hospital. Those proprietary hospitals, which depended on the more profitable patients, experienced strong competition from ambulatory physicians.

The separation between outpatient and inpatient care impacted on the development of the proprietary hospitals. Between 1920 and 1945, the sector became a slowly declining fringe. They geared their interests to those of the ambulatory physicians. The proprietary hospital sector was shaped according to three models that broadly depended on bypassing the inpatient/outpatient split. 1) Proprietary clinics served ambulatory physicians, which needed inpatient capacity. In rural

areas, the necessary capital and patient base were not always available to fund a hospital and its medical staff. In such areas, small open-staff proprietary hospitals could survive, although they were hardly profitable. Ambulatory physicians often held a stake in such facilities. 2) In urban areas, prestigious (ambulatory) physicians could become involved in specialized clinics. For example, an ambulatory ophthalmologist could refer his patients to a specialized clinic where he had an investment interest. Such clinics were able to make a profit as a result of price discrimination (sliding fee scales) and many private patients paid considerably above costs. These clinics formed the backbone of the for-profit hospital sector. 3) Small proprietary inpatient facilities focused on amenities and luxury care. Rehabilitation and preventive care were an important part of the treatment. Initially, this was only available for private and well-off patients. However, from the mid 1950s such programs were included in many statutory schemes and the number of for-profit clinics grew rapidly. Although they focused less on surgery and medical treatment, these clinics provided a means by which proprietary hospitals could survive and a basis for the future growth in for-profit acute care.

### 4.3.2 Prolonged stagnation of the proprietary hospital sector

In the decades immediately after World War II, German hospital care faced severe shortages and a strong increase in demand. A massive scarcity of capital made itself felt daily and the destruction of the capital of proprietary hospitals would have been very 'wasteful'. Moreover, the situation implied the mobilization of as many additional resources as possible.

The scarcity of capital was supplemented by a new political system that prioritized the subsidiarity principle, self-regulation, and a federal constitution. Federal policies on the issue of hospital care could often be modified if they did not fit the needs of the states, the local authorities, the sickness-funds, or the hospital providers. From an institutional perspective, this implied a natural stimulus for pluralism and a diversity of types of hospital ownership. Due to the subsidiarity principle and the associated practice of self-regulation, for-profit hospital ownership was never fundamentally disputed at the national level. At a lower level, there often existed some discretionary room to re-direct federal policies. The states were given constitutional responsibility for the hospital sector. In a general sense, the states and local authorities aligned themselves with the hospital sector. They owned many public hospitals and shared their interests and also had a natural responsibility for adequate treatment opportunities in their jurisdictions.

The above did not imply any fundamental threat to the for-profit hospital sector. However, its funding was far from secure. The complete destruction of the hospital sector and the many refugees in need of treatment were a burden on resources

for many years to come. As a result, funding was highly fragmented. Although the large majority of the population was insured by the sickness funds, these simply could not meet all the necessary hospital expenses and were not allowed to increase their contributions due to general economic policies. As a result, the sickness funds reimbursed well below fifty percent of hospitals' actual total costs.

The natural way out of this dilemma was to make others share this burden. There were only a few options for doing this. 1) The states had a constitutional responsibility and funded many special needs such as investment and maintenance projects. Although most of this money went to public and nonprofit providers, states were not always unwilling to help proprietary providers, especially if they were deemed necessary from a public health perspective. This habit developed into a funding mindset that laid the grounds for the principle of dual funding. 2) It was thought that the owners of hospitals should help to fulfill hospital needs. Nonprofits had to rely on endowments and voluntary contributions to cover capital expenses and high operating losses. Municipalities owned their own hospitals and were thus legally responsible for the losses of such facilities. As a consequence, nonprofit owners and municipalities were given the role as payers of last resort. In 1954, the federal government maintained this situation for the years ahead. Through general legislation, sickness funds 'detracted' such contributions from the *per diem* rates they were allowed to reimburse[205]. Thus, the role of the owners in the funding of the hospital sector became more formalized. 3) Private insurers and private patients paid higher rates. These were used to subsidize losses and underfunding from the statutory insurance scheme. These high fees were also the only possibility to make an investment profit. Proprietary hospitals, which sought to make a profit (and many did not), specialized almost exclusively on (medical) services and amenities for private patients. In addition, from the mid 1950s onwards, profit-oriented providers could step into the growing market for rehabilitation services and preventive treatments to diversify their business.

### 4.3.3 Further decline of the proprietary hospital sector

In 1972, the HFA legally established the dual financing system. The states, supplemented with federal resources, were made responsible for funding the capital investment of most hospitals. This responsibility was tied to state planning procedures for the necessary hospital services. As a funder of one-third of this capital, the federal government issued certain compliance requirements for these state hospital plans. Sickness funds were responsible for the funding of the entirety of the hospitals' operating costs, largely freeing local authorities from their financial obligations to the hospital system. In the wake of this legislation, private

insurers were 'forced' to pay lower reimbursement rates to the hospitals. The HFA supported the entire hospital sector with many additional resources. The number of hospital beds increased rapidly due to major investment in public and nonprofit facilities. For a short period, there was ample public capital at little or no cost to recipients. The larger public hospitals were the main beneficiaries of these reforms.

The HFA brought about a further decline among for-profit hospitals. Normally, for-profit hospitals were not included in state hospital plans since this was prohibited by the HFA. This contrasted to earlier periods when states made such decisions for themselves. In the years immediately after its enactment, public and nonprofit hospitals were supported through large amounts of free capital. In addition, public hospitals could rely on local communities as a lender of last resort. Nonprofits still had access to voluntary means, although this was declining rapidly.

In 1975, all providers that were included in state hospital plans were protected from competition through mandatory contracts with the sickness funds. Payments by private insurers were trimmed because of regulations that sought to create 'classless' hospitals. These measures further increased the competitive disadvantage of for-profit hospitals. Their traditional business models were being tested and – at the same time – their access to growing amounts of 'public' funding was decreasing. As a result, the share of for-profit hospitals continued to decline until the late 1980s.

At first glance, it now seemed that there were few prospects left for the for-profit hospital sector. However, there were some green shoots that eventually helped to pre-structure a turnaround. 1) Although most of the focus was on the public funding of capital, the HFA also implied a large shift in hospital costs towards the sickness funds (see table 4.5). The sickness fund rates were raised considerably because many state and local authorities stopped supplementing the operating costs of hospitals. As a result, sickness fund patients also had more potential for for-profit hospitals. 2) Public capital funds turned out to be vulnerable to budgetary cuts in favor of other more urgent political priorities. As fiscal pressures increased, hospital investments became an obvious target object for budgetary cuts. This caused an erosion of the funding base and many came to favor other solutions. In retrospect, shortly after the introduction of the HFA, the competitive advantage of public and nonprofit hospitals was at its height. It was not long before the mechanisms behind dual funding were undermined.

In 1984, the new Hospital Finance Act (nHFA) removed federal supplements for capital investment. Without any additional monetary compensation, the states now had to bear their hospitals' capital costs in full. A clear shortage of public capital was developing. Being the only formal providers of capital, the states were

given greater discretion in this area. The nHFA ended the prohibition on the inclusion of for-profit providers in state hospital plans.

Gradually, more and more states altered their hospital regulations to the benefit of the for-profit hospital sector. This trend gathered pace particularly after German reunification, when the new federal states were very open to for-profit ownership. The nHFA also made it possible to shift part of the costs of capital to the insurers. It introduced prospective *per diem* rates and a system of prospectively financed special procedures, which expanded gradually. New legislation also supported the growth of prospective payment schemes, which included certain categories of capital costs. At best, such measures consolidated the access of public and nonprofit hospitals to capital, while they made it easier for for-profit hospitals to be reimbursed for their capital costs. More and more public hospitals that now lacked the access to capital to upgrade their facilities and their deficits were mounting again. Once again, hospital deficits became a burden on local budgets, which increased the pressure for privatization. Such underlying trends pre-structured a new and robust business model for the for-profit hospital sector.

### 4.3.4 Rapid growth and consolidation of for-profit hospitals

The availability of public capital went into decline a few years after the introduction of the HFA and access to alternative sources of capital became increasingly important. The broad availability of public capital was soon followed by structural capital shortages. This first drove the decline and then the expansion of the for-profit hospital sector.

Hospital investment was increasingly tied to the fiscal health of the public authorities that were funding it. Since cutting capital budgets was a popular strategy for balancing state budgets, nonprofit and particularly public hospitals encountered shortages of capital funds. The local authorities were also no longer in a position to automatically cover the structural deficits of public hospitals or provide the necessary funding for investment. In the aftermath of the German reunification, many public authorities were short of funds due to prolonged economic slow-down and the need to make solidarity funds available for reconstruction projects in the new eastern states. In western states, the sell-off of struggling public hospitals to for-profit companies seemed to be an increasingly feasible strategy to lower the fiscal burden of local governments.

However, this movement began in the eastern states where the political climate was influenced by free-market ideologies. State hospital plans were favorably disposed to for-profit hospitals. At that point, public authorities owned over ninety percent of the outdated communist hospitals, the remainder being run by semi-autonomous foundations; a well-developed nonprofit sector did not exist.

The purchasing prices for public hospitals were relatively low compared to any standard market valuations. German reunification gave the for-profit hospital sector the ideological and institutional momentum to become major consolidators. If one opted for privatization as a way of modernizing existing hospital infrastructure, a solution which met with little opposition, for-profit hospital companies were the only ones with the necessary expertise to do this job[206].

However, to take advantage of the worsening prospects of the public hospital sector, the for-profit hospital sector had to improve its investment autonomy. Certain specific developments made this possible. 1) The gradual introduction of prospective capital payments (monistic funding) as well as the reduction of separate capital subsidies. 2) The small for-profit hospital companies increased their access to capital through alliances with private equity investors or through stock listings. 3) In sharp contrast to the western states, in the east many public capital funds were made available for investment in outdated hospital infrastructure.

To a certain extent, this created the same situation as shortly after the HFA came into effect in 1972: lavish access to free public capital. However, this time it was for-profit hospital companies who were given access to these resources, often being the preferred party for upgrading outdated hospital infrastructure. Within a few years, their investment autonomy was settled. Access to equity capital had become a crucial competitive advantage for for-profit hospitals. Together, these factors made a significant return on investment much more likely and facilitated strong growth in the for-profit hospital sector. Nonprofits and public hospitals had much less incentive to grow and they also lacked access to the necessary investment autonomy.

The rapid growth of the for-profit hospital sector would not have been possible without the many opportunities for-profits found for consolidation; there was less need for new additional hospital capacity. A significant part of the dissipated hospital stock consists of smaller facilities that did bore less investment risk to the for-profit consolidators. Many physicians in public hospitals did not resist hospital privatization. They could often earn substantially more and enjoy access to better technology and equipment.

For-profit companies gradually increased the scale of the hospital facilities acquired. The for-profit hospital sector thus began to resemble its public and nonprofit counterparts. Case-mixes converged and the for-profit hospitals significantly increased their treatment of sickness fund patients. Due to consolidations and mergers, the patient base of the for-profit hospital sector is now very similar to the patient base of public and nonprofit hospitals.

What is more, the old niche strategy of the for-profit sector also flourished. During the 1980s and the 1990s, private insurers and supplementary insurers had increased their market penetration. The restrictive regulations on private

reimbursements were ended; premium increases were often higher in the private segment of the market. This contributed to a continuing demand for the traditional business model of the for-profit hospital sector, in which private patients are overrepresented and amenities are important. These clinics are mainly located in western Germany and many are still not included in a state hospital plan. Such hospitals focus on carrying out profitable elective treatment. These two business models have had different paths of growth and decline. However, the spectacular growth of a mature for-profit hospital sector that forms a substitute, and not a supplement, to other ownership types is becoming much more evident.

### 4.3.5 Conclusions

In Germany, the existence of for-profit hospital ownership was strengthened by the country's federalism and the principles of subsidiarity and self-regulation. Together, these factors have guaranteed room for a variety of co-existing hospital ownership types. In Germany, ideological disputes over for-profit hospital ownership are resolved at the state and local levels, and less at the federal level. The federal government structures this arena to a certain extent, but is not a decisive actor on the issue of hospital ownership.

The initial business model for the for-profit hospital sector was shaped by the needs of private patients as well as the split between inpatient and outpatient care. These features guaranteed a place for for-profit hospitals, but they also meant that for-profit hospitals remained a niche in the acute care sector as a whole.

An analysis that goes further than the explanation of this niche needs to take account of the way in which capital funding is arranged. Capital funding, so important for the development of the for-profit sector, is rooted in the country's federal structure[207]. The changes in the growth path of the for-profit hospital sector demonstrate the importance of the way capital institutions function. For many years, the for-profit sector lacked access to sources of public capital and without this, it was not possible to operate a hospital above a certain scale of operations. The prospects for for-profit hospitals improved when these public capital subsidies became restricted as a result of increasing fiscal pressures, and when these funds also became available to for-profit hospitals.

These two trends have gradually evolved during the past three decades. Other types of ownership, most notably public hospitals, could not handle the challenges of increasing restrictions on public resources. The privatization of public hospital assets became one way of supporting these clinics with the necessary capital, and also freed local authorities of the strain they were putting on their budgets. The for-profit hospital sector flourished because public hospitals were underfunded and for-profits were able to capitalize on their greater investment autonomy. Nev-

ertheless, at the local level, privatization was often the subject of intense debate. The interests of the unions often conflicted with those of local government. Generally speaking, it was only in cases where local governments were short of money that for-profit hospitals became a feasible option.

Historical events played an especially important role in the German case. Two world wars decimated the assets of hospitals, most notably those of proprietary hospitals. German reunification certainly stimulated rapid growth among for-profit hospitals. In the Eastern states, new right-wing governments were strongly in favor of for-profit hospital ownership. They were supported by the federal government, which had the task of creating a market economy from scratch. Both could fall back on large amounts of capital to build up the new states and create a new hospital infrastructure. Currently, only a handful of for-profit hospital companies account for over one-third of the hospital sector in the Eastern states.

The momentum towards the privatization of public hospitals continues. However, the future prospects of the for-profit hospital sector may be less favorable for three reasons. 1) Easing the split between inpatient and outpatient care may confront them with competition from physician-entrepreneurs. 2) Most 'low-hanging fruit' – cases with an easy turnaround – may have been largely acquired already. For-profit hospital groups are now also increasingly being 'forced' to acquire large maximum-care clinics, which increases their risk. 3) Prospective capital payments may not only create a level playing field of access to public capital subsidies, but also increase the investment autonomy of the other types of ownership, which may be even more important.

## Appendix 4.1: For-profit rehabilitation and preventive care

The for-profit hospital sector has long been linked with for-profit rehabilitation, preventive care, and spa-treatment clinics. Statutory health insurance covers medical rehabilitation, while pension schemes fund for most preventive care. During the 1950s, 1960s, and 1970s, the declining market share of for-profit acute healthcare was partly offset by growth in the number of for-profit rehabilitation and preventive clinics. This created new business opportunities.

Table 4.11 illustrates that the total for-profit hospital sector diversified. After the mid 1950s, acute hospital care has become less important within the for-profit sector as a whole. The number of spa and rehabilitation beds increased. Spa clinics were mostly situated in the south of Germany. Some of these rehabilitation and preventive clinics eventually expanded to acute care when prospects gradually improved during the 1980s and 1990s.

Wittgensteiner Kliniken (Fresenius-Vamed) was founded in 1952 as a clinic for preventive treatments (spa). In 1981, it expanded into medical rehabilitation and later still into acute hospital care too. Damp, SRH, Rhön-Klinikum, and Asklepios all started as rehabilitation companies. They only entered the hospital market when opportunities in that area of health care increased. Most for-profit hospital groups still combine acute care with (medical) rehabilitation. However, after 1989, acute care formed the bulk of their services.

In 2006, for-profit providers had more than two-thirds of the seven billion euro rehabilitation and preventive care markets (table 4.12)[209]. For-profit clinics domi-

**Table 4.11: Acute care as part of total private health care[208]**

| | # For-profit acute care clinics | Acute care beds in for-profit sector (%) | Spa beds in for-profit sector (%) | For-profit beds in total acute care (%) |
|---|---|---|---|---|
| 1959 | 423 | 70.9 | 20.7 | 7.8 |
| 1969 | 493 | 32.6 | 48.9 | 4.2 |
| 1979 | 372 | 21.2 | 55.6 | 3.9 |
| 1989 | 273 | 16.4 | 44.1 | 3.8 |

**Table 4.12: Ownership types of rehabilitation and preventive care[211]**

| | 1992 | 1997 | 2002 | 2006 |
|---|---|---|---|---|
| Total preventive and rehabilitation beds | 149,909 | 188,869 | 184,635 | 173,000 |
| % Public | 21.4 | 15.3 | 16.8 | 17.2 |
| % Nonprofit | 15.0 | 16.0 | 16.4 | 16.0 |
| % For-profit | 63.5 | 68.7 | 66.7 | 66.8 |

nate the rehabilitation market (72% of all beds) but play a less significant role in preventive care (46% of all beds).

In the mid 1990s, the government started to introduce policies to reduce the utilization and spending of rehabilitation and preventive care. The average length-of-stay for rehabilitation benefits was reduced from four to three weeks, co-payments doubled, and in 1996, the minimum time lag between two preventive treatments was increased from three to four years. The rehabilitation budget of the public pension fund was decreased by two billion euro. These measures hit the sector hard. Besides this, new outpatient disease-management programs threatened certain aspects of medical rehabilitation, such as cardiology and internal medicine. Only mental health and neurology programs are still expanding.

Acute hospital care and medical rehabilitation are becoming increasing intertwined through falling demand for stand-alone rehabilitation and an increasing demand for rehabilitation linked to acute treatment. The latter increased from sixteen percent (1993) to thirty-five percent (2000) and was supported by legislation encouraging disease management[210]. Some for-profit hospital groups (Mediclin, Humaine, Damp) saw the combination of acute care and rehabilitation as their preferred business model.

# 5 The Netherlands: the non-emergence of for-profits

## 5.1 Introduction

For-profit hospitals do not operate in the Netherlands. However, in late 2006 a group of investors 'rescued' a troubled hospital, and two years later another private company also bought a struggling hospital. The authorities only allowed these transactions provided that any profits would not be distributed to shareholders, and that no assets would be sold without official approval. The central purpose of this chapter is to explain why there is no for-profit hospital sector in the Netherlands. This chapter contains a historical section (section 5.2) and an analytical section (section 5.3).

I will turn first to the situation before World War II when, in contrast to most other countries, a proprietary hospital sector did not emerge (section 5.2.1). Section 5.2.2 describes government policies between the 1950s and early 1980s – policies which reinforced the exclusion of for-profit providers. Section 5.2.3 describes how the Netherlands handled rapidly rising health care costs. During the 1980s and 1990s, the smooth introduction of for-profit ambulatory surgery centers was blocked (appendix 5.1). Section 5.2.4 describes how recent market reforms, from 2006 and onwards, have affected hospital ownership.

In the analytical section, I will first explore why a proprietary hospital sector did not develop (section 5.3.1), and then analyze how institutions and regulations also prevented the development of any for-profit hospital sector after World War II (section 5.3.2). In section 5.3.3, the role of this institutional framework in excluding for-profits comes to the fore. Section 5.3.4 analyzes the pre-structuring that is currently underway for the possible lift on the exclusion of for-profit hospitals. This chapter ends with my conclusions (section 5.3.5).

## 5.2 Historical description

### 5.2.1 The exclusion of a proprietary hospital sector

In contrast to many other countries, a proprietary hospital sector did not develop in the Netherlands. In 1951, Andries Querido, an influential public health expert

and social democratic member of parliament, expressed a widely held sentiment when he stated that: 'there is one essential objection to proprietary nursing homes: they seek a profit. This stands in the way of an adequate relation between a patient and the way he is nursed. If the current shortage of public and nonprofit nursing beds changes these providers will either decline or disappear'[1]. In other words, if the necessary capital funds were available, other forms of ownership would easily dominate proprietary providers, as had been the case in the hospital sector for a long time.

In 1840, there were some fifty hospitals in the Netherlands and many more were built during the late nineteenth and early twentieth centuries. The hospital sector consisted of three categories of providers: 1) some small cottage hospitals; 2) public hospitals, with a closed medical staff; 3) nonprofit hospitals, generally with religious affiliations and an open medical staff. The strongest growth was among religious providers, most notably Catholic institutions. This trend ran parallel to the empowerment of the Catholic denomination after the formal admittance of a Roman hierarchy (1853).

Table 5.1 illustrates that religious hospitals were the main ownership type by the early decades of the twentieth century. In 1918, smaller facilities were discouraged after the association of physicians concluded that, for reasons of medical quality, a hospital was not viable with less than a hundred beds[2]. This seems to be one of the root causes of the comparatively large scale of the Dutch hospital sector[3]. The remaining cottage hospitals diminished and specialty facilities remained rather uncommon[4].

**Table 5.1: Number of hospitals by province (1924)[5]**

| | Public hospitals | Nonprofit (religious) hospitals |
|---|---|---|
| Groningen | 1 | 4 |
| Friesland | 2 | 8 |
| Drenthe | 1 | 3 |
| Overijssel | 2 | 16 |
| Gelderland | 2 | 35 |
| Utrecht | 4 | 10 |
| North Holland | 10 | 31 |
| South Holland | 12 | 35 |
| Zeeland | 4 | 7 |
| North Brabant | 1 | 58 |
| Limburg | 1 | 14 |
| Total | 40 | 221 |

*How was the hospital sector funded?*

Hospitals were funded in a number of ways. Richer people were charged above full costs; the (lower) middle classes paid through sickness funds[6], hospital savings associations and commercial insurance; the municipalities paid for the poor and the lower classes[7]. Income thresholds excluded richer people from becoming sickness fund subscribers. Due to the strong grip of the physicians on the sickness funds, this income threshold was enforceable.

The system was nevertheless dependent on a delicate financial balance. If many lucrative patients chose to be treated by certain providers, this had a knock-on effect elsewhere with less scope for below-cost treatment[8]. Below-cost treatment was built into the system because many people were uninsured and both the sickness funds and commercial insurers paid below costs, especially for hospital treatments[9]. Hospitals were dependent on a complicated reimbursement structure with many third-party payers, extensive cross-subsidization, and voluntary donations[10].

The more prosperous patients were clearly overrepresented in the nonprofit hospitals. Generally, the richer patients that visited such hospitals had separate rooms and paid comparatively high charges. Nonprofit hospitals operated separate wards on the basis of class. Nevertheless – with a few exceptions in the capital city, Amsterdam[11] – both rich and poor alike were treated within the same hospital facility[12].

Religious hospitals were the first to upgrade to 'modern' hospitals[13], which was indicative of their better access to capital. The necessary capital was raised through voluntary donations (nonprofit facilities) or through taxes (public hospitals). It is important to note that until the late 1950s the Netherlands was one of the most unequal societies in the Western world[14], which probably increased the supply of philanthropy and endowments. Capital costs were not calculated in *per diem* charges and hospitals also lacked an administration that included depreciation expenditures[15].

Most hospitals were not able to make a positive return. The deficit of the public hospital sector grew from five million guilders in 1916 to twelve million guilders in 1920; nonprofit hospitals fared better, their collective deficit was only two million guilders[16]. Due to free voluntary capital and cheap labor from religious orders, nonprofits could operate with a lower cost base. Municipalities had to finance the growing deficits of both nonprofit and, especially, public hospitals and any subsidies were strictly cost-based[17].

During the recession of the 1930s, many municipalities sought to shift costs towards the nonprofit hospitals[18]. At the same time, many patients and subscribers could not pay their hospital bills or insurance contributions. The central government sought a solution in the reduction of hospital expenses. The Frederiks Committee proposed that all those wanting to build hospitals needed legislative

permission from central government. Nonprofit hospitals responded by complying with these proposals – when their representative bodies could decide on how to implement this policy[19]. However, in the end none of the Committee's proposals were implemented. In 1939, the government chose to regulate consumer prices directly and hospital services were included.

*Hospital-physician relations*
Public hospitals often operated with a closed medical staff. In most nonprofit hospitals, ambulatory physicians were initially allowed to treat their patients. Since administrators favored a more closed-staff model for reasons of efficiency and smooth management, the limitations on ambulatory physicians grew somewhat stronger over time. Nevertheless, physicians were not forced to set up their own proprietary facilities in order to access prosperous patients. The need for small facilities in the countryside was also relatively low in a small and densely populated country such as the Netherlands.

For physicians, the case for proprietary ownership was undermined in yet another way. As early as 1912, access to specialist care was regulated by a gatekeeper system. This was an effort to protect the income of primary care doctors, who dominated the physicians' association[20]. They were successful in enforcing these policies, because the physicians' association controlled a significant part of the insurance market through their own sickness funds. Such doctors' funds had no interest in a proprietary hospital sector since this could have hit the income of physicians.

### 5.2.2 The government accommodates the nonprofit hospital sector

In 1941, new compulsory health insurance for sixty percent of the population was evidence of growing government influence. The German occupier propagated some strong statist elements within the existing corporatist system. The sickness funds had comparatively little room for maneuver. This mix of corporate and statist elements continues to dominate Dutch health care to this day. After World War II, the government continued to regulate *per diem* hospital rates on the basis of the Price Enforcement and Stockpiling Act (1939) since the economic situation required a restrictive policy on hospital expenditure.

However, there were large differences in the costs of individual hospitals. In response to this situation, *per diem* rates became tailored to some extent and increased on a case-by-case approach. Uniform increases were thought to reward low-cost facilities with a surplus while, at the same time, high-cost facilities needed even higher rates to continue operating[21]. This legacy of tailored funding was to remain an element of future policy-making. As Louis Groot, founder of Dutch

hospital economics, stated: 'not every possible solution to the problem of hospital reimbursement fits into current practice. This necessarily reduces the range of possible policies, which is a good thing since it is of the utmost importance to maintain effective practices'[22].

However, central government was unable to handle all the red tape that accompanied the detailed planning of the finances of individual hospitals. Government was also caught between the diverging interests of hospitals and insurers. Hospitals faced rising costs due to new technological developments and rapidly declining charity income. As a consequence, actual *per diem* rates were too low. Future increases were often backdated, which led to much irritation among the sickness funds[23].

In 1954, the government first asked the representative bodies of providers and sickness funds to consult each other, before the government settled the final rates. The fact that these bodies represented nonprofit organizations increased the level of mutual trust[24]. It was generally believed that nonprofit providers were able to deliver their services at low costs[25]. It was also held that it made no sense to negotiate at a local level since there were no profit margins to disturb[26]. Nevertheless, at the national level, the negotiating process between the representative bodies of hospitals and sickness funds resulted in a yearly increase that could differ between individual hospitals.

In 1965, the Act on Hospital Tariffs enhanced the power of the nonprofit sector. The Agency of Hospital Remuneration (AHR), a corporatist body including nonprofit providers, sickness funds, and indemnity insurers, with only little government influence, was created. Its task was to calculate how much hospitals were allowed to charge for their services. The agency started out under bright economic circumstances. The mechanisms they developed to calculate hospital rates supported nonprofit provision. Hospital rates were calculated on an individual basis. Hospitals received tailored funding that – importantly – included all of their actual capital expenditure. Only hospitals with a certificate-of-need could charge for their capital costs, and only those that could charge for capital costs were entitled to calculate the *per diem* rates to cover the remaining costs. The AHR calculated special rates for all kinds of hospital services. All such calculations tended to add up to the actual expenses of individual hospitals[27].

However, returns on capital were not reimbursed. Increasing surpluses or making profits was not considered expedient: 'increasing production would mean more surpluses, which violates either the nonprofit principle, or could be used to incur expenses that are not in line with national directives'[28]. Hospital buildings were amortized on a historical basis over fifty years[29]. The depreciation calculated was far too small to cover replacements. Increasingly, hospitals took out long-term

debt to fund their construction plans, while traditional up-front payments ended. Interest on any equity supplied was not reimbursed[30]. Because investment could be entirely financed by reimbursable debt, this was not a significant problem for the nonprofit hospitals[31]. These ownership types were now permitted to hold low levels of equity – about five percent of their balance sheet, which was needed to compensate a possible current deficit[32]. A high level of solvency was not necessary to gain access to capital[33]. Such directives were not adequate for commercial investors; indeed, many stakeholders thought that a more market-based funding model, such as prospective capital reimbursement, would make hospital administrators too dependent on investors and capital markets[34].

*Hospital planning*

Initially, hospital construction depended on charitable donations or subsidies from municipalities. After the war, the rapid disappearance of voluntary funding meant that public financing gained in importance[35]. In 1946, a national building plan allocated only scarce means for hospital construction[36]. The government opted for an individualized approach and approved projects on a case-by-case basis. Prospective funding for hospital construction was not only much too expensive, it was also thought to violate the nonprofit principle – the debt-equity ratio would change in favor of the latter, implying a 'profit' on equity[37].

In comparison with other countries, the access to and funding of capital was clarified early. Essentially, total debt financing took place on the private markets under the shield of public credit enhancement programs and guaranteed amortization through regulated and tailored rates. As a result, hospital rates – even within a single city – differed substantially[38]. In 1949, the central government decided that it would subsidize all interest and depreciation expenditure, insofar as these costs were above the increase in the general cost of living[39]. If hospitals wanted to claim these funds, they first had to obtain government approval for their construction plans; only the actual deficits in such plans were subsidized. Credit enhancement (guaranteed loans) through the government was introduced in 1958[40]. From a hospitals' perspective, capital was free. Strong economic growth and the liberal attitude of the municipalities (who no longer had to contribute financially to hospital construction) when issuing building permits stimulated a construction boom. The sums spent on hospital construction increased from 150 million guilders in 1965 to around 400 million guilders only two years later[41].

The government responded to this growth with more centralized planning regulations. In 1971, the Hospital Facilities Act brought in a national plan – and later regional, plans – for hospital capacity. It soon turned out that this opened a window of opportunity for cost containment through restrictive planning requirements. In 1975, budgetary caps were put in place, which implied the temporization of most

construction activity. Planning requirements turned out to be the most effective way of curbing upgrades in smaller hospitals. The Agency for Hospital Planning proposed the closure of hospitals with fewer than 250 beds, or 450 beds in the large cities, to achieve efficiencies of scale. A large number of smaller hospitals closed or merged with other facilities. During the 1970s, many public hospitals converted to nonprofit status and eventually secular nonprofit foundations came to monopolize hospital ownership.

The Hospital Provision Act contained an important innovation regarding for-profit hospitals. The business model of for-profit hospitals was already unfeasible in the Netherlands, but, with no for-profit sector to protest, this absence was now formalized in law: article 10 of the Hospital Provision Act stated that only public and nonprofit providers could be granted licenses to build hospitals. This provision was added in response to the parliamentary debate on a preliminary draft of the act[42]. Thus, a legal barrier to for-profit hospital ownership was created. Only conversions to for-profit ownership as well as to exploit a for-profit hospital without any public or social insurance funding remained possible. However, this seemed to be a purely theoretical exception at the time.

*Health insurers and physicians have no interest in the existence of for-profit hospitals*

Around seventy percent of the population was covered by social insurance. In 1941, German reforms implied the centralization of decision-making powers[43] and sickness funds became corporations under public law[44]. Over the years, the regulations on obligatory insurance, hospital funding, and hospital planning came to form a tightly knit legal triangle, linking the interests of the sickness funds to the public and nonprofit hospitals. Sickness funds were reluctant to contract any outsiders, as appendix 5.1 illustrates for the ambulatory surgery centers.

Private indemnity insurers, consisting partly of mutual companies and partly of for-profits, enrolled the wealthiest thirty percent of the market. Although these companies held much more discretionary powers than the sickness funds, they did not, as for example in the UK and to a lesser extent in Germany, help to build up a for-profit sector. Nonprofit hospitals already had a tradition of delivering amenities geared to the more affluent clientele. During the 1950s, indemnity claims were as much as fifty percent above sickness fund rates[45]: these private rates were critical to the funding of the hospitals and the self-employed physicians inside those facilities. As a result, private patients were well taken care of within the existing system and a for-profit sector was not needed. Increasingly, indemnity insurers participated in the existing structure of corporatist governance. Moreover, the sickness funds formed private subsidiaries for any of their clients who were over the income-threshold – purely private indemnity insurers entered into long-term decline.

Neither did physicians need for-profit facilities. The nonprofit hospital as a physician's cooperative, Pauly and Redisch's hypothesis, seemed well established. During the 1960s, physicians formed specialty-specific partnerships. These partnerships operated as virtual monopolies; they were the most powerful force in any hospital. Most specialists affiliated with only one hospital. Generally, specialists do not pay a fee for the use of hospital services, which they were supposed to do prior to 1960 when they worked at arm's length from hospitals[46]. Self-employed hospital doctors obtain high fee-for-service payments; they effectively influence the allocation of most of the hospital's surpluses and budgets. Physicians thus had little to gain from a hospital converting to for-profit ownership. On the contrary, for-profit ownership implies additional competition for hospital surpluses from investors and could have led to a loss of autonomy for physicians.

### 5.2.3 Cost-containment and pre-structuring managed competition

During the 1960s and 1970s, health care costs increased rapidly. The government focused on cost-containment measures as their central policy goal and global budgets were introduced as the core of these policies. However, these policies did not create room for for-profit ownership. The existing institutions were very effective in preventing any efforts in that direction, as became clear when physician-entrepreneurs started to develop for-profit ambulatory surgery centers (appendix 5.1). It was not possible to mediate for-profit hospital ownership. This could only have happened through a fundamental redevelopment. Managed competition became the shared 'mental' model for the future of health care governance.

*Developments in hospital funding and planning*

In 1983, hospitals were paid a global budget based mainly on their adjusted historical levels of expenditure. Physicians continued to be reimbursed on a fee-for-service basis. To ensure the necessary liquidity, the existing methods and procedures to gain remuneration stayed intact. Three underlying features remained important regarding the prohibition of for-profit hospital care. 1) Capital costs continued to be calculated separately for each individual hospital and were added to the *per diem* rates. There were no calculated returns on capital. 2) The rates calculated for outpatient treatment were very low and covered only the marginal costs. 3) Sickness funds were not allowed to do business with any potential for-profit providers, and in any case had no interest in doing so. Additional for-profit reimbursements would only add to the obligatory funding of existing hospitals, rather than replacing for these costs.

Cost-containment also dominated planning regulations. Certificate-of-need procedures were used to stimulate mergers and cut the number of hospital beds.

This 'forced' reduction in the number of hospital beds was a policy that lasted well into the 1990s. Once plans to build or to redevelop a facility had been approved, the hospital had to wait until the necessary funding was available, which sometimes meant a considerable wait.

*Physicians: initiators of the first for-profit experiments*

Medical specialists were firmly embedded in the nonprofit hospitals, which acted as physicians cooperatives. During the 1980s, new technology made it possible for physicians to establish ambulatory surgery centers. With limited capital investments, many elective treatments could be positioned outside the hospital. In the mid 1980s, the emergence of for-profit ASCs sparked the first broader discussion of for-profit ownership in health care. The government was of the opinion that hospital planning regulations prohibited such centers. Most hospitals saw ASCs as potential competitors and accused them of cherry-picking.

However, in 1990, the high Court decided that ASCs did not count as hospitals and were therefore not subject to planning regulations. As a consequence, the government decided to allow their existence in a legal 'twilight zone'. However, this did not pave the way for broader for-profit ownership among health care providers. The fact that ASCs could only charge for outpatient rates, which were too low to cover their costs, put their business model under severe pressure. It was not until 1998 that a court ruled that the existing reimbursement differences between ASCs and the hospitals were unfair and illegal. The potential for ASCs to help in solving the problem of growing waiting lists also meant that they were seen in a more favorable light. Gradual institutional adjustments meant that they became more widespread, although the formal prohibition on for-profit ownership was not lifted. In 2006, ASCs still accounted for less than one percent of acute care turnover. Appendix 5.1 discusses the history of for-profit ASCs.

*The development of a new 'policy stream': managed competition*

In 1987, the Dekker Committee proposed universal insurance and managed competition as the cornerstones of a new way of organizing health care in the Netherlands. Its recommendations were based mainly on the ideas of Alan Enthoven. The Committee proposed mandatory health insurance with open enrolment to cover for around eighty-five percent of total health care benefits. This would end the split between sickness funds and private indemnity insurers[47]. The Dekker Committee proposed a model of regulated competition to encourage efficiency. This model was based mainly on risk-adjusted capitation and community rating for the insurers; the funding of hospital services was to be based on output, as well as selective contracting by the insurers of health care providers; price setting and planning regulations could be liberalized.

However, efforts to implement the Dekker proposals and realize a national insurance scheme failed due to opposition from employers, private health insurers, and rightwing politicians. At the time, the 'technical requirements' of the regulated competition model were not available either. In 1993, the Christian Democrats blocked the reforms and closed the window of opportunity that the proposals had created, although the work on the necessary 'technical requirements' continued.

The Dekker Committee had given rise to an alternative 'policy stream' that exerted increasing influence on policy adjustments throughout the 1990s. Thinking about the health care sector in terms of (regulated) markets, products, and consumers became more common[48]. Together with the negative and visible effects of cost-containment policies in the form of waiting lists, this effectively pre-structured the more successful reforms of 2006[49]. Although the Dekker proposals were far-reaching, for-profit hospital ownership was not included explicitly[50]. Despite a new and more positive attitude towards markets, for-profit hospitals remained controversial.

### 5.2.4 Prelude towards for-profit hospital ownership?

During the mid 1990s, cost-containment policies reached their peak. Most cost-containment incentives discouraged treatments and the waiting lists that they gave rise to became a significant political issue. With quite some of the technical prerequisites now available, managed competition became a feasible way of addressing waiting lists and stimulating efficiency. A new right-wing government made mandatory health insurance a top priority. As from January 1st 2006, for-profit or nonprofit health insurers were able to compete to enroll policyholders in a community rated system. Planning and pricing regulations were reformed to accommodate greater liberalization and competition. Hospital prices could be freely negotiated for ten (2005), twenty (2008), and thirty-four (2009) percent of turnover.

Such adjustments seem to be paving the way for a more fundamental shift towards for-profit care. Increasingly, profit incentives were viewed as a useful way of encouraging efficiency. The ideas about the role of profits in health care clearly changed. However, any for-profit hospital had to be integrated into a carefully constructed and sophisticated institutional framework, which formally continues to reject for-profit ownership. From the late 1990s onwards, nonprofit hospitals started to experiment with for-profit subsidiaries. More importantly still, in 2006 and again in 2008 two for-profit companies entered the hospital sector. However, possibly in anticipation of a later acceptance of their profit motivation, they committed themselves to not distributing any of their profits to shareholders for the time being.

*Nonprofit hospitals try to bypass budget constrains*

Waiting lists and a general scarcity of resources led to propose for a system of priority care. Patients would pay additional charges for treatment during out-of-office hours in order to bypass waiting lists. Employers that funded such experiments might see sick employees return to work sooner[51]. Since only spare capacity was used, it was said that the interests of regular patients would not be hurt. Proponents stated that such initiatives served as 'Robin Hoods', raising additional revenue to deliver hospital services to those in need[52].

However, the idea of priority care met with fierce resistance in parliament. In 1998, a large political majority viewed them as unfair and forced the minister to abandon such experiments[53]. Nevertheless, nonprofit hospitals with ambitions for for-profit subsidiaries soon had another chance. In 2003, many of the remaining bans on ASCs were lifted. In 2006, ASCs were permitted to provide overnight stays for ten percent of hospital procedures. Many hospitals decided to establish ASCs as subsidiaries[54]. They did so for various reasons: 1) to bypass any existing budget constraints; 2) to hinder possible new competitors; 3) to satisfy physicians, who wanted to see patients in such a clinic for additional revenues. However, ASC turnover is still estimated at less than one percent of the total hospital market[55].

*Anticipating an end to the exclusion of for-profit hospitals*

Gradually, for-profit hospital ownership became more fashionable[56]. Many newspapers and magazines ran reports on what they claimed was the success of German for-profit hospital chains, most notably Rhön-Klinikum. Scholars were heartened by the positive effects of for-profit ownership that had been reported in international literature[57]. The health department now took action on the issue; it prepared new planning regulations to support the market reforms.

Both the Council for Public Health and Health Care and the High Court viewed the formal prohibition of all for-profit hospital ownership as obsolete[58]. The High Court did not see how the prohibition could fit in with the new market reforms that the government was seeking. It also saw incompatibilities with EU legislation since it blocked the access of foreign (hospital) companies to the Dutch market[59]. The Council for Public Health and Health Care stated that the universal prohibition on for-profit hospitals was not always in the best interest of the public.

At the time, this might have seemed to settle the dispute[60]. The new planning legislation pre-structured a possible lift on the prohibition of for-profit hospitals. For-profit providers would get access to the market if their facility belonged to a category of providers, which were permitted to operate on a for-profit basis. Although the government did not actually name any such category, this was a significant policy shift[61].

In 2005, the government stated in a white paper that it was prepared to lift the ban on for-profit hospitals by 2012 at the latest. It saw this as the logical consequence of a new prospective payment system to fund hospital capital[62]. In anticipation of a formal lift of the ban on for-profit ownership, the minister of health stated that a hospital would be permitted to become a private company, provided it did not pay any dividend to investors[63]. In 2007, the government searched for any market barriers to foreign for-profit hospital chains[64]. In June 2008, the Healthcare Authority was supportive of an experiment with hospitals that were allowed to pay dividends to investors. They were of the opinion that this would encourage efficiency with limited risk to the public interest[65].

It seemed that there was only one more hurdle to jump. The government states that the value of hospital assets, supposedly with the exception of goodwill, may not 'leak' into the hands of private investors[66]. However, in early 2009 the government lost a case brought to court by the providers on this issue. In June 2009, the government stated that strict conditions would be attached to any for-profit ownership. Property rights would be limited to the supply of equity and a risk-related reimbursement for this capital, in a proposal that clearly distanced itself from the 2005 white paper.

The signals made entrepreneurs eager to anticipate the possible end to the prohibition on for-profit hospitals. In 2004, a first step was taken by Mr. Sturkenboom, he founded a consortium with the aim of starting a small hospital chain. However, they received a lukewarm response from the hospitals they targeted and their efforts came to nothing.

In late 2006, the financially distressed Slotervaart hospital in Amsterdam was the first to be bought by investors. Meromi Holding, a real estate company, bought the hospital after a nonprofit consortium of two housing trusts and a long-term care provider retracted its offer after it had already been accepted. The deal was approved in December 2006, under the condition that Meromi would not distribute any profits or sell any assets without prior approval. In its first year as owner of the hospital, Meromi transformed a €4.7 million deficit in a surplus of €6.5 million; however, in 2008 the hospital stated in its annual report that the surplus had decreased to €1.8 million.

In March 2008, the MC Group, a chain of diagnostic clinics, expressed an interest in a local hospital in Weert. In late 2008, in a highly publicized deal, the MC Group bought two distressed hospitals in Lelystad and Emmeloord. To avoid a bankruptcy, the central government supported this bailout with additional means of up to €20 million while the MC group invested some €5 million[67]. Currently, other investors also seem interested in acquiring a stake in the hospital market[68].

## 5.3 Analysis

This section analyzes why no for-profit hospital sector was able to develop in the Netherlands. Section 5.3.1 will look at the early prospects for proprietary hospitals and how good access to voluntary and public resources meant that there was no need for investor capital. Section 5.3.2 analyzes how this situation was prolonged after World War II with government help. The government created an institutional framework that supported nonprofit hospitals effectively and kept any for-profit hospitals out of the mainstream health system. By the mid 1980s, this had resulted in institutional barriers to any for-profit providers that were almost insurmountable, as demonstrated by the high barriers to ASCs. Severe cost-containment policies did not alter the groundwork of this model (section 5.3.3). Section 5.3.4 analyzes why the reforms of 2006 seemed to alter the prospects for for-profit hospitals. The chapter then ends with my conclusions.

### 5.3.1 Insurmountable barriers to proprietary hospitals

Before World War II, nonprofit hospitals were much more competitive than public hospitals. Public hospitals could tap fiscal resources but posed a minimal threat to the proprietary business model because of their focus on poorer patients. Strong voluntary movements gave nonprofit hospitals a significant advantage, partly a result of 'competition' between the different denominations. Nonprofits had access to cheap capital and relied on cheap but comparatively good labor from religious orders[69]. Nonprofit hospitals also treated most of the prosperous patients. Well-to-do patients could receive good quality treatment and amenities in nonprofit hospitals of their own denomination. They did not seek treatment in separate, class-based proprietary hospitals. In short, the expected returns on equity investment were negative and nonprofits had so many competitive advantages that the entry of for-profit hospitals into the market was not feasible.

Additionally, physicians felt no need to start up their own proprietary hospitals for the following reasons. 1) They already had a great deal of autonomy and could control the hospital without bearing any investment risk. 2) Nonprofit hospitals offered broad access due to non-exclusivity (open medical staffs). Physicians were well-paid and treated with great respect. 3) The lack of hospital access did not threaten the income of the large number of family doctors so much. The profession created a gatekeeper system to ease income-related disputes between family practitioners and medical specialists. They could enforce such a system via the dominant position of physician-affiliated sickness funds.

Actually, none of the major stakeholders needed a substantial proprietary hospital sector. The nonprofit hospitals were the preferred workshop of the physicians.

Local authorities did not encourage proprietary facilities because these could have been competition for their own facilities. Prosperous patients did not need proprietary hospitals because of the well-developed amenities of nonprofit facilities. Finally, investors were not interested in establishing proprietary clinics because there was no way of obtaining a stable return on their investment.

### 5.3.2 Institutional barriers replace the barriers of the market

Proprietary hospitals did not exist when the central government entered the health care arena. For-profit interests were therefore not represented in the mix of corporatist and public institutions that were created for hospital governance. In the Netherlands, the dominant structural interests supported nonprofit provision and were not challenged[70]. Although the central government acted as a fiscal guardian, the hospital sector had the autonomy to influence budgetary policies and remuneration procedures to a considerable extent. New public institutions reinforced the dominance of the nonprofit providers.

From the perspective of these nonprofit providers, this was necessary because the availability of voluntary resources diminished after World War II. However, this did not pave the way for for-profit providers for the following reasons. 1) Voluntary capital was replaced by 'public' capital at no cost, exclusively guaranteed for nonprofit and public (municipal) hospitals. Investor capital was unnecessary and since there were no for-profit hospitals, there was no need for the new regulations to accommodate such providers. 2) Social and private health insurers met capital costs through a specific add-on to the regulated *per diem* rates (no dual financing as in Germany). This protected capital expenditure against other expenditure categories. Capital expenditures were masked and accommodated by regular adjustments in the *per diem* rates and not exposed to other political needs. 3) In 1971, the Hospital Facilities Act (WZV) excluded for-profit hospitals from being granted any certificate of need and from obtaining any reimbursement from social health insurance (sickness funds). The appropriation of the building costs was to be mediated through corporatist mechanisms on a case-by-case basis that accommodated historical peculiarities.

In fact, what happened was that the government took over any increasing monetary risks from nonprofit hospitals. Reimbursement was structured according to the principle that there was no room for profit or any return on invested capital. This seemed to pre-structure the formal prohibition of for-profit hospital ownership. Physician interests were still helped by such a nonprofit system, since these hospitals acted as physicians' cooperatives. Both providers and payers helped to build an institutional framework that would prove to be very difficult to dismantle

to any for-profit entrants. The planning of hospital capacity was linked to the reimbursement of hospital services and access to social insurance funding.

In this system, there was no room for for-profit hospitals: they could not received a certificate-of-need, nor access any publicly guaranteed 'free' capital, nor could they levy any *per diem* charges because these included capital reimbursements, and nor could for-profits enter into contracts with the sickness funds. Theoretically, private indemnity insurers could contract for-profit hospitals, which was in any case against their interest as they too increasingly were reliant on the existing mode of governance. Additionally, there were no waiting list to bypass and the quality of nonprofit hospitals was supposedly adequate. From the 1950s to the 1970s, legal and institutional barriers gradually replaced the constraints of the market place. In practice, they seemed to constitute a virtually insurmountable barrier to the establishment of for-profit hospitals.

### 5.3.3 Cost-containment policies consolidate the dominance of nonprofits

Throughout the 1980s and 1990s, the robust institutions that were blocking for-profit hospitals remained intact. There was a political and institutional gridlock on the issue of for-profit hospital care. Initially, cost-containment measures further weakened the business case for for-profit hospitals. The introduction of global hospital budgeting reduced any underlying prospects for an attractive return on investment. This created an incentive for the hospital to do less and for the doctor to do more; additional services were not reimbursed and the monetary interests of hospitals were contrary to those of physicians; both counteract a profitable business model.

Nevertheless, the discussion on for-profit hospital ownership gradually grew in prominence. Entrepreneurial physicians wanted to set up ambulatory surgery centers. During the same period, managed competition emerged as the new policy paradigm, though – remarkably – without any formal recommendation of for-profit hospital care[71]. However, the growing physical excess capacity of hospitals that was the result of reductions in the average length of stay, tended to cancel out incentives to reduce the legal entrance barriers to for-profit hospitals. As a result, the reduction of the absolute legal barriers to for-profit hospitals remained limited.

### 5.3.4 Managed competition paving the way for for-profit hospitals?

During the mid 1980s, managed competition emerged as the new paradigm for the future of health care governance. A strong vision of this future developed rapidly and this arguably shaped many of the coming institutional adjustments. Remarkably, the reform proposals went without any explicit statement on for-profit

hospital ownership. In hindsight, it seems that the entry of for-profit hospitals may have been, though unnoticed at the time, the final consequence of this paradigm. The proposals triggered a gradual change in the existing institutional framework with the overarching goal of stimulating competition.

Managed competition finally achieved momentum during the first few years of the new century. Many fundamental regulatory changes were made: 1) due to the introduction of prospective payment and price competition, hospitals were put increasingly at risk, also for capital costs; 2) new entry regulations now seem to anticipate access of for-profit hospitals. Since 2008, a building license is no longer required for hospitals. The increasing financial risk and low solvency position of many hospitals have increased the need for investor capital. For-profit ownership may therefore be the logical final piece of this reformist agenda of managed competition. Two companies have entered the market in anticipation of the lifting of the for-profit ban. The government did not seek to block these developments, but rather supported them. However, political opposition to for-profit hospitals seems to have gained a new lease of life recently, creating more risks for any for-profit entrants.

### 5.3.5 Conclusions

The Netherlands represents the exception to the rule in terms of this study because, even today, there are no for-profit hospitals that disperse dividends. There are consequently no for-profit hospital sector trends to follow and explain. The main reason for the absence of for-profit hospitals seems to date from the initial phase of hospital development, which explains why no proprietary capital was needed in the Netherlands. Physicians were not interested in for-profit medicine until much later, in the 1980s. All institutions and practices were based on the systematic exclusion of for-profit hospitals.

The introduction of managed competition has been based on a more neutral stance on ownership issues. However, the gradual introduction of prospective capital payments is increasing the level of risk in the nonprofit hospital sector. If these nonprofit hospitals cannot manage their new investment autonomy, for-profit hospitals may become more attractive in the eyes of decision makers, but also in the eyes of the investors or shareholders, provided there is a reasonable prospect of a decent return on their investment.

## Appendix 5.1: for-profit ambulatory acute care

In the 1980s, technological developments made it possible to expand day surgery in the outpatient setting. Entrepreneurial physicians sought to apply such technology in freestanding clinics and ambulatory surgery centers. Generally, these new providers were run for profit. Although they were not hospitals facilities, it is relevant to describe their entry into the health care market. They entered the field at about the same time as the Dekker report was changing thinking on health care governance. However, ASCs were not welcomed as an opportunity to test out the proposed market reforms.

*The government tries to prevent any freestanding for-profit clinics*
In 1985, Boerema, a urologist, tried to start a small group of for-profit diagnostic clinics. He had the support of a large chain of department stores. Others followed, mostly in the fields of plastic surgery, eye diseases, dermatology, fertility disorders, and diagnostics. In addition to the profit-making potential, physician autonomy, patient convenience, and patient access to additional services were also reasons to start such projects. In 1990, The National Council for Health Care counted at least thirty-nine clinics[72]. Most were small scale – as late as 2001 an average clinic employed only twelve employees[73].

In 1985, Dick Dees, the right-wing deputy secretary of health, tried to prohibit all for-profit clinics that delivered acute care. It was stated that these clinics should legally be considered hospitals since they were in fact outpatient departments. Thus, according to the Hospital Facilities Act, these clinics needed a license, which, according to the same law, they were not able to obtain[74].

The government sued two clinics, those of Boerema and Valkenhorst, but both lawsuits were won by the for-profit clinics. Appeals followed. In 1990, the highest court decided that since these clinics had no formal or material ties to a hospital, and neither did their patients stay overnight, the government's claim that they needed to comply to the Hospital Facilities Act was not valid. It turned out that the regulations contained a loophole for freestanding for-profit clinics that did not deliver inpatient care[75].

However, there were more problems with the business model of the ASCs. Most freestanding clinics did not receive adequate remuneration to cover their costs, had little access to capital, and received few referrals from other professionals. Many new clinics, like the ambitious Boerema project, therefore went out of business over time. Very few clinics were profitable[76]. However, the lawsuits had put the issue on the political agenda; the government had to determine what to do about the loopholes in legislation on for-profit health care.

*Freestanding for-profit clinics in the twilight zone*

A new centre-left government (1989–1994) adopted a more liberal approach. Health care policies were based on the ideas of the Dekker Committee: regulated competition and universal health insurance. Hans Simons, the social democratic deputy secretary of health care, decided not to close the legal loophole regarding for-profit care. Freestanding clinics were able to compete with hospitals, and, eventually, were considered compatible with the system of regulated competition. For the time being, the clinics were tolerated although regulations on remuneration were used to cap payment rates at only a small amount above the physician's fee[77]. As a result, these clinics were attractive to indemnity insurers,[78] although sickness funds remained hesitant to contract with and reimburse freestanding clinics[79].

The clinics struggled with the low reimbursements; many received negative publicity as a result of illegally high charges for their services[80]. In 1994, Els Borst, the new social-liberal health minister, curbed the range of services the clinics could provide[81]. She wanted them to integrate into the nonprofit hospitals and attacked irregularities in remuneration. On the other hand, after several court proceedings, the clinics were able to improve their remuneration. In 1997, they were allowed to charge seventy, later rising to one hundred, percent of the formal inpatient rates for the same procedure. However, they still could not charge the important *per diem* rates that included capital expenditures[82].

In 1998, the Rule on Freestanding Clinics clarified the ambiguous position of the clinics further. The goal was to legalize current practices, but also to hold down the total number of clinics. To obtain regulatory approval, clinics needed to form alliances with hospitals. More definite arrangements were to be made by the anticipated reform of hospital planning regulations[83]. These clinics would now be allowed to serve patients on social insurance, although the sickness funds were not required to allow them any contracts. Formally, the clinics could not obtain profits from obligatory entitlements and many clinics therefore operated with both nonprofit and for-profit subsidiaries. In 2000, thirty-four clinics with sixty-five medical specialists[84], less than half of the applicants, were officially granted lawful status. A separate trade association represented these clinics, most of which operate in the densely populated West of the country.

Table 5.2 shows that this 'legalization' process left many problems unresolved. In contrast to other (for-profit) sectors, the acute care clinics had considerable problems. Providers in acute care were less content with remuneration, the functioning of the Agency of Health Care Remuneration as well as with the policies of the health insurers. Nevertheless, the clinics were able to increase the number of patients they treated considerably and reduce their debt[85]. In 2001, only ten percent of the freestanding clinics distributed a 'dividend' to shareholders and eighty percent still did not meet adequate solvency standards[86].

**Table 5.2: Experienced constraints by (outpatient) for-profit providers[87]**

| | Acute care | Home care | Mental health |
|---|---|---|---|
| I have many difficulties with the health department | 44% | 40% | 17% |
| I have many difficulties with the agency for remuneration | 56% | 14% | 8% |
| Remuneration regulations are adequate | 32% | 81% | 70% |
| I have many difficulties with the health insurers | 68% | 29% | 25% |

For-profit initiatives in the other sectors were doing better. Between 1994 and 1998, the development of for-profit mental health got a boost from privatization measures in social security. Employers were becoming exposed to increasing financial risks for sick employees and those unable to work. This created an incentive to deter avoidable absenteeism. Since for-profit ownership in occupational health was a less sensitive proposition[88], new mental health clinics were able to spring up. It was estimated that the five largest for-profit providers had a market share of almost fifteen percent[89]. Many traditional providers responded with (for-profit) subsidiaries. In 2005, some for-profit inpatient mental health became possible. Dutch patients could obtain treatment for addiction and eating disorders in the clinics of the Priory Group in the UK[90], which had been bought by the Dutch bank ABN-AMRO a couple of months earlier.

Home care was the primary battlefield over market experiments. In 1994, for-profit home care providers entered the market as a result of another legal loophole[91]. Existing nonprofit providers also hired these new for-profit providers to deliver additional services. Sometimes, such arrangements were attacked because irregular activities were suspected. The growth of for-profit home care was also stimulated by new funding experiments. In 1995, patients could opt to receive a personal budget with which to purchase home care services themselves. Due to regulatory flexibility, inpatient long-term care sometimes can be delivered on an outpatient basis, which allowed for-profit homes to serve the rich elderly[92].

*The government reluctantly supports freestanding clinics*

In 2003, regulations became slightly more accommodating to freestanding clinics. 1) Sickness funds no longer had a say in determining whether for-profit clinics would be granted a certificate-of-need. 2) The existence of waiting lists was no longer a requirement. 3) Clinics no longer needed a cooperative venture with a hospital. On the other hand, for what proved to be a very short time, hospitals

and sickness funds could not participate in freestanding clinics as separate subsidiaries[93].

The implementation of a new system for hospital remuneration appeared highly promising for the clinics. *Per diem* rates would be abolished and substituted by prospective payment rates that were related directly to costs. Diagnosis treatment combinations (DTCs) became the new method of setting payment rates. Freestanding clinics profited as: 1) in 2003, a reimbursement for capital costs was included in their rates[94]; 2) in 2005, ten percent of hospital fees could be freely negotiated with the insurers. Freestanding clinics provided a comparatively much larger proportion of such elective services.

However, some clouds remained on the now much brighter horizon. In June 2003, the Health Inspectorate decided to check the quality of care in the freestanding clinics and concluded that there were severe failures[95]. The report led to some political turmoil, and the clinics were made subject to quality regulations. Quality audits intensified, and in 2004 the Inspector General concluded there had been improvements[96]. The number of clinics had already started to grow – thirty began operating during 2003 and early 2004[97]. Some entrepreneurs set up small chains of three or four clinics. Medinova, the largest chain with five clinics, demonstrated that the business was still risky. In 2003, Medinova went almost bankrupt and was rescued through turnaround management and an additional infusion of funds from its major investors.

In 2006, the special regulation of the freestanding clinics was abolished and they became subject to mainstream regulations. The new insurance legislation created a level playing field by lifting obligatory contracting between insurers and hospitals[98]. However, during the summer of 2006 it turned out that the new outpatient rates had not been correctly calculated and need to be cut. This hit the freestanding clinics because of their less complex workload and lack of budgetary guarantees.

The Dutch Healthcare Authority concluded that the total patient volume of freestanding clinics, although they were growing rapidly, was still less than one percent of total covered hospital care. Even this figure was inflated since many clinics were subsidiaries of nonprofit hospitals. The Dutch Healthcare Authority estimated that fifteen of the approximately one hundred clinics had strong ties to a hospital. They also concluded that their charges were substantially lower than those of hospitals[99]. The agency thus took the opinion that creating more clinics would be in the public interest. They proposed a greater number of freely negotiated rates as the best way to obtain this goal. The Health Inspectorate was also content with the development of the quality of care in the freestanding clinics. In late 2009, they published an optimistic report on the increasing quality of care in these clinics, especially regarding eye care, orthopedics, and plastic and cosmetic surgery[100].

# 6 A comparative and longitudinal analysis of for-profit hospital development

## 6.1 Introduction

This chapter seeks to provide an integrated explanation of the comparative and longitudinal differences and similarities in the development of the for-profit hospital sector. This explanation is based on the analysis of the development of the for-profit hospital sector in the four countries that were studied in the preceding chapters. The chapter starts by describing the quantitative patterns in the growth in the number of for-profit hospital beds. I then summarize the differences and similarities in these patterns for the countries studied. What, on a country-by-country basis, were main reasons for these trends? Three different stages can be recognized that present a preliminary answer to how for-profit hospital ownership has evolved within the four health care systems (section 6.2). However, how can we understand and explain for-profit hospital development over a longer period of time? Why does the development of the for-profit hospitals differ between countries? I structure my analysis to answer these research questions by examining specific questions on the most notable differences and similarities.

Section 6.3 concerns proprietary hospital care. Why did proprietary hospitals win a greater market share in some countries than in others (section 6.3.1)? Why did proprietary hospital care enter a period of long-term decline (section 6.3.2)? Section 6.4 investigates the process of stagnation between the decline of the proprietary sector and the growth of the for-profit hospital sector. What were the factors that halted the decline of the proprietary sector (section 6.4.1)? Did proprietary hospital care pre-structure a for-profit hospital sector, and if so, how (section 6.4.2)? Section 6.5 focuses on the subsequent growth of the for-profit hospital sector. How was strong growth able to re-emerge after such a long period of decline (section 6.5.1)? Why did for-profit hospital growth emerge sooner in some countries than in others (section 6.5.2)? Why did for-profit business models differ in some respects (section 6.5.3)? In section 6.6, I present the most important key determinant of the development of the for-profit hospital sector and present the most powerful constraints on the development of the for-profit hospital sector.

**Table 6.1: Major factors/determinants of the emergence of proprietary hospital care**

| | Impact on proprietary ownership | Nether-lands | UK | Germany | US |
|---|---|---|---|---|---|
| Physician access to hospitals | | | | | |
| Early distinction between GPs and specialists | Yes = negative | Yes | Yes | No | No |
| Early dominance of 'open' staff models | Yes = negative | Yes | Limited | No | No |
| Large share of nonprofit hospitals | Yes = negative | Yes | Limited | Limited | Yes |
| Financial constraints | | | | | |
| Access to capital | No = negative | No | Limited | Limited | Limited |
| Existence of self-pay market | No = negative | Limited | Fair | Fair | Good |
| Possibility to isolate from competition | No = negative | No | Fair | Fair | Fair |

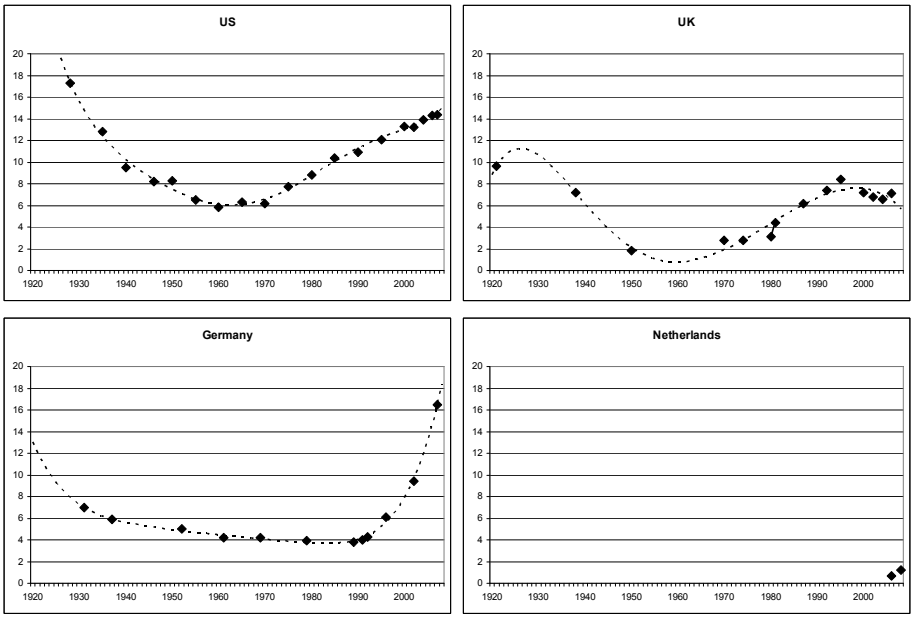
## 6.2 Patterns in for-profit hospital development

Figure 6.1 summarizes the patterns in for-profit hospital development on the basis of the four case studies. It can be seen that the graphs showing for-profit hospital development are characterized by u-shaped curves in the US, the UK, and Germany. In the Netherlands, for-profit companies have only recently entered hospital care and are not permitted to distribute any profits. The three u-shaped curves show that for-profit sectors have declined and grown at different rates, and also began to grow again at different points in time. In fact, the later the gradient begins to rise, the steeper the curve.

The rising curve is clearly the steepest in the case of Germany, followed by the UK, and the US. On the left-hand side of figure 6.1, these three countries all faced a steady decline in proprietary hospital care. This decline was the steepest in the US, followed by the UK, and was the least steep in Germany. The bottom stage of the u-curve lasts the longest in Germany, followed by both the UK and the US. It can also be seen that in recent years, for-profit hospital growth has stagnated in the UK; in the US there were short interruptions during the late 1980s and again during the late 1990s.

These patterns can be divided into the following three consecutive stages, which are more or less pronounced in each of the three countries.

**Figure 6.1: Patterns in the percentage of proprietary and for-profit hospital beds (plotted with trend line)**




*Stage 1: declining proprietary hospital care*

The origin of modern for-profit hospital care begins with the establishment of proprietary hospital facilities[1]. Proprietary hospitals developed in the late nineteenth and early twentieth centuries. During this period, hospitals that had formerly been almshouses gradually evolved to become the mainstream providers of acute-care. Although still limited, the number of paying patients grew; the interest of physicians in securing access to and control of these hospital facilities increased. Physician-owned proprietary hospitals provided the most straightforward ownership type for this access and control. This seemed more important than the opportunity to gain a return on investment.

Proprietary hospitals operated on a small scale and often focused on treating better-off patients. The proprietary sector consisted predominantly of stand-alone facilities, which were geographically disparate. In comparison to other types of ownership, they had a much smaller scope of activities. However, our case studies show that proprietary facilities soon turned out to be less successful than their public and, especially, nonprofit counterparts.

The proprietary hospital sector was the most developed in the US[2]. Figure 6.1 illustrates that although the share of proprietary beds was already declining, it accounted for at least eighteen percent of all hospital beds in 1928. Proprietary hospital care was also significant in the UK, where the share of beds in pay hospitals

and nursing homes exceeded ten percent. The German proprietary hospital sector was somewhat smaller; in 1931, it accounted for seven percent of all hospital beds. A proprietary hospital sector never developed in the Netherlands. More specific data in our case studies show that the turnover of proprietary hospital care was well below their share in the number of beds. Proprietary hospitals delivered less complex care. On the other hand, the observation that a long-term marginalization of proprietary hospital care took place, has to be qualified somewhat. The decline in the proprietary hospital sector was predominantly relative rather than being a decline in the absolute numbers of proprietary beds. Other types of ownership were able to grow faster than the proprietary hospital sector.

*Stage 2: Stagnation of proprietary hospital care*

Figure 6.1 then shows a period in which the decline of the proprietary sector eases and the share of the sector stabilizes for some time. In the US, this period last from the mid 1950s until the late 1960s; in the UK, it lasts from the 1950s until the late 1970s; in Germany, this period spans the entire period between the early 1960s and German reunification in 1990. Although on the surface it would appear that not much was happening during this stage, in fact the proprietary sectors were gradually being replaced by the modern for-profit hospital sector.

Supported by broader public investment in the construction of a welfare state, proprietary hospitals were able to develop into more profitable niche players. In the US, this depended primarily on seizing some of the opportunities offered by employer-based health care funding; in the UK, it depended on the provision of 'supplementary' services that the NHS did not provide; in Germany, niches were created by certain forms of specialization as well as treating private patients.

During this second stage, the decline of proprietary hospital sector care came to a halt before for-profit hospitals began their growth. For physicians, the importance of acquiring hospital access and control was substantially reduced, meaning that profit-making had become the main reason for the existence of the proprietary hospital sector. On the other hand, free or voluntary sources of capital could not keep pace with the increasing demand for hospital services. The way the different health systems 'solved' the problem of rapidly declining voluntary sources, most notably capital, determined the structure of their for-profit sector. The existence of a reasonable number of (stand-alone) proprietary hospitals fed the initial growth of the new for-profit hospital chains.

*Stage 3: strong for-profit hospital growth*

Figure 6.1 illustrates strong for-profit hospital growth in each of the countries, except the Netherlands. The US saw significant for-profit hospital growth from the early 1970s onwards. In the UK, the for-profit hospital sector grew very

strongly during the 1980s and, to a somewhat lesser extent, during the 1990s. In Germany, for-profit growth began after the reunification and continues to this day. In the Netherlands, two for-profit companies recently entered the hospital market. Growth was preceded by a long period of relative decline or stabilization in the for-profit hospital sector. A different model was emerging, unlike the sector's previous model of proprietary hospital care.

Large hospital chains were established and soon formed the core of the for-profit sector. The average scale of the for-profit hospital increased and they began to deliver a broader range of services. On such indicators, for-profit hospitals became more comparable with public and nonprofit facilities, but the governance of for-profits focused more strongly on investment returns. In contrast to the old, physician-dominated proprietary hospitals, stock-listed firms and private equity companies dominated the ownership of these new for-profit hospitals. How did this turnaround in the characteristics of the for-profit hospital sector occur? What are the similarities and differences between the countries in this study?

This turnaround is even more remarkable since proprietary hospitals had been losing market share for many decades or, as in the Netherlands, were unable to develop at all. Indeed, only a few years before or even after these reversals, scholars had concentrated mainly on the reasons for nonprofit growth as well as proprietary decline[3]. The combined share of public and nonprofit hospitals continues to outweigh for-profit hospital ownership in these four countries, which remains firmly below twenty percent; however, the share of for-profit ownership has increased substantially. In these four cases, the start of the revival in for-profit ownership occurred at a different time, which would suggest that country-specific developments and institutions have played a role. This is also supported by the fact that these revivals occurred fairly suddenly. There is little evidence for a tipping point explanation, by which slow growth suddenly accelerates due to a certain threshold being reached[4].

## 6.3 The expansion and decline of proprietary hospital care

This section analyzes the expansion and decline of proprietary hospital care. Proprietary hospitals, which were mainly owned and controlled by physicians, were the first forms of ownership that were formally able to distribute profits to their shareholders. This section focuses on the reasons for the establishment of proprietary hospitals, the differences in their market share between countries, as well as the their long-term decline soon after their emergence. Two questions structure the analysis: 1) Why did proprietary hospitals emerge and why did market shares differ between countries? 2) Why did proprietary hospitals enter into long-term decline?

### 6.3.1 Why did proprietary hospitals emerge and why did market shares differ between countries?

During the early decades of the twentieth century, technological progress was transforming hospitals into the core institutions of acute health care[5]. Hospitals now had a broader patient base that was no longer limited to the poor and needy. Both the growing middle classes and the better-off were seeking increasing amounts of hospital treatment. These patients were able to pay for their treatment, often at higher amounts than the actual costs. This created opportunities for a proprietary hospital sector: 1) since treatment shifted to the hospital environment, hospital access became much more important to physicians and private ownership was the most direct way for a physician to obtain such access; and 2) due to the growing number of paying patients, financial constraints eased, which helped to mitigate the risks involved in owning a proprietary hospital.

Our case studies show that these trends and the way they were handled took different forms in different countries. Physicians' need for hospital access could be eased due to the separation of general treatment by family practitioners and specialized treatment by specialists in hospitals. Family practitioners' need for hospital access thus vanished. Such arrangements could often be proposed and enforced by the profession itself (self-regulation). Providers could help to ease the tensions between physicians over hospital access by choosing an open medical staff. In such cases, doctors could easily follow their patients into the hospital. In practice, the availability of open staff hospitals depended on the availability of voluntary sources to fund such hospitals. The financial constraints on proprietary hospitals could be eased by the existence of a large self-pay market or other kinds of financial advantages, for example access to capital or the absence of competition. Table 6.1 summarizes the ordinal scores of the countries studied on how physician access to hospitals was structured as well as the importance of financial constraints to a proprietary hospital sector.

*Physician access to hospitals*

Constraints on hospital access were very important to physicians. In fact, the physicians' need for access to a broad patient base is crucial to understanding the origins of the proprietary hospital sector. Other constraints were, necessarily, of secondary importance, since few proprietary facilities generated significant profits on their hospital services. Individual physicians or physician partnerships dominated proprietary ownership[6]. In those days, physicians needed enough well-off patients to gain a reasonable income. In contrast to current health care systems, physician incomes were much less protected and secure. There existed a relatively large pool of doctors due to the unregulated expansion of the number of

medical schools. The medical profession was less stratified into different segments or specializations and doctors were competing for as many (paying) patients and treatments as possible. Hospital access was thus increasingly the key to a doctor's professional success.

A physician-owned proprietary hospital provided the most radical opportunity to gain access to paying patients and control over the inpatient surroundings. However, such a decision implied a trade-off between different opportunity costs, since physicians might also have been able to treat their patients in public or in nonprofit hospitals. In such cases, other factors would determine physician access: the main models involved a 'closed' or an 'open' medical staff. The precise meaning of such terms was articulated by specific regulations that were subject to local variations[7].

Public hospitals mainly operated on the basis of a salaried or 'closed' staff; they treated few richer patients. However, this hindered physician-access to patients: such facilities often offered them lower financial rewards due to their focus on the poor and needy. Nonprofit hospitals often had good access to capital, a high number of paying patients, and allowed physicians considerable control over day-to-day operations.

Physicians in search of access to patients were best off with 'open' staff nonprofit hospitals. If their patients needed hospital treatment, they could follow them and use the available equipment and facilities. This implies that in the presence of well-established nonprofit hospitals with 'open' staff models, it was difficult for proprietary facilities to become established. If there were many public hospitals and nonprofit hospitals that retained a strictly 'closed' staff model existed, this may have stimulated the co-existence of proprietary hospitals.

*Financial constraints*

Financial constraints were important in deciding whether to set up and operate a proprietary hospital. Proprietary hospitals were exposed to high financial risks. Three aspects were important to achieve a sound financial position and a sustained flow of revenue: 1) access to capital; 2) stable funding to cover for all costs; 3) a pseudo-monopolistic position, if other types of ownership could afford to charge at lower fees.

It is often assumed that for-profit hospitals have a better access to capital than their public and non-profit counterparts because they can tap into the financial markets. Ninety years ago, however, this was not automatically the case. Due to the limited prospect of profits, such access was often limited. Financial markets were less developed than they are now, and transaction costs were higher for both equity capital and commercial loans. As a consequence, most entrepreneurs had to fall back on their own funds or form a partnership with congenial initiators, but

building a hospital was expensive and this was not easily done. In late-nineteenth-century Germany, for example, the cost of funding a hospital was estimated to equal the costs of a complete regiment of the Prussian army[8]. In 1928, a US physician needed some $70,000, a small fortune in those days, to set up a small proprietary clinic. Nonprofits could invest substantially higher capital sums per bed.

Another important constraint was the lack of stable sources of funding. Third-party payments were poorly developed and often did not cover costs in full. This implied that proprietary hospitals depended on paying patients – an unstable source of funding that fluctuated according to the general economic climate. Many proprietary clinics tried to overcome these difficulties by pursuing niche strategies to attract a better-off clientele. However, the severity of these financial constraints was such that the survival of proprietary facilities was often determined by the absence of competition from other types of ownership, especially nonprofits. Indeed, quite a number of proprietary hospitals emerged in remote rural surroundings that were unable to provide the funds for a nonprofit hospital.

The remainder of this section analyzes the specific constraints presented by physician access and financial resources to the emergence of proprietary hospital care in our four cases.

*The Netherlands*

We can deduce some important reasons for the absence of proprietary hospital care in the Netherlands from table 6.1. Financial constraints on building proprietary hospitals were considerable, at least in comparison with the other countries studied here: 1) small, specialized hospitals were discouraged by the medical profession for reasons of quality, which increased the relative cost of hospital construction; 2) religious hospitals were comparatively well-funded and available, and these attracted many well-to-do patients; however, the total number of paying patients was comparatively small due to a less developed economy and comparatively large income disparities; 3) proprietary hospitals would face considerable competition since, in a geographically small country, the next hospital was never far away.

From a physicians' perspective, the opportunity costs involved in owning a proprietary hospital to secure patient access were also high: 1) nonprofits developed from the late nineteenth century onwards and accounted for a large proportion of hospitals in the Netherlands; 2) most of these nonprofit hospitals had an open medical staff; 3) due to the early development of a gatekeeper system, hospital access was less crucial for most family physicians. The remaining physicians had good access to nonprofit hospitals; they had no need for proprietary hospitals. If physicians had, in spite of this, chosen to participate in proprietary ownership, they were faced with high financial constraints.

*The UK*

In comparison with nonprofits in the other countries in this study, UK nonprofit hospitals were the worst funded. The affluent did not visit nonprofit facilities; they preferred treatment in their own homes or in small proprietary clinics. Class-consciousness was important in such decisions. However, since voluntary hospitals were expected to deliver 'free' treatment, they often could also not provide the services the rich preferred[9]. Nonprofit hospitals did not provide many additional amenities or luxury facilities. This meant that the demands of paying patients were not well-served, creating an opportunity for proprietary clinics.

Indeed, UK proprietary hospitals, more so than their counterparts in other countries, focused exclusively on well-off patients. Such a separation of hospital treatment along class lines limited competition between the different types of ownership. In the UK, financial constraints did not prohibit the existence of a proprietary hospital sector. On the other hand, physicians' need for hospital access was not as pronounced as in some other countries due to the early development of a gatekeeper system. GPs stopped treating patients in hospitals comparatively early, which limited their need for hospital access. Both public and nonprofit hospitals operated on the basis of a 'closed' medical staff, which limited the access of physicians to their patients. However, since there were few paying patients outside the proprietary hospital sector, this did not present a problem to most physicians.

*Germany*

The limited access of physicians to hospitals is important to understanding proprietary hospital care. However, most German physicians were salaried in both public and nonprofit hospitals. There were large numbers of ambulatory physicians, many of which specialized in certain diseases and treatments. German physicians practiced in a rather competitive market and their numbers increased quickly. It was not until 1933, when, unlike in other countries, medical services were strictly separated along the lines of inpatient and outpatient treatment, that physician segmentation became clear. By then, limited access to hospitals had generated a proprietary hospital sector.

A distinguishing characteristic of the German case is the early development of social insurance and a system of sliding scales of hospital reimbursement (high incomes paid substantially more, but also had more amenities). Generally, sickness funds were permitted to contract with proprietary providers. The system of sliding scales permitted cross-subsidization to less profitable services as well as the possibility of attracting richer patients with amenities and physicians with a good reputation. Physicians who also held senior university positions initiated many proprietary clinics. These clinics were located in the cities and were able to attract a richer clientele. In rural surroundings with less voluntary funds, in the north and

south of the country for example, proprietary hospitals could sometimes develop into natural monopolies. Voluntary funds were unevenly spread throughout the country and concentrated in the industrial west where they helped to support the dominance of the nonprofit hospital sector. A variety of factors thus influenced the viability of proprietary hospitals.

*The US*

Table 6.1 shows that the proprietary hospital sector was the most widespread in the US. Financial constraints were relatively limited and the constraints on physicians' hospital access were severe. This combination promotes proprietary hospital ownership as a natural 'solution'. The lack of physician access to hospitals was a clear explanation for the establishment of proprietary facilities. US physicians developed no gatekeeper system, and nor was there a split between inpatient and outpatient care. Initially most nonprofit hospitals operated on the basis of a 'closed' medical staff. These providers only gradually opened their doors to larger numbers of practitioners. By then, competition for hospital access was considerable and this had led to the founding of quite a number of physician-owned proprietary hospitals.

In the US, proprietary hospitals also had the fewest financial constraints. More proprietary facilities were established in comparison with other countries, which indicated rather better access to capital. Immigration continued and the demand for medical services rose rapidly. The most important factor seems to have been that due to a large middle class and comparatively high-income levels, the number of paying patients was much larger than in the three other countries[10]. This made it possible for a significant proprietary hospital sector to develop. However, proprietary ownership was unevenly spread across the country. In the southern and western regions, nonprofits represented a much lesser threat to proprietary hospitals. In those places, voluntary sources were less available; many who could afford it preferred proprietary treatment above a stay in a public hospital; in rural areas proprietary hospitals faced little competition.

*Conclusion*

This analysis shows that hospital-physician relations are the most dominant factor in explaining the development of a proprietary hospital sector. The presence of hospitals with closed medical staffs among public and nonprofit providers correlates with proprietary ownership. Hospital access was a very acute concern to physicians, who lacked such privileges. However, the prospect of making a decent return on capital over time, a crucial condition to for-profit ownership, generally did not exist. The flow of patient reimbursements was insecure as a result of bad debts, limited insurance coverage, and price-sensitive buyers; costs for labor and

capital were higher for proprietary hospitals than for other types of ownership; the number of patients who could pay for charges above costs was limited. On the other hand, the 'contractibility' of proprietary care was still rather high due to the focus on amenities and the lack of sophisticated technology. Because of good 'contractibility' and their focus on the better off, proprietary hospitals were not considered as a public service and initially there were few cultural and regulatory constraints (see figures 1.1 and 1.2).

Nevertheless, the risks associated with owning a hospital were considerable and, from a physician's perspective, proprietary clinics seemed a 'second best' solution. Most physicians thus preferred nonprofit 'open staff' hospitals. However, during the late nineteenth and early twentieth century these simply were not always widely available. Public hospitals dominated the scene, creating a niche for proprietary hospitals that treated paying patients who were looking for facilities with amenities. The preference of doctors for nonprofit 'open staff' hospitals was underlined by the initial strategies of the new physician interest groups that were founded during the same time-period: 1) limiting inter-doctor competition through self-enforced referral models eased the pressures to set up proprietary hospitals; 2) favoring the opening of (nonprofit) 'closed' staff hospitals to more physicians; 3) opposing the establishment of corporate hospitals or investor-owned proprietary facilities.

### 6.3.2 Why did proprietary hospital care go into long-term decline?

Table 6.2 shows that the proprietary hospital sector went into serious decline almost immediately after its emergence. The proprietary hospital sector did not prove to be a successful business model. This can be explained as a result of improving physician access to their preferred nonprofit hospital ownership types. The proprietary hospital sector was also unable to compete with the growing number of nonprofit hospitals. From a proprietary hospital's perspective, the set of conditions on which they depended for their success, as set out in table 6.1, worsened over time. Physicians obtained effective control over nonprofit hospitals; the opportunity costs for proprietary ownership increased. The effect of the deteriorating prospects for proprietary hospitals can be most clearly seen in the US[11].

**Table 6.2: Estimated percentage of proprietary hospital beds[12]**

| | 1921 | 1928 | 1931 | 1935 | 1937 | 1938 | 1940 | 1946 |
|---|---|---|---|---|---|---|---|---|
| Germany | | | 7.0 | | 5.9 | | | |
| UK | 9.6 | | | | | 7.2 | | |
| US | | 17.3 | | 12.8 | | | 9.5 | 8.2 |

*Physician access to hospitals*

The medical profession continued to specialize and stratify. They were increasingly successful in enforcing referral models: general practitioners in the UK and the Netherlands, an outpatient-inpatient split in Germany. This limited the competition among physicians for hospital privileges. In the US, physician interests supported the emergence of 'open staff' voluntary hospitals as the dominant form of ownership. In all countries, physicians increasingly dominated hospital decisions concerning staff privileges, hospital strategies, as well as day-to-day operations[13]. They became the single most powerful force within public and nonprofit hospitals[14]. Physicians, rather than the formal owners, held effective control of the hospital.

Fewer and fewer physicians had any interest in formal control over hospitals through proprietary ownership; formal control increased their exposure to financial risk, with only limited opportunities for additional control and revenues. This argument appears to verify Pauly and Redisch's hypothesis that the nonprofit hospital is a physicians' cooperative (see section 1.3). Physicians who harbored ethical doubts about profit making now also had an economic rationale to reject proprietary hospitals. Hospital profits were seen as an unjustified claim on a doctor's income. In the US, physicians argued that the full return on their labor belonged to them, which included all possible returns on investment. The necessary capital had to be donated by the public authorities or the communities for 'free'. Proprietary hospitals could only be reconciled with such reasoning if they were owned by physicians or physician partnerships, not if they were incorporated and owned by investors.

*Financial constraints*

Prior to World War II, financial constraints remained strong. Table 6.2 suggests that a sound business model for proprietary care became increasingly unfeasible. The need for capital continued to increase, partly due to technological developments. Proprietary hospitals were unable to attract such capital from the markets[15]; public facilities could fall back on tax appropriations and nonprofits benefited significantly from philanthropically motivated sources of capital. Nonprofit hospitals had also access to substantial amounts of cheap and comparatively competent religious labor. Additionally, the emergence of third-party payers was not necessarily in the interest of proprietary clinics. Proprietary hospitals charged above costs, while most third-party payers, if they reimbursed proprietary clinics, did so below actual costs. Capital costs were normally not included in third-party reimbursements. This was less of a problem for public and nonprofit owners that got their capital 'free' or at very low cost and thus had much lower fixed costs. A final factor that affected the proprietary hospital sector negatively was the political

and economic turmoil of the first half of the twentieth century. Small proprietary hospitals were the most vulnerable to economic fluctuations due to their reliance on self-pay patients. The German economy suffered severely during the 1920s, while the global recession of the 1930s hit the US the hardest.

*Reasons for the decline of the proprietary hospitals are validated by the case of the US*

Table 6.2 illustrates that until World War II, the decline of the proprietary hospital sector was the most persistent and enduring in the US. If the above constraints do indeed explain the decline of proprietary hospital care, they should also have been the most prominent in the US. Although other countries were catching up, the US had by far the largest share of self-pay patients, which implied a good basis for the development of a proprietary hospital sector (but also made the US proprietary hospitals the most vulnerable to the economic depression of the 1930s).

However, as is indicated above, the interests of physicians may have been more important than the actual financial constraints. Indeed, physician pressure for hospital access decreased strongly over time. As early as 1933, five out of six physicians, both family doctors and specialists, were affiliated with at least one acute-care hospital[16]. Hospital privileges were virtually non-existent for most physicians in the late nineteenth century; they remained uncommon during the early years of the twentieth century. Since the voluntary, 'open' staff hospital emerged as the preferred option for most physicians, the legitimacy of proprietary facilities had largely vanished.

Other barriers to proprietary hospitals in the US also increased. 1) Supported by the medical associations, several US state courts ruled that corporate, for-profit medicine violated 'sound public policy'. Many states prohibited incorporated hospitals; proprietary hospitals were not exempted from taxes. There were no such legal battles curbing proprietary hospital sector in the other three countries. 2) Nonprofit hospitals dominated Blue Cross plans, which dominated the health insurance industry. Blue Cross sometimes did not reimburse treatment in proprietary hospitals and almost always negotiated lower rates for these types of ownership. The mixing of interests between third-party payers and (nonprofit) providers was less in most other countries; for example German sickness funds were less hesitant to reimburse proprietary hospitals. 3) Another barrier was the general economic situation. In the US, the recession of the 1930s was the most severe. Hospital receipts from self-pay patients fell heavily over a very short span of time. 4) In the US, it was easier for proprietary hospitals to convert to nonprofit or to public ownership. In the UK, for example, conversion was a more complex process. The exclusive focus of proprietary hospitals on the well-off did not fit

with the practices of the other types of ownership. In Germany, proprietary conversions to public or nonprofit status often implied a complicated change in the self-employed status of physicians to a salaried position.

Together with the (exceptionally) strong growth in physician access to (nonprofit) hospitals, such constraints explain why the decline of the for-profit hospital sector proceeded faster in the US than in Germany or the UK. These constraints thus validate the central importance of the hospital access of physicians to hospitals (and of certain financial constraints) to the rise and decline of a proprietary hospital sector. However, the US case also illustrates the growing importance of governmental influence in the hospital sector: proprietary ownership was discouraged by both legal and self-regulations, while conversion to other types of ownership was encouraged.

*Conclusion*

This section has analyzed the decline of the proprietary hospital sector until World War II. This decline resulted from a relative increase in certain important constraints to proprietary hospital ownership. Both public and nonprofit hospitals were better positioned to receive funds from emerging third-party payers. The considerable growth of nonprofit hospitals indicated the strengthening of voluntary resources, while proprietary hospitals were more vulnerable to economic downturns. More importantly, most physicians preferred access to nonprofit hospitals over access to proprietary facilities and this option became much more real, especially in the US and the Netherlands.

Physicians canalized their activities through professional referral systems as well as professional segmentation. This limited the competition for hospital access to smaller numbers of doctors. Ownership regulations that curbed the proprietary sector were increasingly sought after, especially in the US. The developments in the US validate the important role played by these constraints in the decline of the proprietary hospital sector. The US was not only the country in where the conversion to nonprofit or public ownership was relatively easy, but also where the decline of the proprietary hospital sector was relatively sharp.

## 6.4 Stagnation and pre-structuring a for-profit hospital sector

Figure 6.1 illustrates that the proprietary sectors of the US, the UK, and Germany all show periods of stagnation. The length of these periods of stagnation differs and was rather shorter in the US (from the mid 1950s until the late 1960s) than in the UK (from the 1950s until the late 1970s) and in Germany (from the 1960s until the early 1990s). This section analyzes these periods of stagnation. This is important

because we can see that the rate of decline among proprietary ownership eased off; sometimes there was even some slow growth (UK).

The stagnation of proprietary hospital care predates the rapid growth of the various for-profit sectors. The immediate determinants for such rapid growth are analyzed in section 6.5. Three questions structure the analysis of this period of stagnation and the pre-structuring of a for-profit hospital sector: 1) Why did the rate of decline of the proprietary hospital sector level off? 2) How did the shaping of new institutional frameworks pre-structure a for-profit hospital sector? 3) Did the existence of proprietary hospitals pre-structure a for-profit sector?

### 6.4.1 Why stagnated the decline of the proprietary hospital sector?

Historically, proprietary hospitals have depended on self-pay patients for most of their funding. The gradual transformation of self-pay markets into private insurance is thus important. If private insurers depend on proprietary hospitals to serve their subscribers, this implies that the position of these types of ownership might improve. This is because the financial basis and stability provided by private insurers is probably more able to support the proprietary sector than individual self-pay patients. Table 6.3 depicts the relative role of private health insurance in the three countries with a proprietary hospital sector.

**Table 6.3: Dependence of private insurance and self-pay patients on proprietary hospitals**

| | Germany (1960s to early 1990s) | UK (1950s to late 1970s) | US (Mid 1950s to late 1960s) |
|---|---|---|---|
| Self-pay market | High | High | Modest |
| Private insurance | Fairly high | Very high | Modest |

*Germany*

The rate of decline of the German proprietary sector leveled off between the early 1960s and the late 1980s. The new federal constitution of the Republic was one factor in ending the decline of this sector. States had constitutional discretion regarding the hospital sector. This increased ownership pluralism, and in addition, all available capacity was needed to provide the necessary services as a result of the damage the war had done to the hospital infrastructure. However, the benefits of federalism to the for-profit hospital sector disappeared after the implementation of the HFA (1972). Private insurance increasingly replaced the self-pay markets for amenities and higher-end services. Proprietary facilities were the natural institutions for these kinds of high-end services; co-operation between private

insurers and private hospitals flourished. This brought a halt to the decline of the proprietary hospital sector.

*UK*

In the UK, stagnation went hand in hand with some growth in the independent hospital sector. The decline of UK proprietary care ended more or less with the introduction of the NHS. The creation of the NHS represented a watershed that, overnight, seemed to destroy the prospects of the proprietary hospital sector; indeed most of these hospitals went out of business. However, the NHS did not deliver the amenities and standard treatment by consultants that many of the upper-middle classes demanded. This market of self-pay patients was gradually replaced by private medical insurance. The viability of these insurance companies was tied to the existence of an independent hospital sector. They needed private hospital capacity and a complete reliance on NHS-pay beds may have been too great a political risk. Private insurers were even willing to (help) found new commercially aware hospital groups (section 3.2.5). Thus, not only did the decline of independent hospital care end, it was actually replaced by a period of limited growth.

*US*

In the US, the stagnation in the decline of the proprietary hospital sector was clearly the least visible and least enduring (see table 2.4). The main reason for the leveling off in the decline of the proprietary sector was the establishment of employer-based health insurance coverage for workers. As employer-based insurance matured, Blue Cross plans were passed over by commercial indemnity insurers as the preferred option for health insurance. These insurers were more accommodating to proprietary hospitals; Blue Cross plans tended to prefer nonprofit hospital provision. In contrast to Germany, state responsibilities towards hospital planning did not favor the proprietary sector. State agencies which overviewed Hill-Burton funds sometimes, as in New York, enacted new regulations that forced proprietary facilities to terminate their operations (section 2.2.3). The main reason for any leveling off in proprietary decline was much broader insurance cover, especially by commercial private indemnity insurers.

*Conclusion*

The transformation of self-pay markets into private insurance markets improved the prospects for proprietary hospitals. The increased strength of private insurance helped to slow down the rate of decline among proprietary hospitals for a lengthy period before they resumed rapid growth. In fact, the stronger private insurers had an interest in the existence of proprietary care. Table 6.3 shows that

this interest was strongest in the UK, followed by Germany, but less obvious in the US. Indeed, in the UK, there was even a gradual increase in the size of the independent hospital sector; in Germany, the rise of private insurance implied a deceleration in the rate of decline followed by longer period of stability in the size of the sector; in the US, the prospects of the proprietary hospital sector were the most volatile among the three countries. However, in the US, new institutions that improved proprietary prospects arrived the earliest (see section 6.5.1).

### 6.4.2 Did changing institutional frameworks and physician interests pre-structure for-profit sectors?

The opportunity costs of for-profit hospital ownership had remained higher than those of their public and nonprofit counterparts for a long period. However, after World War II, the capital required by the latter could no longer be met as easily through up-front public payments or by philanthropic donations. Cheap labor by religious orders, another important voluntary source, declined rapidly; in Germany, religious nurses cost up to seventy-five percent less than secular nurses. During the same period, the demand for hospital services increased.

How did countries deal with declining community sources and pressure on public budgets? These highly institutionalized responses differed. Countries with a high nonprofit hospital stake and a comparatively rapid decline in voluntary resources, such as the Netherlands and the UK, felt the pressure to act most keenly. Philanthropic sources in Germany and, especially, in the US declined more slowly. The decline of voluntary sources was also the first driver behind a gradual commercial transformation of the nonprofit hospital sector (see section 1.2).

*Changes in hospital funding, capital, and planning*

Governments had to intervene to resolve the issue of rising hospital demand and declining voluntary resources. Since new welfare regimes were built to increase hospital access and coverage, these 'solutions' involved increasing (public) funding. New institutional configurations broadened the coverage of hospital services; increasingly, hospitals were publicly guaranteed access to capital sources; the increase of public funding for capital induced government involvement, most notably regarding hospital planning. What was the impact of these changes on the viability of the for-profit hospital sector? Table 6.4 shows that the chosen policies and institutional constraints differed between the four countries. Nevertheless in all countries, capital funds were used almost exclusively to support public and nonprofit hospitals.

**Table 6.4: Funding, planning, and capital (early 1960s)**

| | | Netherlands | US | Germany | UK |
|---|---|---|---|---|---|
| Third-party funding | Main third-party payers | Social/private insurance | Employer-based private insurance | Social/Private insurance | State |
| | Scope of coverage | Broad | Less broad | Broad | Universal |
| Hospital planning | Formal responsibilities | Central regulations | Federal program | State regulations | Central government |
| | Executive responsibilities | Decentralized | State level | State level | Central |
| Access to (public) capital | Reimbursement | By insurers once 'passed through' | Upfront subsidies (federal/state) | Upfront subsidies by states | Upfront subsidies by government |
| | Eligibility | Public/non-profits | Public/non-profits | Mainly focused on public and nonprofits | Public |

*The Netherlands*

The most important difference between the Netherlands and the other three countries was the country's solution to the problem of reimbursing capital. In the Netherlands, this was tackled comparatively early; by the late 1950s the means of funding capital was fairly clear. Capital payments were based on actual annual costs without any reimbursements for equity and were included in the *per diem* rates on a case-by-case base. This represented an important entry barrier, since for-profit clinics had no access to regular funding. Private indemnity insurance and self-pay patients became an integral part of this system. Importantly, capital subsidies to hospitals were kept off the public balance sheets, and thus the risk of this investment being crowding out by other expenditure categories was limited. As a result, the need for investor capital was absent.

*The US*

US public and nonprofit hospitals could rely on Hill-Burton funds for their construction activities. For-profit hospitals were not eligible for these capital funds, but were not excluded from other sources of reimbursement. Proprietary clinics were eligible for reimbursement from the growing commercial insurers, which often paid above costs. At both a federal and a local level, the Hill-Burton funds

were constrained by other public budget categories. The way access to capital was secured, turned out to be less stable over time than was the case in the Netherlands.

*Germany*
German policies had to be pragmatic. The funding of the war-ravaged hospital sector posed a major challenge that put pressure on hospitals regardless of their type of ownership. Public and nonprofit owners were 'forced' to bear part of this burden. The states had major discretionary powers over the hospital sector due to the new federalist constitution. Federalism seems to have allowed for a pluralist hospital landscape. Additionally, the severity of the capacity shortages implied that for-profit hospitals may be tolerated in state funding programs. Although, like most other types of ownership, most for-profit hospitals were underfunded, they were able to capitalize to a certain extent on the much higher reimbursements from private indemnity insurers, which favored their amenities.

*The UK*
The most radical reform program took place in the UK. The NHS created a dichotomy between public hospitals and all other types of ownership. Apart from some rather sporadic commissioning, independent sector hospitals had no access to public funding. NHS hospitals operated with (semi) budgetary constraints. The stricter these constraints, the higher the demand tended to be from certain categories of richer patients for duplicate or supplementary for-profit hospital services and amenities. The viability of the independent sector depended on whether the NHS succeeded in delivering hospital services that met the standards of the better off.

*Changing physician interests towards hospital types of ownership*
Hospital access was important for physician incomes; as we have seen, this constitutes one explanation for the founding of proprietary hospitals. Section 6.3 analyzes how the four countries dealt with physician access to hospitals, which in general reduced the need for proprietary hospitals. However, the resulting 'solutions' did not end the interest of physicians in hospital employment conditions. The importance of the problem of absence of hospital access eased, but now direct physician incomes became more important in decisions on the provision of their services.

Salaried physicians are confronted with greater limitations on their incomes than self-employed doctors. Section 6.3.2 stipulates that most physicians preferred self-employed status in 'open' nonprofit hospitals, not the least because of the effect on their income. It is important to note that self-employed physicians are also better able to capitalize on their productivity gains than salaried physicians. Table

6.5 shows that high physician remuneration in nonprofit hospitals continued into the early 1960s. Since keeping their physicians 'happy' is often part of the for-profit business model, proprietary hospitals are more able to attract doctors than public hospitals who pay lower physician remuneration. The trade off between working in public hospitals versus working in for-profit hospitals may have led doctors to seek additional income in the private sector. The existing data in this research do indeed validate this notion.

In the UK, salaried consultants were allowed to treat private patients in NHS pay-beds or in independent sector hospitals. The interests of consultants were thus aligned with the independent sector, not because of better hospital access, but because of a generous supplementary source of income. In both Germany and the US, too, public and for-profit hospitals operated in the same geographical areas. Regions with a large share of nonprofit hospitals have fewer proprietary facilities. The fact that physicians could earn significantly higher reimbursements in for-profit hospitals compared to public facilities may explain the growing willingness of physicians to work in such institutions.

Table 6.5 illustrates that, over time, for-profit hospitals also pay the high level of physician reimbursements of the nonprofit providers[17]. Such trends exist in all three countries with a for-profit sector. However, improvements in physician remuneration still had to be traded off against the risk of proprietary ownership. The outcome of this trade-off may still have been negative to most physicians. There seems to be one clear exception to this. If an incorporated company took over the risk of insolvency and business volatility, many more physicians may favor (working in) for-profit hospitals.

**Table 6.5: Physician employment status, hospital access, and income levels (early 1960s)**

| | UK | Germany | Netherlands | US |
|---|---|---|---|---|
| Dominant employment status | Salaried | Salaried | Self-employed | Self-employed |
| Regular hospital access | Closed staff | Closed staff | Closed staff | Open staff |
| Highest physician payments (early 1960s) | Independent sector hospitals | Nonprofit hospitals | Nonprofit hospitals | Nonprofit hospitals |
| Highest physician payments (current) | Independent sector hospitals | For-profit hospitals | Nonprofit hospitals | For-profit hospitals |

*Conclusion*

Why was strong for-profit hospital growth able to emerge after such a long-term decline in proprietary hospitals? The underlying factors that had stimulated nonprofit and public ownership – better access to capital and voluntary sources and the value of physician privileges to their facilities – had already weakened even before rapid for-profit growth began to resume. This implied a relative decrease in the production costs of proprietary and for-profit hospitals. The reimbursement levels of third-party payers increased to the level of the actual costs, which enhanced profit margins.

However, whether these underlying forces would really come to the fore depended to a large extent on new regulations and institutions. Governments stepped in to ensure the increasing demand for capital and funding of the public and nonprofit sectors was met. The conditions attached to the access to new public sources of capital that often excluded for-profits were particularly important. The robustness and endurance of such institutions had a strong impact on the prospects of further for-profit growth. The solutions of the Netherlands turned out to be the most robust in prohibiting for-profit entrance; US and German institutions were less stable, which eventually turned out to be very important in encouraging rapid for-profit growth.

Regarding physician incentives, the focus on hospital access (indirect source of income) had been replaced by a focus on more direct sources of remuneration. UK independent sector payments soon came to form a significant share of the remuneration of NHS consultants. In the other countries, salaried physicians in public hospitals were also attracted to higher remuneration from for-profit providers; in the Netherlands, many public hospitals converted to nonprofit ownership. In the US and Germany, the underlying erosion of nonprofit competitiveness also gradually put pressure on their ability to pay their physicians the best remuneration packages. Note that this also undermined a continuing growth of the nonprofit hospital as a physician's cooperative (see section 1.3.2).

### 6.4.3 Did proprietary hospitals pre-structure a for-profit sector?

The new for-profit hospital chains were able to grow by building new facilities or acquiring other hospitals. Existing proprietary hospitals were logical first targets for acquisition. There were often fewer political, legal, and other barriers to for-profit chains acquiring a (stand-alone) proprietary hospital, while the patrons of public and nonprofit hospitals could fiercely resist a for-profit acquisition. The larger scale and greater asset-specificity of public and nonprofit hospitals, as well as their radically different governance structures, created additional investment risks. At the same time, as I have argued, proprietary hospitals experienced seri-

ous constraints from their inception. However, proprietary hospitals often lacked good exit options[18] and the emergence of for-profit chains therefore provided an opportunity for struggling proprietary hospitals to exit under reasonable terms. Nevertheless, table 6.6 shows that when for-profit chains entered the scene, the available targets for acquisitions differed in importance among the three countries included in this study.

**Table 6.6: Conditions to for-profit growth (during initial growth of for-profit sector)**

| | UK (Late 1970s) | US (Early 1970s) | Germany (Early 1990s) |
|---|---|---|---|
| Conditions for new construction | Available | Available | Tied to acquisition |
| Conditions for proprietary acquisitions | Few available | Available | Available |
| Conditions for public acquisitions | None | Few available | Available |
| Conditions for nonprofit acquisitions | Available | Few available | Few available |

The initial growth of the US for-profit chains depended on the acquisition of (financially troubled) proprietary hospitals, as well as the construction of new hospitals. When for-profit hospital chains were formed, the US had the largest proprietary sector; due to exceptionally good reimbursement of capital investments, new hospital construction was also possible. Other types of ownership were far less involved in mergers and acquisitions until the 1980s. In the US, the existence of a proprietary hospital sector clearly pre-structured the growth of for-profit hospital chains.

UK for-profit hospital chains were dependent on the construction of new hospitals, as well as acquisitions from the independent hospital sector. However, at the time when for-profit hospital groups were formed, the independent sector consisted mainly of nonprofit hospitals. Nevertheless, we must note that most of these nonprofit hospitals had a much more commercial orientation due to the dichotomy between the NHS and the independent sector. Initially, this meant that for-profit groups acquired nonprofit hospitals or built new for-profit facilities. The significance of proprietary hospitals in the pre-structuring of a for-profit sector was limited. Independent nonprofit hospitals in the UK depended largely on trading activities and thus, in effect, resembled a proprietary sector.

In Germany, proprietary hospitals were available for acquisition, although this sector was smaller than was the case in the US. German proprietary hospitals were less in need of exit options, due to their specific business model; however, for the same reason, they were also less attractive to the emerging for-profit hospital groups. Most proprietary hospitals operated according to niche models and were not included in planning regulations[19]. The prospects for further growth in these

niche models were limited. Although such hospitals were available for acquisition by for-profit groups, this was less lucrative than the acquisition of public hospitals that were included in the state hospital plans and whose assets could be acquired on much more favorable terms. Once such public hospitals were acquired, there were also good opportunities for large construction projects to upgrade the acquired facility. The practical significance of German proprietary hospitals in pre-structuring a for-profit sector was limited.

*Conclusion*
In countries with a still significant proprietary hospital sector, these hospitals were able to pre-structure the growth of for-profit hospitals. Generally, the transaction costs of acquiring proprietary hospitals can be considered less than those of their public and nonprofit counterparts. This section shows that, of the three countries, this was only the case in the US. To a certain extent, this proposition might also be validated in the UK – if, that is, one takes into account the fact that UK nonprofit hospitals were more commercially oriented and thus bore a greater resemblance to proprietary ownership. The German case gives no support to this proposition.

## 6.5 Strong for-profit hospital growth

Figure 6.1 shows the strong increase in the market share of the for-profit hospital sectors during recent decades. The share of US for-profit hospital beds has more than doubled since the 1970s. In the UK, the independent sector grew strongly from the 1980s until the mid 1990s; UK for-profit groups increased their market share within the total independent sector from the mid 1970s onwards. Germany saw the steepest increase in for-profit hospital beds and has recently passed the US in terms of the share of for-profit beds. In Germany, the market share of for-profit hospitals increased to four times that of the late 1980s, for-profit intensive care units have increased even faster.

The goal of this section is to analyze the specific reasons behind such rapid growth and put them in a comparative perspective: 1) Why did such a turnaround occur and at such different points in time in these countries? 2) Why, and to what extent, could the for-profit hospital sector converge to the scale and scope of other types of ownership? 3.) What has led to interruption of rapid for-profit growth?

### 6.5.1 Why did the turnaround in the for-profit sectors occur at different points in time?

The timing of strong for-profit hospital growth differs between the four countries. Rapid growth started in the 1970s (US), the 1980s (UK), and the 1990s (Germany). Changes in country-specific institutions were important in the timing of these for-profit hospital take-offs. The different case studies explain that 'sudden' changes in for-profit constraints were largely driven by policy changes. What drove these policy changes? Section 6.4.2 illustrates that governments had to solve the growing need for funding and capital among public and nonprofit hospitals.

Funding, capital reimbursement, and hospital planning had to be developed anew (see table 6.4), and this was the basis for new institutional configurations. It turned out that adjustments in the configurations would be crucial in the rapid growth of the for-profit hospital sector in the three countries. Table 6.7 illustrates the impact of the institutional arrangements on the start of for-profit hospital growth. In this section, the specific relevance of these changes is analyzed for each of the studied countries. I then look at the question of whether there is any common ground in these different institutional changes.

**Table 6.7: Institutional changes and their effect on strong for-profit hospital growth**

| | Funding | Capital reimbursement | Planning regulations |
|---|---|---|---|
| US | Positive | Positive | Neutral |
| UK | Positive | Neutral | Positive |
| Germany | Neutral | Positive | Positive |
| Netherlands | Negative | Negative | Negative |

*The US*

US for-profit hospital care was the first to experience rapid growth among these countries. This can be explained by the comparatively late arrival of public programs to fund hospital care. In contrast to the other countries, such programs were built upon the reimbursement mechanisms of the existing private indemnity insurers, which also administered these programs. Medicare and Medicaid increased hospital funding enormously through large infusions of new money. The execution of these programs was based on practices in the private insurance system that was already established[20]; type of ownership made no difference for reimbursement that took place on a fee-for-service basis. At the time, this was the only way of implementing Medicare and Medicaid and honoring Lyndon Johnson's 1964 election promises before the next general elections.

**Table 6.8: Differences in acquisitions and scope of for-profit activities[22]**

| | Acquisitions | | | For-profits: average bed capacity versus other types. | Scope: ratio of total for-profit costs versus total for-profit bed capacity |
|---|---|---|---|---|---|
| | For-profit | Non-profit | Public | | |
| UK | ++ | ++ | n/a | 0.09 | 1.2 |
| US | ++ | ++ | + | 0.76 | 0.7 |
| Germany | + | + | ++ | 0.43 | 0.7–1.1[23] |
| The Netherlands | n/a | ++ | n/a | n/a | n/a |

The terms of Medicare were very generous to for-profit hospitals. For-profit hospitals were allowed to calculate their Medicare reimbursements on a fee-for-service basis, which included a profit margin on their invested capital without any risk. Neither nonprofit hospitals, nor public hospitals were entitled to such a guaranteed return on their investment. As a logical consequence of Medicare reimbursement for capital, the Hill-Burton program was gradually phased out. Together with the lasting decline of philanthropic donations, this implied a radical change in capital constraints among the different types of ownership. The competitive advantage of nonprofit and public hospitals came to and end. The for-profit hospital sector not only gained access to public capital, they also got the most generous conditions. This brought about a very profitable business model for the for-profit sector.

*The UK*

The UK independent hospital sector functioned both as a supplement to and a substitute for the NHS. During the mid and late 1970s, the constraints placed on the independent sector by planning regulations paved the way for a for-profit hospital sector. Such an intervention was incompatible with the system's two-tier logic, which depended on certain implicit links between both sectors: the impact on remuneration for NHS consultants and the demand for (independent) hospital capacity from private insurers. The government's policies united NHS consultants, private insurers, and the independent hospital sector.

New for-profit providers were able to fill the gap left by the declining level of private treatment in the NHS. Due to their access to equity capital, these new for-profit hospital groups were more responsive to the opportunities for growth than independent nonprofit hospitals. This became apparent in the first half of the 1980s. The UK was a frontrunner in the movement towards the retrenchment of the welfare state. It is no coincidence that the rapid growth of the independent hospital sector began at about the same time. Cuts in NHS services fit very well

with the business model of the for-profits, which sought to meet the demand for hospital services among those able to pay for them.

The other side of the retrenchment agenda was a stimulation of the private market forces. Subscribing to private medical insurance became more attractive through new tax-benefits. NHS consultants were enticed into supplementing their limited salaries with additional private work[21]. There was no direct institutional framework to steer the independent sector, but changes in NHS constraints as well as the growth in private medical insurance led to improved prospects of the for-profit hospital sector and it was able to grow rapidly.

*Germany*

The biggest for-profit hospital boom began in Germany during the early 1990s. Since 1972, the Hospital Finance Act had curbed for-profit growth fairly effectively. For-profit hospitals were kept more or less out of the mainstream service delivery system. However, these capital institutions proved unable to endure over the long term. There were no incentives to limit the demand for capital. The practical ability to invest in hospital construction depended on fiscal constraints imposed by the state and local governments, who faced a high demand for capital. These fiscal constraints gradually increased over time, bringing about a need for investor capital. The shortage of capital was the most urgent among public providers, which were completely dependent on public subsidies and had hardly any access to other sources of funding (retained earnings). Ultimately, this made them vulnerable to acquisition by the for-profit sector.

In the early 1990s, German reunification proved to be the watershed of rapid growth among for-profit hospitals. In Germany's new eastern states, dominated by right-wing governments and supported by the federal authorities, the privatization of public hospitals assets was a priority. It was only for-profit hospital groups, which were able to respond to this new policy environment, and which were able to access the required equity and acquire a share of the privatized hospital sector in the Eastern states. In these new states, for-profits were included in the state hospital plans. They gained access to public hospital assets as well as public capital subsidies on very generous terms.

In contrast to the old states, large amounts of public capital were generated to rebuild and strengthen the outdated infrastructure of the new states. Because of this additional public funding, the Eastern states passed Westerns states in their total level of investment per hospital bed (see table 4.9). Rapid for-profit growth also spread to the Western states, although for different reasons. Increasing fiscal constraints on state and local authorities, partly as a consequence of the solidarity payments to the new states, as well as the amendments to the (state) hospital law(s) to support a more pluralist hospital landscape stimulated the process of privatization.

*The Netherlands*

Table 6.7 shows that constraints on for-profit hospital development were at their strongest in the Netherlands. The mix of hospital funding, capital reimbursement structures, and hospital planning regulations together effectively scuppered the prospects of for-profit hospital ownership. By implication, the institutional framework as a whole would have to be altered if the entry of for-profit hospitals had been permitted. After the 2006 reforms, two for-profit companies were allowed to buy two hospitals in financial difficulty, but only provided that they would not distribute any profits. Planning regulations have become more flexible, but still prohibit for-profit hospitals; reimbursements structures are gradually being altered to prospective payment models, which are better suited to for-profit ownership than global budgets.

*Conclusion*

The reimbursement of and access to capital are crucial in explaining the rapid for-profit hospital growth in Germany and the US. The relationship is less straightforward in the UK; there, the impact of the dichotomy between the NHS and the independent hospital sector dominates for-profit viability. Funding and planning regulations, especially when linked to capital reimbursements, are also important. In the different countries, time lags between rapid for-profit hospital growth exist because of the political nature of reforming these institutions and because of the fact that the viability of for-profit hospitals was not central to these reforms.

The institutional changes mentioned above were primarily rooted in and shaped by larger political issues: 1) in the US, the politics of coverage benefits meant that Medicare had to be modeled on private insurance plans; 2) in the UK, an ideological retrenchment of the welfare state corresponded with the specific business model of the for-profit hospital sector; 3) in Germany, fiscal restraints and the 'sudden' change in the political direction in the new states created new opportunities for for-profit hospitals, based on the privatization of public facilities; 4) the Dutch model of implementing managed competition gradually increased risk, putting pressure on less well-managed hospitals; in other words, the rationale behind for-profit ownership increased.

These institutional changes took place in different phases of welfare state development: US for-profit hospitals capitalized on the implementation of large-scale welfare state programs; UK for-profit hospitals capitalized on welfare state retrenchment policies; German for-profit hospitals capitalized on their inclusion in the hospital system as a 'solution' to inefficient public provision and a lack of access to capital by these providers; and in the Netherlands, a potentially larger role for the for-profit sector seems consistent with reforms that seek to improve efficiency. This shows that when institutional constraints are favorable, for-profit

hospital sectors have been able to expand in a variety of political environments and during different stages of welfare state development.

### 6.5.2 Did for-profit hospitals have similar business models in the countries studied?

In many respects, the transformation processes of the for-profit hospital sectors in these countries have seemed to resemble one another. For-profit chains have replaced stand-alone proprietary hospitals as the dominant type of ownership in the for-profit sector. The major characteristics of such hospital chains are fairly similar. 1) They have a clear focus on investment returns. 2) Although the average number of beds in for-profit facilities remained below their public and nonprofit counterparts, they substantially increased the scale of their operations. 3) In contrast to other types of ownership, for-profit hospital chains created networks that operated on a national scale. 4) The business model of the for-profit chains often proved unviable outside their national borders. The management of country-specific political, regulatory, and professional risks necessitated a business model that was tailored on a country-by-country basis and was associated with substantial transaction costs. 5) Consolidation within the for-profit hospital sector has been significant and a few companies came to dominate the for-profit hospital sector over a short span of time. 6) Generally speaking, for-profit hospital chains grew through acquisitions instead of new construction activities.

Why is this picture so similar across the three countries in this study? Rapid for-profit growth was triggered by the opportunity to obtain healthy investment returns for the first time. It was possible to place capital returns at the front of the business model. The primary reason underlying the existence of proprietary hospital care – physician access to and formal control of hospitals – took a back seat.

Strategies to obtain capital returns are determined by the nature of hospital operations. High fixed-costs imply inherent entrance and exit barriers. Hospitals that operate on a larger scale are more attractive to physicians, who demand a broad range of sophisticated technological facilities. Scale also provided important advantages to individual hospital companies. It enhanced the bargaining power versus third-party payers and subcontractors. It often implied better access to capital on more favorable terms. Better access to specific and valuable knowledge about how to handle the complex billing routines in a way that favors the hospital company was essential. This not only reduced administration costs but also facilitated profitable up-coding strategies. Finally, hospital chains can often save on overhead costs such as controlling, auditing, human resources and the like, by centralizing them.

Increases in for-profit scale are also the result of acquiring larger public and nonprofit hospitals. For-profit hospitals chains prefer acquisitions to the construction of entirely new plant. Goodwill is of essential importance in hospital care, especially among larger facilities where asset-specificity most increases investment risks. However, hospital chains often encounter less risk if they acquire the necessary goodwill through public and nonprofit bailouts.

*Differences between the for-profit hospital sectors of the countries studied*
Table 6.8 shows that there are also certain important differences between the for-profit hospital sectors in the countries in this study. The main acquisition targets of the for-profit chains are not exactly the same. In all countries, for-profit chains routinely acquire or merge with other for-profit hospitals. However, UK and US for-profits have mainly acquired nonprofit facilities, while German for-profit hospital groups have primarily acquired public hospitals.

How can the different for-profit acquisition strategies across countries be explained? In the UK, the dichotomy between the NHS and the independent hospital sector prohibits for-profits from acquiring public hospitals. Public hospitals are also the least acquired among US for-profit chains. As a result of their location in city centers and their tradition of serving the poor, many public hospitals have high levels of uncompensated care. In Germany, public hospitals are more vulnerable to acquisition than nonprofits. They lack access to necessary capital, experience the most fiscal pressure, and, in contrast to both nonprofit and for-profit hospitals, employ their physicians on lower salaries. For-profits can add value through their better access to capital and the fact that they can offer physicians a substantially higher level of income.

Table 6.8 illustrates that the relative scale and scope of for-profit operations differs between the countries. In all countries, average for-profit bed capacity is (much) lower than of their nonprofit and public counterparts. This difference is by far the most pronounced in the UK, which indicates the supplementary function the for-profits have in relation to the NHS for the rather small section of the population with access to private medical insurance. The average number of for-profit hospital beds is the most similar to the other types of ownership in the US. This is the result of a long-term trend of converging scales (see also figure 2.1). However, high chances of bad debt, competition from ASCs, below-cost reimbursement, and stiff negotiations by managed care organizations do not permit their entry into every segment of the market; for-profit hospital chains focus on medium-scale community hospitals. The increase in scale is much larger among German for-profit hospitals. Here, as explained briefly, for-profit maximum care hospitals are more common alongside many smaller for-profit hospitals.

With the exception of the UK and certain German states, the share of for-profit hospital costs is lower than their share of hospital beds. A ratio of less than 1.0 is no surprise since the case studies have shown that for-profit hospitals generally focus on a less complex patient base. Higher ratios point towards a more complex patient-mix, as is the case in certain Eastern German states, or towards more inefficiency, as in the UK for example. The UK independent sector focuses exclusively on elective care, amenities, and high physician remuneration, and it operates in a low-volume environment with high logistic costs; the relatively high cost ratio of for-profit versus NHS beds thus reveals inefficiencies and a focus on niche markets for those willing to pay. In Germany, the scope of the for-profit hospital sector differs across the country. In Western Germany, the for-profit sector has historically operated on a small scale and focused on specialized elective treatments and less-complex general acute care. In the new states, for-profit hospitals operate on a similar scale and scope to the other types. They have access to all sources of reimbursement, often on better terms than other types of ownership. It is the only region in this study where the scope of the hospital activities has converged among the various types of ownership.

*Conclusion*

Why are the different for-profit hospital sectors similar on certain aspects, while there are also significant differences? The trend towards for-profit hospital chains that has followed a broadly similar course in the different countries is best explained by the disciplining forces of seeking (and needing) a return on investment as well as the specific characteristics of the hospital market. Due to the fact that hospitals have high fixed-costs, consolidation is the obvious strategy to bring about additional efficiencies of scale. Nevertheless, there have been country-specific differences in this consolidation process. These are the preferred targets for acquisition (in terms of their ownership type), and the scale and scope of the different for-profit hospital sectors. These differences can be explained by the specific institutional characteristics in the various countries, as well as the operational fit between for-profit hospitals and the other types of ownership.

### 6.5.3 What has caused the interruption in rapid for-profit growth?

In the UK, the share of the independent hospital sector peaked during the late 1990s and a new impulse has not yet returned (figure 6.1). The continuation of US for-profit growth was interrupted for short periods in the late 1980s and again in the late 1990s. This section, which is based mainly on evidence from the UK and US, addresses the reasons behind these interruptions of rapid for-profit growth. Which specific constraints have caused slow-downs in the growth of for-profit

hospitals? What strategies have for-profits used to bypass such constraints? Have these been successful?

*The UK*

The relative growth of the independent hospital sector stagnated in the late 1990s. New Labour's agenda focused on improving the NHS quality, reducing waiting lists, and increasing responsiveness to patients' concerns. NHS funds were massively increased to accomplish these goals. Waiting lists were reduced and patients got more choice about where they underwent treatment. Physicians received significant salary increases; they could earn additional income by joining medical compliance programs. This reduced the attractiveness to physicians of working in the independent sector. Investment programs upgraded the appearance of NHS facilities.

Chapter 3 concluded that improving NHS performance represents a fundamental threat to the independent hospital sector that depends on the willingness of people to bypass the NHS and pay for such services themselves. However, the independent sector was allowed to gain a share of NHS business if they fit certain conditions. Among other requirements, charges needed to be brought more into line with NHS reimbursements, implying a drastically lower cost basis. Figure 6.1 suggests that the for-profit hospitals are struggling with these challenges.

*The US*

US for-profit hospital growth experienced interruptions in the late 1980s and again in the late 1990s. In the mid 1980s, Medicare introduced prospective payment as well as significant reductions in the generous for-profit capital reimbursements. In the 1990s, prospective capital payments created a level playing field: now nonprofit and public hospitals received the same capital reimbursements as for-profits[24]. Since 1987, patients in need of emergency care and complex medical treatment could no longer be denied treatment. This increased for-profit exposure to the risk of bad debt. These factors caused a temporary dip in further for-profit hospital growth (section 2.2.7).

During the 1990s growing managed care penetration put the entire hospital sector under pressure. For-profits relied more on fee-for-service reimbursement to fund for comparatively high volumes of elective treatments and all kinds of additional services. They were somewhat more vulnerable to managed care strategies. More importantly still, in 1997, Medicare payment cuts under the Balanced Budget Act brought the sector to a more or less complete budgetary standstill for three years. New physician-owned specialty hospitals and ambulatory surgery centers focused on the more profitable patients. Such facilities could greatly enhance physician income. Physicians could fund them internally; they also had good access to other

sources of capital since these enterprises were inherently very profitable. Many such companies located in the same states as the for-profit hospitals, putting a strong constraint on the growth of for-profit hospitals.

*Bypassing constraints: diversification and lobbying*

The for-profit hospital sectors responded to increasing constraints with a range of strategies: diversification into other market segments, mergers and acquisitions, terminating unprofitable services, and lobbying to influence political decisions. These efforts had mixed success. US for-profit hospitals that diversified into insurance or outpatient treatment were not very successful. Such services competed with hospital care in a zero-sum game for the profit margins. Both US and UK for-profits had some success in diversifying into specialty care sectors, most notably acute mental health. However, government cost containment policies, such as the implementation of prospective payment schemes, eventually spread to these segments also. In the UK, the independent hospital sector tried to share in the growing resources of the NHS. However, the terms were not generous.

In hospital care, political lobbying can be a successful strategy in overcoming important constraints. With the support of others, the US for-profit hospital sector scored some points: 1) the 'whole hospital' exemption from self-referral prohibitions in the Stark laws; 2) a moratorium on specialty hospitals; 3) the reversal of many of the cost-containment measures in the Balanced Budget Act; 4) ensuring that the appropriateness of nonprofit tax-benefits was on the political agenda; 5) successful efforts to orchestrate a backlash among managed care subscription and raise hospital reimbursement rates[25].

*Conclusion*

Government policies in the UK and the US led for-profit hospitals to adjust their business model. This was especially detrimental to for-profit growth if such adjustments pressured for-profits to lower their cost base. UK for-profits are increasingly exposed to the expansion of NHS-funded care. They have had to adjust their business model, which had focused on delivering supplementary medical services, towards one of being a subcontractor of NHS services, a major adjustment. In the US, increasing for-profit exposure to stiffer government reimbursements, more managed care organizations, and physician-owned providers forced them to lower costs or lose profits. Over time, the pressure of government policies and managed care organizations eased, but not that from physician-owned providers. The for-profit hospital sector organized an effective lobby to ease regulatory constraints. Nevertheless, this required the support of other stakeholders (physicians, insurers, other types of ownership) to adjust the relevant institutions in their favor.

## 6.6 Key determinants in the development of for-profit hospitals

### 6.6.1 A hierarchy of determinants

This section seeks to develop an analytical hierarchy among the most important determinants of the development of a for-profit hospital sector (see table 6.9). The study has shown that a prosperous for-profit hospital sector does have a couple of important determinants. There is the straightforward premise that, to prosper, these facilities should be able to generate a profitable return on the capital invested. This return on capital should be able to grow, or at least remain steady, over longer time periods. Growing returns on capital attracts the entry of profit-oriented hospitals. To guarantee a for-profit hospitals' continuity, its capital returns at least need to account for amortization and appreciation of its assets. This study has shown that this is not always possible.

As a matter of fact, the existence of proprietary hospital sectors can be better explained by their direct utility for physicians who needed access to hospitals to earn an income. This implies that physician interests are often a major determinant of hospital ownership types. Indeed, physicians are a strong force in the hospital sector, with effective control of many day-to-day activities. If for-profit hospitals cannot align their interests with the doctors that work in their facilities, investment risks might be excessively high. The potential to steer or direct physicians limits the actual governance modes of for-profit hospitals. It explains why physicians often have a stake in hospital equity or why hospitals try to keep their physicians happy as a way of gathering patient referrals.

Which factors lead to positive returns on investment and thus are important in for-profit hospital care? This study shows that over time, many factors have stimulated or limited such returns: the level of private insurance, willingness to pay among the well-off, the availability of cheap labor from religious orders, tax policies, reimbursement possibilities, the opportunities for cherry-picking and the impact of technological innovations. However, conditions that determine access to and the price of capital have been shown to be important in all the case studies.

**Table 6.9: The importance of various determinants of for-profit hospital development**

| | Access to capital | Physician income | Ownership regulations | Exposure to competition |
|---|---|---|---|---|
| UK | + | +++ | −− | ++ |
| Netherlands | −−− | − | −−− | −−− |
| US | +++ | ++ | − | + |
| Germany | +++ | ++ | + | + |

*Access to capital*

From the point of view of public and nonprofit hospitals, capital was both free and available during much of the first half of the twentieth century. It was paid upfront on the basis of need by public authorities or philanthropic sources. Since proprietary hospitals had no access to these means, they had a lasting structural competitive disadvantage. Although they were subject to few formal constraints, most proprietary hospitals could not obtain a decent return on investment. After World War II, the relative price of and access to capital sources gradually became less favorable for nonprofit and public hospitals. The up-front provision of free capital from governments and philanthropic organizations came under pressure and could not cover the growing demand for hospital services.

New institutions structured the price and access to hospital capital. The majority of such institutions still reserved capital sources for public and nonprofit ownership types. However, with the exception of in the Netherlands, these new institutions did not endure, gradually creating more discretionary room for for-profit hospitals. For-profit hospital chains could, during specific periods, count on even more favorable capital reimbursement than other types of ownership (US, Germany). The capital advantage of for-profit hospitals increased over time because of structural pressures on public budgets that reduced the capital access of public hospitals (Germany). This study shows that access to and the reimbursement of capital are crucial in understanding the rapid growth of for-profit hospitals in Germany and the US or its late appearance in the Netherlands.

*Physician income*

I now turn to the relationship between hospital ownership and physician interests, most notably their income. Proprietary hospitals were a second-best alternative for physicians who lacked access to hospitals with other types of ownership. Investment returns were of secondary importance. Nonprofit hospitals gave physicians the best access to the highest earning potential, effective control over important decisions, and involved no investment risk. In other words, physicians preferred nonprofit hospitals over proprietary facilities. With the spread of physician access to nonprofit hospitals, the proprietary sector went into decline.

However, if nonprofit hospitals acted as physician cooperatives, how was the for-profit hospital sector able to gain in importance again? This study shows that the emerging for-profit hospital chains were able to pay their physicians the highest remuneration (other workers were often worse off). Higher physician income seems to be an important factor in the growth of the for-profit hospital sector. UK for-profit hospitals generated substantial additional income for NHS consultants. German for-profits paid higher wages an offered better financial incentives than

public hospitals, their main acquisition targets. US for-profit hospitals offered generous reimbursements and financial incentives to their self-employed physicians.

*Ownership regulations*

For-profit hospitals have often been exposed to restrictive ownership regulations. These regulatory restrictions have eased in recent decades. One reason for this is that they were often tied to the reimbursement of capital. Since capital is increasingly reimbursed through prospective payments, the rationale for hospital planning agencies and certificate-of-need regulations is declining.

The two federalist countries in this study have allowed for the greatest variety among types of hospital ownership. Since jurisdiction over hospital planning regulations resides at state level, specific local peculiarities helped proprietary hospitals to continue operating in spite of severe constraints. Federalism permits a breeding ground for (political) experiments where formal for-profit constraints can be eased. For example, right-wing states in the US were the first to abandon or stop enforcing certificate-of-need policies. In Germany, the new governments of the Eastern states were eager to abandon the communist legacy of state ownership. In unitary states, ownership decisions are much more centralized. In both the UK and the Netherlands, there is much less variety among types of ownership. Although, during the 1970s, UK efforts to curb for-profit ownership were counterproductive, ownership regulation has been very effective in the Netherlands.

*Exposure to competition*

The changing competitive positions of the different types of hospital ownership have already been discussed thoroughly. In the UK, increases in NHS funding altered the for-profit business model. However, the hospital sector is also exposed to competition from other provider types. Technological progress has facilitated outpatient treatments or treatments in alternative, less capital-intensive surroundings. This could gradually alter hospitals' monopoly on acute health care provision.

Physicians may become less dependent on hospital access. They may, once again, find it viable to found their own facilities, like ambulatory surgery centers and specialty hospitals. From a physician perspective, the financial rewards of such investments may be substantial. This could develop into a serious threat to the for-profit hospital sector, which builds part of their business on physicians seeking high remunerations. In the US, exposure to such new forms of competition is more manifest than in the other countries. Especially in Germany, the traditional dichotomy between inpatient and outpatient care persists to a large extent.

### 6.6.2 Summarizing the answers to the research questions

Three questions have guided this work. Four case studies have shown how for-profit ownership has actually developed within the context of different Western health care systems (question 1). Access to and reimbursement of capital, together with physician interests matter most if one is seeking to understand the development of for-profit hospital ownership over the long term. These factors are more important to for-profit development than ownership-related performance differences regarding efficiency, medical outcomes, or community benefits (question 2). The different development paths of the for-profit hospital sector in Western countries are predominantly the result of how and when the institutions regarding capital and physician interests were shaped (question 3).

# Notes

## Chapter 1

1 It is notoriously difficult to cut health-care services due to political and public opposition; most efforts thus concentrate on increasing efficiency, for example by bringing the market in.

2 For a short overview: Tiemann and Schreyögg, 2009, p. 116–118.

3 Newhouse (1970), Feldstein (1971), Pauly and Redisch (1973) were among the first health economists to analyze the (severe) economic problems of nonprofit hospitals. During the 1980s and 1990s, many studies by Frank Sloan indicated that for-profit hospitals performed at least as well, or better than other types of providers. Kessler and McClellan (2002) studied the spill-over effects of for-profit ownership to other ownership types and suggested that for-profit ownership was superior if such spill-over effects were included.

4 The exchange between Arnold Relman and Uwe Reinhardt (1986, p. 209–223), published in the landmark study of the Institute of Medicine on for-profit health care, forms an instructive example of such reasoning.

5 Schlesinger and Gray, 2006, p. w289-w290.

6 Wörz compares and analyzes the results of eleven systematic meta-reviews on the level of their included studies. He studied 186 articles on the cost-efficiency of for-profits versus nonprofits (Wörz, 2007, p. 66–92).

7 Wörz shows that German for-profits, belonging to a hospital chain, charge substantially above nonprofit and public facilities (2007, p. 156–169).

8 A longitudinal perspective on for-profit care has been used by Higgins (1988) for the UK; and Schlesinger, Marmor, and Smithey (1987) and Gray (1991) for the USA. Lindorff (1992) and Lutz, Grossman, and Bigalke (1998) wrote work that is more popular. Broader themes – such as the privatization or corporatization of health care – have received more attention. Paul Starr's work (1982) on the social transformation of American medicine stands out in particular.

9 The work of Weisbrod (for example 1998) on nonprofit theory and development is well known. Simon (2000) describes the post-war history of German hospital politics. UK scholars such as Klein (1983) and Hunter (2008) concentrate on the NHS. Rosenberg (1987) and Stevens (1989, rep. 1999) describe the history of the US hospital sector.

10 Feldstein, 1979, p. 186–188.

11 Anheier and Ben-ner (2003) edited an overview of theories and approaches on nonprofit ownership. Many scholars see nonprofits as more responsive towards public goals. This can be explained by specific nonprofit objectives such as a maximization of quantity and quality over profits (Newhouse, 1970) or external mechanisms like the non-distribution constraint (Hansmann, 1980). Pauly and Redisch (1973) suggest that physician cartels capture nonprofit hospitals in an effort to meet personal interests. Weisbrod (1975) stated that nonprofits are understandable as an alternative mechanism for providing public-type services. The more homogenous a society is, the more similar its citizens' preferences, and

the smaller the need for nonprofit organizations. A preference of the nonprofit workforce towards altruistic goals (Rose-Ackerman, 1996) might also be a possibility.

12 Alchian and Demsetz, 1973, p. 19.

13 Furubotn and Pejovich, 1972, p. 1148.

14 Hansmann and Kraakman, 2001, p. 439. In their article 'The end of history for corporate law', they refer towards a convergence of corporate law towards the shareholder-oriented model of the US and the UK. During the post-World War II period, this model outcompeted the three alternative models of corporate governance: the managerial model (the Netherlands), the labor-oriented model (Germany), and the state-oriented model (Japan).

15 Hansmann, 1996, p. 12–16.

16 Hansmann (1980, p. 838–840) first uses the term non-distribution constraint.

17 Saltman, 2003, p. 24–29.

18 Saltman, 2003, p. 25.

19 Frumkin 2002, p. 3–8.

20 Pauly and Redisch, 1973; Glaeser, 2002.

21 Hansmann (1980) also points towards the dimensions of mutual and entrepreneurial nonprofits.

22 Weisbrod, 1988, p. 223.

23 A recent study underscores the importance of local politics for the operation of public hospital facilities. Public hospital employment correlates positively with the local unemployment rate, and more strongly so in left-wing municipalities, whereas no such relationship is found in non-public hospitals (Clark and Milcent, 2008).

24 Preker and Harding, 2003, p. 52–57.

25 Hansmann, 1996, p. 11.

26 Demsetz, 1967.

27 Waldron (1981), Bajt (1993), and Furubotn and Richter (1998) discuss this point in property rights theory.

28 Mayhew, 1985.

29 Hansmann, 1996, p. 245.

30 Evans, 1984.

31 Pauly, 1986.

32 Silverman and Skinner, 2004.

33 Robinson and Luft, 1885; Zwanzinger, Melnick, and Bamnezai, 2000.

34 Alchian, 1965.

35 See Barzel (1997) for an overview of this approach.

36 The political philosophy of John Locke (1986) – a treatise on government – made such a case many years earlier; he stated that the central goal of government was to privatize the commons.

37 McMaster, 2002.

38 Alchian, 1974, p. 2.

39 Horwitz and Nicholl, 2007, p. 10; Lakdawalla and Phillipson, 2005.

40 Hansmann, 1996, p. 22.

41 Wörz, 2007, p. 23.

42 According to Evans (2005, p. 286): 'there are powerful incentives for participants to erode or circumvent regulatory controls and move in the natural direction'.

43 DiMaggio and Powell, 1991, p.66; Silvers, 2001, p. 1022.

44 Burns, 1990, p. 102.
45 Horwitz, 2005; Horwitz and Nichol, 2007, p. 29.
46 Tiemann and Schreyögg, 2009, p. 129.
47 Demsetz, 1967.
48 Starr, 1982, p. 389.
49 Anheier, 2005, p.13.
50 Weisbrod, 1975, p. 171–195.
51 Arrow, 1963, p. 941–973.
52 See for example Ben-Ner and van Hoomissen, 1993.
53 See Krashinsky (2003) for a general overview.
54 Horwitz, 2003, p. 1377.
55 James, 1987.
56 Pauly and Redisch, 1973.
57 Steinberg and Gray, 1993.
58 Alexander, Morrissey, and Shortell, 1986, p. 409–410.
59 Hansmann, 1980, p. 843–844; 1987, p. 29; and, 1996, p. 228.
60 See for example Glaeser and Shleifer, 2001 for a description of such reasoning.
61 For-profit hospitals have a continuing and significant bias towards the more profitable and better 'contractable' services such as heart surgery, magnetic resource imaging, and extracorporeal shockwave lithotripters (Horwitz 2003, 2005; Horwitz and Nichols, 2007).
62 Hultman, 1991, p. 614–622.
63 Two institutions can be said to be complementary if the presence (or efficiency) increases the returns from (or efficiency of ) the other (Hall and Soskice, 2001, p. 17).
64 Salomon and Anheier, 1996.
65 Salomon, 1995.
66 Anheier, 2005, p. 131.
67 Francois and Vlassopoulos, 2007, p. 4.
68 Roomkin and Weisbrod, 1999, 752–755.
69 James, 1987, p. 404.
70 Some scholars propose that due to the fact that agents derive an additional non-monetary benefit from a socially worthwhile good, low wages, unrelated to performance, help to select a labor force driven by concern for the firm's output (Francois, 2007). The empirical evidence for such a proposition is mixed: nonprofits do obtain greater labor donations than for-profits, but nonprofits, at the same time, pay identical workers more than for-profits (Mocan and Tekin, 2000).
71 Rose-Ackermann, 1996; Glaser and Shleifer, 2001.
72 Lakdawalla and Philipson (2005) argue with a formal analysis that nonprofits have a competitive advantage over for-profits and can be analyzed as for-profit firms with lower costs.
73 Francois and Vlassopoulos, 2007, p. 20–24.
74 This position is also defended by Klein and Marmor (2006, p 905).
75 Yin, 1999.
76 Ragin, 1987, p. vii.
77 Immergut, 1992, p. 9.
78 Immergut, 1992, p. 10–18.
79 Fuchs (2000, p. 147) made this point for the discipline of health economics, where he argues for a more institutional, historic, and linguistic approach.

80 Lieberson, 1991, p. 312–315.

81 The pilot-study, in Dutch, is available on request by the author.

Table: statements on the conditions and constraints of for-profit hospital ownership

| Institutionalist | Micro-economic (SCP paradigm) | Actorist / political |
|---|---|---|
| Property rights (+) | Low price-elasticity in market (+) | Existence of successful entrepreneurs (+) |
| 'Liberal' welfare state (+) | High income-elasticity in market (+) | Global Entrepreneurship Monitor (+) |
| Consensual political culture (+) | High information-asymmetry (+) | Right-wing governments with a majority rule (+) |
| Historical presence (path-dependence) (+) | High labor intensity in services (–) | Fit with existing administrative and regulatory framework (+) |
| Shared mental model of the superior performance of free markets (+) | High capital intensity (+) | Large private (indemnity) insurance sector (+) |
| Institutional room for supplementary services (+) | Market is regionally oriented (–) | Existence of one dominant non-profit interest group (+) |
| Formal institutions pre-structuring policy changes (+) | Concentrated provider market (+) | Effective patient and consumer organizations (–) |
| Institutions guarantees for trust (+) | Limited possibility for differentiation services (–) | Limited physician-ownership opportunities in hospital sector (–) |
| Physicians on salary (+) | High entrance barriers (+) | |
| 'Instability' of institutional constraints (+) | High organic growth of market (+) | |
| Fewer gate keeping constraints (+) | Concentrated purchaser market (–) | |
| A large for-profit sector in other health care sectors (+) | High share of fixed-costs (–) | |
| Less access to capital (+) | | |

(+) Positively related; (–) negatively related

Source: Jeurissen, 2005 unpublished

82 Lieberson, 1991, p. 317.

83 Hansmann, 1996, p ix.

84 Starr (1982, p. 227) makes this methodological point in the final part of his chapters on the rise of medical authority and the shaping of a medical system. He thinks, discussing the work of Kenneth Arrow on the logicalness of non-profit providers in health care, that a purely and deductively economic or sociological approach bears the risk of a presump-

tion that what is real is also rational, or, in the case of sociologists, what is structural is functional.

85 Oliver and Mossalios, 2004.

86 Here one includes a more variable-oriented approach with the historical data. See e.g. Ragin (1987) and Bates et. al. (1998).

87 Ragin, 1987, p. 31.

88 Goldman and Romley, 2008.

89 Dolfsma, 2002, p. 449–457.

90 Przeworski and Teune, 1970, p. 50–51. The system-level variables should, ideally, be used to explain variation across systems in within-system relationships.

91 Ragin, 1987 p. vii-xv.

92 This figure is based on Scott and Meyer (1991, p. 124).

93 Gerring, 2007.

94 Przeworski and Teune, 1970; Ragin, 1987. We can illustrate this by a selection of related health care systems, according to some common criteria, and the existence of a for-profit hospital sector. Canada, the UK, and Australia all operate a National Health Service and are related in other respects (language, culture, economy). However, the size of their for-profit hospital sectors is very different: negligible (Canada), medium (UK), and significant (Australia). Germany, Austria, and the Netherlands are also related with their histories of Bismarckian systems and similarities in culture and welfare governance. Nevertheless, the number of for-profits varies substantially: none (the Netherlands), medium (Austria), and substantial (Germany). This implies that is hard to explain differences in for-profit ownership by using a, somewhat superficial, strategy of seeking most similar countries.

95 Lieberson, 1991, p. 308.

96 However, Switzerland is the archetypical consensus-democracy.

97 See Arts and Gelissen (2002) for a general discussion of modifications to Esping-Andersen's typology of the welfare state. Wendt et al. (2009) argue that other dimensions (provision, regulation) need also to be included since one dimension does not necessarily determine these other dimensions.

98 Salamon and Anheier, 1996.

99 Doering, 1995; scale −1 towards +1.

100 Amable, 2003, p. 158–159.

101 Although Britain might be increasingly typified as a 'liberal' welfare state regime, the National Health Service still stands out as a 'social democratic' archetype: no means-testing, total access for the entire population, few co-payments, and funded by tax-payers.

102 Wendt, Frisina, and Rothgang, 2009, p. 73.

103 I have not included the market reforms of 2006. 1.) This research covers the period roughly until 2006. 2.) The changes are at the highest policy level, but many of the secondary institutional constraints are still based on the former system.

104 Ragin, 1987, p. 3.

105 Cutler, 2002.

106 Wörz, 2007, p. 96.

107 Total monetary compensation is substantially higher in the for-profit hospital sector; also bonuses being absolutely and relatively greater in the for-profit sector (Roomkin and Weisbrod, 1999, p. 750).

108 Carter, Massa and Power, 1997, p. 63–87; Centers of Medicare and Medicaid, 2003e; Ozcan, Luke, and Haksever (1992, p. 781) all state that for-profits use labor inputs more efficiently, but capital inputs less efficiently than other providers.
109 See for example Burgess and Wilson, 1996, p. 110–123; White and Ozcan, 1996, p. 297–311.
110 Shukla, Pestian, and Clement, 1997, p 117–134; Suzuki, 2002.
111 Borzekowski (2002) showed that for-profits, for their ICT-investments, were more responsive towards incentives.
112 Shen, 2006.
113 Hansmann et. al., 2002.
114 Center of Healthcare Industry Performance Studies, 1998, p. 102; Silverman and Skinner, 2004, p. 369–389; Davny, 2005, p. 1525–1547.
115 Hultman, 1991, p. 613–622; Potter, 2000.
116 Kessler and McClellan, 2002, p. 488–506.
117 Herr, 2008, p. 1068.
118 Eggleston et. al., 2006, p. 19.
119 McClellan and Staiger, 2000.
120 Schlesinger et. al., 1989, p. 244–257; Garg and Powe, 2001, p. 153–156; Deveraux et. al., 2002, p. 2449–257.
121 Stafford, 1991; Braverman et. al., 2005; Goodbick and Salancik, 1996; Lanska and Kryscio, 1998.
122 Thomas, Orav, Brennan, 2000, p. 745–761.
123 Eggleston, Shen, Lau, Schmidt, and Chan, 2008.
124 Horwitz (2005) explored the relative p rofitability of acute hospital services in the US. Unprofitable treatments are: AIDS/HIV, burn care, emergency rooms, substance abuse, psychiatric emergency care, child/adolescent psychiatric care, obstetrics, and trauma centers. Relatively profitable services are: cardiac care, orthopedic surgery, extracorporeal shock wave lithotripsy, diagnostic imaging, women's health, neonatal and pediatric intensive care, and related services.
125 Thorpe, Florence, and Seiber, 2001.
126 Cutler and Horwitz, 1998, p. 30.
127 Herzlinger and Krasker, 1987; Sheils and Haught, 2004.
128 Morrissey, Wediw, and Hassan, 1996, p. 132–144; Ferris and Graddy, 1999, p. 18–31.
129 Based on Wörz, 2007, p. 69–75; supplemented with own unpublished work.
130 Lawson, 1995, p. 116; Badham and Brandup, 2000, p. 162.
131 Milcent, 2005, p. 1151.
132 Herr, 2008; Tiemann and Schreyögg, 2009.
133 Tiemann and Schreyögg, 2009, p. 129.
134 Wörz, 2007, p. 145–147.

## Chapter 2

1 Physicians were paid in prestige and clinical access; hospital trustees in deference and the opportunity for spiritual accomplishment; nurses and patients were compensated with creature comforts: food, heat, and a place to sleep; patients offered deference and their bodies as teaching material (Rosenberg, 1987, p. 339).

2 Rosenberg, 1987, p.5.
3 Starr, 1982, p. 72; Rosenberg, 1987, p. 402.
4 Rosenberg, 1987, p. 9; Stevens, 1999.
5 Rosenberg, 1987, p. 341.
6 These included mental health, tuberculosis, and other institutional facilities. Besides, the AMA registration there existed 458 smaller facilities (12,754 beds). Registered hospitals can be subdivided into acute care hospitals (4,538 facilities, exploiting 370,613 beds) and specialty hospitals (719 facilities, exploiting 42,788 beds). There were 553 mental health facilities (393,737 beds); 507 facilities for tuberculosis (61,999 beds); and 535 other institutional facilities with 23,797 beds (Rorem, 1930).
7 Already by 1885, the Catholic community had opened 154 hospitals throughout the United States, more than had existed in the total country in the late 1860s (Rosenberg, 1987, p. 111).
8 White, 1982, p. 147.
9 The proportion of Americans living in towns of 2,500 or more increased from just six percent in 1800 to fifteen percent by 1850; it then jumped to thirty-seven percent (1890) and forty-six percent (1910). Urban growth led to higher property values, forcing many families to abandon private houses for apartments in multi-family dwellings, which limited their ability to set aside rooms for sickness or childbirth (Starr, 1982; p 62, 74).
10 Rosenberg, 1987, p. 244–245.
11 Stevens, 1999, p. 20.
12 The Bureau of Education found in a survey that sixteen percent of 692 hospitals were proprietary-owned (Stevens, 1999, p. 368–369). However, many proprietary facilities were small-scale and might not have been included in or responded to such investigations.
13 Rosenberg, 1987, p. 32.
14 Rosenberg, 1987, p. 239.
15 Rosenberg, 1987, p. 243.
16 Stevens, 1999, p. 43.
17 Burdett, 1895.
18 Stevens, 1999, p. 24.
19 Stevens, 1999, p. 30.
20 Stevens, 1999, p. 31.
21 Starr, 1982, p. 161.
22 In contrast to European facilities, American hospitals tended to be smaller in size with more private accommodations; in 1908, forty percent of the hospital beds were single rooms
23 Rosenberg, 1987, p. 238.
24 Stevens, 1999, p. 106.
25 Rosenberg, 1987, p. 249.
26 Starr, 1982, p. 162.
27 Rosenberg, 1987, p. 253.
28 For example there were 55 physicians in the UK per 100,000, against 50 in Germany, and 169 in the US (1910) (Stevens, 1999, p. 374).
29 Rosenberg, 1987, p. 316–317.
30 Rosenberg, 1987, p. 255.
31 Rosenberg, 1987, p. 48.

32 Rosenberg, 1987, p. 271–272.
33 Starr, 1982, p. 165.
34 Rosenberg, 1987, p. 174.
35 Rosenberg, 1987, p. 249.
36 Clapsattle, 1941.
37 White, 1982, p. 154.
38 Starr, 1982.
39 Gray, 1986a, p. xviii.
40 Starr, 1982.
41 Stevens, 1999, p. 31.
42 Rorem, 1930 (own calculations)
43 Rorem, 1930 (own calculations)
44 Rorem, 1931, p. 60.
45 In 1929 California doctors earned an average income of $ 6,700 (Kuznets and Friedman, 1939). Rorem found that doctors participating in private group clinics could earn up to $ 9,747 as cash income. Capital investments for an average private group clinic amounted $ 41,500 (Rorem, 1931). This implied that to start a hospital, a group of professionals had to donate large proportions of incomes.
46 In Pennsylvania, investments per bed increased from $ 2,422 (1923) to $ 3,422 (1927); in New York City, investments per bed increased from $ 5,203 (1912) to $ 8,001 (1927) for a group of thirteen hospitals (Rorem, 1930).
47 Between 1925 and 1929, $ 890 million was spent on the construction of hospitals, almost eighty percent more than was spent between 1921 and 1924 (Stevens, 1999, p. 111).
48 As a consequence only proprietary hospitals did calculate depreciation costs in their administrations.
49 However, one has to consider that many long-stay facilities, like the neuropsychiatric and tuberculosis hospitals, were in public hands, and they didn't collect charges at all (Rorem, 1930).
50 Rorem, 1930, p. 178–179.
51 It was estimated that 5.5 percent of all nonprofit beds can be supported through endowment funds on a yearly basis. However, these funds were spread unevenly and concentrated in the larger hospitals in the North, Middle Atlantic, and Central Western states (Rorem, 1930).
52 Rorem, 1930.
53 Steinwald and Neuhauser, 1970.
54 Stevens, 1999, p. 204.
55 Stevens, 1999, p. 147.
56 Starr, 1982, p. 295.
57 Stevens, 1999, p. 147.
58 Stevens, 1999, p. 151.
59 Davis and Rorem, 1932.
60 Kuznets and Friedman, 1939.
61 Stevens, 1999, p. 151, 152, 183.
62 Starr, 1982, p. 167.
63 Schwartz, 1938.

64 Some doctors wanted to keep their independence and for these private group clinics emerged during the nineteen-twenties. Private group clinics were highly heterogeneous. They were characterized by 1.) Physicians conducted their practice in a common facility, 2.) They shared group responsibility for patient care, 3.) Physicians 'pooled' their income, and 4.) More than one specialty was represented in the group. They were organized as professional partnerships, although some formed separate corporations for the ownership of buildings. Occasionally, the groups owned hospital facilities, but more typically was that they acted as the closed-staff of certain hospitals. Rorem, who first researched such facilities, concluded they were in a position to fulfill basic requirements of good medical care with high efficiency (Rorem, 1931, p. 110). In 1930, about 150 multispecialty medical groups existed – most of these clinics were in the Middle West, in Southern and in Western states and in towns of less than 50.000 inhabitants (Rorem, 1931, p 16). In 1965 their number had risen towards approximately 1,500 groups.
65 Davis, 1932 p. 76.
66 In the case of for-profit hospitals the public might be told on any irregularities (Stevens, 1999, p. 124).
67 Vladeck, 1980.
68 Pauly and Redisch, 1973.
69 White, 1982, p. 158.
70 Stevens, 1999, p. 143.
71 Stevens, 1999, p. 159.
72 The life-insurance sector was highly consolidated with Metropolitan Life and Prudential holding seventy-two percent of this business. In 1911 premiums in policies for funeral and end-of-life illnesses were a total of $ 183 million – about as much as Germany spent on its entire social insurance system. This profitable business was threatened by the reformers' inclusion of a funeral benefit in their proposal for a compulsory insurance (Starr, 1982).
73 In 1920, the AMA was influenced by a revolt from conservative segments of its membership and formally declared its opposition to compulsory health insurance (Oberlander, 2003, p. 19).
74 Blumenthal and Morone, 2008, p. 21–57.
75 Schlesinger et. al., 1987, p. 432.
76 Stevens, 1999, p. 189, 192.
77 Starr, 1982, p. 298.
78 Stevens, 1999, p. 201.
79 Bays, 1983, p. 850.
80 Stevens, 1999, p. 232.
81 The impact of the growth of community income on the growth and conversion of for-profit hospitals to nonprofit ownership appears a weaker hypothesis (Lave and Lave, 1974). The declining importance of philanthropic capital meant that the income of the surrounding area was less relevant to hospital expansions and the additional funds for nonprofits available through the Hill-Burton legislation appears to make less plausible the hypothesis that hospital growth was a function of rising income levels in the surrounding area.
82 Kushman and Nucton, 1977, p. 203.
83 Stevens, 1999, p. 229.
84 White, 1982, p. 152–153.
85 Stevens, 1999, p. 209.

86 At that time, it was still a politically weak and fragmented organization, a federation of independent state associations. Its major constituency was, and still is, small and medium-sized voluntary nonprofit hospitals (Feshbach, 1979, p. 318).

87 Feshbach, 1979, p. 313.

88 The Hill-Burton Act limited aid to states with no more than 4.5 beds per 1,000 people. This was a figure far above the levels in any state (Starr, 1982. p. 349).

89 Table: Non-federal general and allied short-term specialty hospital beds per 1,000 population

| | Northeast | North Central | South | West | Total |
|---|---|---|---|---|---|
| 1928 | 3,60 | 2,91 | 1,67 | 3,86 | 2,81 |
| 1940 | 3,78 | 3,01 | 2,10 | 3,91 | 3,03 |
| 1950 | 3,86 | 3,41 | 2,75 | 3,50 | 3,33 |
| 1960 | 3,98 | 3,80 | 3,58 | 3,16 | 3,68 |
| 1970 | 4,31 | 4,55 | 3,97 | 3,74 | 4,17 |

Source: White, 1982, p. 150

90 HMFA, 2004a, p. 6.

91 These were not available in the whole country. There were only fourteen local hospital planning agencies throughout the US (Stevens, 1999, p. 276).

92 Feshbach, 1979, p. 333.

93 Perlstadt, 1995.

94 Stevens, 1999, p. 269.

95 Feshbach, 1979, p. 328.

96 Young, 1986, p. 774.

97 Schweitzer and Rafferty, 1976. However, although nonprofits are overrepresented in complex care, controlling for case-mix, there was no confirming evidence for this thesis (Freund et. al., 1985, p. 34).

98 Davis, 1955, p. 34–35.

99 Brock and Buchanan, 1986, 228.

100 Hill-Burton supported the small-scale hospital – the dominion of proprietary care – creating and transforming small community units into well equipped acute hospital centers (Stevens, 1999, p. 229).

101 Alford, 1975, p. 202.

102 Brown, 1959, p. 26.

103 The Hill-Burton program (1961) was extended to provide money for area wide health planning – voluntary planning at the local level (Stevens, 1999, p. 276). New York headed much of this movement. In New York City the closure of proprietary hospitals was already recommended in 1960 by the influential Eurich report (Alford, 1975, p. 40).

104 Ruchin et. al., 1973, p. 14.

105 Evans, 1986, p. 28.

106 Roemer, 1972, p. 120.

107 Brown, 1959, p. 28.

108 Starr, 1982, p. 328.

109 However, these reimbursements were roughly between sixty and seventy percent of the average hospital costs (Stevens, 1999, p. 257).

110 Starr, 1982, p. 311.
111 Starr, 1982, p. 313.
112 Indemnity insurance holds more variety in benefits and co-payments, and could be more easily coordinated on a national level. Indemnity insurance companies also provided one-stop service for a variety of insurance products. However, experience rating was probably most attractive to employers, since this meant cheaper rates for their workforce.
113 Starr, 1982, p. 332.
114 Rorem, 1982, p. 131.
115 Rorem, 1950, rep. 1982, p. 133–134.
116 Stevens, 1999, p. 234–235.
117 Stevens, 1999, p. 237.
118 Stevens, 1999, p. 263.
119 Schlesinger et. al., 1987, p. 434.
120 Sundquist, 1968, p. 13–56.
121 Blumenthal and Morone, 2008, p. 205.
122 For a comprehensive overview of the evolution of the Medicaid program see Smit and Moore, 2008.
123 In fact: the most obvious force of hospital history since 1965 is the overwhelming influence of hospital federal policies (Stevens, 1999, p. 284).
124 Stevens, 1999, p. 281.
125 Table: Assets of non-federal short-term hospitals, selected years ($ millions), market share in brackets

| | Nonprofit (%) | Public (%) | For-profit (%) | Total |
|---|---|---|---|---|
| 1947 | 2,697 (78.4) | 612 (17.8) | 129 (3.8) | 3,439 |
| 1950 | 3,350 (77.0) | 861 (19.8) | 138 (3.2) | 4,349 |
| 1955 | 5,223 (74.8) | 1,614 (23.1) | 148 (2.1) | 6,985 |
| 1960 | 8,422 (77.6) | 2,193 (20.2) | 243 (2.2) | 10,858 |
| 1965 | 12,476 (76.2) | 3,474 (21.2) | 414 (2.6) | 16,364 |
| 1970 | 20,502 (76.9) | 5,301 (19.9) | 871 (3.2) | 26,674 |
| 1975 | 35,827 (75.8) | 8,890 (18.8) | 2,538 (5.4) | 47,256 |
| 1977 | 46,686 (76.4) | 10,953 (17.9) | 3,494 (5.7) | 61,133 |

Source: Stevens, 1999, p. 287.

126 Oberlander, 2003, p. 108.
127 Robinson and Luft, 1985, p. 333–356.
128 Stevens, 1999, p. 289.
129 Stevens, 1999, p. 294.
130 Rorem, 1968, rep. 1983, p. 173.
131 Blue Cross cost-based plans are one exemption: they sometimes pay nonprofits a premium on top of cost in lieu of an equity payment. However, these payments are small (Valvano and Sloan, 1988, p. 352–353).
132 Gray, 1986b, p. 51.
133 Gray, 1986b, p. 51.

134 Medicare had not finally determined in regulations how much of the costs associated with hospital acquisitions would be recognized as allowable by the Medicare program (GAO, 1983, p. i).

135 General Accounting Office (GAO), 1984.

136 Cohodes and Kinkhead, 1984.

137 Valvona and Sloan, 1988, p. 352.

138 Gray, 1984.

139 In 1972 a new credit enhancement technique became available: American Municipal Bond Assurance Corporation (AMBAC) began to offer insurance for hospital tax-exempt bonds. In 1978 the FHA also extended its debt insurance program from hospital mortgage loans towards all tax-exempt hospital bonds (Gray, 1984, p. 6).

140 If approved, the FHA insures a hospital's mortgage. The maximum term is 25 years following completion of the construction and up to ninety percent debt financing is accepted. In return for the insurance, the hospital pays a yearly premium equal to ½ percent of the outstanding loan balance. This permitted many hospitals to borrow at levels not possible through conventional means (Gray, 1984, p. 5).

141 Kinkhead, 1984.

142 New Stock Issues as a Percentage of Change in Value of Equity from Previous Year for Hospital Companies

| Year | New Stock (Percent) | Year | New Stock (percent) |
|---|---|---|---|
| 1972 | 19.1 | 1979 | 61.8 |
| 1973 | 6.6 | 1980 | 31.9 |
| 1974 | 0.5 | 1981 | 57.7 |
| 1975 | 5.7 | 1982 | 53.8 |
| 1976 | 30.7 | 1983 | 41.3 |
| 1977 | 6.9 | 1984 | 10.7 |
| 1978 | 48.0 | 1985 | 24.8 |

Source: Valvona and Sloan, 1988, p. 350

143 'As a nonprofit entity, the only available sources of equity capital are philanthropy and retained earnings. Both have suffered in recent years. As nonprofit institutions assume more debt to finance needed facilities, the point of maximum leverage is eventually reached, and the debt markets are closed. Many nonprofits have begun to meet this challenge by corporate restructuring (…) the creation of one or more affiliated corporations that are for-profit and can rate equity capital for themselves and the nonprofit hospitals' (Gray, 1984, p. 8).

144 General Accounting Office, 1986b.

145 Gray, 1986b, p. 55.

146 Salmon, 1995, p. 12; in 1982–1984 and in 1995–1997 two more fiscal crisis were proclaimed. This is because Medicare politics are 'trust-fund driven'. When revenues in the trust fund account appear low, a financial crisis is claimed to ensue (Oberlander, 2003, p. 85).

147 Jimmy Carter again sought a freeze of hospital rates in 1977, but this proposal died in the House of Representatives after massive lobbying by the hospital industry.

148 Schlesinger et. al., 1987, p. 435.
149 Starr, 1982, p. 396; Young, 1986, p. 766.
150 Stevens, 1999, p. 285.
151 For-profit hospitals admitted fewer emergency room patients to the hospital (Ruchin et. al., 1973, p. 21); issues were raised on the quality of the delivered care, and the efficiency with which proprietary hospitals claimed to operate (Stewart, 1973, p. 5).
152 Kushman and Nucton, 1977, p. 190.
153 Alford, 1975, p. 176.
154 The National Health Planning and Development Act (Starr, 1982, p. 399).
155 Table: Deductions from Revenue as a Percent of Total Patient Charges (California)

| | Voluntary | Public | For-profit independent | For-profit chain |
|---|---|---|---|---|
| 1977–1978 | | | | |
| Medicare contractual | 6 | 4 | 7 | 9 |
| Medi-Cal contractual | 3 | 5 | 3 | 3 |
| Charity | 0 | 0 | 0 | 0 |
| Bad Debt | 2 | 2 | 2 | 2 |
| Other | 1 | 2 | 1 | 2 |
| Total deductions | 12 | 13 | 13 | 16 |
| 1981–1982 | | | | |
| Medicare contractual | 10 | 6 | 10 | 14 |
| Medi-Cal contractual | 4 | 6 | 4 | 5 |
| Charity | 0 | 1 | 0 | 0 |
| Bad Debt | 2 | 6 | 3 | 2 |
| Other | 1 | 1 | 1 | 2 |
| Total deductions | 17 | 20 | 18 | 23 |

Source: Pattison, 1986, p. 297

156 Zweifel and Eichenberger (1992, p. 97) state that the unique control of the AMA over the accreditation of hospitals for medical training results in perfect control over access to the market and keeps physician density low. This is another reason for comparatively high income in the US.
157 Weiss, 1997, p. 36.
158 Brock and Buchanan, 1986, p. 239.
159 Stevens, 1999, p. 299.
160 Alford, 1975, p. 214.
161 Galen and McNamee, 1993.
162 Musacchio et. al., 1986, p. 394.
163 Townsend, 1986, p. 463.
164 Gray, 1986b, p. 153–154, p. 161.
165 Stevens, 1999, p. 290.
166 Kuttner, 1996, p. 363.

167 Along with twenty colleagues and four Nashville businessmen, Dr. Frist Sr. founded a partnership to build a new private hospital in Nashville (Rodengen, 2003, p. 13).
168 Ferber, 1971, p. 49,
169 Rodengen, 2003, p. 21.
170 Ferber, 1971, p. 50.
171 The state laws prohibiting the corporate practice of medicine were not enforced, because of exceptions that allowed the employment of residents and interns that were built into the 1973 HMO-act, and because of the development and growth of professional corporations. These laws can be seen as legal remnants of an old and nearly forgotten war against corporate practice (Starr, 1982), half-buried on a field fast being populated with new forms of health care organizations (Rosoff, 1984, p. 4).
172 Gray, 1986b, p. 174.
173 Starr, 1982, p. 431.
174 The financial benefits resulting from increased management expertise, access to specialized services, and access to joint purchasing and capital are important reasons for hospitals to participate in management contracts (Alexander and Lewis, 1984, p. 231. The number of hospitals and beds that were under the management of an investor-owned company increased from 179 hospitals representing 19,912 beds in 1978 to 282 hospitals and 35,000 beds in 1983 (Custer and Musacchio, 1986, p. 229).
175 Gray, 1986b, p. 26.
176 Starr, 1982, p. 430.
177 Table: Number of proprietary hospitals and beds by type of ownership, 1973 and 1982

| Type of Ownership | 1973 | | 1982 | | % Change |
|---|---|---|---|---|---|
| | No. | % | No. | % | |
| Individual | | | | | |
| Hospitals | 68 | 7.0 | 21 | 2.1 | −69.1 |
| Beds | 3,041 | 4.0 | 1,346 | 1.2 | −55.7 |
| Partnership | | | | | |
| Hospitals | 90 | 9.3 | 54 | 5.4 | −40.0 |
| Beds | 7,550 | 9.8 | 6,136 | 5.5 | −18.7 |
| Corporation | | | | | |
| Hospitals | 493 | 51.0 | 255 | 25.6 | −48.3 |
| Beds | 29,295 | 38.1 | 14,663 | 13.2 | −49.9 |
| Chains | | | | | |
| Hospitals | 317 | 32.7 | 668 | 66.9 | 110.7 |
| Beds | 36,976 | 48.1 | 89,171 | 80.1 | 141.2 |

Source: Mullner and Hadley, 1984, p. 145.

178 General Accounting Office, 1986, p. 21.
179 These are community, psychiatric and specialty hospitals owned by corporations that own or managed three or more hospitals; for-profit community hospitals are AHA statistics.
180 Gray, 1986b, p. 28; Mullner and Hadley, 1984, p. 145.

181 Table: Mean Realized Rates of Return by Industry

| | 1972–1983 | 1972–1977 | 1978–1983 | 1984–1985 |
|---|---|---|---|---|
| Hospital Companies | 29.43 | 10.54 | 48.33 | 10.77 |
| Manufacturing | 11.87 | 5.85 | 17.89 | 9.54 |
| Commercial | 12.18 | 3.41 | 20.94 | 16.22 |
| Transportation | 11.68 | 2.93 | 20.43 | 5.9 |
| Public Utilities | 3.02 | 2.01 | 4.02 | 14.82 |
| Communications | 12.51 | 5.12 | 19.90 | 18.63 |
| All above industries except hospital companies | 10.50 | 4.82 | 16.14 | 11.04 |

Source: Valvona and Sloan, 1988, p. 349

182 Rheinhardt, 1999.

183 Pauly, 1986, p. 8–9.

184 Valvona and Sloan, 1988, p. 349.

185 The states with the largest share of for-profit beds in 1984 were: Nevada (50%), Florida (44%), Tennessee (38%), Texas (32%), Virginia (31%), California (31%), Louisiana (31%), Alabama (29%), Georgia (29%), Kentucky (23%), and South Carolina (21%). There existed no for-profit hospitals in New York, Rhode Island, Vermont, and North Dakota (Gray, 1986b, p. 31).

186 Watt et. al., 1986, p. 268–270.

187 Bays, 1983, p. 855–856.

188 Watt et. al., 1986, p. 270.

189 Rodengen, 2003.

190 Ferber, 1971, p. 54.

191 Musacchio et. al., 1986, p. 388.

192 DiMaggio and Powell, 1991.

193 Gray, 1986b, p. 9

194 Net patient margins increased from −6.0% (1963), −3.4% (1970), −3.0% (1975), 0.3% (1980), towards 2.0% in 1984 (Gray, 1986b, p. 99).

195 Gray, 1986b, p. 30.

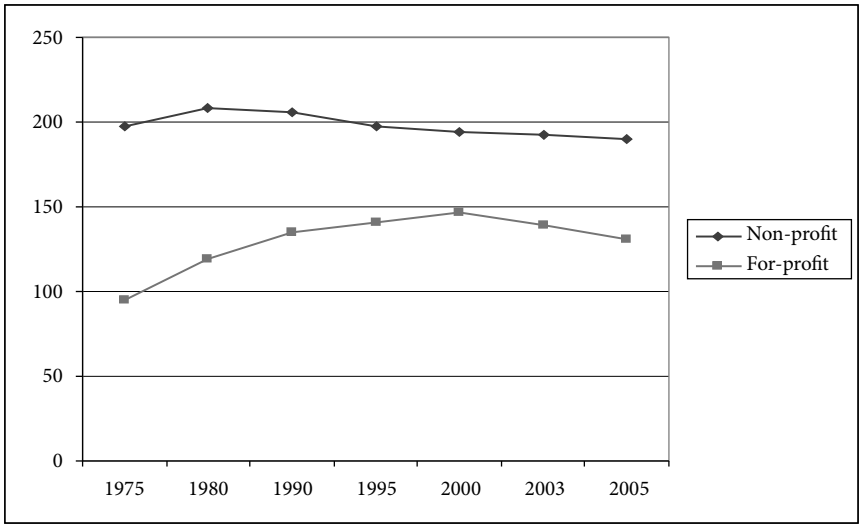
196 Some claimed that during this period almost fifty percent of converting facilities were government hospitals (Wu, 1992). This is supported by a report of the General Accounting Office on forty acquisitions in the Southeast. There most acquisitions were of small public facilities (GAO, 1986).

197 Table: Decomposition of the Change in Nonprofit-to-For-Profit Average Size Ratio

| Category | 70–74 | 74–78 | 78–82 | 82–86 | 86–90 | 90–94 | 94–98 |
|---|---|---|---|---|---|---|---|
| Stayers | −0.8 | −1.0 | −3.3 | −4.5 | 0.6 | −0.3 | −0.7 |
| Exitors | −7.2 | −6.7 | −4.0 | −4.7 | −5.7 | −1.3 | −1.4 |
| Entrants | −5.9 | −2.3 | 0.5 | 0.8 | −0.9 | −1.2 | −1.0 |
| Switch into for-profit | −1.0 | −0.3 | 2.9 | 2.5 | 1.8 | −1.6 | −3.6 |
| Switch from for-profit | 0.1 | −1.3 | −0.8 | −1.2 | −3.1 | −2.3 | −1.0 |
| Total | −14.9 | −11.6 | −4.7 | −7.1 | −7.3 | −6.7 | −7.7 |

Source: David, 2005:11

198 Figure: Average number of nonprofit versus for-profit beds in a single facility




Source: CDC.

199 Davis, 2005, p. 5.

200 Dranove, 2000, p. 59.

201 Relman, 1980.

202 Young, 1986, p. 766.

203 General Accounting Office, 1983, 1986.

204 Evans, 1986, p. 608.

205 McNerney, 1986, p. ix.

206 Many 'academic pamphlets' were published against (Lindorff, 1992; Weiss, 1997) or in favor of for-profit ownership (Herzlinger, 1997; Lutz, 1993). These authors made it very clear were they stood. Weiss dedicated his book to: 'those who have suffered or died as victims of a health system dedicated to maximum profit rather than universal access' (Weiss, 1997, p. v).

207 Relman and Rheinhardt, 1986, 221, 223.

208 McNerney, 1986, p. ix.

209 Gray, 1986b, p. 4–11.

210 The Committee presented three arguments against a level playing field policy. 1.) A level playing field between for-profits and nonprofits would require that competitors procure resource inputs, including financial capital, in the same markets and on the same terms. This is not possible. 2.) The Committee thought that there were more pressing policy concerns than whether the advantages and disadvantages of for-profit and nonprofit ownership balanced each other. 3.) The Committee saw no particular reason why the goal of policy should be the equivalence in treatment by the government rather than a substantive goal such as to assure access to care and quality care (Gray, 1986b, p. 63).

211 In 1985 the Utah State Supreme Court – in a highly relevant case on the Intermountain Health System – denied property tax exemption to two nonprofit hospitals because of lack of evidence of community services (Sanders, 1995, p. 451).

212 Gray, 1986b, p. 65.

213 There was discussion about the nonprofit status of the Blues for a long time. Half the states refused to grant the plans tax-exempt status, while the IRS ruled early in their history that donations to the plans were not tax-deductible (Schlesinger, 1987, p. 431).

214 Clark, 1980, p. 17–89.

215 Watt et. al., 1986b, p. 89.

216 Gaumer, 1986, p. 367.

217 Pattison, 1986, p. 290.

218 Coelen, 1986, p. 329.

219 The GAO concluded that: 'proprietary (4.3%) and not-for-profit (4.7%) hospitals provide about the same level of uncompensated care, measured as a percent of total expenses, but that the public hospitals' level (9.9%) is about twice that of other hospitals' (GAO, 1986, p. 46).

220 Gray, 1986b, p. 191.

221 Stevens, 1982.

222 Brock and Buchanan, 1986, p. 225.

223 Brock and Buchanan, 1986, p. 244.

224 Schlesinger et. al., 1987, p. 427.

225 Gray, 1991, p. xii.

226 Shactman and Altman, 1996, p. 38.

227 Table: For-profit hospitals, Beds, and Admissions

| | Hospitals | Beds | Admissions (in thousands) |
|---|---|---|---|
| 1980 | 730 | 87,000 | 3,165 |
| 1985 | 805 | 104,000 | 3,242 |
| 1990 | 749 | 101,000 | 3,066 |
| 1995 | 752 | 106,000 | 3,428 |
| 2000 | 749 | 110,000 | 4,141 |
| 2002 | 766 | 108,000 | 4,365 |

Source, Hospital Statistics, 2004

228 Hospital Statistics, 2004.

229 At hindsight some called this the end of the golden age era of hospital reimbursement (Gray, 1991, p. 37).

230 Gray, 1991, p. 40.

231 Gray, 1991, p. 33.

232 A correct allocation of debt depends on an accurate determination of the value of the assets acquired. Section 203 of Medicare's Provider Reimbursement Manual sets forth a method for determining the amount of debt that can be allocated for Medicare's purposes to acquired assets when the purchase price exceeds the book value of the assets. Section 203 requires that the allowable costs of the asset related to patient care can be subtracted from the purchasing price. The resulting amount (goodwill and asset value not related to patient care) is not recognizable for Medicare purposes (GAO, 1983, p. 19–20).

233 Specifically, different useful lives were used in appraising and depreciating the acquired assets; in computing depreciation, acquired assets were assumed to have no salvage value; and values were assigned to leased assets, which resulted in higher interest and depreciation expenses being claimed. In addition, the independence and accuracy of the appraisals were questionable because they were changed at HCA's request (GAO, 1983, p. 26–27).

234 General Accounting Office, 1986b, p. 5.

235 Gray, 1991, p. 23–24.

236 Table: health spending by business as a percentage of pre-tax corporate profits and of total labor compensation,

| | Health costs as share of pretax profits | Health costs as share of total compensation |
|---|---|---|
| 1965 | 8.7 | 2.1 |
| 1970 | 20.2 | 3.2 |
| 1975 | 22.8 | 4.1 |
| 1980 | 28.7 | 5.2 |
| 1985 | 51.0 | 6.0 |
| 1987 | 48.7 | 6.2 |

Source: Levit, Freeland and Waldo, 1989

237 Salmon, 1995, p. 24.

238 Frank and Salkever, 2000, p. 209.

239 Iglehart, 1990.

240 General Accounting Office, 1993b, p. 8.

241 Another important exception to the Stark provisions was the in-office ancillary exception, which allowed physicians to provide lab tests, imaging, and other services to their own patients as long as the laboratory or x-ray machine was directly supervised by the physician and physically located near the physicians office suite.

242 Gray, 1991, p. 24.

243 The Provider Reimbursement Review Boards was established in 1972 to give due process to providers who had objections to determinations of allowable costs for reimbursement purposes.

244 The American Hospital Associations is not included in these numbers. As the largest trade association they represent the interest of nonprofit, for-profit and public hospitals. However, mostly nonprofit interest does dominate the AHA's viewpoints.

245 Table: PAC contributions to political candidates reported to the Federal Election Commission, by hospital sector ($)

| | 1981–1982 | 1985–1986 |
|---|---|---|
| For-profit | | |
| Universal Health Services | | 2,654 |
| NME | 29,460 | 81,150 |
| Humana | 3,800 | 8,300 |
| Charter | 9,570 | 10,450 |
| AMI | 3,000 | 53,500 |
| HCA | 8,150 | 35,034 |
| National Ass. Private Psychiatric Hospitals | 19,300 | 25,800 |
| Federation American Health Systems | 201,625 | 135,517 |
| Nonprofit | | |
| Voluntary Hospitals of America | | 17,500 |
| Mixed | | |
| American Hospital Association | 182,925 | 279,896 |

Source: Gray, 1991, p. 162

246 Gray, 1991, p. 42.

247 Table: decline in size of major investor-owned companies

| | Maximum hospitals | Number owned late 1987 | Number owned late 1989 |
|---|---|---|---|
| HCA | 202 (1982) | 82 | 78 |
| AMI | 115 (1984) | 86 | 54 |
| Humana | 90 (1981) | 81 | 81 |
| NME | 47 (1982) | 38 | 36 |
| Charter | 41 (1984) | 14 | 90 |
| Republic | 24 (1984) | 19 | 18 |

Source: Gray, 1991, p. 43

248 Gray, 1991, p. 43.

249 Kuttner, 1996, p. 363.

250 Cleverly, 1999, p. 6.

251 Herzlinger, 1997, p. 143–145; Kleinke, 1998, p. 137–141.

252 In 1981 HCA acquired Hospital Affiliates; in 1987 Health Trust was a spin-off; in 1989 there was a leveraged buyout until 1992 and the company was restructured; the merger with Columbia was in 1993; in 1999 Triad and LifePoint were spin-offs (Rodengen, 2003, p. 126–127).

253 Hacker, 2004, p. 252.

254 CMS, 2003a; Bloche, 2006.

255 The number of firms offering (additional) health coverage for retired employees sharply declined as a result of a 1990 ruling by the Financial Accounting Standard Board (FASB)

that stated that the associated future health care liabilities had to be carried on the companies balance sheets (Blumenthal, 2006, p. 84).

256 Hacker, 2004, p. 253.

257 By 2002 Medicaid MCOs covered fifty-eight percent of the programs' enrollees (McCue et. al., 1999, p. 223).

258 For example, Miller and Luft, 1994.

259 'In President Clinton's Health Security Act, each state or region of the nation would develop a single organization for the purchasing of health insurance using the principles of standard benefits, multiple choice, open enrollment, and cost-conscious consumer choice. Health alliances would contract with HMOs and indemnity plans, contributing 80 percent of the average premium. Individual consumers would contribute the remaining 20 percent, plus the full difference between the premiums of the low and high cost plans if they choose a more expensive option. The health alliances would ensure that consumers had choice among health plans regardless of their health status or medical history, using risk-adjusted premiums to compensate plans that attracted the sickest enrollees. A national health board would standardize the benefits to which all Americans would be entitled. (...) Employers would be required to offer coverage for full-time employees, contributing 80 percent of the average health plan premium, and to pay a payroll tax to cover their part-time and temporary employees' (Robinson, 1999, p. 45).

260 Bloche, 2003, p. xiii.

261 Beaulieu, 2003, p. 42.

262 Cutler et. al., 2000.

263 Rosko, 2001, p. 449.

264 Dranove, 2000, p. 89–90.

265 Table: Health Plan Enrolment for Covered Workers by Plan Type

| | HMO | POS | PPO | Indemnity |
|---|---|---|---|---|
| 1988 | 16% | | 11% | 73% |
| 1993 | 21% | 7% | 26% | 46% |
| 1996 | 31% | 14% | 28% | 27% |
| 1998 | 27% | 24% | 35% | 14% |
| 2000 | 29% | 22% | 41% | 8% |
| 2002 | 26% | 18% | 52% | 5% |

Source: CMS, 2003a, p. 10

266 Massachusetts leads this movement and tries to have universal coverage for the 550,000 uninsured by 2007. The plan sees for strong incentives for smaller employers to offer health plans. Other states with universal health care laws or mandatory provider-posted pricing were California, Nevada, Maine, Vermont, Ohio, Illinois, Missouri, Minnesota, Kansas, Nebraska, New Hampshire, New York and Rhode Island (PWC, 2006, p. 6).

267 Kaiser, Employer Health Benefits 2006 summary of findings.

268 Gray, 1986b, p. 64.

269 Watt et. al., 1986, p. 283.

270 Table: Hospital Characteristics Associated With Lower and Higher Ratios of Capital to Operating Costs (excludes return on equity)

| | |
|---|---|
| Government ownership | 5.65% |
| Teaching Hospitals | 5.68% |
| New England location | 5.97% |
| National Average | 6.89% |
| For-profit ownership | 9.75% |

Source: GAO, August 1986, p. 37

271 In 1984 the overall occupancy rate of for-profit hospitals was 57.4%, against 71.4% for nonprofit hospitals, 64.6% for local government, and 71.9% for state hospital facilities (GAO, 1986, p. 31).

272 The average age of for-profit hospitals was 5.5 years in 1982 against 8.9 years for governmental facilities, and 8.0 years for nonprofit facilities (GAO, 1986, p. 32).

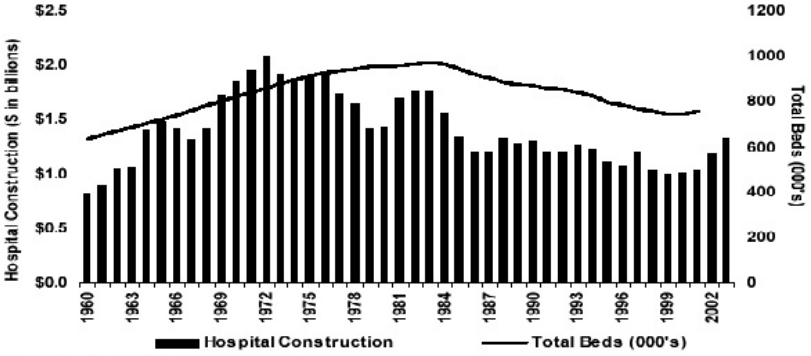
273 Gentry and Frank, 2000, p. 321.

274 HHS was in favor of a rather short term (four years) to implement prospective capital reimbursement; the AHA wanted a much longer transition-period of fifteen years (GAO, 1986, p. 14,15).

275 General Accounting Office, 1986, p. 23–24.

276 Hospital debt financing decreased from 48.1% in 1990 to 42% in 1997 (Cleverly, 1999, p. 8).

277 Figure: Hospital Construction and Bed Capacity, 1960–2003 YTD




Source. Banc of America Securities, inflation adjusted.

CMS, 2003b, p. 23

278 The Lewin Group, 2004.

279 HMFA, 2006, p. 9.

280 Table: Percentage of External Capital from various Sources

| | 1997 | 2002 |
|---|---|---|
| For-profit debt / equity | 14% | 13% |
| Tax-exempt bond issues | 39% | 54% |
| Bank loans | 36% | 7% |
| Philanthropy | 5% | 10% |
| Leasing | 7% | 16% |

Source: HMFA, 2003a, p.4

281 Bank loans dropped from $ 24.9 billion in 1997, to $ 3.8 billion in 2000 (CMS, 2002a, p. 23).

282 CMS, 2002a, p. 21, 23.

283 HMFA, 2004a, p. 9.

284 'Those who said that they would increase capital spending were overwhelmingly at nonprofit hospitals CFOs from for-profit hospitals were the only group in which the majority did not expect to increase capital spending by 15 percent or more. (…) This finding is substantiated by the nation's largest for-profit chain, HCA. In 2003, HCA spent $ 2 billion on capital investments on existing hospitals, up from $ 1.7 billion the previous year. However, HCA is predicting decreases in capital investment in 2004 and 2005 (HMFA, 2004b, p. 12).

285 In a leveraged buyout: 'Large volumes of debt capital are deployed to buy out a firm's publicly traded stock, typically at a premium above the shares' market price, and convert the firm to private for-profit ownership. Some of the debt is paid down through asset sales, but the acquired firm remains heavily leveraged and therefore is constrained to pay out free cash flows to bondholders rather than squandering them on conglomerate diversification or other forms of agency failure. The firm is controlled by a self-perpetuating board of directors, not subject to election or recall by shareholders but monitored by bond rating agencies and bond investors. The for-profit firm subject to a leveraged buyout comes to adopt a financial and governance structure similar to that of the nonprofit organization, in which nonelected, self-perpetuating directors wield authority under the watchful eyes of their tax-exempt bondholders' (Robinson, 2000, p. 66).

286 HMFA, 2003a, p. 7; HMFA, 2004a, p. 5.

287 Oberlander, 2003, p. 14.

288 Table: Historical Inpatient PPS Payment Updates

| Fiscal Year | Large Urban | Other Urban | Rural | Market Basker Update |
|---|---|---|---|---|
| 1988 | 1.50% | 1.00% | 3.00% | 4.7% |
| 1989 | 3.40% | 2.90% | 3.90% | 5.4% |
| 1990 | 5.62% | 4.97% | 9.72% | 5.5% |
| 1991 | 3.20% | 3.20% | 4.50% | 5.2% |
| 1992 | 2.80% | 2.80% | 3.80% | 4.4% |
| 1993 | 2.55% | 2.55% | 3.55% | 4.1% |
| 1994 | 1.80% | 1.80% | 3.30% | 4.3% |
| 1995 | 1.10% | 1.10% | 8.40% | 3.6% |
| 1996 | 1.50% | 1.50% | 1.50% | 3.5% |
| 1997 | 2.00% | 2.00% | 2.00% | 2.5% |
| 1998 | 0.00% | 0.00% | 0.00% | 2.7% |
| 1999 | 0.50% | 0.50% | 0.50% | 2.4% |
| 2000 | 1.10% | 1.10% | 1.10% | 2.9% |
| 2001 | 3.40% | 3.40% | 3.40% | 3.4% |
| 2002 | 2.75% | 2.75% | 2.75% | 3.3% |
| 2003 | 2.95% | 2.95% | 2.95% | 3.5% |
| 2004 (proposed) | 3.50% | 3.50% | 3.50% | 3.5% |

Source: CMS, 2002a, p. 6; CMS, 2003b, p. 10

289 Oberlander, 2003, p. 164.

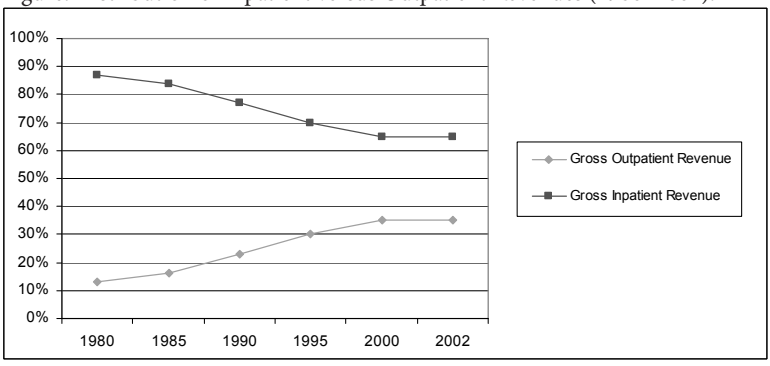
290 However, in 2002 Medicare + Choice appeared to be a clear policy failure. Enrollments were declining with rapid speed (Oberlander, 2003, p. 194).

291 Silvers, 2001, p. 1026.

292 Rodengen, 2003, p. vi.

293 CMS, 2002a, p. 7.

294 Figure: Distribution of Inpatient versus Outpatient Revenues (1980–2002).




Source: The Lewin Group, 2004

295 The idea is that such referrals would produce little personal economic gain, because hospitals tend to provide a diverse and large group of services (GAO, 2003).
296 Iglehart, 2005, p. 81.
297 Gabel, Fahlman, Kang, Wozniak, Kletke, and Hay, 2008.
298 Goldsmith, 1998, p. 28.
299 Kuttner, 1996, p. 362.
300 The Lewin Group, 2004.
301 The General Accounting Office (2003) defines a specialty hospital as a facility in which the diagnoses of two thirds of its Medicare patients fell into no more than two major classifications according to the diagnosis-related group system, or those in which at least two thirds of its Medicare patients were classified into surgical DRGs.
302 HMFA, 2004b, p. 9.
303 Iglehart, 2005, p. 83.
304 Lynk and Longley, 2002; Bian and Morrisey, 2007.
305 Herzlinger, 1997; Porter and Teisberg, 2006.
306 General Accounting Office, 2003.
307 Iglehart, 2005, p. 78.
308 General Accounting Office, 2005b, p. 2.
309 General Accounting Office, 2006, p. 2
310 Iglehart, 2005, p. 79.
311 The Lewin Group, 2004.
312 Stevens, 1999, p. 352.
313 Hansmann (1989) stipulates the withdrawal of the doctrine of charitable immunity from torts (1940); the passage of the unrelated business income tax (1950), which withdrew corporate income tax exemption from for-profit commercial activities by nonprofits; the elimination of state unemployment tax exemption (1970); the deletion by the National Labor Board of worthy cause exemptions that shielded nonprofits from federal labor law (1970–1976); the requirement that nonprofits should pay social security taxes (1983); the more aggressive application of antitrust laws (1980 onwards); and, after the Intermountain case (1985), specific fiscal community benefit requirements.
314 Kuttner, 1996, p. 365.
315 Nonprofit hospitals are exempted from federal and (mostly) state and local taxes if they meet certain tests, set by the IRS. Between 1956 and 1969, the test for tax-exempt status included specific reference to providing (to the extent the hospital's finances allowed) charity services to those not able to pay. Since 1969, the IRS has not required such care so long as the hospital provides benefits to the community in other ways. In 1983 it was decided that also hospitals that did not operate an emergency room could get a tax-exemption status (GAO), 1990, p. 2, 47).
316 Scholars raised issues of methodology; about the data (unaudited and self-reported by hospitals); and about ignorance of state-level differences (Gray, 1997b, p. 39). Most studies found evidence of a lack of community benefits by nonprofit hospitals if the value of exempt taxes was balanced against the total of paid taxes, distributed dividends and stock appreciations by for-profits (Young and Desai, 1999, p. 146–147). However, conversions from nonprofit, and especially public, hospitals towards for-profit status did lead to less uncompensated care: Thorpe found that uncompensated care as a percent of total hospital expenses were .6 percent lower in nonprofit hospitals that converted towards for-profit

ownership versus all nonprofit hospitals; uncompensated care was 2.7 percent lower in public hospitals that converted towards for-profit status (Thorpe et. al., 2000, p. 191).

317 $ 4.6 billion exemptions from income taxes; $ 1.7 billion property exemptions; $ 1.1 billion tax-benefits for donors; and, $ 0.4 benefits related to tax-exempt bonds. Bloche states that the ability to pay tax-free interest on borrowed funds is of more importance than the shielding of nonprofits earnings from federal and state income taxes (Bloche, 2003b, p. 188).

318 Gentry and Penrod, 2000, p. 286–287.

319 'The question concerns policy makers seeking revenues for public purposes, advocates of the uninsured seeking improved availability of services, and for-profits seeking competitive advantage (...) The idea that nonprofit hospitals should provide measurable community benefits (...) is not applied to (...) other types of nonprofit organizations, and the notion that the resource allocation decisions of nonprofit organizations are properly set by government is antithetical to the idea that the third sector's role is to contribute something that is distinct from that of government' (Gray, 1998, p. 311). More specifically, Gray thought that the social benefits of nonprofits lay not only in the provision of community benefits, but also in regulatory benefits and trustworthiness (Gray, 1997b, p. 36–38). Still others were concerned about the possible damage to pre-existing professional linkages between physicians and institutions (Gurewich et. al., 2003, p. 554).

320 For-profit community benefits focus on uncompensated care, a biased figure since it constitutes up to eighty percent 'ordinary' bad debt (Josephson, 1997, p. 65) and, without the large negotiated discount by MCOs, is valued at distorted high charges. Many for-profit (but also nonprofit) hospitals reported charity care in terms of charges instead of at real costs (PWC, 2006, p. 15); since 1980, the ratio of charges to costs has grown from 1,1 to 2,6 (Tompkins et. al., 2006).

321 Sanders, 1995; Reinhardt, 2000; Gentry and Penrod, 2000; and, Bloche, 2003b.

322 General Accounting Office, 1990, p. 5 and 2005a, p. 10, 19.

323 Examples of community benefit reporting requirements are California, Connecticut, Georgia, Idaho, Illinois, Indiana, Maryland, Minnesota, New Hampshire, New York, Pennsylvania, Texas, Utah (mandatory), and Massachusetts, Missouri, Oklahoma, Oregon, Tennessee, West Virginia, and Wisconsin (voluntary) (PwC, 2006, p. 8–9, 11).

324 Josephson, 1997, p. 68.

325 Uncompensated care was estimated at $ 21 billion (2001), but increased to $ 27 billion in 2004 (PwC, 2006, p. 4).

326 'In 1995 around half of private hospitals were solo, compared with 42 percent in 2000. (...) In 1995, 33 percent of private hospitals were part of a system that owned at least one other hospital partner in the same metropolitan statistical area, and this proportion increased to 43 percent in 2000. (...) The third category, private hospitals in a system with no local partner, grew only slightly. The number of solo for-profit hospitals decreased from around 22 percent in 1995 towards 18 percent in 2000, the number of for-profit hospitals with at least one other local partner stayed flat, and the number of for-profit hospitals in a system without local partners did grew from about 23 percent in 1995 towards 29 percent in 2000' (Evans Cuellar and Gertler, 2003, p. 79–80).

327 Hollins, 1997, p. 132.

328 Columbia's founder, Richard Scott, bought his first two hospitals in El Paso in 1988. Colombia operated twelve hospitals in 1991and then acquired Basic American Health (1992, 8 hospitals), Galen (1993, 71 hospitals), HCA (1994, 97 hospitals), Medical Care America

(1994, 96 ambulatory surgery centers), and HealthTrust (1995, 117 hospitals). Before its fall in 1997 it also bought numerous nonprofit hospitals (Kuttner, 1996, p. 364).

329 Rodengen, 2003, p. 88.

330 Kuttner, 1996, p. 362.

331 Rodengen, 2003, p. 121.

332 These included access to capital; actual and expected profit declines, debt service, and financial self-interest by nonprofit managers and directors (Cutler and Horwitz, 2000, p. 57–59).

333 Cutler and Horwitz, 2000, p. 46, 57.

334 Mark, 1999, p. 83.

335 In 1996, conversion foundations hold $ 9.3 billion in assets, about half in California.

336 Many give priority to improving children's' well being, discouraging teen pregnancy, preventing violence, and addressing the root causes of poor health. A smaller number fund – or in some cases provide – health services for uninsured and indigent patients or underwrite the costs of sending physicians or medical residents to underserved areas. Where health is not the main or exclusive priority, conversion foundations tend to fund a broad array of community activities (Isaacs et. al., 1997, p. 229).

337 General Accounting Office, 1997, p. 15.

338 The value of a hospital is determined by a multiplied factor of the hospital's earnings before interest, taxes, depreciation, and amortization (EBITDA). The actual multiple varies from hospital to hospital depending on the existing debt, the market share of the hospital, and the age of the hospital's capital plant. In the nineties a multiple of six times EBITDA has been applied to most sales of nonprofit hospitals (Anderson, 1997, p. 144).

339 Anderson, 1997, p. 145; Gray, 1997b, p. 32. Others found that the purchase prices paid by for profits were correct, or perhaps even too high (Sloan et. al., 2000).

340 Kuttner, 1996, p. 446.

341 Miller, 1997, p. 115; Butler, 1997, p. 71; Bloche, 2003b, p. 188.

342 General Accounting Office, 1997, p. 22.

343 Shactman and Altman, 1996, p. 52; Cutler and Horwitz, 2000, p. 49.

344 Kleinke, 1998b, p. 12.

345 In Dickinson, Tennessee, where Goodlark Hospital was sold in 1995 to Columbia/HCA, the local state representative, served both as a trustee of Goodlark and as its lawyer before its sale and as head of the new foundation afterward (Kuttner, 1996, p. 447).

346 General Accounting Office, 1993a.

347 Rodengen, 2003, p. 103.

348 Bloche, 2003b, p. 186.

349 Baser et. al., 2009, p. 1154.

350 Cutler and Sheiner, 1999, p. 5; Cleverly, 1999, p. 14.

351 Hansmann (1996, p. 239) states that such a result should perhaps be no surprising: 'Managers of nonprofit firms are not much differntly situated than managers of large publicly traded investor-owned firms in which shareholders exercise no meaninful voting control. (...) firms of the latter type are, in an important sense, effectively producer nonprofits: they are managed on behalf of their shareholders, but not by their shareholders. Indeed, if investor-owned firms are in fact managed more efficienctly than are nonprofit firms, and in particular are better at cost minimzation. In large part this may not be because the managers of the investor-owned firms are more effectively monitored, but because their organization's stated goal is clearer'.

352 Oberlander, 2003, p. 132.
353 In the late nineties commercial health insurers increased premiums much faster than the actual growth of workers earnings.

## Chapter 3

1 British Medical Journal, 29th May, 1886, p. 1030; cited by Abel-Smith, 1964, p. 113.
2 However, the scheme expanded slowly; in 1939, half of the population was still not insured and hospital care was excluded (Blainpain, Delesie, and Nys, 1978).
3 This hindered charges according to ability-to-pay. A German hospital, which was controlled by a physician, could discriminate between different classes of patients. Such a system was not acceptable in British hospitals (Abel-Smith, 1964, p. 138).
4 Abel-Smith, 1964, p.4.
5 Such yearly gifts were not totally disinterested since regular subscribers were often given the right to nominate a certain number of beneficiaries to the charity. Subscriptions were essential for the hospital. Burdett (1896, p. 32) states: 'every one versed in hospital management knows that the secret of financial soundness in things charitable is summed up in the successful attainment of a large proportion of the income from annual subscriptions. Subscribers are more attached to their charity and give more legacies.'
6 New matrons demanded a higher ratio of staff to patients and required a much higher standard of accommodation (Abel-Smith, 1964, p. 134).
7 Abel-Smith, 1964, p. 250.
8 Burdett (1896, p. 92–96) sums up the other objections: 1.) The difficulty of arranging the fees, which the medical attendant shall receive; 2.) Exclusion of other non-paying and poorer patients.
9 Abel-Smith, 1964, p. 118.
10 In 1889, St. Thomas operates forty-two such beds in separate surroundings and earned a net profit of 500 to 600 pounds on a turnover of £ 5.600 (Abel-Smith, 1964, p. 148).
11 The 1906 conference of the BMA resolved that pay beds were not incompatible with the voluntary system, on the condition that they are open to every member of the medical profession, who shall be paid fees to be arranged between him and his patient (Abel-Smith, 1964, p. 196).
12 Burdett, 1896, p. 6.
13 Burdett, 1896, p. 32, p. 92.
14 H.C. Burdett (1847–1920) publicized much on the subject and was strongly supporting many efforts for paying for treatment. He wrote 'Pay hospitals and paying wards throughout the world' (London, 1880), the first comparative book on this subject.
15 Abel-Smith, 1964, p. 137 and 138.
16 Abel-Smith, 1964, p. 142.
17 Abel-Smith, 1964, p. 190.
18 Abel-Smith, 1964, p. 199.
19 Abel-Smith, 1964.
20 It is estimated that this figure includes some 1,000 London pay-beds. London guarantees about fifty percent total of voluntary capacity.

21 These were convalescent homes and nursing homes. Nursing homes can be physician-owned cottage hospitals or lay-owned institutions.
22 Abel-Smith, 1964, p. 308.
23 Provident schemes aimed to cover full-cost including the cost of medical attendance. The first scheme started in 1921, in Brighton, and gave patients in return for their contributions the right to pre-paid care in a number of co-operating hospitals (Abel-Smith, 1964, p. 311). A contributory scheme was a system of partial pre-payment, which did not aim to cover the total costs of hospital care, such as The Hospital Savings Association that started in 1922.
24 Abel-Smith, 1964, p. 328.
25 Lee, 1978.
26 In 1929, the Local Government Act merged Poor Law authorities and local authorities by handing over the power to the latter (Blainpain, Delesie and Nys, 1978). Public hospitals were required to treat anyone who needed treatment and thus formally became responsible for acute care for the poor.
27 Higgins, 1988, p. 11.
28 Higgins, 1988, p. 10.
29 Evelyn Waugh, 1999, p. 271–278.
30 Abel-Smith, 1964, p. 343.
31 Abel-Smith, 1964, p. 395.
32 Willcocks, 1967.
33 Abel-Smith, 1964, p. 438.
34 Titmuss, 1958.
35 Forsyth, 1973; Foot, 1975; Higgins, 1988.
36 House of Commons, 30th April 1946, col. 57.
37 Consultants, which account for some thirty percent of the medical staff, could chose between a part-time and a full-time NHS-contract. Only under part-time contracts it was allowed to treat private patients. The number of consultants with a part-time contract was quite high at the beginning of the NHS (76%). In 1959 it was 73%, in 1964 69% it then slipped to 43% in 1976 (Higgins, 1988).
38 GPs, who were represented by the BMA, stayed formally independent but were only allowed to treat private patients if these patients, were *not* registered as NHS patients.
39 Abel-Smith, 1964, p. 480.
40 Higgins, 1988, p. 18.
41 Jacobs et. al., 2003.
42 Hughes-Tuohy, 1999.
43 Bevan made special agreements with Cardinal Griffin. Some other facilities also did not fit in the NHS, like the Royal Masonic Hospital and two well-established private psychiatric hospitals (Higgins, 1988). Rehabilitation was an important part of the activities and services of many disclaimed hospitals.
44 Higgins (1988, p. 28) estimates the total independent sector at about 230 small-scale facilities.
45 Jewkes and Jewkes, 1961.
46 Pre-war membership was around 10 million, but due to bad political maneuvering, the schemes did not get a significant role in the NHS (Gorsky and Mohan, 2004).
47 Nowadays they are called Health Cash Plans and cover around 6 million people (2001). Contribution income was £ 377,5 million, of which they paid £ 280,7 as cash benefits.

Around 35% of these cash benefits are paid for hospital related services. Hospital Savings Association (HSA) is the largest provider with a 27% market share. Nonprofit operators (85%) dominate this market (Laing&Buisson, 2002a & 2003).

48 BUPA was based outside London. The largest London association (PPP) and also, some well-established regional associations (including WPA, BCWA and Exeter) were strong enough to remain independent.

49 Office of Health Economics, 2004.

50 Forsythe, 1973.

51 Forsyth, 1973.

52 In the NHS, patients had no possibility to decide when to get treatment.

53 BUPA held a market share of 75%; the combined market share of PPP and WPA was 23% (Higgins, 1988 p. 47).

54 Calnan, Cant, and Grabe, 1993.

55 Sources: Higgins, 1988; Laing&Buisson, 2003; Office of Health Economics, 2004.

56 Amenity beds are beds in single rooms. It is possible for a small cash payment to occupy these rooms, if they are not required for a higher priority case. The patient is still a full NHS-patient and so there is no private treatment by a consultant.

57 Bryant, 1968.

58 The NHS counted 5,260 pay beds in 1960 and 4,919 in 1970. Both Labour and the Conservatives were hesitant on this issue. The Conservatives did not try to increase the number of pay beds; Labour did not really try to reduce pay beds. The only exception was Minister Robinson (Labour) who in 1966 tried to reduce the number of pay beds by 24% (Higgins, 1988).

59 Lee, 1978.

60 House of Commons, 1972.

61 Klein, 1971.

62 NHS union membership was lower than in other sectors of the economy, but reached 60% in 1974 (1948, 40%).

63 Higgins, 1988.

64 Hughes-Tuohy, 1999, p. 63.

65 Klein, 2005, p. 46.

66 There seemed to be some evidence that the NHS did not identify all services provided to private patients due to weak administrative procedures. Private patients in the NHS might have on average a higher case mix. Since 1968, pay bed rates were determined on a national level on the basis of average per diem costs (Higgins, 1988).

67 Laing, 1985, p. 21.

68 Robb and Brown, 1984.

69 Higgins, 1988.

70 Sources. Higgins, 1988; Leadbeater, 1990.

71 Change of definitions.

72 The ownership was of course still in the hands of a not-for-profit group, which initially provided soft capital from the insurance solvency fund. That technique was later ended by Insurance Directives.

73 BUPA and PPP owned Nuffield, but turned this company towards a charity because the government could not touch a charity. Since BUPA at that time still owned a couple of hospitals and under European legislation it was forbidden as an insurance company directly

to manage non-insurance businesses, BUPA Hospitals Ltd was formed with a separated management.

74 Lee, 1978: years 1970–1976; Laing & Buisson, 2007: years 1980–1984.

75 Laing, 1985, p. 52.

76 Hughes-Tuohy, 1999, p. 63.

77 Hensher, 1999.

78 Capital expenditure declined from 6,6 percent (1970) to 4,7 percent (1980) as a percentage of total health care expenditures (OECD, 2004).

79 Traditionally, the NHS owns its infrastructure and capital is tax-financed.

80 Most of the increases were in the affluent South. In 1985, the Thames regions accounted for between 25 and 38 private beds per 100,000 inhabitants. Wessex accounted for 23, Wales for 9, Scotland for 8, Northern Ireland for 6 and Northern England for only 5. The average number in England was 20 private beds per 100,000 inhabitants (Association of Independent Hospitals, 1985).

81 Laing&Buisson, 2003.

82 Laing, 1985, p. 15.

83 Between 1981 and 1986, cardiac operations in the private sector increased from 640 to 3,830 (Leadbeater, 1990).

84 1.) The independent sector was a prominent player in elective surgery with a market share of 13,2% (1983). 2.) The Association of Independent Hospitals (1985) listed 42 screening facilities, most of which were only recently started. 3.) Since the Abortion Act of 1967, independent providers moved into this area. The NHS was very hesitant and thus for-profits and a few specialized voluntary providers dominated the market. Due to the UK's more liberal legislation a lot of the clients come from overseas (Griffith et al., 1985).

85 Leadbeater, 1990.

86 Laing&Buisson, 2003.

87 Higgins, 1988, p. 84

88 Early in the first-term, a system of mandatory private insurance was considered by an internal government think-thank and leaked to the press (Hughes-Tuohy, 1999, p. 65).

89 Hughes-Tuohy, 1999, p. 66.

90 Calnan, 2000.

91 Hurst, 1992.

92 Butler, 1992, p. 5.

93 There were six principles: common waiting lists for private and public patients, access to facilities on clinical considerations, same standards of clinical care, single rooms should not be kept vacant for private patients, no significant prejudice to non-paying patients and earlier private consultations should not lead to earlier admissions (Department of Health and Social Services, 1980).

94 Higgins, 1988, p. 105.

95 They could only be enforced if the proposed facility was larger than 120 beds or if it would have a significant adverse effect on the NHS.

96 Calnan, 2000.

97 Higgins, 1988.

98 Besides, the raising of capital for small-scale entrepreneurial activity (in any business) was eased through a start-up scheme, making it more attractive for doctors to invest in independent hospital care (Calnan, 2000).

99 Griffith, Rayner, and Mohan, 1985,
100 Calnan, 2000.
101 Laing, 1992.
102 In 1981, the number of NHS discharges in independent hospitals was 24,063 patients, down from 37,376 (1963). The number of outpatient attendances for the NHS was 101,932, down from 432,574 (1963) (Rathwell, Sics, and Williams, 1985)
103 Calnan, 2000.
104 Laing, 1985, p. 49.
105 National Audit Office, 1989.
106 In 1981, all workers earning less than £ 8,500 per annum would be exempt from paying tax on the value of PMI paid by their employer. Companies were also allowed to set PMI premiums against the corporation tax, as had been the case until the nineteen-sixties (Higgins, 1988).
107 In 1980, they covered 2 percent of all subscribers, but in 1984 this had risen to 8,5 percent (Grant, 1985).
108 In 1981 more than 15 percent of the patients in private clinics were from overseas, mostly for an abortion. Excluding abortions, 6,7 percent of all operations were for overseas patients (Williams et al., 1984). Reasons for the reduction of overseas patients were: hospital building in the Middle East, rising tariffs in the private sector and additional for use of NHS facilities by overseas patients (Higgins, 1988).
109 Grant, 1985.
110 By 1989 waiting lists included some 950,000 people, up from 550,000 (1975). There were especially long waits for elective care, the core business of the independent sector (Jacobs, Martin, and Rice, 2003).
111 Martin and Smith, 1998; Besley, Hall, and Preston, 1999.
112 The requirement to seek permission for a 120-bed hospital ended, just as the remaining curbs on pay beds.
113 The proposal was implemented in 1991. The idea was to relieve pressure on the NHS for the treatment of older people and that people who were formerly in a company scheme, could more easily continue their coverage once they were retired.
114 Table: Persons insured, number of subscribers, claims and TPA business 1985–2000

| | Persons insured % UK population | Subscribers (thousands) | Claims as % Subscriptions | Persons in third party plans (% UK population) |
|---|---|---|---|---|
| 1985 | 8.9 | 2380 | 88 | n/a |
| 1990 | 11.6 | 3300 | 89 | n/a |
| 1992 | 11.5 | 3366 | 82 | 0.20 |
| 1994 | 11.3 | 3390 | 80 | 0.31 |
| 1996 | 11.5 | 3484 | 80 | 0.60 |
| 1998 | 11.7 | 3585 | 82 | 0.70 |
| 2000 | 11.7 | 3679 | 79 | 1.07 |

Laing&Buisson, 2002b & 2003; Office of Health Economics, 2004.

115 Enthoven, 1985.

116 Higgins, 2004.
117 Dowdeswell and Heasman, 2004.
118 European Observatory on Health Care Systems, 1999.
119 Propper, 2003.
120 LeGrand (ed.). 1997; Propper, Burgess, and Gossage, 2003.
121 Hughes-Tuohy, 1999, p. 169–171.
122 Jacobs, Martin, and Rice, 2003.
123 Leadbeater, 1990; Salter, 1995.
124 Propper, Burgess, and Gossage, 2003; Field and Peck, 2004.
125 Hughes-Tuohy, 1999, p. 187.
126 Laing, 1985; Leadbeater, 1990.
127 Most private patient units operate on a small-scale. However, the London market differs because it treats a lot of non-British patients and as a consequence has a relatively high proportion of self-pay patients. London is considered to be a high cost market due to the high cost of living.
128 Independent Hospital Association, 1995.
129 Thomasson, 1994
130 For a basket of nine high volume elective procedures, fees charged by UK private surgeons are found to be approximately sixty percent higher than US Medicare fees, Spanish PMI fees and fees recommended by the Australian Medical Association. UK private surgeons' fees are four times as high than the typical German fees and even more than four times as high as Canadian Medicare fees. Finally, UK private fees are over five times as high as French social security rates and some 1¾ times higher than private fees charged by French surgeons (Laing, 1992, p 23).
131 Laing, 1992.
132 The HMSO estimated that in 1992 17,100 consultants out of 23,100 were engaged in private practice. Of these 2,500 were retired and 200 worked exclusively in the private sector. NHS specialist who did not engage in private practice did so because of lack of opportunity (e.g. emergency medicine and psychiatry), or their location (Northern Ireland and rural Wales and Scotland) (HMSO, 1994).
133 In 1989, The NAO concluded that current arrangements did not provide assurance that all consultants were fulfilling their NHS commitments, although the limited evidence did not suggest significant neglect. The Conservative government was not considering compliance measures. It stated that: 'there was no evidence that the present arrangements were unacceptable or ineffective. If a consultant fulfilled the contract to do the work expected of him, then any extra work undertaken should not be a problem as far as the NHS was concerned (Pay & Workforce Research, 1999).
134 Consultants could charge their patients a higher fee and than the insurer reimburses, but that was seldom the case as that would pressure the relationship between physician and patient.
135 HMSO, 1994.
136 A Conservative MP, who wanted to redress a decision on the closure of a London emergency department in his constituency, the indirect result of the internal market reforms, induced the election. It illustrates the political salience of health care, also in the era of market reforms (Hughes-Tuohy, 1999, p. 194).
137 European Observatory on Health Care Systems, 1999.

138 Field and Peck, 2004.
139 Dowdeswell and Heasman, 2004.
140 Shaoul, Stafford, and Stapleton, 2008.
141 Laing & Buisson, 2007, p. 76.
142 In 1998, the Acheson Report calls for a review of how private practice affect access to effective treatments, resource allocation and staff deployment. In 2001, Williams, Whatmough, McGill, and Rushton found that the supply of NHS resources positively correlates to regions that reported most longstanding illnesses. However, in less deprived regions, the uptake of NHS services is greater among the same socio-economic groups who use the private sector, indicating that the more deprived sections of the population in those regions may face a double whammy.
143 Hunter, 2008, p. 83–87.
144 Hunter, 2008, p. 16.
145 The NHS covers for 85% of independent mental health hospital revenues; PMI covers for 7%, while the remaining being self pay revenues (Laing & Buisson, 2007, p. 262).
146 Laing & Buisson, 2007, p. 272.
147 Laing & Buisson, 2003 and 2007.
148 Department of Health, 2000a.
149 Field and Peck, 2004.
150 Financial Times, May 31st, 2004b.
151 This research focuses on the relationship between Westminster Health Care and their NHS partners. Service provisions include intermediate care for older people, long-term care for people with intractable mental health problems, continuing care and nursing home care. Although the research didn't address the acute care sector, government policy was even more stimulating in long term care indicating that in acute care the conclusions probably would also be significant (Field and Peck, 2004).
152 Department of Health, 2000.
153 There are 32 core standards and 45 more specialized standards. These standards address the perceived weaknesses of the old system by placing more emphasis on inspecting clinical practice and outcomes, fully informing and involving patients in decisions about their treatment, ensuring that relevant safeguards are in place, as well as installing an effective complaints procedure. At first the regulator was the body that was also responsible for the long-term care sector. Much to the joy of the sector, they are now being inspected by the same body as the NHS (Commission for Health Care Audit and Inspection) (Laing&Buisson, 2003).
154 Robinson, 2003.
155 NHS Executive, 2000; BUPA, 1999; Ishak, 2003.
156 Department of Health, 2002.
157 The Economist, June 17th, 2004a.
158 Cost per finished consultant episode: £ 1,435 (2005/2006); £ 1,350 (2004/2005); £ 1,815 (2002/2003).
159 Laing & Buisson, 2007, p. 131.
160 Mason, Street, Miraldo, and Siciliani, 2009.
161 Hunter, 2008, p. 35.
162 Initially, independent providers were prohibited from employing anyone who had worked for the NHS in the past six months. The clause was relaxed in the second phase of contracts

so that it applied only to a defined set of shortage professions with NHS consultants constrained to work for contracted private providers only during their 'non-contracted' hours (Mason, Street, Miraldo, and Siciliani, 2009, p, 13.)

163 In early 2004 these were US companies (New York Presbyterian, Mercury Health and Nations Healthcare), South African Companies (Netcare and Afrox) and an Anglo Canadian Group. Only the Birkdale clinic was a pure UK based group (Dash, 2004). Later also Nuffield and Swedish Capio got a large contract.

164 Some of the hospital groups formed the Independent Hospital Forum, which is more loosely structured.

165 Dash, 2004.

166 The government also funded two US companies (Kaiser and United Health) to work with primary care trusts across England to deliver care in new ways through disease management (Dash, 2004), with the prospect that this too might become a service offered by the independent sector.

167 House of Commons Health Committee, Independent Sector Treatment Centers, Session 2005–2006.

168 Laing & Buisson, 2007, p. 90.

169 Department of Health, 2004b; BMJ, 2004b.

170 The Independent Hospital Association argues that the increase in purchased acute medical care develops too slowly and is in itself a major contributor to the increase in self-pay patients since the later nineties (Financial Times, 2003a).

171 Code to promote use of private hospitals (Financial Times, January 27th, 2008a).

172 Private sector alarmed at cuts to NHS work (Financial Times, November 14th, 2007g).

173 NHS business board disbands as members say it was 'wasting time', (Financial Times, September 26th, 2007d).

174 Pay & Workforce Research, 1999.

175 Light, 1997.

176 Department of Health, 1999.

177 The BMA wanted to abolish the ten percent rule for independent sector work, build rewards for on-call work into the NHS contracts, establish a link between contract, job plan and remuneration and was strongly opposing 'closed contracts' (PWR, 1999).

178 Yates, 1995.

179 Some scholars strongly disputed if the generous settlement of the consultants corresponded with NHS productivity gains (Hunter, 2008, p. 71).

180 National Audit Office, 2007; House of Common's Health Committee, 2000.

181 An average of £ 71,500; however, sixty percent earned up between £ 20,000; ten percent earned more than £ 100,000 (BMA, 2005).

182 This was an attempt to reduce costs through the concentration of patient volume. In 1998, average occupancy rates had gone down to forty-eight percent, which increased the fixed-costs of contracting all the hospitals.

183 Laing & Buisson, 2007, p. 79.

184 Laing & Buisson, 2007, p. 181. The reason behind this trends is an increase in the incidence of small claims, effective management of claims costs by insurers, and some impact by the restructuring of prices following the competition from treatment centers.

185 Table: Persons insured, number of subscribers, claims and TPA business 2000–2006

| | Persons insured % UK population | Subscribers (thousands) | Claims as % Subscriptions | Persons in third party plans (% UK population) |
|---|---|---|---|---|
| 2000 | 11.7 | 3677 | 79 | 1.07 |
| 2002 | 11.3 | 3701 | 77 | 1.45 |
| 2004 | 10.9 | 3601 | 78 | 1.72 |
| 2006 | 10.6 | 3626 | 77 | 1.64 |

Laing & Buisson, 2007, p. 177.

186 Critical illness insurance guarantees a lump sum payment in the event of the insured being diagnosed with one of the critical illness conditions covered by the policy. It is possible that some of the benefits are feeding through into self-pay demand for private healthcare. Critical illness policies exploded from 1,2 million in 1996 to 3,9 million in 2001 (Laing & Buisson, 2002b).

187 Williams, 1999 (1981–1999); Laing & Buisson, 2007 (2000–2006).

188 Source: Laing & Buisson, 2007, p.97.

189 Capio itself was sold to a consortium with Apax Partners (Financial Times, October 6th, 2006), that also had a major interest in the General Healthcare Group.

190 Ramsay targets growth, Wallstreet Journal Europe, November 9th, 2007.

191 Independent nonprofit providers do not have to pay taxes on surplus (otherwise thirty percent) and VAT (otherwise 17½ percent), although the NHS is free-of-charge. However, in 2004 a discussion on the abolishment of the tax-exempt status of nonprofit hospitals started leading to reconsideration whether some independent hospitals should pay taxes (Financial Times, September 30th, 2004c).

192 Laing & Buisson, 2007, p. 108.

193 Laing & Buisson, 2003.

194 GHG buys Nuffield hospitals for £ 140 million (Financial Times, December 15th, 2007h).

195 Companies UK: Cinven poised to acquire 26 BUPA hospitals (Financial Times, June 18th, 2007a).

196 Laing & Buisson, 2007, p. 103.

197 Table: Market share private sector in elective surgery (excluding maternity and abortions)

| | |
|---|---|
| 1981 | 13.2% |
| 1986 | 14.8% |
| 1992/93 | 14.1% |
| 1997/98 | 13.4% |

Williams, 1999

198 Audit Commission, 1998.

199 Such services are only seldom available from the NHS, nor can they be privately insured.

200 Williams, 1994 and 1999.

201 In contrast to continental Europe, sliding scales were not used, which hindered payment according to means.

202 Goldman and Romley (2008) found that a increase of one-standard deviation in amenities, increased hospital's demand by 38.4%, whereas demand is substantially less responsive to changes in clinical quality.
203 Rudolf Klein also contends that the existence of a private sector encourages patients to leave the NHS rather than fight for a particular service from within (1989, p. 156).
204 In 1984, eighty-five percent of the consultants were involved in private practice; in 1992, an average consultant earned almost thirty percent of his total income from private practice.
205 NERA Economic Consulting, 2006.
206 People with PMI always use certain complex NHS health services and sometimes also use NHS elective services instead of their private entitlement.

## Chapter 4

1 Kallmorgen, 1936.
2 Winkelman, 1971.
3 Specialization was typical for the development of German medicine and was leading in the Western World (Stevens, 1999).
4 Teltzrow, 1969.
5 However, variety was rather large and some proprietary clinics served more than forty beds (Winkelman, 1971).
6 In 1876, Billroth estimated that the costs of a (university) clinic were larger than for a complete regiment of the Prussian army and that maintenance costs were about the same (Winkelman, 1971).
7 Stürzbecher, 1969.
8 Veraghtert and Widdershoven, 2002.
9 In 1914 there were six for-profit insurers who issued some forty-three thousand policies (Veraghtert en Widdershoven, 2002).
10 In 1910 there existed almost twenty-four thousand funds (Veraghtert and Widdershoven, 2002).
11 In the early years social health insurance was mainly about sick pay.
12 Veraghtert and Widdershoven, 2002.
13 Premiums were frozen at a maximum of 4½ percent of the paycheck. Local or regional authorities had to supplement deficits. The number of sickness funds halved towards 9,200 (1919).
14 In an attempt to counter the revolutionary atmosphere the government decided that workers were allowed to fill two-thirds of the seats in the boards of the local and regional funds. It became forbidden to found new (employer dominated) factory funds although this regulation was eased later on (Veraghtert and Widdershoven, 2002).
15 European Observatory on Health Care Systems, 2000.
16 Wendt, Rothgang, and Helmert, 2005, p. 9.
17 European Observatory on Health Care Systems, 2000.
18 Mayntz and Rosewitz, 1988.
19 Federal Statistics Office, 1959.
20 Reichsthaler, 2001.
21 Wendt, Rothgang, and Helmert, 2005.

22 Schmidt, 1987; Schmidt, 2001.
23 Neubauer, 2003.
24 A small but not insignificant change was the decision that employees paid half of the premiums instead of the former two-thirds. As a consequence the influence of the employers in the boards of the funds increased.
25 In 1950 there existed 1,996 funds with an average membership of slightly over 10,200 (excluding their families). In 1975 (1990) there were 1,465 (1,149) funds with an average membership of 22,860 (32,815) (Veraghtert and Widdershoven, 2002).
26 Important were the inclusion of self-employed farmers and their families (1972), students (1975), disabled persons (1975) and artists (1981) (Veraghtert and Widdershoven, 2002).
27 Giaimo and Manow, 1999, p. 976.
28 Müschenich, 2003.
29 Busse and Wörz, 2004.
30 § 107 (2) SGBV states that hospitals are under the medical lead of doctors.
31 A hospital under 'Regiebetrieb' forms a direct part of the government. The hospital has no capital funds and is leaded by the responsible politicians. The hospital has more freedom if it forms and 'Eigenbetrieb' (trust). The management is responsible for the hospital operations and politicians are in the board. Still, the hospitals' surpluses or deficits form part of the public budget. State regulations define the responsibilities of the hospital management versus the political representatives. 'Regie'- and 'Eigenbetrieb' can only form part of one community (Karl, 1999).
32 Simon, 2000.
33 Open-staff hospitals contained 9½ percent of all beds. In the southern states this share was higher: Bavaria (10,7 %), Baden-Wuertemberg (10,1%), Rhineland-Palatinate (12,4%), and Hesse (19%) (Federal Statistics Office, 1959).
34 This is stated in § 30 of the law for private companies (Gewerbeordnung), which also regulates the specific duties of these hospitals (trustworthiness and commitment to health care regulations and inspections). Tax law (§ 15 Einkommenssteurgesetz) refers to the importance of profit maximization (Karl, 1999).
35 Veraghtert and Widdershoven, 2002.
36 § 120 of the Constitution.
37 Simon, 2000.
38 Adam, 1958.
39 Simon, 2000.
40 Simon, 2000.
41 France, 2008, p. 679.
42 Simon, 2000.
43 This implicates that a hospital could only be replaced every hundred years against fifty years for most other buildings. Depreciation rates were not increased until 1966 (Simon, 2000).
44 Simon, 2000.
45 Eichorn, 1964.
46 Reichsthaler, 2001.
47 Auerbach, 1961.
48 Public hospitals had contracts with religious orders to employ cheap nurses in their facilities. The wage of a religious nurse was about seventy-five percent lower than the costs for a

secular nurse (Häring, 1956). In 1953, thirty percent of the nurses in communal hospitals belonged to a religious order (Simon, 2000).

49 Reichsthaler, 2001.

50 Bölke G., 1990, p. 303.

51 In 1968, Dr. Krukemeyer founded the for-profit Paracelsus hospital (Clade, 2003). Its concept implied that inpatient and outpatient care were in the same surroundings, stimulating higher utilization of capital (Krukemeyer, 1988). The second clinic was only founded in the late seventies (www.parcelsus-kliniken.de).

52 Karl, 1999.

53 Gehrt, 1963.

54 Rothgang, 1994, p. 115.

55 Federal Statistics Office, 1959 and 1969; own calculations.

56 Federal Statistics Office, 1959 and 1969; own calculations.

57 Federal Statistics Office, different years; own calculations.

58 Simon, 2000.

59 The funding of capital, separate (dual) or included in the regular payments (monistic), turned out to be among the most discussed concepts until the current day (Klinger, 2005, p. 42).

60 The coalition between the hospitals and the local authorities split. States and municipalities had more interest in the fact that the structural yearly deficits were now bared by the sickness funds.

61 'The goal of this act is to secure hospital funding, to solve the population's needs for adequate hospital care and to stimulate bearable per diem rates' (§ 1 Abs. 1 HFA).

62 Bruckenberger, 2008, p. 5.

63 State hospital plans rely on current capacity. Future calculations are rather straightforward and based upon demographic figures, average length of stay, number of facilities, and bed-utilization (Neubauer, 2003).

64 Karl, 1999.

65 § 17 (2), (Federal Hospital Reimbursement Ordinance, 1973).

66 Simon, 2000.

67 Table: Unadjusted public expenditures

| | Public capital expenditure (billion DM) | Public current expenditure (billion DM) |
|---|---|---|
| 1970 | 1.975 | 1.259 |
| 1975 | 3.551 | 1.399 |
| 1980 | 4.824 | 1.744 |
| 1985 | 5.401 | 2.186 |
| 1990 | 6.469 | 1.651 |

Source: Simon, 2000.

68 Bruckenberger, 2003.

69 Klinger, 2005, p. 55.

70 Volk, 1989.

71 § 8 Abs 1, HFA

72 Original text: 'Die Einschränkung der Förderung wurde von den ärtzlichen Standesvertretungen und der Kassenärtzlichen Vereinigung abgelehnt. Da 81,9 Prozent aller

Krankenhäuser unter 100 Betten Privatkliniken waren, kämpften die Standesorganisationen somit um den Erhalt einer ergiebigen Einnahmequelle. Obwohl sie bei der Forderung der Streichung der '100-Betten-Klausel' die Unterstützung der CDU/CSU erhielten, konnten sie sich letzendlich nicht durchsetzen, vermutlich auch deshalb, weil offensichtlich wurde, daß der medizinisch-technische Fortschritt zur Bildung größerer Krankenhäuser drängte' (Löber, 1974).

73 Between 1975 and 1984, 375 hospitals were closed (Prößdorf, 1988, p. 299).

74 Karl, 1999.

75 Federal Statistics Office, 1979.

76 Karl, 1999.

77 Reichsthaler, 2001.

78 § 4 (3.2), HFA.

79 Original text: 'Krankenhäuser, deren Betrieb auf Gewinnerzielung gerichtet ist, sollen in die Förderung nicht einbezogen werden. Deshalb sind Krankenhäuser, die nicht gemeinnützig sind, von der Förderung ausgeschlossen' (Federal Assembly sixth election period, 1971).

80 Gerdelmann, 1994.

81 § 17 (5), HFA.

82 Robbers, 1998, p. 246.

83 For-profit clinics in Schleswig-Holstein were often in new buildings In 1975, fifty-four percent of for-profit facilities were built in the last five years; only twenty percent of for-profit hospitals were older than twenty-five years, against fifty-one percent of the public and nonprofit hospitals (Brandecker, 1978).

84 Karl, 1999.

85 The outlook for preventive care and rehabilitation remained bright. These facilities dominated for-profit health care by the late 1960s and increased their position until the 1990s. Some for-profits mixed acute and rehabilitative services (see Appendix 4.1).

86 Löser-Priester, 2003.

87 Federal Statistics Office, different years.

88 156,1 billion DM (1972); 802 billion DM (1986), (Prößdorf, 1988, p. 298).

89 Table: Public capital supplements 1972–1988 (million DM).

| | 1972 | 1974 | 1976 | 1978 | 1980 | 1982 | 1984 | 1986 | 1988 |
|---|---|---|---|---|---|---|---|---|---|
| States | 998 | 3.513 | 3.540 | 3.611 | 3.970 | 4.361 | 4.457 | 4.666 | 4.630 |
| Federal | 350 | 370 | 404 | 290 | 226 | 255 | | | |

Source: Bölke, 1990, p. 304.

90 Bruckenberger, 2008, p. 3.

91 Giaimo and Manow, 1999, p. 981; Bruckenberger, 2008.

92 Karl,1999.

93 Löser-Priester, 2003.

94 Giaimo and Manow, 1999, p. 983.

95 Table: Number of private insured people (million)

| | Private health insurance | Supplementary insurance |
|---|---|---|
| 1980 | 4.8 | 3.6 |
| 1985 | 5.2 | 4.2 |
| 1990 | 6.6 | 5.2 |
| 1995 | 6.9 | 6.0 |
| 2000 | 7.5 | 7.5 |
| 2002 | 7.9 | 7.7 |

Source: Private health Insures, 2002

96 Robert-Bosch foundation, 1983.

97 Advisory Council for the Concerted Action in Health Care, 1983.

98 Bölke, 1990, p. 304.

99 Advisory Council for the Concerted Action in Health Care, 1989, p.89.

100 In 1972, 29,000 beds could be constructed with HFA means, but in 1993 no more than 11,000 beds could be built (Robbers, 1998, p. 246).

101 Bölke, 1990, p. 306.

102 Small hospitals in Hamburg got 2,452 DM (1991) for each bed, while large clinics in Hesse got 5,090 DM (1991) (Bölke, 1990, p. 307).

103 Reichsthaler, 2001.

104 Karl, 1999.

105 Original text: 'Bei der Durchführung des Gesetzes ist die Vielfalt der Krankenhausträger zu beachten. Dabei ist nach Maßgabe des Landesrechts insbesondere die wirtschaftliche Sicherung freigemeinnütziger und private Krankenhäuser zu gewährleisten. Die Gewährung von Fördernmittel nach diesem Gesetz darf nicht mit Auflagen verbunden werden, durch die die Selbständigkeit und Unabhängigkeit von Krankenhäusern über die Erfordernisse der Krankenhausplanung und der wirtschaflichen Betriebsführung hinaus beeinträchtigt werden' (§1, (2), nHFA).

106 Karl, 1999.

107 However, the nHFA also required that a hospital should serve at least forty percent patients on social insurance; it should not seek higher reimbursements than normal per-diem rates, to be included in a state hospital plan (Saed-Hedayatiy, 1995; Knorr and Wernick, 1991).

108 Karl, 1999.

109 Karl, 1999.

110 However, this result can be disputed since for-profit hospitals treat a less complex patient base and not all for-profit costs are fully included like capital costs and physician fees in the open staff facilities. Nevertheless, not adjusted for such differences the public hospitals still have some one-third higher costs than for-profit hospitals (my own interpretation and calculation of the data of Breyer F., D. Paffrath, W. Preuß, and R. Schmidt, 1987).

111 Schick, 1986.

112 Saed-Hedayatiy, 1995.

113 This also meant a discussion if privatization was allowed by the constitution. On the one hand there was the subsidiary principle and the social market system, but on the other hand opponents thought that privatizations might hurt the public health for which the

government is responsible. However, most scholars support the legal and economic case for privatization (Däubler, 1980; Saed-Hedayitiy, 1995).

114 Rogge, 1984; Imdahl, 1993; Bosch, 1995.

115 Here it is important to note that in German health care politics, stabilization of the statutory premiums as a part of the GDP is a main goal. However, often this was a direct consequence of the strong economic growth, especially in the 1980s. Thus budgetary reforms were not immediately necessary and delayed. On the other hand the income related premiums of the statutory funds did increase sharply due to a decreasing share of wages in the GDP. This implied that there was a feeling of exploding costs under the German population (Breyer et. al., 2001; Simon, 2001; Löser-Priester, 2003; Schölkopf and Stapf-Finë, 2003).

116 Bosch, 1995.

117 In 1991, Sana did a management turnaround in the city hospital of Wuppertal and the nonprofit St. Catharine hospital in Stuttgart. Typically in such contracts, Sana gets a lump sum as well as part of the efficiency gains (Losse, B, 1994).

118 Löser-Priester, 2003.

119 European Observatory on Health Systems and Policies, 2004, p. 192.

120 Ocker, 1995, p. 73.

121 Hospitals payments would be prospective general fees or, for certain procedures, specific rates. The federal government decides on the construction of the rates. Small investments and building expenditures are included on a replacement base (Karl, 1999).

122 Löser-Priester, 2003.

123 Between 1993 and 1995, the number of hospitals that offered outpatient care before treatment increased from 6¼ percent to 38¾ percent. Outpatient care after treatment increased from 5½ percent to 37½ percent. Ambulatory surgery penetration increased form 11 percent to 32¾ percent of the hospitals (Karl, 1999).

124 Karl, 1999.

125 Neubauer, 2003.

126. Table: Rate adjustments by state (1998)

| | Point-rates labor costs | Point-rates material costs |
|---|---|---|
| Baden-Wuerttemberg | 1,089 | 1,093 |
| Bavaria | 1,090 | 1,090 |
| Berlin | 1,080 | 1,080 |
| Brandenburg | 0,901 | 1,075 |
| Bremen | 1,060 | 1,060 |
| Hamburg | 1,082 | 1,084 |
| Hesse | 1,083 | 1,085 |
| Mecklenburg-Western Pomerania | 0,907 | 1,075 |
| Lower Saxony | 1,060 | 1,060 |
| Northrhine-Westphalia | 1,082 | 1,071 |
| Rhineland-Palatinate | 1,060 | 1,060 |
| Saarland | 1,065 | 1,065 |

| | | |
|---|---|---|
| Saxony | 0,900 | 1,075 |
| Saxony-Anhalt | 0,903 | 1,073 |
| Schleswig-Holstein | 1,059 | 1,063 |
| Thuringia | 0,907 | 1,080 |

Source: Reichthaler, 2001.

127 Original text: 'Außergewöhnliche Tatbestände eines Krankenhauses können dazu führen, dass erhöhte Fixkosten vorliegen. Aufgrund der Kostenkalkulation muss das pauschalierte Entgelt auch diese Kosten anteilsmäßig verrechnen, was durch Kalkulation eines entsprechenden Zuschlags möglich ist. Als solche außergewöhnlichen Tatbestände können bauliche Gegebenheiten, Kosten zur Qualitätssicherung oder Finanzierung der Investitionskosten bei der nicht oder nur teilweise geförderten Häusern gelten' (Reichsthaler, 2001).

128 Wendt, Rothgang, and Helmert, 2005, p. 4. Hospitals are required to publish a quality reports and their scores on 26 quantitative quality indicators.

129 Busse and Wörz, 2004.

130 Federal Physicians' Chamber, 2007, p. 16.

131 Augurzky et. al., 2007, p. 19.

132 Bruckenberger, 2002; Schmidt 2001; Augurzky et. al., 2004.

133 Table: Average state capital supplements pro included bed in the hospital plan (total 1991–2000 in €)

| | |
|---|---|
| Mecklenburg-Western Pomerania | 148.931 |
| Saxony-Anhalt | 144.014 |
| Berlin | 138.788 |
| Thuringia | 130.167 |
| Brandenburg | 129.470 |
| Saxony | 121.206 |
| Bavaria | 90.024 |
| Hamburg | 80.831 |
| Saarland | 66.054 |
| Baden-Wuerttemberg | 65.854 |
| Hesse | 64.942 |
| Bremen | 64.633 |
| Rhineland-Palatinate | 63.261 |
| Schleswig-Holstein | 60.544 |
| Lower Saxony | 54.322 |
| North Rhine-Westphalia | 47.273 |

Source: Bruckenberger, 2003

134 Bruckenberger, 2008, p. 10.

135 Bruckenberger, 2002.

136 Augurzky, et. al., 2007, p. 17.

137 Original text: 'Faktisch ist in vielen Bundesländer heute schon eine quasi monistische Finanzierung Realität. Die Fördermittel einzelner Bundesländer sind mittlerweile zu eine Marginalität verkommen (...) Mittlerweile ist aus Sicht der Krankenhäuser die Kontrahierungspflicht weitaus wertvoller als die spärlichen Fördermittel.' (Neubauer, 2003).

138 Hahn and Polei, 2000, p. 191.

139 Augurzky et. al., 2004

140 Between 1989 and 2001, Rhön-Klinikum went three times to the stock exchange for additional capital. In 2005, Fresenius went to the stock market to finance its acquisition of Helios.

141 Augurzky, et. al., 2004.

142 Federal For-profit Hospital association, 2009, p. 17.

143 Handelsblatt, July 10th, 2008.

144 Karl, 1999.

145 In 2006 their EBITDA margin was 10.5 percent, versus 2.2 percent for nonprofits, and 0.9 percent for public hospitals (Augurzky et al., 2009, p. 16).

146 For-profits (2006) have 16.3 percent liabilities on their balance sheet; nonprofits have 8.1 percent and public hospitals 9.7 percent (Everling and Kampe, 2008, p. 88).

147 For example, local authorities often do not guarantee for hospital loans (Bruckenberger, 2008, p. 8).

148 Table: Average capital investment quote of average hospital turnover (%) 2002

| | Public hospitals | Nonprofit hospitals | For-profit hospitals |
|---|---|---|---|
| Public capital subsidies | 7.7 | 6.8 | 9.7 |
| Other capital funds | 4.2 | 3.3 | 8.0 |

Source: Federal Physicians' Chamber, 2007, p. 18.

149 Original text: 'Diese Möglichkeiten waren insbesondere bei kleineren Krankenhäusern gegeben. Die zum Teil sehr rückständig gemanaged wurden. Hier waren oft mit einfachen Mitteln der Geschäftsführung sehr schnell entsprechende Erfolge zu Erzielen. Im DRG-System werden diese Möglichkeiten auf der Ertragsseite beseitigt (…) für große Krankenhäuser mit einem überproportionalen Investitionsbedarf ist fraglich, ob allein auf dieser Grundlage privat betriebene Krankenhäuser über 20 Jahre und mehr derartige absolute und relative Kostenvorteile herausarbeiten können' (Strehl, 2003).

150 Augurzky, et. al., 2004.

151 Federal Statistic Office, different years.

152 Original text: 'Angesichts der historisch bedingten einseitigen Trägerstrukturen in der ehemaligen DDR (89 prozent der Krankenhausbetten sind in öffentlicher Trägerschaft) plädiert die DKG an alle Verantwortlichen, die Voraussetzungen dafür zu schaffen, daß auch in den neuen Ländern sich ein ausgewogenes System der pluralen Trägerschaft von freigemeinnützigen, öffentlichen und privaten Krankenhausträgern entwickeln kann' (German Hospital association, 1990, p. 571).

153 German Hospital Association, 1990, p. 569.

154 § 21 (5) Reunification Treaty.

155 Table: Change (%) in health care costs old and new states

| | Old states including Berlin | New States |
|---|---|---|
| 1992 | 8.4 | 25.6 |
| 1993 | 3.9 | 11.6 |
| 1994 | 3.6 | 11.0 |
| 1995 | 5.4 | 8.2 |
| 1996 | 0.6 | 4.2 |

Federal Statistics Office

156 Robbers, 1995, p. 247.

157 Das Krankenhaus (the Hospital) no. 12, 2000, p. 970.

158 Tiemann and Schreyögg, 2009, p. 127.

159 German Hospital Association, 1990b, p. 249.

160 Original text: 'Daneben ist zu empfehlen,daß in geeigneten Fällen und im Rahmen der Krankenhausplanung zur Entlastung der öffentlichen Hand auch der Einsatz von Kapital des Krankenhausträgers ermöglicht wird. In diesen Fällen ist vorher mit den Sozialleistungsträgern eine Vereinbarung über die Berücksichtigung entsprechender Abschreibungen, Zinsen und Anpassungsrückstellungen in den Pflegesätzen zu treffen bzw. Sicherzustellen, daß die für die Investitionsförderung zuständigen Behörden entsprechende Annuitätshilfen übernehmen.' (German Hospital Association, 1990b, p. 250).

161 Federal Ministry of Health, 1995.

162 In Mecklenburg-Western Pomerania a private third party has to become part of the new for-profit hospital for a conversion to be approved (Thier, 2001).

163 Karl,1999.

164 Table: Market share five largest for-profit hospital groups (% of total hospitals) in 2001.

| | For-profit market share | Five largest groups |
|---|---|---|
| Baden-Wuertemberg | 30 | 5 |
| Bavaria | 29 | 5 |
| Berlin | 30 | 1 |
| Brandenburg | 14 | 6 |
| Bremen | 14 | 0 |
| Hamburg | 15 | 6 |
| Hesse | 21 | 8 |
| Mecklenburg-Western Pomerania | 21 | 18 |
| Lower Saxony | 25 | 7 |
| Northrhine-Westphalia | 7 | 1 |
| Rhineland-Palatinate | 17 | 3 |
| Saxony | 26 | 17 |
| Saxony-Anhalt | 9 | 6 |

| | | |
|---|---|---|
| Schleswig-Holstein | 41 | 7 |
| Thuringia | 22 | 18 |
| Total | 22 | 6 |

Source: Schlüchtermann and Albrecht, 2003 (rounded figures).

165 Statistisches Bundesamt Wiesbaden, different years; Bruckenberger, 2008, p. 10.

166 Westphal, 1991; Rathje, 2001.

167 From 880,000 fte (1996) to 792,000 fte (2006) (German Hospital Association, 2008, p. 23).

168 Das Krankenhaus (the Hospital), no. 4, 2008, p. 301.

169 In 2009 changes for default were 1.8 percent for public hospitals, 0.8 percent for non-profit hospitals, and 1.2 percent for for-profit hospitals. However, the possibility of default among for-profits is concentrated at small chains and stand-alone hospitals, not at the large for-profit hospital chains (Augurzky et. al., 2009, p. 112, 115).

170 Augurzky et. al., 2008, p. 210.

171 Herr, 2008, p. 1068.

172 Knorr and Wernicke, 1991.

173 For-profit hospitals pay 151 million euro's corporate tax or 1.7 percent of turnover (2006), nonprofits pay 4 million and public clinics another 15 million (Augurzky et al., 2009, p. 17, 27). Public and nonprofit hospitals pay a reduced value-added tax rate of 7% (Herr, 2008, p. 1058).

174 Klinger, 2005, p. 148.

175 It is hardly possible to discharge employees during a conversion. It is also not possible to resign civil servants or change their conditions of employment. The legal protection of other employees is slightly less. Employees which are older than forty or work longer than fifteen years in the hospital also cannot be dismissed. It is also not possible to change the wages, including all pension benefits, after a conversion (Saed-Hedayatiy, 1995; Karl, 1999).

176 In general wages are 'too high' for lower employees and 'too low' for higher educated employees (Strehl, 2003). Public hospitals in Berlin, North Rhine-Westphalia, Lower Saxony and Schleswig-Holstein suffer under additional costs from the 'Zusatzversorgung' of the federal government and the states (Rocke, 2002).

177 Saed-Hedayatiy, 1995.

178 Löser-Priester, 2003.

179 Karl, 1999; Strohe et. al, 2003a, p. 882.

180 In 2006, for-profit investments as percentage of the balance sheet were 11.5 percent, versus 9.9 percent (nonprofits) and 8.6 percent for public hospitals (Augurzky et al. 2009, p. 12).

181 Strohe et. al, 2003a, p. 886–887.

182 Federal Physicians' Chamber, 2007, p. 82–90.

183 Strohe et. al., 2003b.

184 Original text: 'Für den Deutschen Städtetag (…) kommt eine völlige oder weitgehende Übertragung der Krankenhausversorgung auf private Träger nicht in Betracht (…). Der Grund liegt darin, daß sich die kommunalen Krankenhäuser aus der Verplichtung der Gemeinden für die allgemeine Daseinsvorsorge entwickelt haben (…). Der Deutsche Städtetag räumt allerdings ein, daß im Einzellfall die Privatisierung kommunaler Krankenhäuser durchaus wünschenswert sein kann, was jedoch im einzelnen einer Abwägung der Aufgabenstellung und der örtlichen Gegebenheiten und Verhältnisse bedarf' (Saed-Hedayatiy, 1995).

185 Federal For-profit Hospital Association (BDPK), 2009, p. 20, 48.

186 For example Rhön-Klinikum, which was interested in the medical faculty of the university of Leipzig could not get the approval of the state of Saxonia (Saed-Hedayatiy, 1995). Hamburg is another good example.

187 Recent research states that university hospitals are clearly associated with lower levels of efficiency (Tiemann and Schreyögg, 2009, p. 125.

188 Klinger, 2005, p. 91; Strohe et. al., 2003a, p. 882–883.

189 Schnack, 2004.

190 Table: Estimated turnover (million.) and market share of for-profit hospital chains.

| | | |
|---|---|---|
| Rhön-Klinikum | € 950 | 18 % |
| Helios-Kliniken | € 900 | 17 % |
| Asklepios-Kliniken | € 690 | 13 % |
| Sana-Kliniken | € 430 | 8 % |
| SRH-Kliniken | € 310 | 6 % |
| Paracelsus-kliniken | € 240 | 5 % |
| Humaine-kliniken | € 160 | 3 % |
| Mediclin | € 150 | 3 % |
| Damp Holding | € 150 | 3 % |
| Fresenius Pro Serve | € 110 | 2 % |
| Other | € 1,200 | 23 % |

Source: www.helios-kliniken.de

191 Augurzky et. al., 2007, p. 13.

192 Augurzky et al., 2009, p. 18. Note that this partly may be a result of stronger incentives to upcoding by for-profit hospitals.

193 Gerste, 2003.

194 Rosenow and Steinberg, 2003.

195 Table: Nurse education places in hospitals

| | Total | For-profit share |
|---|---|---|
| 1992 | 70,149 | 0.4% |
| 1997 | 69,885 | 0.8% |
| 2002 | 67,649 | 3.0% |

Federal Statistics Office, different years

196 Augurzky et al., 2009, p. 32.

197 Table: Intensive care beds in hospitals

| | Total | For-profits share |
|---|---|---|
| 1992 | 19,662 | 2.2% |
| 1997 | 21,675 | 4.6% |
| 2002 | 22,948 | 7.3% |

Federal Statistics Office, different years

198 Reichsthaler, 2001.
199 In 2006, for-profit hospitals pay a yearly average of about € 1,100 per full-time staff member for their pensions, against € 2,700 at public hospitals (Augurzky et. al., 2007, p. 57).
200 Licas, Reimers, Henke, and Schlette, 2010, p. 47.
201 Licas, Reimers, Henke, and Schlette, 2010, p. 47.
202 Augurzky et. al., 2009, p. 70.
203 Frankfurter Allgemeine Zeitung, August 4th, 2008.
204 Federal Statistical Office, different years.
205 This was their first major success in their continuing efforts to increase federal power over hospital policies (Bruckenberger, 2008, p. 2).
206 Most for-profit hospital groups were also founded in the comparatively large rehabilitation and preventive care sectors. Thus they could draw upon a reservoir of management capabilities, expertise and capital.
207 I argue that France's recent finding that German federalism has little to do with health care financing have at least one exception: its impact on the growth of the for-profit hospital sector (France, 2008, p. 696).
208 Federal Statistics Office, different years: own calculations.
209 Messemer and Margreiter, 2003.
210 Erler, 2002; Busse, 2004.
211 Rosenow and Steinberg, 2003; Augurzky, et. al 2009.,

## Chapter 5

1 Querido, 1951, p. 34–35.
2 Juch, 1997, p. 242.
3 Another one is the fact that the Netherlands is a small but densely populated country.
4 There were some nonprofit hospitals for children and a limited number of other diseases. There also were women's clinics and sanatoria for more prosperous patients, but these kinds of facilities were rare and eventually disappeared (Juch, 1997, p. 129).
5 Juch, 1997, p. 124.
6 Sickness funds did develop since the late nineteenth century. They started with a religious or socialist background. Since 1910, physicians started their own sickness funds. These funds dominated the market by the late 1930s (Companje, 2001).
7 The law for the poor (1854) allotted municipalities to deliver or pay hospital services for the poor (Groot, 1960, p. 13).
8 Van der Velden, 1993, p. 49.
9 Initially, hospital care was not reimbursed by many sickness funds. In 1907 only fifty-eight funds covered some hospital costs (Widdershoven, 2005, p. 127)
10 Municipalities financed hospital services for those unable to pay; hundreds of local sickness funds existed that financed, mostly on a per capita base, some expenses of physicians and medicine; since the nineteen-twenties special funds for hospital costs were founded; commercial insurers operated for the middle-classes that sought some kind of financial coverage; out-of-pocket payments made up a substantial amount of total hospital turnover. Cities and charity foundations paid for the capital costs.

11 In Amsterdam, the large public hospitals had a bad name and three smaller private clinics developed: the Prinsengracht hospital for the rich; the Civilian hospital for the prosperous middle classes; and, the Central-Israelitic hospital for richer Jews (Van der Velden, 1992, p. 174).
12 Querido, 1960, p. 70–71.
13 'Modern' hospitals started in the late nineteenth century. They operated an equipped surgery room and held X-rays and other (diagnostic) equipment. Schooled nurses assisted the physicians (Juch, 1997, p. 59).
14 In the Netherlands, the gini index was, with the exception of West Germany, the lowest among ten nations (1950). The top five percent earned a larger share (24%) of national income than in the U.S. (20%), the UK (20 %), or Sweden (17 %). (Lijphart, 1968, p. 28–35).
15 Querido, 1960, p. 72; Valk, 1951.
16 Van der Velden, 1993, p. 75.
17 In industrial Schiedam, public per diem payments for services delivered by the new catholic hospital were strictly cost-based. The city council did not want this hospital to generate a profit Van der Velden, 1993, p. 121.
18 Juch describes the typical situation in a provincial town of sixty thousand inhabitants. In Arnhem there existed a catholic, a protestant and a public hospital. In 1921, the protestant hospital only treated six out-of two thousand patients against a reduced rate. In 1931, the City Council decided that poor patients could seek treatment in religious hospitals, and many did so. As a consequence, the public hospital soon operated with large deficits (Juch, 1997, p. 60–62, 257).
19 Van der Velden, 1993, p. 210–211.
20 Juch, 1997, p. 209–211.
21 Groot, 1960, p. 25–26.
22 Groot, 1960, p. 109.
23 Festen, 1984 p. 22.
24 In 1956, the hospital sector consisted of 43 public hospitals, 102 Roman-Catholic, 43 Protestant, 1 Jewish, and thirty independent nonprofit facilities (Groot, 1960, p. 109).
25 Mr. C. van Lienden, the respected chairman of a body of sickness funds, marked in 1951: 'both hospitals and sickness funds need each other and do not obtain for any profit. Hospitals have to be reimbursed for their costs and sickness funds have to pay their fair share, which partly depends on their means' (Festen, 1984, p. 17). Mr. J. Maenen, chairman of the Catholic Hospital Association and member of parliament, stated in 1959: 'we think that their is no reason whatsoever that nonprofit providers would charge rates that are, from a public perspective, more unreasonable than normal for-profit companies. Thus the government should not determine these rates' (Festen, 1984, p. 24).
26 Groot, 1960, p. 131.
27 Groot, 1984, p. 86.
28 Wagner, 1978, p. 217.
29 Such practice factually started in the late forties (Groot, 1964, p. 298).
30 Van Straaten, 1984, p. 113.
31 Van Straaten, 1984, p. 116.
32 Deficits were possible because some expenses were not calculated in the per diem rates (start-up losses on new equipment because of low utilities, fraud, and the consequences of bad management).

33 Van Straaten, 1984, p. 118.
34 Groot, 1985, p. 13.
35 Groot, 1960, p. 39.
36 Fifty-five percent was allocated for industrial projects; twenty-five percent for residential property; and twenty percent for all other construction (Sijmons, 2006, p. 116).
37 Van der Meyden, 1961, p. 209–220.
38 Groot (1960, p. 156) stated that even 'all-out' per diem rates lay between ƒ 6,45 and ƒ18,10.
39 The government paid 3/7 of the construction costs. The hospital should pay the remainder from regular rate increases that were on par with the rising costs of living (Groot, 1960, p. 52).
40 Groot, 1960, p. 52–53.
41 Sijmons, 2006, p. 125.
42 Sijmons, 2006, p. 133.
43 The number of sickness funds was severely reduced along geographical lines and they did not compete for new enrollees. Decisions on covered services as well as reimbursements were centralized and contributions became dependent on income.
44 Companje, 2001, p. 172.
45 Telder Foundation, 1963, p. 206.
46 Zwaan, 2008, p. 25–26.
47 The system struggled with the consequences of the lack of community rating in private insurance and the higher costs of the sickness funds due to its overrepresentation of elderly. For the moment, these problems were solved (1986) in anticipation of a more definite solution.
48 Lieverdink, 2001, p. 1191–1192.
49 Helderman, 2007, p. 208–217.
50 Committee Structure and Remuneration Health Care, 1987.
51 After a regulatory change (1994), employers stood at risk for the continuation of payments to employees unable to work.
52 Van Montfort, 1998, p. 355; Brouwer and Hermans, 1999.
53 They got some support from academics that thought priority care unfair. Van Dartel states that health care is placed in an economic context, and that thus the interest of the chronically ill, who already got few chances in society, is neglected (van Dartel, 1997, p. 229).
54 The total number of certificate-of-need for freestanding clinics increased from 35 (2002) to 158 (2006) (Dutch Healthcare Authority, 2007, p. 20).
55 Dutch Healthcare Authority, 2007, p. 7, 9.
56 Elsinga and Keuzenkamp, 2001; Council for Public Health and Health Care, 2002.
57 Central Planning Bureau, 2003; Hers and Wijnker, 2004; Dijkgraaf et. al., 2006.
58 Hermans, 2004, p. 425.
59 Sijmons, 2006, p. 218, 318–319.
60 Sijmons, 2006, p. 221.
61 An earlier draft stated that only nonprofit providers get a license to be active on the health care market (Sijmons, 2006, p. 217).
62 Ministry of Health, 2005.
63 Sijmons, 2006, p. 222.
64 PwC, 2007a and 2007b.
65 Dutch HealthCare Authority, 2008, p. 7–8.
66 Sijmons, 2006, p. 257, 308.

67 Medisch Contact, 2009, p. 234.
68 See De Volkskrant (Peoples Daily), December 31th, 2008).
69 Van der Heyden, 1994, p. 74.
70 See Robert Alford (1975) for a thorough analysis of the importance of structural interests in the development of health care policy.
71 Any fundamental causalities between the external incentives of managed competition and the internal stimuli of for-profit property-rights were not given much thought.
72 National Council for Health Care, 1991, p. 5.
73 Jeurissen, 2002, p. 15.
74 The Agency for Hospital Planning stated that it always had been the intention of the Hospital Provider Law to include all acute care facilities, save physician offices and residential property (National Council for Health Care, 1991, p. 8).
75 Knoors, Vrijland, and van Zenderen, 2000.
76 Jeurissen, 2002.
77 Knoors, Vrijland, and van Zenderen, 2000, p. 482.
78 The sickness funds, in contrast to indemnity insurers, were forced to contract all hospitals and thus paid for their fixed costs. It was in their interest that hospital utility stayed high.
79 Turnover (2001) of freestanding clinics depends for twenty-five percent on indemnity insurers; turnover from sickness funds was twenty-three percent; remaining revenues were largely out-of-pocket payments (Jeurissen, 2002, p. 37).
80 Van Delft, 2001.
81 This was to prevent these clinics to deliver in-vitro-fertilization techniques, which was possible on an outpatient base.
82 Knoors,Vrijland, and van Zenderen, 2000.
83 Knoors, Vrijland, and van Zenderen, 2000, p. 483.
84 Internal spreadsheet data of the Agency for Hospital Planning.
85 Jeurissen, 2002, p. 43–44.
86 Jeurissen, 2002, p. 49–50.
87 Jeurissen, 2002, p. 34–35.
88 Occupational health is a well-developed separate sector. The consequence is that there exist specialized services that do not form part of the health care sector.
89 Research voor Beleid, 1999, p. iii.
90 This indicates the changing climate regarding for-profit care. Most experiments start in long-term care and mental health.
91 It was possible that more than one provider delivered care in a certain region; insurers were obliged to contract those new providers (Breedveld, 2003, p. 192–200).
92 CBZ, 1999, p. 1.
93 Hermans, 2004, p. 418–420.
94 A surcharge of 12,5 percent could be calculated to include capital expenditure.
95 IGZ, 2003.
96 IGZ, 2004.
97 IGZ, 2004, p. 5.
98 Formerly, sickness funds had to contract all hospitals, which was not in the interest of the freestanding clinics.
99 About twenty-two percent (Dutch Health Authority, 2006, p. 21, 24, 46).
100 Inspectorate Health Care (IGZ), 2009, p. 6.

## Chapter 6

1 This is clearly the case in the US, the UK, and Germany. The Netherlands did not develop a proprietary sector.
2 It must be noted that these older statistics probably do not use the same definitions and therefore are not completely comparable.
3 The theoretical arguments of Arrow (1963), market failures due to information asymmetry; Pauly and Redisch (1973), nonprofit hospitals as physician cooperatives; and Weisbrod (1975), heterogeneous demand of public type services, all seem to predict the increasing dominance of nonprofit ownership and a further decline of proprietary ownership types.
4 In sociology, a tipping point refers to the fact that a rare phenomenon becomes rapidly more common. Slow growth suddenly accelerates. It stems from the study by Grodzins in the 1950s. He used it to explain 'white' flight from neighborhoods when the number of minorities reaches a certain level.
5 Rosenberg, 1987.
6 Other proprietary owners were (industrial) companies that did not seek actual profits. Only in the Western part of the US did a few corporate hospital companies develop.
7 Salaried physicians were always on the hospitals' 'closed' list. However, they could be supplemented with self-employed physicians that held such preferences. In many 'open staff' hospitals there were also soft constraints on the medical staff. For example Catholic hospitals may only be 'open' to Catholic physicians. In both 'closed' and 'open' staff models, it was common that physicians provided some services in return for their hospital affiliation.
8 Winkelman, 1971.
9 In fact, until 1936, it was 'illegal' for nonprofits to charge private fees and keep their charity status (Lee, 1978).
10 See also Stevens, 1999.
11 The available data are most comprehensive for the US, which increases scientific reliability for any statements on this case. Table 6.2 also shows that the slope of the curve in the years predating World War II is most steep for the US.
12 This table is composed of different statistics from the individual countries. Thus they may not be completely comparable.
13 Rosenberg (1987) describes this process of decreasing power by hospital boards and administrators.
14 They already occupied such a position in the proprietary hospitals, which they owned.
15 Proprietary hospitals often had limited access to capital because the prospects of a reasonable return on investments were limited.
16 Starr, 1982, p. 167.
17 The emergence of stock-listed for-profit hospital companies opened important additional reimbursement possibilities. Physicians that affiliated to for-profit hospital chains could participate in highly lucrative equity compensation schemes.
18 In the US, conversions to nonprofit ownership were a possibility. However, in general capital traps and high exit-barriers typify the hospital sector. (Hansmann, Kessler, and McClellan, 2002).
19 The proprietary hospital sector consisted of: 1) specialized facilities that hold no certificate-of-need, and 2) small general acute open-staff facilities, which, due to increasing

ambulatory alternatives and easier access to more developed hospitals, were less needed in the rural surroundings where they had their base. Diversification into rehabilitation and spa treatments was necessary for those that sought to grow.

20 Oberlander, 2003, p. 37.

21 In a less efficient way, the independent sector eased pressure on public budgets. They 'paid' for part of the consultant salary and delivered services that otherwise would place an additional burden on NHS budgets.

22 These ratios are my own calculations, based on the data gathered for this study.

23 This range is calculated on a state-by-state basis.

24 Two characteristics prohibited a completely level playing field. Nonprofit and public hospital still had access to cheap tax-exempt bonds. For-profits still had access to the commercial equity markets. If these considered hospitals a very good long-term investment, for-profits might get temporary access to capital on favorable conditions.

25 A recent book by Alan Miller – CEO of for-profit Universal Health Services – illustrates some health care reforms the sector still wishes: 1) tort reform to limit jury awards for noneconomic damages; 2) allow insurance companies to sell policies across state lines; 3) tax credits to those that buy insurance on the individual market (Miller, 2009).

# List of interviewed experts

## United States

Phillip Betbeze, Healthleaders Magazine
Don Cox, Office of the Assistant Secretary of Planning and Evaluation (ASPE)
David Cutler, Harvard University
Randy Fenninger, American Surgical Hospital Association
Matt Gallivan, Nashville Health Care Council
Bradford Gray, Urban Institute
Steven Speil, Federation of American Hospitals
Jana Joustra Davis, HCA
John Butler, Nashville Chamber of Commerce

## United Kingdom

Mr. Charles Auld, CEO (non-executive), General Healthcare Group
Mrs. Joan Higgins, Professor health policy, University of Manchester
Mr. William Laing, Director, Laing&Buisson
Mr. David Lewsey, Group Financial Controller, Aspen Healthcare
Mr. Michael Neeb, CFO and Vice President International Operations, HCA International
Mr. Stephen Withers, Director European Affairs, BUPA

## Germany

Mr. Boris Augurzky, RWI, Essen.
Mr. Markus Wörz, Technische Universität Berlin
Mr. Dietmar Pawlik, CFO Rhön-Klinikum
Mr. Kai Klinger, Universität Mannheim
Mr. Michael Burkhart, PricewaterhouseCoopers
Mr. Claus Wendt, University of Mannheim

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# Samenvatting

## Opzet van dit onderzoek

Dit onderzoek is een vergelijkende en historische analyse van de ontwikkeling van winstbeogende ziekenhuizen in de Verenigde Staten, het Verenigd Koninkrijk, de Duitse Bondsrepubliek en Nederland. Drie vragen worden beantwoord. 1) Hoe heeft de for-profit ziekenhuissector zich ontwikkeld binnen deze vier landen? 2) Hoe kunnen we de ontwikkeling van de *for-profit* ziekenhuissector verklaren? 3) Waarom verschilt de ontwikkeling van de *for-profit* ziekenhuissector tussen deze landen?

In het onderzoek komen vier mogelijke theoretische verklaringen voor de eigendomsverhoudingen in de ziekenhuissector aan de orde. Een eerste verklaring heeft betrekking op de kosten van kapitaal en het rendement op investeringen. Het feit dat in alle onderzochte landen de marktpenetratie van *nonprofit* en publieke ziekenhuizen hoger is dan die van *for-profit* ziekenhuizen zou (mede) een gevolg kunnen zijn van de hogere (kapitaals)kosten bij deze laatste eigendomsvorm. Voldoende rendement op eigen vermogen vormt een natuurlijke voorwaarde voor het bestaansrecht van een *for-profit* ziekenhuissector. Of er voldoende rendement kan worden behaald, hangt af van de prijzen die in rekening kunnen worden gebracht, de toegang tot productiefactoren (kapitaal, arbeid en technologie) en de grip op de kosten. Hoe minder marktimperfecties er zijn, hoe meer men mag verwachten dat de *for-profit* instellingen een hogere toegevoegde waarde zullen bieden dan andere eigendomsvormen.

Een tweede verklaring heeft betrekking op de mogelijkheid om goede contractuele afspraken te kunnen maken over de te leveren prestaties. Wanneer dat niet goed mogelijk is, bijvoorbeeld omdat kwaliteit niet goed observeerbaar is, bestaat het risico dat *for-profit* instellingen geneigd zijn om te beknibbelen op kwaliteit als dat meer winst oplevert (opportunistisch gedrag). In dit geval is er sprake van *contractfalen* en zijn *nonprofit* instellingen voor zorggebruikers aantrekkelijk omdat het ontbreken van uitkeerbare winst of het bestaan van altruïstische doelstellingen aangeeft dat de instelling minder of geen belang heeft bij een dergelijk opportunistisch gedrag.

Een derde verklaring voor de specifieke eigendomsstructuur van de ziekenhuissector heeft betrekking op het belang dat artsen hebben bij een bepaalde eigendomsvorm. Zo kunnen artsen belang hebben bij de vaak zwakkere *governance* structuur van *nonprofit* instellingen of juist een belang hebben bij *for-profit* instellingen wegens een betere beloning of andere arbeidscondities.

Tenslotte kan het bestaan van publieke- en *nonprofit* instellingen mogelijk ook een gevolg zijn van de hoge mate van complementariteit tussen overheid en *nonprofit* sector.

De drie onderzoeksvragen worden beantwoord met behulp van een inductieve strategie, waarbij door middel van een analyse van literatuur en historisch bronnenmateriaal en op grond van interviews met deskundigen en betrokkenen in de betreffende landen geprobeerd is om de ontwikkeling van de eigendomsverhoudingen in de ziekenhuissector te beschrijven en te verklaren. De keuze van de vier casussen is gebaseerd op: 1) verschillen in de institutionele omgeving; 2) verschillen in de kenmerken van de ziekenhuissector; en 3) verschillen in de omvang van de *for-profit* sector. Het empirische onderzoek beschrijft een ruime periode, vanaf de opkomst van het 'moderne' ziekenhuis (begin twintigste eeuw) tot de huidige tijd. De nadruk ligt echter op de moderne verzorgingsstaat en op de periode na de Tweede Wereldoorlog. De analyses van het chronologisch gerangschikte empirische materiaal vinden in eerste instantie plaats op het niveau van elke individuele casus. Vervolgens vindt een vergelijkende analyse tussen de verschillende casussen plaats.

## Verenigde Staten: de ontwikkelingen in de grootste *for-profit* sector

De geschiedenis van de Amerikaanse *for-profit* sector is ruwweg in te verdelen in een drietal perioden. Vanaf het begin van de twintigste eeuw to het midden van de jaren zestig werd deze sector met een dalende relatieve omvang geconfronteerd. Tot het midden van de jaren tachtig was er aansluitend een snelle groei van het aantal *for-profit* ziekenhuizen. Tot slot volgt een periode die wordt gekenmerkt door gematigde groei, soms zelfs stagnatie, van de *for-profit* sector. Uit het onderzoek blijkt dat drie factoren deze ontwikkeling kunnen verklaren.

Ten eerste de relatieve toegang tot (of kosten van) kapitaal. Deze was tot medio jaren zestig namelijk (veel) gunstiger voor de publieke- en voor de *nonprofit* ziekenhuizen. Na de komst van Medicare (1965) sloeg deze situatie radicaal om en hadden de *for-profit* ziekenhuizen de beste toegang, dankzij een 'gegarandeerd' en hoog rendement op het eigen vermogen. In de recente periode zijn deze voordelen grotendeels afgebouwd; er is een min of meer gelijk speelveld tussen de verschillende eigendomsvormen gecreëerd.

De tweede belangrijke verklarende factor is gelegen in de belangen van artsen bij bepaalde eigendomsvormen. Aanvankelijk startten veel artsen en maatschappen *proprietary hospitals* (privéklinieken) omdat ze geen toegang hadden tot publieke en *nonprofit* instellingen. Toen dit probleem was opgelost, waren de artsenorganisaties het meest gecharmeerd van *nonprofit* ziekenhuizen – die functioneerden als *physician co-operatives* – en tegen het bestaan van *proprietary* instellingen. Sinds

de jaren zeventig is de opstelling van de medische beroepsgroep minder uitgesproken. Dit wordt veroorzaakt doordat veel *for-profit* ziekenhuizen inmiddels betere arbeidsvoorwaarden bieden dan ziekenhuizen met andere eigendomsvormen.

Een laatste factor – van groot belang in de Verenigde Staten – vormt de aanwezigheid van grote groepen on(der)verzekerde patiënten. Dit vormt een probleem omdat het weigeren van deze patiënten in de regel geen optie vormt, zeker niet als het gaat om spoedeisende behandelingen. De oninbare vorderingen die hiervan het gevolg zijn zetten de winsten onder druk. Dit werd voor het eerst duidelijk tijdens de crisis in de jaren dertig toen bleek dat de grote afhankelijkheid van de (*proprietary*) ziekenhuizen van eigen betalingen hun kwetsbaar maakte tijdens een economische neergang. Voor *nonprofit* instellingen is het probleem van niet betalende patiënten minder groot omdat zij als compensatie hiervoor belastingvrijstelling kregen en omdat zij genoegen namen met lagere winstmarges. Medicare (1965) en Medicaid (1966) hebben dit probleem verminderd. Sinds het midden van de jaren tachtig is het aantal onverzekerde patiënten weer geleidelijk toegenomen. Bovendien betalen Medicare, sommige zorgverzekeraars, en Medicaid de ziekenhuizen steeds minder vaak een kostendekkende vergoeding.

### Het Verenigd Koninkrijk: *for-profit* instellingen buiten het publieke systeem

De Engelse *proprietary* sector heeft zich vanaf haar oorsprong sterk gericht op de bovenste laag van de bevolking. Mede doordat *nonprofit* instellingen zich minder op deze groep richtte, was haar marktaandeel bij deze patiëntengroep zeer groot. Deze *proprietary* instellingen waren vaak eigendom van verpleegsters, met artsen in een consultatieve rol.

De in 1948 opgerichte National Health Service (NHS) nationaliseerde bijna de gehele ziekenhuissector of 'dwong' instellingen om te stoppen met hun activiteiten. De resterende instellingen werden verenigd in een 'onafhankelijke' sector. Deze sector was vooral interessant voor de beter gesitueerden die behandeling door senior specialisten uit de NHS wilden en gesteld waren op extra luxe. Overigens domineerde de NHS deze markt met eigen private voorzieningen (*pay-beds*).

De 'onafhankelijke' instellingen begonnen na invoering van de NHS aan een groei die min of meer ononderbroken voortduurt. Wel is het tempo van de groei sterk afhankelijk van de investeringen in de NHS en de beloning van artsen. Ten eerste neemt de vraag naar 'onafhankelijke' zorg toe als de NHS slechter presteert, bijvoorbeeld door groeiende wachtlijsten. Ten tweede zijn de senior specialisten in de NHS voor een aanzienlijk deel van hun inkomen afhankelijk van extra werk in de 'onafhankelijke' sector. Daarnaast is de groei van de onafhankelijke sector ook gestimuleerd door een groeiende rol van particuliere zorgverzekeraars, die hun bestaansrecht grotendeels ontleenden aan de 'onafhankelijke' ziekenhuizen.

Deze verzekeraars wilden niet afhankelijk zijn van een politiek bestuurde publieke zorginfrastructuur. Met eigen middelen werd de ontwikkeling van een separate private ziekenhuissector herhaaldelijk ondersteund.

Hoewel de 'onafhankelijke' sector lange tijd groeide, bleef ze toch betrekkelijk marginaal; de NHS domineerde lange tijd de markt voor luxe zorg. Dit alles veranderde radicaal in de jaren zeventig. Een poging van de nieuwe *Labour* regering specialisten te ontmoedigen om dit type zorg te verlenen mislukte faliekant. Patiëntenstromen werden verlegd van de NHS naar de 'onafhankelijke' sector en daarbinnen weer naar de *for-profit* instellingen. Toen bovendien het ideologische tij enkele jaren later omsloeg, kon de sector snel groeien. Deze groei werd opgevuld door (nieuwe) ketens van *for-profit* ziekenhuizen die de toegang tot het benodigde kapitaal hadden en ook veel individuele *nonprofit* en *for-profit* instellingen opkochten.

De komst van een interne markt (1991) impliceerde dat de *for-profit* instellingen betere toegang tot NHS contracten konden krijgen. Dit kwam echter nauwelijks van de grond door lage NHS tarieven voor dit soort werk alsmede andere institutionele belemmeringen. Vanaf 1997 investeerde de *Labour* regering massief in verbetering van de NHS. Hoewel de *for-profit* sector nu met meer succes aanspraak maakte op een deel van deze middelen, was het gevolg daarvan dat zij langzaam meer geïncorporeerd werd in het NHS-systeem, wat leidde tot een afkalving van het traditionele bedrijfsmodel dat dreef op de 'noodzaak' van een alternatief voor de NHS (zowel voor patiënten als voor de senior specialisten).

## Duitsland: impact van publieke investeringssubsidies op *for-profit* instellingen

Medische hoogleraren hadden een niet onbelangrijk aandeel in het ontstaan van de eerste Duitse privéklinieken. Deze kenmerkten zich door een relatief hoog kwaliteitsniveau en door de concentratie op één of enkele specialismen. De primaire doelgroep bestond uit patiënten uit de bovenlaag van de bevolking.

De wettelijke scheiding tussen de ambulante en de intramurale zorg (1932) was een nadeel voor de ontwikkeling van de *proprietary* sector. Verliesgevende patiënten konden worden doorverwezen; winstgevende patiënten konden (zo lang mogelijk) bij de ambulante artsen blijven. Naast gespecialiseerde privéklinieken in de stedelijke gebieden en een aantal instellingen met luxe zorg, bestond er enkel ruimte voor een aantal plattelandsziekenhuizen die functioneerden als een platform voor de lokale ambulante dokter.

Na de Tweede Wereldoorlog zorgde de combinatie van een federale constitutie, subsidiariteit en zelfregulering dat een beperkt aantal *for-profit* instellingen bleef bestaan. Alle ziekenhuizen hadden het moeilijk door het ontbreken van een kapi-

taalkrachtige vraagzijde. Voor publieke en *nonprofit* ziekenhuizen veranderde dit met de komst van een planningswet in 1972. Aanvankelijk hadden de *for-profit* ziekenhuizen geen toegang tot het 'gratis' kapitaal op basis van deze wet. Vanaf de invoering van de planningswet speelt de toegang tot en de prijs van kapitaal een cruciale rol bij de verdere ontwikkeling van de *for-profit* sector. Door steeds grotere bezuinigingen op de fondsen voor publieke investeringen, sloeg het aanvankelijke voordeel van publieke en *nonprofit* ziekenhuizen langzamerhand om in een nadeel. Toegang tot de private kapitaalmarkten werd een steeds belangrijker concurrentievoordeel. Bovendien kregen de *for-profit* ziekenhuizen door veranderingen in de wet- en regelgeving steeds betere toegang tot deze publieke investeringsmiddelen.

De Duitse eenwording zorgde voor een plotselinge en definitieve doorbraak van de *for-profit* sector. In het oosten moest de publieke ziekenhuissector worden gesaneerd. Het waren de *for-profit* ziekenhuizen die de noodzakelijke politiek-ideologische en financiële steun kregen om deze taak ter hand te nemen. Deze wisten een marktaandeel van rond de dertig procent op te bouwen en behandelen min of meer dezelfde patiëntenpopulatie als de andere aanbieders. In de deelstaten in het westen werden steeds meer publieke ziekenhuizen geprivatiseerd omdat veel steden niet langer konden opdraaien voor structurele exploitatietekorten en omdat noodzakelijke middelen voor nieuwe investeringen niet voorhanden waren. De toegang van commerciële ziekenhuisketens tot de financiële markten werd een steeds groter voordeel. Deze dynamiek is tot op dit moment intact.

## Nederland: het wegblijven van een *for-profit* sector

Tot op de dag van vandaag bestaat er in Nederland geen *for-profit* ziekenhuissector. De belangrijkste oorzaken hiervoor liggen in het begin van de twintigste eeuw. Artsen hadden geen behoefte aan privéklinieken; ze hadden voor de behandeling van hun kapitaalkrachtige clientèle in de regel al toegang tot één of meerdere *nonprofit* ziekenhuizen. De beroepsgroep kon voor haar belangenbehartiging en financiering terugvallen op een groot aantal eigen ziekenfondsen die de markt domineerden.

Na de Tweede Wereldoorlog werd de opkomst van een *for-profit* ziekenhuissector verhinderd door een steeds fijnmaziger en onderling vervlochten systeem van instituties. Toegang tot kapitaal werd gegarandeerd uit collectieve middelen en exclusief voorbehouden aan instellingen zonder winstoogmerk.

Snelle invoering van *for-profit* ziekenhuizen was nog steeds niet mogelijk toen gereguleerde marktwerking vanaf het midden van de jaren tachtig het heersende bestuurlijke oriëntatiepunt werd. Niettemin wordt het verbod op winstuitkering sinds 2005 langzaam maar zeker ondermijnd door de geleidelijke liberalisering

van de prijsvorming en de geleidelijke afschaffing van de collectieve bekostiging van kapitaalslasten. Dit wordt onderstreept door recente investeringen van commerciële partijen in twee ziekenhuizen. Als *nonprofit* ziekenhuizen hun toegenomen investeringsautonomie niet kunnen waarmaken dan komt overname door commerciële partijen in beeld. Zolang winstuitkering wettelijk nog niet is toegestaan, is de komst van een *for-profit* ziekenhuissector echter nog steeds geen volledig uitgemaakte zaak.

## Vergelijkende en longitudinale analyse

Een vergelijking tussen de vier landen maakt duidelijk dat: 1) de toegang tot en de vergoeding van kapitaal, samen met 2) de (inkomens)belangen van de medisch specialisten de belangrijkste factoren zijn die de verschillen in de ontwikkeling van de *for-profit* ziekenhuissector verklaren. De gevonden kwantitatieve patronen hangen sterk samen met de instituties die de toegang en prijs van kapitaal alsmede de belangen van de artsen bepalen.

In de eerste helft van de twintigste eeuw kregen publieke en *nonprofit* ziekenhuizen het benodigde kapitaal in de regel om niet. *Proprietary* ziekenhuizen hadden daardoor een behoorlijk nadeel. Meer in het algemeen was het behalen van een positief rendement op het geïnvesteerde vermogen een lastige opgave. Dit voordeel van publieke en *nonprofit* ziekenhuizen werd na de Tweede Wereldoorlog geleidelijk minder. De vraag naar ziekenhuisinvesteringen nam sterk toe en het benodigde kapitaal kon veelal niet meer rechtstreeks worden opgebracht. Dankzij de toenemende rol van ziektekostenverzekeringen nam de potentiële klantenkring toe en werd de *for-profit* sector minder gevoelig voor conjunctuurschommelingen. Nieuwe instituties werden ontwikkeld om de toegang tot en de prijs van kapitaal te reguleren. Meestal waren deze instituties nog steeds veel gunstiger voor de publieke- en de *nonprofit* ziekenhuizen dan voor de *for-profit* instellingen. Echter, met uitzondering van Nederland, waren deze instituties niet stabiel over een lange reeks van jaren. Institutionele aanpassingen boden meer en meer ruimte voor *for-profit* instellingen. Gedurende bepaalde perioden hadden *for-profit* instellingen in sommige landen zelfs betere investeringsvoorwaarden dan de andere eigendomsvormen. De regulering van de toegang tot en prijs van kapitaal is essentieel om de snelle groei van *for-profit* instellingen in Duitsland en de Verenigde Staten te begrijpen, maar ook de lange periode van complete afwezigheid van dit type instellingen in Nederland. In het Verenigd Koninkrijk is de kwaliteit van de dienstverlening van de NHS een belangrijke determinant van de ontwikkeling van de *for-profit* ziekenhuissector.

*Nonprofit* ziekenhuizen boden artsen lange tijd de beste arbeidsvoorwaarden. Dit betrof zowel het inkomen, de controle over belangrijke aspecten van de be-

drijfsvoering, maar ook het ontbreken van enig investeringsrisico. Artsen hadden een voorkeur voor *nonprofit* ziekenhuizen boven *proprietary* instellingen, maar omdat zij aanvankelijk niet overal toegang kregen tot *nonprofit* ziekenhuizen waren de *proprietary* instellingen soms wel een belangrijk alternatief. De toenemende toegang van artsen tot *nonprofit* instellingen droeg dan ook bij aan de neergang van de *proprietary* sector. Vele jaren later waren de opkomende *for-profit* ketens in staat om de artsen een beter arbeidsvoorwaardenpakket te bieden, inclusief toegang tot technologische vernieuwingen. In het VK konden de senior specialisten uit de NHS riante vergoedingen krijgen als ze een deel van hun tijd in *for-profit* klinieken doorbrachten. Duitse *for-profit* ketens betalen meestal meer salaris (en vooral extra bonussen) dan de publieke instellingen, hun primaire acquisitiedoel. Amerikaanse commerciële ketens creëren aantrekkelijke arbeidsvoorwaarden voor de vrijgevestigde specialisten die van deze faciliteiten gebruik maken. Wel ondergraaft de komst van kapitaalextensieve behandelcentra het natuurlijke monopolie van de ziekenhuissector op curatieve zorg. Dit is bedreigend voor *for-profit* ziekenhuizen die hun bedrijfsmodel mede baseren op het bieden van een behandelplatform aan die artsen die georiënteerd zijn op maximalisatie van hun inkomens en nu met deze centra een alternatief hebben voor behandelingen in een ziekenhuis. Tot op heden is deze competitie meer manifest in de Verenigde Staten dan in de andere landen; zo is de traditionele dichotomie tussen ambulante en intramurale zorg in Duitsland nog steeds grotendeels aanwezig.

# Dankwoord

Vlak na de officiële goedkeuring van dit proefschrift, begon voor mij en ons gezin een periode van grote onzekerheid. Op woensdag 30 december 2009, een paar dagen na Kerstmis, werd namelijk een hersentumor bij onze zoon Lucas geconstateerd. Op dinsdag 6 april 2010, twee dagen na Pasen, twee operaties en heel veel onzekerheid verder, kregen wij het bericht dat de verwijderde tumor goedaardig bleek te zijn, iets waar het op basis van de gemaakte scans lange tijd niet naar uitzag.

Het schrijven van een proefschrift en alles wat daarbij komt kijken valt volstrekt in het niet bij het belang van de genezing van je eigen kind van zo'n levensbedreigende ziekte. Ik neem daarom de vrijheid om op de eerste plaats de betrokken neurochirurg, mw. M.L. van Veelen, te bedanken. Hiernaast is er ook veel dank en respect voor de kennis en betrokkenheid van haar ondersteunende staf, alle medewerkers van de verpleegafdelingen 1-Noord en IC 1 van het Sophia kinderziekenhuis.

In de vaste overtuiging dat het doorstaan van dit soort gebeurtenissen om meer vraagt dan professionele bekwaamheid, wil ik ook alle mensen bedanken – te veel om op te noemen – die ons in deze moeilijke periode hebben gesteund met hun gebeden en blijken van medeleven. Het is goed om je omringd te weten door medemensen. Zoals gezegd, het zijn er veel te veel om op te noemen, maar een uitzondering moet gemaakt voor Mgr. H. Steinkamp, die nog tijdens de beide operaties van Lucas de heilige mis voor hem heeft opgedragen.

Dan nu waar dit dankwoord feitelijk voor bedoeld is, het bedanken van de mensen die op een of andere wijze hebben bijgedragen aan de totstandkoming van dit proefschrift. Op de eerste plaats zijn dat natuurlijk mijn beide promotoren: Tom van der Grinten en Erik Schut. Ik ben blij dat ze mij mijn eigen 'verhaal' hebben laten maken, een integraal 'verhaal' van de ziekenhuizen met winstoogmerk. Zonder hun kritische maar altijd opbouwende houding was er een ander proefschrift uitgekomen: op de eerste plaats veel langer, op de tweede plaats minder goed. Ik ben ook Pieter Vos, algemeen secretaris van de RVZ, veel dank verschuldigd. Zonder zijn jarenlange steun was het onmogelijk geweest om dit project uit te voeren; ik heb bovendien veel van hem geleerd.

Dan zijn er de mensen die conceptteksten hebben doorgelezen en van commentaar voorzien. George Greenberg (Department of Health and Human Services) heeft alles gelezen. Hem dank ik voor de vele verbeteringen van mijn Engels en

voor de consequenties van zijn vragen voor mijn analyses. Hiernaast heb ik veel gehad aan het commentaar van Stephen Withers (BUPA), Bradford Gray (Urban Institute), Boris Augurzki (RWI-Essen), Claus Wendt (Universität Mannheim) en Markus Wörz (Technische Universität Berlin) op individuele landenhoofdstukken.

Hans Maarse (UvM), Jan-Kees Helderman (RU), Kim Putters (EUR) en Wendy van der Kraan (RVZ) hebben ook nuttig commentaar geleverd op eerdere conceptteksten. Alfred Driessen, Gerben Brummelman, René Groot-Koerkamp en Simone Jeurissen hebben bijgedragen aan het verwezenlijken van enkele niet onbelangrijke details. Zonder de steun en 'goedheid' van mijn vrouw Janine was dit alles ook zeer zeker niet mogelijk geweest.

Het einde is ook het begin. 'Maar er moet feest en vrolijkheid zijn, omdat die zoon van je dood was en levend is geworden, verloren was en is teruggevonden (naar Lc 15, 32)'.

# Curriculum vitae

Patrick Jeurissen is getrouwd met Janine en heeft twee kinderen, Hanna (2001) en Lucas (2004). Hij werkt bij het Ministerie van Volksgezondheid, Welzijn en Sport als clustercoördinator strategie en kennis bij de Directie macro-economische vraagstukken en arbeidsvoorwaardenbeleid. Hiervoor was hij werkzaam bij de Raad voor de Volksgezondheid en Zorg en het Erasmus MC. Daarvoor studeerde hij bestuurskunde aan de Erasmus Universiteit en Indiana University.

Vraagstukken op het terrein van het strategische zorgbeleid, de financiering van de zorg en de internationale vergelijking van zorgsystemen hebben zijn bijzondere interesse. Binnen het brede terrein van de zorgsector heeft hij vooral affiniteit met zorgverzekeringen, academische- en topklinische zorg, geestelijke gezondheidszorg, eerstelijnszorg en de publieke gezondheid. Hij publiceert met enige regelmaat over deze onderwerpen en houdt hierover voordrachten in binnen- en buitenland.

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