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A Win-Win for Taxpayers and the Poor

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By Dr. Francois Melese
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Executive Summary

Hospital expenditures accounted for almost a third of the $1.6 trillion the United States spent on health care last year. According to the U.S. Department of Health and Human Services, over the ten-year period from 1990 to 2000 the average cost of an inpatient stay at a public hospital increased nearly 50 percent, compared to only 20 percent at private for-profit hospitals. By 2001 the $7,400 cost of a stay at a public hospital was 24 percent greater than at a private for-profit ($5,972). Why are costs rising so rapidly? In the case of public hospitals, a conflicting mix of social, political, and business objectives results in weak incentives to control costs. Cost burdens come from inefficient accounting, restrictive government personnel and procurement regulations, a tangled web of bureaucracy, and a general lack of accountability.

Bureaucracy, red tape, and outdated medical reporting and accounting systems not only inflate costs, but can also jeopardize lives. By one estimate, shoddy quality control costs Americans $500 billion per year in avoidable medical costs, or roughly 30 percent of all health care spending. Of course lives lost are more important than money lost. Medical errors claim anywhere from 44,000 to 98,000 American lives every year, roughly 15 to 30 times the death toll from the terrorist attacks on September 11, 2001. Two potent antidotes to medical errors are investing in new diagnostic devices and harnessing the latest advances in information technology. The inherent inefficiency of publicly run hospitals and their limited access to capital ensures that most will continue to lag behind the technology curve. Restricted in their ability to raise taxes to pay for new technology, governments must decide whether they can continue to afford to own and operate a public hospital.

Many attractive alternatives exist that benefit both taxpayers and the poor. Municipalities throughout the country and around the world have demonstrated they can serve indigents more efficiently and effectively by selling public hospital assets and turning to the private sector. In the United States, communities often receive

a cash payment to retire debt and establish trust funds for community health care. Since 1994, over 100 charities have emerged from hospital sales that control a combined total of nearly five billion dollars. Even strong advocates of socialized medicine now acknowledge the growing scrutiny of public hospitals has "raised the level of the discussion…[and increased] focus on the need for care by uninsured citizens…on the services required, and on how to finance and deliver those services."

Besides crowding out private insurance, when well-meaning state and local governments run public hospitals and pass well-intentioned regulations and mandates, evidence suggests they inadvertently raise health care costs and lower performance. It is time to reengineer our safety nets. Carefully crafted deregulation and privatization, combined with subsidized medical savings account vouchers (MSAVs) and a high-deductible insurance policy for indigents, can bring us the best of all worlds: lower taxes and better services.

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Part 1

Introduction

The impact of private ownership on performance is neatly illustrated in a retrospective study of 92 expeditions made to the Arctic over the period 1818 to 1909.[1] Most major discoveries were made by privately funded expeditions. Most tragedies (lost ships and lives) occurred on publicly funded expeditions. Why? It turns out that incentives matter.

Private expeditions more clearly aligned rewards with discoveries. This resulted in systematic differences in the way public and private expeditions were organized. The same is true of most government-funded enterprises.

Take hospitals. Last year hospitals accounted for almost a third of the $1.6 trillion the United States spent on health care.[2] The American Hospital Association reports public hospitals—run by state and local governments—make up nearly a quarter of the nation's 4,895 community hospitals.[3]

Public and private hospitals are organized very differently, and for good reason. One must satisfy a community of *stakeholders*, the other a community of *shareholders*. In the case of public hospitals, a conflicting mix of social, political, and business objectives results in weak incentives to control costs.[4]

By 2001 the $7,400 cost of a stay at a public hospital was 24 percent greater than at a private for-profit ($5,972).

Incentives Matter

Public hospitals are expensive. For instance, where I live, a night's stay in intensive care at the public hospital (Natividad) carries a price tag of over $6,000—nearly twice the price reported by the two private community hospitals in the area (Community Hospital of the Monterey Peninsula and Salinas Valley Memorial). According to the U.S. Department of Health and Human Services, over the ten-year period from 1990 to 2000 the average cost of an inpatient stay at a public hospital increased nearly 50 percent, compared to only 20 percent at private for-profit hospitals. By 2001 the $7,400 cost of a stay at a public hospital was 24 percent greater than at a private for-profit ($5,972).[5]

Unfortunately, high cost does not necessarily buy better care. The quality of health care in public hospitals is typically no better than that in private hospitals. In fact, a recent study finds "for-profit hospitals offer better

quality."[6] Instead, the cost burden comes from inefficient accounting, restrictive personnel and procurement regulations, a tangled web of bureaucracy, and a general lack of accountability.

Consider the case of Natividad, a California public hospital owned and operated by Monterey County. Most private hospitals do not actually employ physicians. They act as workstations where doctors perform services. After surgery, the surgeon and anesthesiologist each bill the patient, and the hospital bills for services it provides. Doctors that use private hospitals have an incentive to keep track of their patients. Natividad's doctors don't. They're staff. They receive a salary regardless of whether or not procedures are recorded.[7] Predictably, this contributes to a dismal recording system filled with gaps (unreported procedures and uncollected co-payments), incorrect coding (one out of four bills contains an error) and lack of follow through (missed billing deadlines).[8] The best-run hospitals typically collect payments within 50 to 60 days. Natividad's average is around 70 days and has been as high as 133 days.[9]

While incentive problems conspire to shrink revenues, Natividad is also afflicted with inflated costs. Restrictive personnel rules such as fixed salary schedules make it difficult to recruit and retain hard-to-fill positions. This results in public hospitals like Natividad increasingly turning to overtime and temporary workers that cost up to three times as much.

Part 2

Theory and Reality of Government Ownership

Faced with inflated costs and shrinking revenues, many public hospitals are bleeding red ink and so have a hard time making investments necessary to cut costs and increase performance. Given tight state and local budgets, new investment funding for hospital equipment and information technology (IT) directly competes with funding for other public programs. This generally leads to calls for higher taxes, reinforced by threats of cuts in health services.[10] In the case of Natividad, Monterey County voters rejected a tax measure (Proposition Q) designed to further increase subsidies to fund new investments in the public hospital.[11] Limited in their ability to raise taxes, county governments must decide whether they can continue to own and operate a hospital.[12]

The economic argument for government ownership and control usually rests on some perceived market failure.[13] In the case of public community hospitals, the most common fear is that the poor and under-insured will fall through the cracks.

California's cities and counties have a statutory obligation to address the needs of the indigent under welfare and institutions code section 17000. Public hospitals were meant as a safety net for "all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident…[and] not supported…by their relatives or friends [or] by their own means, or by…private institutions."[14] Whereas the public hospital has been a fixture of American life for decades, suburbanization and ongoing revolutions in health care delivery challenge conventional wisdom that a public hospital is the best way for government to deliver health services.

First, new technologies and drugs have radically reduced the number and length of hospital stays. The result, according to a study by the Urban Institute, was a 14 percent drop in total hospitals in the United States from 1979 to 1998. Over that same period almost a third of public hospitals were either converted or closed.[15] In California, no new public hospital districts were formed between 1978 and 1998.

Second, many hospital districts that were first conceived in the aftermath of WWII, when Congress saw a need for rural public hospitals, today face a changed environment. Rapid urbanization, telemedicine, remote monitoring, and the Internet are revolutionizing rural health care markets, attracting competition from private clinics, specialty hospitals, and for-profit and nonprofit private hospitals.

In the early 1990s California's courts ruled public hospitals like Natividad no longer had the exclusive obligation to serve their traditional base of publicly insured patients. They could now compete with private clinics and hospitals for privately insured patients.[16]

Since medical care is highly complex and difficult to evaluate, patients choosing among competing hospitals face considerable uncertainty in measuring the quality of care. This leads to two hypotheses. First, when patients are not well-informed, for-profit hospitals that face financial incentives might be inclined to save money by reducing the quality of care. Second, the nonprofit status of public and nonprofit hospitals might signal to consumers that those hospitals are more committed to quality and less to the "bottom line."

This leads to two predictions: 1) for-profit hospitals might offer lower quality and lower costs, and 2) public (and nonprofit) hospitals might offer higher quality and higher costs.[17]

The reality is that private for-profit and nonprofit hospitals, and public hospitals, rarely operate independently. In fact, they routinely compete in the same markets. In this case, economic theory predicts a better outcome.[18] Competitive spillovers could lead to the best of all worlds: higher quality care in for-profit hospitals, and lower costs in public and nonprofits. Shifting from theory to data offers some striking conclusions.

The data reveal significant benefits when for-profit hospitals compete in the marketplace. It turns out for-profits have important spillover benefits for medical productivity.

The reality is that private for-profit and nonprofit hospitals, and public hospitals, rarely operate independently.

Most public hospitals lack the strategic advantages enjoyed by private hospitals including: a marketing orientation, volume purchasing systems, state-of-the-art information systems, standardization of supplies, outcome management systems, computerized case management systems with cost-per-procedure variables among physicians performing the same procedures, physician practice management, and technologically advanced patient care. These innovations boost productivity and cut costs. Private, for-profit hospitals blazing technological trails exert a "peer effect" when their public and not-for-profit counterparts mimic their behavior.[19]

Where there are for-profit hospitals, those areas have lower levels of hospital expenditures, but virtually the same patient health care outcomes.[20] According to a recent study "…there is no evidence suggesting that newly converted for-profit hospitals shirked from providing unprofitable care…they did not turn away unprofitable patients once they took over the hospital."[21] In fact, a recent study finds "for-profit hospitals offer better quality."[22]

Economic theory suggests a mix of hospital ownership types (public, nonprofit and for-profit) will generate competitive spillovers that help keep quality and costs under control. In searching for the optimum mix of hospital types, the latest empirical research recommends cutting public (and nonprofit) hospitals and increasing the number of for-profit hospitals. The study concludes a "greater quality of care per dollar could …be achieved by encouraging more for-profit hospitals to enter into some market areas of the U.S."[23] This

suggests selling public hospitals could lower costs and increase quality in some markets, especially if the conversions were to for-profit hospitals.

A. Unintended Consequences

While some see regulation as a way to ensure broad access to quality health care, excessive regulation can cost lives. According to a recent study, health regulations in the United States amount to a net "hidden tax" of some $169 billion annually. These added costs translate into some 22,000 deaths annually, mostly from higher costs that restrict access to care.[24] Excessive health care regulations and unfunded mandates compound the challenges facing public hospitals.

Consider California's new nurse-to-patient ratio. This new mandate requires hospitals to have one nurse for every five patients around the clock.[25] Of course, two options exist for hospitals to meet a nurse/patient ratio. Focus on the numerator and increase nurses, or focus on the denominator and decrease patients.

Fiddling with the denominator to meet the ratio mandate is not what legislators had in mind. Yet, since increasing nurses is expensive, public hospitals may find it easier to meet the new mandate by reducing patient loads. Anecdotal evidence suggests hospitals already restrict incoming patients in certain wings to preserve required ratios when nurses are not immediately available.[26] "Patients' conditions often change by the hour, and hospitals face a continual turnover of patients with diverse medical needs, all of which impact staffing requirements."[27]

The ratio mandate can be achieved by closing beds in medical and surgical wards or by keeping people longer in the emergency room. Keeping people longer in emergency rooms prolongs pain and suffering. Closing beds increases waiting times for hospitalization, putting patients at risk. In a 2004 special report the California Healthcare Association recognized "once the proposed staffing ratios are fully in effect…the nurse shortage may become even more acute, and access to patient-care services may be jeopardized."[28]

While some see regulation as a way to ensure broad access to quality health care, excessive regulation can cost lives.

The California Nurses Association claims the new ratio mandate will make hospitals safer. That may be true, but it ignores the potential unintended consequences. In fact, California's overall patient population could end up worse off. Worse yet, rigid ratio mandates fail to account for technological progress. For instance, investments in remote monitoring and sensing equipment could reduce staffing requirements while preserving or even increasing the quality of patient care—releasing scarce nursing resources to provide more valuable services elsewhere. Costly mandates choke off valuable investments. Since personnel expenses already consume more than half of public hospital operating revenues, new unfunded mandates like nurse staffing ratios risk further squeezing new cost-saving or life-saving capital investments.[29]

Today health care delivery is a labor-intensive business that calls on a wide range of clinical skills. Since public hospitals face strict personnel rules, tight capital constraints, and burdensome decision-making processes, they already lag in acquiring key information technology (IT) that can reduce staffing requirements while preserving or increasing quality. Investments in digitized patient records, remote monitoring,

telemedicine, and virtual clinics are either rejected outright or deferred due to capital and organizational constraints.[30]

Hospital Technology

High-tech investments have the potential to transform rural hospitals that could not otherwise afford $200,000+ to hire full-time specialists. For example, these hospitals could have 24-hour access to expert radiology interpretation skills remotely. An important regulatory barrier exists, however, that restricts competition and the opportunity for health care professionals to provide remote health care services. Restrictive medical licensing regulations currently prevent diagnoses or treatment across state lines. Ironically, whereas patients can travel across state lines to get care, doctors cannot provide care (even remotely) across state lines. And instead of embracing telemedicine, certain states are considering erecting new regulatory barriers.[31]

Managing health care through regulations and mandates leads to unintended consequences. New, unfunded mandates like nurse staffing ratios can compound the problem—and further inflate labor costs. These unintended results are especially prevalent when governments try to control inputs (nurse staffing ratios for example), instead of outputs and outcomes like patient satisfaction, survival rates, or Quality-Adjusted Life Years (measures that attempt to capture the benefit of alternative medical interventions and are often used in medical cost-benefit analyses).

State and local governments that own and operate a public hospital can fall into the same trap. By grappling with the conflicting interests of multiple stakeholders, they risk paying more attention to inputs (the desires of conflicting internal stakeholders) than outcomes (superior health care for indigents at the lowest possible cost to taxpayers).

B. Who's in Charge?

The many and diverse stakeholders in public hospitals have a conflicting mix of social, political, and business objectives. It is often unclear who is in charge: the CEO, board of supervisors, trustees, employee unions, doctors, patients, inspectors, or taxpayers.

Ideally, the elected county board of supervisors outlines broad health care policy and approves major expenses and the yearly budget. Together with oversight from appointed trustees, the hospital CEO drafts a budget and approves expenses and plans that follow the Supervisors' guidelines.

In reality, unresolved issues of authority and accountability complicate the budget process, interfere with construction and procurement decisions, and slow innovation. For instance, in 1993 construction began to replace Natividad's main hospital building at a cost of an estimated $75 million. Five years later the project was finally completed, and costs had mushroomed over 50 percent to $116 million. Cost overruns translated into hiring freezes and slowed innovation, further restricting investments in new medical equipment and, ironically, in computerized accounting systems.[32] Revealing the dismal state of Natividad's cost accounting system, the last CEO complains: "We didn't know how many positions we had."[33]

Besides the obvious potential for fraud and abuse, sluggishness in adopting new computerized accounting systems and digitized patient records reflects a weakness that partly stems from multiple stakeholders and a tangled bureaucracy. According to a University of Arizona study, elected boards overseeing public hospitals tend to micromanage operations to satisfy political objectives that create inefficiencies and that might not always coincide with providing the best care for indigents. The authors conclude that "[p]ublic board meetings, intense monitoring and (relatively) poor salaries for CEOs contribute…to the poor performance [of public hospitals]." [34]

It is also instructive to examine the experience in other nations. In an interesting case of "triple nationalization," the United Kingdom funds health care for everyone (not just indigents), manages and regulates the program, and is the primary provider of that care (mostly through government-owned and operated hospitals and clinics). In an early pioneering article on the U.K. National Health Service, one author prophetically observed: "The British health industry exists for its own sake, in the interest of the producer groups (physicians, nurses, hospital administrators, non-medical staff, etc.) that make it up. The welfare of patients is a random byproduct, depending on how conflicts between the groups and between them and government happen [to be resolved]."[35]

"The British health industry exists for its own sake, in the interest of the producer groups (physicians, nurses, hospital administrators, non-medical staff, etc.) that make it up."

When governments run the health care system, the way doctors, nurses, and non-medical staff increase their income is by persuading government to pay them more. When government and not patients control the money, doctors tend to decide the care that is provided. Often overworked, their incentive is to encourage patients to demand less care, as opposed to persuading them they can benefit from more care, say as doctors do in private medical markets that exist for laser eye surgery and plastic surgery in the United States.

Part 3

First Aid for Hospitals

A. Red Tape Can Kill…Information Technology (IT) is the Antidote

Bureaucracy, red tape, and outdated medical reporting and accounting systems not only inflate costs, but can also jeopardize lives. By one estimate, shoddy quality control costs Americans $500 billion per year in avoidable medical costs, or roughly 30 percent of all health care spending.[36] Of course lives lost are more important than money lost. Medical errors claim anywhere from 44,000 to 98,000 American lives every year, roughly 15 to 30 times the death toll suffered from the terrorist attacks on September 11, 2001.

Most experts agree that increasing nurse-to-patient ratios is at best a short-term response to the deadly epidemic of medical errors. The long-term prescription is for hospitals to invest in digitized patient files, computerized prescriptions, telemedicine, and other IT investments. The returns on these investments can lower costs and make hospitals safer.[37] Today, only 17 percent of the nation's hospitals use computerized order-entry systems; a mere 13 percent have adopted electronic patient records.[38]

In general private hospitals face stronger incentives to adopt IT than do public hospitals. Blazing the trail is one of the nation's most innovative private nonprofit health care providers, Kaiser Permanente. Since its 3.2 million members in Northern California pre-pay, Kaiser has an incentive to keep costs down and keep its customers healthy. Each patient/member has an electronic medical record that includes lab and test results, radiology images, hospitalization records, diagnoses, prescriptions, allergies and other data, all accessible from the desks of 5,000 Kaiser doctors or any of 12,000 of the company's examining rooms.[39] Doctors can quickly access medical histories and test results, while computerized expert systems alert them to potentially harmful interactions in the event of multiple prescriptions.

Of course lives lost are more important than money lost.

Another example of major IT investments is St. Vincent's Hospital in Birmingham, Alabama, a showcase for the nation's largest private nonprofit health system, Ascension Health. Doctors can instantly download lab results, X-rays, and CAT scans from the hospital's wireless (Wi-Fi) network. Robot arms perform precise surgery, machines measure medicines, surgical tools have bar codes so they can be tracked and don't end up in patients, and nurses can scan bar codes on patients to check that medicines are given as doctors prescribe.

Expert computer systems automatically check for problems such as drug interactions and allergies and can even guide doctors in choosing treatments.[40]

Investments in new diagnostic devices save lives. The private hospital chain HCA (Hospital Corporation of America) is implementing a computerized order-entry system for medicines at many of its 190 hospitals. An order instantly goes to nurses and to the pharmacy. Once approved by a pharmacist, a drawer at the patient ward clicks open and the nurse can pull out the appropriate pills. The drawer automatically tracks inventory and nurses use scanners to read the bar code on the pill bottle to confirm it's the right drug and dosage, and on the patient to ensure it's the right patient. Digitizing has cut HCA's drug-dispensing time in half and weeded out some 20,000 potential errors.[41]

Recently, IBM joined forces with the renowned Mayo Clinic, a private nonprofit. Their objective is to analyze electronic medical records to rapidly assess patients' responses to new treatments for cancer and other diseases. When combined with information emerging from the human genome project, this collaboration should accelerate doctors' ability to identify causes and prevention of diseases.[42]

According to the Institute of Medicine the routine use of electronic records should help reduce tens of thousands of deaths and injuries caused by medical mistakes every year.[43] A paperless system also cuts administrative costs by eliminating the need to produce, maintain and store enormous amounts of paper files.

Telemedicine is also poised to save lives and cut costs. This involves the use of sophisticated remote electronic and video-monitoring systems that let one doctor (or nurse) treat several patients simultaneously, and to remotely consult and provide expert care.

According to the Institute of Medicine the routine use of electronic records should help reduce tens of thousands of deaths and injuries caused by medical mistakes every year.

As an experiment, a pair of doctors at the Johns Hopkins University School of Medicine set up video-conferencing equipment at an Intensive Care Unit (ICU) at Hopkins' sister hospital across town. They sent the video feeds, along with real-time patient vital sign data, to computers in the doctors' homes. For four months, the doctors took turns watching patients from home on 24-hour shifts. The results were astonishing: Deaths declined by 50 percent. According to one doctor: "Catching a lot of little things added up."[44]

The doctors eventually launched a company with an eICU that functions like a Bloomberg terminal for patient data. It displays readings on blood-oxygen levels and other data, and with the click of a mouse can switch from one patient to another. Proprietary software continuously monitors vital signs and pops up "smart alerts" when patients deviate beyond established ranges.

Instead of simply adding nurses to improve the quality of care, a Norfolk-based private health care system, Sentara Healthcare, invested in eICUs to monitor 55 beds in three hospitals. In 2002, Sentara reported the system saved 90 lives a year, while also saving millions of dollars by avoiding pricey complications.[45] Although launched with the best of intentions, nurse ratio mandates such as California's could have the perverse effect of delaying implementation of potentially life-saving IT investments.

Some 2,000 hospitals have joined an initiative known as the '100,000 Live' campaign to cut down medical errors. Led by Harvard's Dr. Berwick, chief of the nonprofit Institute of Healthcare Improvement in Cambridge, Massachusetts., his employees scour the world for simple, proven remedies for medicine's reliability woes, anything from better infection control to eliminating drug mix-ups, and standardizing basic procedures. Key initiatives include: measuring performance and issuing report cards releasing performance results to the public; instituting teamwork training and empowering nurses to challenge doctors; and pushing for the digitization of medical records so crucial test results and other vital records can be tracked and communicated. Innovative hospitals are showing they can drastically cut medication errors and all but eliminate some deadly hospital infections.[46]

Medicine and Information Technology

After the President of the United States recently observed "one of the reasons why there's still high cost in medicine is because they don't use any information technology," he issued an executive order that calls for the widespread deployment of electronic medical records by 2014. Eventually, every American will have a personal, electronic health record. The head of this effort is David Brailer. Interestingly, virtually no federal funds have been allocated to this effort. Instead, the government is relying almost exclusively on private initiatives of for-profit and nonprofit hospitals and health care systems. Brailer's vision includes a medical Internet to connect electronic health records through a nationwide information network. His objectives are threefold: First, to give physicians access to electronic health records at the point of care, second, to allow consumers access to their own records and other relevant health information online, and third, to improve public health research and the monitoring of new drugs and medical procedures. Besides monitoring disease outbreaks or biological attacks, if privacy issues are successfully overcome, in the future public health officials could access electronic records to quickly spot trends such as the increased risk of heart attack and stroke recently associated with the painkiller Vioxx.[47]

Strategic IT investments lower costs and make hospitals safer. The challenge facing many public hospitals today is how to fund investments like the digitization of patient information, and the computerization of prescriptions, billing, and other administrative tasks. Public hospitals face three main obstacles.

First, IT requires large up-front investments in training people and in specialized equipment. Since public hospitals cannot access equity markets, this limits their funding choices. Their options include navigating the bureaucratic decision-making process to generate internal funding, raising money from the community (through nonprofit foundations for example), or requesting additional tax dollars from the federal government or from state and local governments (issuing bonds or passing tax increases).

Another reason public hospitals are slow to adopt IT is a fear of job losses. Some controlling stakeholders (unions, etc.) automatically object to labor-saving investments.

Finally, public hospitals face perverse incentives. Excessively dependent on public insurance,[48] large, powerful monopsonistic buyers like Medicare (for seniors) and Medicaid (for the poor), stand to reap most of the savings generated by IT. Also, since public hospitals are largely paid based on volume, IT that eliminates duplication, unnecessary tests, shortens hospital stays, and gets patients out of intensive care units faster can cut a public hospital's revenues faster than it cuts costs. This gives public hospitals even more reason to resist

adopting new technology. It also helps explain why the cost per stay has grown so persistently in public hospitals.

In sharp contrast, a private medical care system, like Trinity Health in Novi, Michigan, has a better chance to earn a return on its IT investments. With 44,000 full-time employees, Trinity Health has implemented an automation project worth more than $200 million that includes 23 hospitals and hundreds of outpatient facilities. Its investment in an expert system that alerts doctors to harmful drug side effects caused doctors to revise their orders some 25,000 times over three years. This saved scores of patients from potential complications. Another critical IT investment, creating electronic records, means patients now get faster treatment.[49]

B. The Opposite of "Privatization" is "Nationalization"

Canada, France, Germany, Sweden and the United Kingdom are a few of the countries that belong to the "triple nationalization" club. Under their nationalized health care systems, the government pays for health care, manages and regulates it, and is the primary provider of that care. Yet, a recent report indicates that "over the course of the past decade almost every European country with a national health care system ["socialized medicine"] has introduced market-oriented reforms and turned to the private sector to reduce the cost of care and increase the availability and effectiveness of treatments."[50]

Today privately provided health care is the fastest growing segment in most of these countries. Take Sweden for example. In 1991 Sweden introduced sweeping reforms that today allow private providers to deliver more than 40 percent of all health care services, and in Stockholm, nearly 80 percent of primary care.[51]

The recent health care revolution in Sweden began with a manifesto adopted by the Stockholm County Council in 1991. Instead of annual budget allocations, health care providers were to be funded through earnings (an internal market that involves a transfer pricing-type system based on annual price lists and Diagnosis Related Groups). Health care providers were to work on a commercial basis to the extent possible, covering their own costs. Competition between health care providers was explicitly encouraged to "contribute towards higher quality and better utilization of resources." The manifesto also called for "improved systems of accounting." Finally, it was established that resource allocation "shall be guided by the patient's choice of provider."[52]

Results were felt almost immediately. Performance-based hospital funding, greater independence for hospitals, and free mobility (competition) between health care providers, along with Web postings of waiting times, resulted in hospital productivity rising by an average of 16 percent between 1991 and 1993. Meanwhile, competitive procurement cut costs, anywhere from 10 percent for ambulance service, to 40 percent in the case of medical laboratories and radiography. Health care entrepreneurs played a key role. The revolution made it possible for more private players to become engaged. Many former health care workers launched start-ups. By 2003 there were a reported 290 health care enterprises, many owned and operated by nurses. The health care job market has been transformed, and the abundance of new job opportunities offered by this new system explains why most health care unions supported the reforms. According to one expert, "the Stockholm model of free choice and diversity of private initiative in health care is here to stay."[53] In 1999 Stockholm's Health Services Council privatized one of Sweden's largest public hospitals (St. Goran's).[54]

Meanwhile, in the United Kingdom, to reduce patient waiting lists "the British National Health Service…[has agreed to] treat some patients in private hospitals, reversing a long-standing policy of using only public hospitals."[55] Ironically, Britain's National Health Service (NHS) has become the largest provider of private care in the country. The NHS earns approximately $500 million per year in fees from treating private patients. While many British patients still wait for care, 10,000 private pay patients—about half foreigners—received treatment in Britain's NHS hospitals in 2001.

Despite clear signals pointing to the benefits of competition, and the costs of government health care monopolies, the perceived wisdom remains that publicly provided care in Canada, Europe, Sweden and the United Kingdom is better and cheaper. While it is true the United States spends more on health care than other countries, we also get more.[56] Consider two interesting quality indicators. First, Canadian and British doctors see 50 percent more patients than do American doctors. Second, whereas Britain invented the CAT scanner, today it has half the number (per capita) as we do in the United States.[57]

While it is true the United States spends more on health care than other countries, we also get more.

C. Measuring Health Care Success

However, the two most popular measures of the success of health care systems are life expectancy and infant mortality. Although the United States spends more on health care, life expectancy is lower and infant mortality higher than in many other countries.[58] This is often cited as evidence of the superiority of socialized medicine (or nationalized health care systems) and the inferiority of a private health care orientation like that found in the United States.[59]

Even our own Government Accountability Office (GAO) admonishes "[t]he U.S. now spends over 15% of its GDP on health care—far more than other major industrialized nations. Yet relative to these nations, the U.S. performs below par in such measures as rates of infant mortality [and] life expectancy…"[60]

It turns out these two measures deserve a closer look. Both measures are impacted less by the quality of health care systems than by lifestyle, demographics and other variables. In fact, the lifespan of U.S. citizens of European descent is about the same as that of Europeans. Asians live longer and Blacks tend not to live as long.[61] The reasons likely have more to do with social conditions (including the incidence of violent crime), and demographic characteristics, than the quality of medical care.

Similarly, if adjustments are made to account for the fact that U.S. hospitals actively try to save underweight (premature) babies and that we count them as live births, then infant mortality is the same in the United States as in Switzerland.[62] It turns out neither life expectancy nor infant mortality is a satisfactory measure. In the case of life expectancy, the quality of medical services may not make much difference. The same is probably true of infant mortality in industrialized countries, and many of those countries are not even measuring the same thing.

In sharp contrast to these two rather unsatisfactory measures often used to compare health care systems, are two where the quality of medical services can have a dramatic impact: recovery rates from breast cancer for women and from prostate cancer for men. Examining these two measures paints a very different picture of socialized medicine.

Among women diagnosed with breast cancer, only 20 percent die in the United States, compared to 33 percent in France and Germany and nearly 50 percent in the United Kingdom. Among men diagnosed with prostate cancer, fewer than 20 percent die in the United States, compared to 25 percent in Canada, almost 50 percent in France, and over 50 percent in the United Kingdom.[63] According to a recent study by Goodman, Musgrave and Herrick (2004), "the difference in cancer mortality and survival rates [in the UK]…has been attributed to the general shortage of specialists, unavailability of the latest cancer drugs and relative lack of investment in radiotherapy equipment…" Moreover, "because one way to control drug expenditures is to delay their introduction, Taxol, widely prescribed in the U.S. to beat breast cancer is unavailable in some regions of the UK."[64]

Combining this sobering data with the trend toward market-oriented health care suggests searching for alternatives to public hospitals to provide indigent care. The challenge remains how to offer the best possible health care to the poor at the lowest possible cost to taxpayers.

Among women diagnosed with breast cancer, only 20 percent die in the United States, compared to 33 percent in France and Germany and nearly 50 percent in the United Kingdom.

D. What are the Options?

Local governments are increasingly quitting the hospital business. In 1980, there were some 1,800 public hospitals. By 2003, after a wave of closures, consolidations and privatizations, the number had dropped almost 40 percent to 1,121.[65]

Health care is more than just hospital care. When a public hospital becomes too expensive to own and operate, multiple options exist for states, cities and counties to cut costs and continue to serve their communities' health care needs. These include: selective outsourcing, public-private partnerships (via joint operating agreements, joint ventures, and lease agreements), or the outright sale of the hospital.

Outsourcing

Think of a hospital as a collection of small to medium businesses operating under one organizational roof. This can include anything from laundry and maintenance services to laboratory and clinical services. Selective outsourcing first entails the conceptual transformation of a hospital into a holding company that owns and operates a host of profit centers (kitchen, laundry, maintenance, information systems, medical legal services, laboratory test facilities, clinical services, etc). It is useful to distinguish between "core" and "non-core" functions and activities. Core functions define the hospital's competitive advantage. Non-core functions are standard services widely available in the marketplace. These non-core functions are candidates for

outsourcing. Once identified, non-core profit centers can calculate their costs, and reconfigure themselves to compete against outside contractors that offer similar services. Outsourcing opportunities can include anything from non-clinical support services (cleaning, catering, building maintenance), to clinical support services (laboratory services) or specialized clinical services (such as radiology or lithotripsy) and routine procedures (such as cataract removal).

Public-Private Partnerships

In a *joint* public-private *operating agreement*, the government can turn over management of the public hospital to the private sector and still retain some control by appointing part of the board overseeing the agreement. Under a *joint* public-private *venture*, governments can sell a portion of public hospital assets for cash, retaining power to appoint board members of the new entity. For example, in 1997 California's Sequoia Healthcare District netted $30 million in cash from its joint venture with the private nonprofit Catholic Healthcare West (CHW). The newly created Sequoia Health Services is governed by a 10-member board (equally split between the hospital district and CHW). CHW was granted a 30-year contract to operate the hospital. Another public-private partnership option is to *lease* the hospital, clinics, and equipment to a management firm. For example in New Mexico, a private company, Province Healthcare, has agreed to lease the county's Memorial Medical Center for 40 years agreeing to a pre-paid rent of $150 million.[66] Several safeguards were explicitly built into the contract. These include: "sustaining the same types and level of services as currently offered," "maintaining access for indigent and uninsured patients on defined terms of reimbursement," and "…enhancing measurable levels of quality and satisfaction of patients, physicians, and employees."[67]

Sale

A sale produces a cash payment that can be used to retire debts and establish a trust fund for community health care. For example, after retiring public bond debt from the sale of Conroe Regional Medical Center in Texas, the county used the residual "profit" from its privatization to launch a nonprofit foundation to meet ongoing community health needs. The community also collected new property taxes and other payments from the now-private for-profit hospital. Indigents fared best of all. Here privatization raised cash, reduced debt, and created a better system for serving the poor and uninsured.[68] Closing a public hospital does not mean the government can walk away from its responsibility for indigent care. After shedding their public hospital(s), many governments switch from the role of *producers* to that of *providers* or *purchasers*, contracting with local hospitals and clinics to purchase only the bed days they need for indigent care. For example, Orange County, California, no longer owns and operates any hospitals. Instead, the Health Care Agency administers indigent care through multiple (HMO) contracts with local hospitals and clinics.

Part 4

Where's the Safety Net?

Many local governments have shifted from running hospitals to becoming selective purchasers of health care. Instead of owning and operating a public hospital and producing health care for indigents, governments are increasingly contracting with private providers to treat indigents. Consider the case of Milwaukee's public hospital—first known as County General and later as Doyne Hospital.[69]

By the 1980s Doyne's managers were making regular visits to the county board of supervisors to report budget shortfalls. Annual bailouts ran as high as $15 million per year. Moreover, deferred maintenance and an inability to raise sufficient funds to invest in new facilities, equipment, and technology began to impact performance. By 1995 the drain on public resources combined with a threat to the county's bond rating forced county supervisors to shut down the public hospital.

The county instantly transformed itself from a *producer* of health care through its public hospital, to a *purchaser* of health care through private for-profit and nonprofit hospitals and clinics. Taking the $37 million a year in local, state and federal money that it had used to pay for indigent care at Doyne, the county placed the money in a program they call the General Assistance Medical Program (GAMP). Much like Medicaid, GAMP pays private hospitals and clinics a fee for seeing its patients.

Milwaukee residents who might otherwise have gone to Doyne can now visit any of dozens of hospitals and clinics. All 10 private hospitals and 15 neighborhood clinics signed contracts with the county to treat the medically indigent. Milwaukee's experience suggests a community can live without a public hospital and still provide a safety net.

Milwaukee's experience suggests a community can live without a public hospital and still provide a safety net.

An assessment made five years after the hospital closed indicated the county's indigent population had roughly the same access to medical care as before. However, patients today have more choices in terms of how to access that care. In fact, fewer use emergency rooms, and more visit clinics where early diagnosis and treatment prevents more costly interventions later. Prescriptions are filled at local pharmacies instead of the public hospital, and many now get their health care right in their own neighborhoods at local clinics or private hospitals. Meanwhile, all of this is costing taxpayers less money than before.

While from the county's perspective, running GAMP is not cheap, it's a bargain compared with the constant drain of running a public hospital. It also offers a more predictable budget for health care than did the public hospital.

Interestingly, in shutting down the public hospital, the county also did away with many of the competing stakeholders (special interest groups) that indirectly supported health care for the poor. In the past, squeezing money out of indigent care meant cutting the public hospital and a likely battle with 2,000 unionized employees. Now the county buys its indigent care like a commodity, and it represents little more than a line item in the budget. A risk is that since the health care budget has lost some of its stakeholders, and now competes directly with other line items like roads, parks and police, politicians may be more tempted to cut the health care budget to fund other priorities.

The new safety net also has some other gaps. Federal law requires emergency rooms to take all comers, regardless of ability to pay. Some state and federal laws also require hospitals to provide charity care. In Milwaukee, private hospitals and clinics have had to step in to cover more uncompensated care. In some cases matching funds are available to pay a share of the care provided to Medicaid patients and the uninsured. However, many specialists have grown frustrated with the paperwork involved with GAMP and have dropped out of the program.[70] Yet, even if private hospitals and clinics lose money on GAMP, they do not lose as much as they would without it, so they rank among its biggest supporters. Finally, GAMP only covers 20,000 of Milwaukee's estimated 120,000 uninsured. The lesson is that responsibility for indigent care does not disappear with the public hospital. A safety net for indigent care still needs to be in place.

With free health care or insurance people are less likely to choose jobs with higher salaries and no health benefits.

Reengineering the Safety Net

The aim of most public health care programs in the United States is to improve access to medical care mostly by filling the gaps in the private health insurance market. These public programs typically include direct subsidies to health care providers (public or private hospitals) to provide health care, or the provision of some insurance to the uninsured.

Public hospitals exist to provide medical services directly to the uninsured, but there are several alternatives. One option is to subsidize private providers by providing direct subsidies for uncompensated care or reimbursement through public health insurance (like GAMP or Medicaid). Fees are paid to private hospitals or HMOs for each indigent served. Another option is to purchase private insurance for indigents (like Blue Cross/Shield).

Finally, state and local governments could be pioneers in the new frontier of health insurance and offer indigents medical savings account vouchers (MSAVs) combined with catastrophic health care coverage. Public health care dollars could be placed in accounts individually owned and controlled by indigents and the uninsured. Patients would pay with MSAVs for most medical services from those accounts. Private hospitals and clinics would compete on the basis of value for money. The government would make regular deposits to

the MSAVs of patients with chronic conditions, leaving them free to choose among competing "focused factories" (specialized hospitals and clinics) for ongoing treatment.[71]

A major problem is that providing free hospital care or free insurance results in a substitution away from private health care. People are less likely to purchase private insurance and more likely to choose jobs with higher salaries and no health benefits. In 1999 the Andril Fireplace Motel in Pacific Grove, California offered its service workers a health care plan that included a small co-payment. The workers refused the employer-provided health insurance, instead choosing to accept more money, because they said they could get free health care at the emergency room at Monterey County's public hospital, Natividad. [72]

According to a recent study, publicly provided insurance in any form tends to crowd out private insurance: "…the presence of public hospital services is a substitute for private insurance." "It is estimated…that 9.8% of those with incomes below the poverty line are crowded out." It turns out "the number of public hospital beds in the community has a significant and negative effect on the likelihood of private health insurance coverage in both the below-poverty and low-income groups." Surprisingly though, "almost 30% or 1/3 (63% or 2/3) of the Community Tracking Survey (CTS) sample with family incomes below the poverty level (between 100%-200% of the poverty level) had private insurance." [73]

Roughly a third of the uninsured live in households with incomes greater than $50,000 per year apparently choosing not to purchase health insurance even though they can afford it.

So, who are the uninsured? "In the CTS sample, the rates of uninsured are higher among single adults and lower among the more educated across all income levels." According to the National Center for Policy Analysis, many of the uninsured are uninsured by choice.[74] This implies that either the uninsured: a) self-insure and pay for the care they need, b) obtain free care, or c) they are healthy and see no need for insurance.

> *Roughly a third of the uninsured live in households with incomes greater than $50,000 per year apparently choosing not to purchase health insurance even though they can afford it. Of those who become uninsured at any point in time, Census Bureau Data show that roughly 75 percent obtain insurance within one year, while only 2.5 percent remain uninsured more than three years.*[75]

An unintended consequence of governments trying to help the uninsured is they inadvertently create more of them. According to one critic, "California's public hospitals…confront a severe crisis…a steadily growing demand by uninsured and vulnerable patients…matched against a shrinking pool of funds available to pay for care."[76] Today, California's public hospitals are all paying close attention to a federal decision to freeze Medicaid (Medi-Cal) payments and shift over half a million enrolled patients into HMOs (similar to what Orange County has done). Directing Medicaid money to HMOs instead of safety net hospitals and shifting more of the burden from the state to counties is expected to present even more challenges for the state's public hospitals.

Part 5

Conclusion

Benevolent citizens have learned the hard way that running a public hospital is a tough business. Municipalities throughout the country and around the world have demonstrated they can serve indigents more efficiently and effectively by selling public hospital assets and turning to the private sector. In the United States, communities often receive a cash payment to retire debt and establish trust funds for community health care. Since 1994, over 100 charities have emerged from hospital sales that control a combined total of nearly five billion dollars.[77] Even strong advocates of nationalization now acknowledge that the growing scrutiny of public hospitals has "raised the level of the discussion…[and increased] focus on the need for care by uninsured citizens…on the services required, and on how to finance and deliver those services."[78]

As Nobel Prize winner Milton Friedman stated with regard to the high cost of health care, "a cure requires reversing course, re-privatizing medical care by eliminating most third-party payment, and restoring the role of insurance to providing protection against major medical catastrophe." He sees medical savings accounts as one way to resolve the growing financial and administrative burden of Medicare and Medicaid: "a medical savings account enables individuals to deposit tax-free funds in an account usable only for medical expenses, provided they have a high-deductible insurance policy that limits their expenses." In effect, "it would be a way to voucherize Medicare and Medicaid. It would enable participants to spend their own money on themselves for routine medical care," rather than having to rely on public hospitals or on HMO's, while still insuring indigents against medical catastrophes.[79]

Besides crowding out private insurance, when well-meaning state and local governments run public hospitals and pass well-intentioned regulations and mandates, evidence suggests they inadvertently raise health care costs and lower performance. It is time to reengineer our safety nets. Carefully crafted deregulation and privatization, combined with subsidized medical savings account vouchers (MSAVs) and high-deductible insurance for indigents, can bring us the best of all worlds: lower taxes and better services.[80]

Related Reason Foundation Studies

Richard L. Tradewell, *Privatizing Public Hospitals: Strategic options in an era of industry-wide consolidation,* Policy Study No. 242, August 1998: reason.org/ps242.html

John Hood, *Solving the Medicaid Puzzle: Ideas and Strategies for Entitlement Reform,* Policy Study No. 233, October 1997: reason.org/socialservices/ps233.html

Ted Balaker and Adam B. Summers, *Emergency Medical Services Privatization: Frequently Asked Questions,* Policy Study No. 310, August 2003: reason.org/ps310.pdf

Richard H. Dougherty with William D. Eggers, *Delivering Services for the Mentally Ill and Developmentally Disables: A Consumer Choice Model*, Policy Study No. 215, October 1996: reason.org/socialservices/ps215.html

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for Government: Integrating Activity-Based Costing, the Balanced Scorecard and Total Quality Management with the Planning, Programming and Budgeting System" (International Public Management Review, Vol. 5, No. 2, 2004, www.ipmr.net)

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Endnotes

[1] Jonathan M. Karpoff, *Public versus Private Initiative in Arctic Exploration: The Effects of Incentives and Organizational Structure*, (Working Paper #23, The Independent Institute, June 2000) www.independent.org.

[2] According to the American Hospital Association (AHA), nearly 15 percent of the U.S. Gross Domestic Product (GDP) was spent on health care. The latest report to the President and Congress by the Department of Health and Human Services indicates that 56 percent of health expenditures were private, while the remaining 46 percent were public—paid by federal, state, or local governments. (Tommy Thompson, Julie Gerberding, and Edward Sondik, *Health, United States, 2004*, Publication # 2004-1232 (U.S. Department of Health and Human Services (DHHS), Centers for Disease Control, and National Center for Health Statistics, Sept. 2004) p. 326.

[3] According to a 2003 AHA national survey, out of a total 4,895 community hospitals, 1,121 were public (run by state or local governments). Of the private hospitals, the majority were not-for-profit (2,984), and the remainder, for-profits (790). The Department of Health & Human Services (DHHS) reports that in 2002, of the 4,927 community hospitals in the United States, 1,136 were public. Of the remainder, 3,025 were nonprofits and 766 were for-profit. In terms of beds, Public hospitals controlled 130,050 beds, while private hospitals offered 690,600 beds (582,180 nonprofit and 108,420 for-profit). (Thompson, et. al., *Health, United States, 2004*, DHHS, p. 317).

[4] Thompson, et. al., *Health, United States, 2004*, DHHS, pp. 304, 317 and 341.

[5] Expenses per inpatient stay at private nonprofit hospitals increased 34 percent over the ten year (1990-2000) time period. By 2001 a stay at a private nonprofit was (on average) 18 percent more expensive than at a private for-profit. (Thompson, et. al., *Health, United States, 2004*, DHHS, p. 341).

[6] Mark McClellan and Douglas Staiger, *Comparing Hospital Quality at For-Profit and Not-for-Profit Hospitals*, WP #7324 (Cambridge, Mass.: National Bureau of Economic Research, 2000). Another theory is that public hospitals only produce those things that are visible and measurable and that matter to their funders and stakeholders…something like "length of stay." In contrast, for-profit hospitals (and specialized clinics) are more likely to be evaluated by customers who vote with their feet. The implication is that for-profits tend to provide aspects of health care (like bedside manner) that public hospitals might not. Consequently, even if costs were to appear higher at for-profit hospitals, this might be explained by the fact they are providing more (and different) services.

[7] Out of the 658,123 doctors practicing medicine in the United States in 2002, 141,877 (21.5%) were in hospital-based practice (45,330 were full-time hospital staff and the rest residents or interns). (Thompson, et. al., *Health, United States, 2004*, DHHS, p.310).

[8] Alex Friedrich, "How money falls through the cracks," *Monterey County Herald* November 16, 2003.

[9] Ibid.

[10] Another strategy used to protect public hospitals mostly bypasses traditional tax debates. It involves creating hospital districts, independent governmental units with the power to tax. Many hospital districts are located in rural areas where they are often the only means small communities can obtain hospital

services. In Montana, for example, over half of the non-operating revenues of the state's small rural hospitals comes from hospital district taxes or local county taxes.

[11] Raising taxes may be a losing battle. From 1970-1995 whereas U.S. acute hospital costs rose nearly 14 fold, U.S. local government property tax revenues only rose 4.9 times. See p.2 in John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (New York: Rowman & Littlefield Publishers Inc. in Cooperation with the National Center for Policy Analysis, 2004).

[12] Inefficiencies have caught up to Natividad. Having chosen to tighten eligibility requirements and to require a small co-payment for services, these restrictions have reduced options for undocumented (illegal) immigrants, and in some cases have been blamed for premature deaths. (See Joe Livernois, "The fraying safety net" *Monterey County Herald*, November 21, 2004) This urgently calls for a renewed focus on funding indigent care, rather than on owning and operating a county hospital that is too costly, too inefficient, and too bogged down in politics.

[13] In a recent survey of health care finance *The Economist* magazine concludes that instead of trying to supplant the market, governments should be striving to promote competition. "The traditional argument has been that health care is too important to leave to the market. The opposite holds true: it is too important not to be exposed to the market." ("The health of nations," *The Economist*, July 17, 2004 p.19).

[14] California code section 17000: "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

[15] Yu-Chu Shen, "Changes in Hospital Performance After Ownership Conversions," *Inquiry* vol. 40, 2003.

[16] In 13 target counties California's Medi-Cal managed care program was initially structured to offer public hospitals a chance to "compete" for their traditional customer base of Medi-Cal patients. Of the two plans that had to be offered to recipients, one was a "local initiative" established by the county board of supervisors that involved a contract with public hospitals and other safety net providers. (*Medicaid and Public Hospitals*, Kellog Paper, www.ncsl.org downloaded 3/27/05).

[17] Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* vol. 53 (1963).

[18] The introduction of telemedicine and remote patient monitoring has the potential to intensify competition, ultimately cutting costs and improving performance.

[19] Leslie G. Eldenburg and Ranjani Krishnan, *Public Subsidization vs. Private Donations: A Study of Incentives and Operational Performance*, (University of Arizona, College of Business and Public Administration, 2000.

[20] See Duggan, "Hospital Market Structure and the Behavior of Not-for-Profit Hospitals," *Rand Journal.* pp.433-46, and Kessler and McClellan, "The Effects of Hospital Ownership on Medical Productivity," *Rand Journal*, pp.488-506.

[21] Yu-Chu Shen, "Changes in Hospital Performance After Ownership Conversions," *Inquiry* vol. 40, 2003 p.231.

[22] McClellan and Staiger, *Comparing Hospital Quality at For-Profit and Not-for-Profit Hospitals.*

[23] Rexford E. Santerre and John A. Vernon, *Hospital Ownership Mix Efficiency in the U.S.: An Exploratory Study*, (Cambridge, Mass.: National Bureau of Economic Research, 2005). (www.nber.org/papers/w11192).

[24] catoinstitute.com/pubs/pas/pa-527es.html.

[25] Robert Jablon, "Hospitals Rush to Close Nurse Ratio Gap," *Monterey County Herald*, March 27, 2005.

[26] Author interview with a managing nurse at a prominent California nonprofit, May 21, 2005.

[27] Ibid.

[28] "California's Hospitals' Financial Condition: On Life Support," California Healthcare Association, June 2004, p.2.

[29] In short-term general, and in specialty hospitals, personnel expenses typically comprise more than half of operating revenue. (Paul Shoemaker and Douglas Howell, *Trends in the Use of Contract Labor Among Hospitals*, American Hospital Directory, Inc., August 20, 2004). In 2002 employee payroll and benefit expenses comprised 52 percent of expenses in community hospitals and 62 percent in federal hospitals. (Thompson, et. al., *Health, United States, 2004*, DHHS, pp. 341).

[30] "The E-Gang: Medical Marvels," *Forbes,* Sept 2, 2002 p.156.

[31] The National Conference of State Legislatures tracks telemedicine legislation: http://www.ncsl.org/programs/health/teleleg.htm.

[32] According to Professor Sager at the Boston University School of Health, rebuilding a public hospital can be a double-edged sword. "In Detroit and Boston, after the new buildings were opened, local governments decided…they could not afford to pay for both the costs of caring for uninsured people and the costs of paying off the bonds. So they leased them to nearby [private] non-profits." (Alan Sager, *Threats to Urban Public Hospitals and How to Respond to Them*, Doctors Day Address, District of Columbia General Hospital, Wash. D.C., March 30, 2001) www.dcwatch.com downloaded 3/27/05.

[33] Friedrich, "How money falls through the cracks."

[34] According to one study, "[w]hile public hospitals have lower administrative expenses compared to the non-profit hospitals, they do not have lower total operating costs. This suggests public hospitals monitor administrative costs but not other costs related to medical care for patients…" Interestingly, the study concludes that: "…poor salaries for CEOs contributes as much or more to the poor performance of these organizations." Leslie G. Eldenburg and Ranjani Krishnan. Krishnan, *Public Subsidization vs. Private Donations: A Study of Incentives and Operational Performance*, (University of Arizona, College of Business and Public Administration, 2000).

[35] Dennis Lees, "Economics and Non-Economics of Health Services," p.12 in *Financing Medical Care*, ed. Hemut Shoeck (Caldwell, Idaho: Caxton Printers, 1963).

[36] Robert Langreth, "Fixing Hospitals," *Forbes*, June 20, 2005 p. 70.

[37] Focusing on selected high-risk procedures to develop sufficient volume and expertise also helps. For example, "[t]he specialty hospital…seems to be more efficient and produces better health outcomes…" Sean Parnell, "Who's Afraid of Specialty Hospitals," *Privatization Watch*, vol. 29, no. 1 (2005) p.6.

[38] Rob Wherry, "Data Docs," *Forbes*, June 20, 2005, p.80.

[39] Daniel Weintraub, "A Possible High-Tech antidote to rising health care costs," *Monterey County Herald*, November 29, 2004.

[40] Matthew Herper, "Doctors, Untethered: Could Wi-Fi be the Key to Cutting Down on Deadly Medical Mistakes?" *Forbes*, June 21, 2004.

[41] Rob Wherry, "Data Docs," *Forbes*, June 20, 2005 p.82.

[42] Rick Callahan, "High-Tech Health: Hospitals Trying out Paperless Record Systems," *Monterey County Herald*, August 6, 2004.

[43] Steve Lohr, "Health Industry Under Pressure to Computerize," *New York Times,* February 19, 2005.

[44] "The E-Gang: Medical Marvels," *Forbes*, Sept 2, 2002 p.156.

[45] Ibid.

[46] Robert Langreth, "Fixing Hospitals," *Forbes*, June 20, 2005.

[47] Building the Medical Internet," *Government Executive*, Feb. 2005 p.73-4.

[48] Thompson, et. al., *Health, United States, 2004*, DHHS.

[49] "Building the Medical Internet," *Government Executive*, Feb 2005 p.73-4.

[50] Goodman, et. al., *Lives at Risk*, 2004.

[51] Johan Hjertqvist, The Timbro Health Policy Unit, May 2003 http://health.timbro.se or www.iedm.org/library/hjertqvist_en.html.

[52] Ibid.

[53] Ibid.

[54] In February 2004 the Swedish government took a step back. It banned any further hospital privatization, fearing it could destroy the principle of fair and free public health service, and attempted to end the practice of patients "buying their way past hospital waiting lists." Under the terms of the new bill, existing private hospitals will be allowed to continue in existence, and private profit-making companies will be allowed to start new hospitals, as long as they do not treat state-insured patients. *British Medical Journal*, Feb. 28, 2004 (found at www.pswatch.ca).

[55] Reuters Health 12/4/01.

[56] In 2000, the United.States spent 13.3 % of its GDP, Canada 9.2%, France 9.3%, Germany 10.6%, Japan 7.7%, Sweden 8.4%, Switzerland 10.7%, and the United. Kingdom 7.3%. (Thompson, et. al., *Health, United States, 2004*, DHHS).

[57] OECD Health Data 2003.

[58] In terms of life expectancy, for 1999, the Department of Health and Human Services reports male life expectancy at 73.9 years and female at 79.4 years, ranking the U.S. 23rd. For males, Hong Kong ranked first for males at 77.7 years, and Japan first for females at 84 years. (Tommy Thompson, et. al., *Health, United States, 2004*, DHHS, p.141) In terms of infant mortality, the United States was ranked 27th at 6.9 infant deaths per thousand live births. Singapore ranked first with only 2.5 deaths per thousand live births. Switzerland was 14th with 4.9 deaths per thousand live births. (Thompson, et. al., *Health, United States, 2004*, DHHS, p.140).

[59] The private health care orientation in the United States is only relative to that of other countries. There is still significant public involvement. According to the OECD (Organization for Economic Cooperation and Development) Health Data report, in 2003 the ratio of public expenditures to total expenditures on health was: 45% for the United States; 70% for Canada; 76% for France; 78% for Germany; 83% for the United Kingdom; and 85% for Sweden. (www.oecd.org).

[60] U.S. Government Accountability Office, *21st Century Challenges: Reexamining the Base of the Federal Government*," GAO-05-325SP (Washington, D.C.: Government Accountability Office, Feb. 2005), p.33.

[61] See Thompson, et. al., *Health, United States, 2004*, DHHS, p.143.

[62] Goodman, et. al *Lives at Risk: Single-Payer Health Insurance Around the World* (New York: Rowman & Littlefield Publishers Inc., 2004) in cooperation with the National Center for Policy Analysis.

[63] Goodman, et. al., *Lives at Risk*, 2004 p.72-3, 162 and 169.

[64] Since there is unlimited demand for health care it will always be rationed. The only choice is how a country rations…by waiting (queuing) or by price…and whether it allows individual choice or forces collective choices. In Canada a recent ruling set a new precedent that has broken the Quebec government's monopoly over health care. It entitled an elderly patient waiting for hip-replacement surgery to purchase private health insurance to pay for a speedier private operation. The province previously outlawed private health insurance. ("Private Concerns," *The Economist*, June 18, 2005).

[65] Thompson, et. al., *Health, United States, 2004*, DHHS, p.317.

[66] Joseph Lupica (Advisor to Dona Ana County, New Mexico), Guest Column published in the *Las Cruces Sun-News*, April 25, 2004.

[67] Joseph Lupica (Healthcare Advisor to Dona Ana County) "Community Criteria for our Hospital Partner," *Comann & Montague Investment Banking*, September 2003 (www.investmentbank.com).

[68] Conroe, Texas: the winning bidder paid $70 million. The community realized a net "profit" of $11.4 million after $58.6 million in bond debt was paid. (Tradewell, *Privatizing Public Hospitals*, RPPI, 1998).

[69] Much of this case is based on *Governing* magazine's feature article entitled "Rising from a Hospital's Ruins," September 2001 (http://governing.com).

[70] A recent article claims specialty care for the uninsured in the United States is the "biggest hole in the safety net." According to the article, although basic medical services are available for the needy at community clinics across the country, specialty care is often "limited and poorly coordinated with primary care." (Judith Graham, "No Insurance, No Specialist," *Monterey County Herald*, May 25, 2005).

[71] Goodman et. al., *Lives at Risk*, , p. 249-50.

[72] Personal conversation with the owner, Kevin Smith March 28, 2005.

[73] Kevin N. Rask and Kimberly .J. Rask, "Public Insurance Substituting for Private Insurance," *Journal of Health Economics*, vol. 19, no. 1 (2000).

[74] Goodman, et al. *Lives at Risk.*

[75] Ibid.

[76] California Association of Public Hospitals and Health Systems (CAPH), *On the Brink: How the Crisis in California's Public Hospitals Threatens Access to Care for Millions*, (Oakland, CA: CAPH 2004) www.caph.org. (Jordan Rau and Charles Ornstein, "State's Hospital Funding Revamped," *Los Angeles Times*, June 23, 2005).

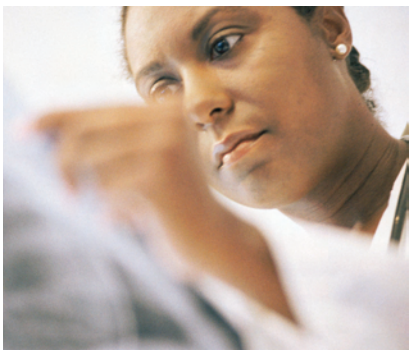
[77] Municipalities are refocusing on meeting the needs of the disadvantaged, rather than the business of running a hospital. In California the rush to the exits is reflected in the fact less than 15 percent of California's hospitals are public while 85 percent are private. In seven counties, Medi-Cal obligations are now being carried out by a sort of county-operated HMO. For example, in Orange County, Cal Optima contracts with a panel of health care providers—hospitals, pharamacies, physicians and clinics, who agree to offer discounted services to MediCal enrollees.

[78] Sager, Threats to Urban Public Hospitals and How to Respond to Them. Another discussion is whether to expand coverage to more people (the uninsured) and/or to cover more procedures.

[79] Milton Friedman, "How to Cure Health Care," *The Public Interest*, Winter 2001.

[80] Ibid, pp. 9-10.





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