



CHAPTER
2

The U.S. Health System in Vivo

In the last chapter I presented a somewhat academic view of the health system with a fair amount of data about demographics, health expenditures, hospitals, ambulatory care, and other related subjects. In this chapter I will review the real world of health care by commenting on a sample of health-related newspaper articles that appeared in the year 2003. My focus in this chapter will be on technology and clinical developments, fraud and abuse, health systems and quality, and finances.

As a manager, it is imperative to be au courant with what the public knows and be able to respond to any board, staff, or public inquiries about these matters. For example, when I was CEO of a health system, one of the morning television shows presented a segment on automatic defibrillators. Several hours later a few of my board members (including the chairman) called to ask about these devices, inquiring about their cost, availability, and, of course, how many we owned. I immediately needed to be a “quick study” on the subject. Within weeks, I was also asked to set up demonstrations and was required to make a presentation to the board on whether we should purchase and install the devices throughout our facilities. The lesson here is simple: Not only must managers be on top of the professional literature (which often tends to be both academic and a trifle dated) but they also must be tuned into the popular media, particularly the major dailies and news magazines.

TECHNOLOGY AND CLINICAL DEVELOPMENTS

The health system and its components are both the beneficiaries and victims of technology. The benefits of technology are often obvious, such as safer and better drugs, procedures, or devices. The negatives are often less visible, such as when a drug or medical device passes through the Food and Drug Administration (FDA) process and is introduced, only to be found several years into use to have such negative side effects that it must be recalled and eliminated from the market. Consider the following seven articles and what they might mean for the health system, including those people receiving care, those providing the care, and those paying for the care.

1. Alzheimer's drug: On June 15, 2003, the *New York Times* reported that families with loved ones with Alzheimer's disease were turning to memantine, a drug not approved by the FDA in the United States but used in Europe, for treating the disease.¹ Like legions of people before them, these families were desperate because conventional treatment had failed. Similarly, in the world of cancer therapy, people have tried numerous alternative cures, the most famous of which is laetril. Inevitably, some of these therapies work, for reasons sometimes unknown. However, the issue the health system must contend with is still who should get these experimental, unapproved treatments and who should pay for them. The answer is that usually only the wealthy can afford to go outside the traditional system; rarely will insurance or governmental programs pay for these alternatives. Since 1992, the federal government has been trying to deal with many of these issues through its National Institute of Medicine-based National Center for Complementary and Alternative Medicine (NCCAM) (and its predecessor, the Office of Alternative Medicine) that, according to its website, is focused on "exploring complementary and alternative practices in the context of rigorous science, training complementary and alternative medicine researchers, and disseminating authoritative

¹"Desperate families embrace unapproved Alzheimer drug," *The New York Times*, June 15, 2003, p. 1.

information to the public and professionals.”² All of these goals were to be met in 2003 with a budget of \$114,149,000, or less than 50 cents per American!

2. Sunscreen study: On June 3, 2003, the *Daily Hampshire Gazette*, my Northampton, Massachusetts hometown paper—and one of the oldest dailies in America—reported a *Los Angeles Times* article about Australian research finding that regular daily use of sunscreen, not just smearing it on oneself when going to the beach, will dramatically reduce the incidence of precancers of the skin.³ The same study debunked the value of beta-carotene supplements to prevent skin precancers. Here we see an existing over-the-counter “supplement” that can help prevent a serious and expensive problem. This is an opportunity for the health system to utilize the tool of health education to save people the anguish and discomfort of skin cancers and also save the system the expense of dealing with the problem. Similarly, the system could educate people about the waste of money involved in using beta-carotene to stave off precancers (although it may have other important functions in a diet). Unfortunately, here as elsewhere, even though sunscreen may be an excellent form of preventive medicine for many consumers, I am unaware of any health insurance program that would pay for a sunscreen prescription.
3. Hormone therapy: A page 1 article in the May 28, 2003, issue of the *Boston Globe* reported that after years of study it was found that the risk of dementia doubled for women who took hormone replacement therapy.⁴ For women going through menopause, the issue of whether to take replacement hormones has been a controversial and anxiety-ridden decision. Current research now contradicts earlier findings that suggested hormone replacement therapy not only had a dramatic effect on mitigating menopausal symptoms but also reduced the susceptibility to certain ailments such as heart disease. This new finding, though, indicates a slightly elevated risk of dementia associated with the drug. The dilemma is

²Data retrieved (n.d.) from www.nccam.nih.gov/about/.

³Study of sunscreen. *The Daily Hampshire Gazette*, June 3, 2003, p. C2.

⁴“Study ties hormone therapy to more risk,” *The Boston Globe*, May 28, 2003, p. 1.

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still in the hands of the consumer. She must make the final choice, often between what her physician may advise and her own limited knowledge. From a systems perspective, we have one final issue: The hormones prescribed by the physician will be covered by insurance (if there is a drug benefit); but any natural solutions, such as those found in the increasingly proliferating health food stores, or other self-care strategies, such as diet and exercise, will not have any subsidy through health insurance. Perhaps it is best to recognize that health insurance is primarily sickness insurance.

4. New delivery system for the flu vaccine: Building a better mouse-trap is often a good idea with significant benefits for everyone, except owners of the old traps. For most of us, taking a flu shot is a less-than-pleasant experience: Roll up the sleeve, turn your head, feel the alcohol swab, then the needle, and finally, we are done. When I was in the Navy, it was a regular assembly line with some type of compressed air gun delivering the shot. At last, as reported in the *New York Times*, a civilized approach developed in the 1960s will become widely available almost 40 years later. The system will simply be a mist sprayed up the nose, much like taking a nasal decongestant. The manufacturers expect to heavily promote this product, whose cost is estimated at \$50–55 per dose compared with \$10–25 per injection dose, by advertising in the pre-flu season.⁵ For managers and consumers, the issue as demonstrated by the flu mist system is why is there such a time lag in getting new technology to the market. Several answers are suggested by this case. First, the FDA goes through its own process of scrutinizing new technology. In the case of the mist, the difference is not merely turning the vaccine into an aerosol but is the use of live vaccine compared with the dead viruses introduced into the system via the needle. Second, the live vaccines “have been engineered to survive in the cooler temperatures of the nose but not the warmer temperatures of the lungs. It provokes the immune system but does not cause serious disease.”⁶ So, to begin with, there are the technical and clinical issues that must be addressed. Next there are the financial issues that inevitably involve Wall Street. A major new

⁵“FDA backs flu vaccine given by mist not a needle,” *The New York Times*, June 18, 2003, p. C4.

⁶*Ibid.*

product costs money in terms of production and marketing, and promoters of such a project need the backing of analysts and investors. In essence, then, it sometimes takes decades between the invention of the new mousetrap and its first sale.

5. Aspirin—Back to the basics: Although the idea of new technology certainly has its attractions, sometimes the older technology or drugs do just as good a job at a fraction of the cost. On June 11, 2003, the *Wall Street Journal* reported on a study published in the *Journal of the American Medical Association* that found that the relatively new high-tech drug ticlopine (at a cost of \$100 per month) works no better than aspirin (at a cost of \$10 per month) in preventing the recurrence of strokes in African-Americans.⁷ How is it that the health system allows the development of expensive new drugs or technology that are essentially a replacement for equally efficient older drugs or technology? A cynic would answer that it is all about profit. The companies see a market, make a slightly different product, and hope to capture the old market. A research scientist might say that his or her profession is always looking for a more efficient or elegant formulation to attack a significant problem and that the new product may indeed have special benefits, like reduced side effects or a better delivery system. For example, my favorite antibiotic is Zithromax, a drug similar to erythromycin but more expensive. I like the Zithromax because, unlike other antibiotics that require me to take the pill 4 times a day for 10 days, Zithromax has me taking 6 pills: 2 the first day and 1 every day thereafter. The Z-pak, as it is called, is more convenient and perhaps more effective because of higher compliance . . . but that remains to be studied.
6. Technology and unanticipated consequences: How many of us would choose to have surgery if we knew the consequences would be a brain injury? From a *New York Times* article of May 13, 2003, we learn about “pumpheads.”⁸ “Pumpheads” are the unfortunate people who suffer brain injury as a result of being put on a heart-lung machine during open-heart surgery. Although it is not exactly clear what the cause of the injuries are, some surgeons are responding by

⁷“Antistroke drug performs no better than aspirin,” *The Wall Street Journal*, June 11, 2003, p. D6.

⁸“Heart pump and brain injury: A riddle deepens with time,” *The New York Times*, May 13, 2002, p. D1.

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doing the bypass surgery without using the heart-lung machine, a procedure known as off-pump surgery. Here we have an example of a problem (heart blockage); a solution (bypass surgery); the unanticipated consequence (“pumpheads”); and, finally, a search for an alternative route (off-pump surgery). Unfortunately, the last word will not be written on this issue until at least 2006, when the government will have completed a study comparing the two approaches. Once again, as in the case of treating prostate cancer, the consumers are left to making an uninformed decision guided only by their relatively uninformed practitioners, whose judgment is usually based on their own limited experience, and their equally uninformed (and arguably self-interested) insurance companies.

7. A new world of surgery: Minimally invasive surgery (MIS) is described in a *Boston Globe* article as such a significant breakthrough that “it constitutes a shift in practice so profound that its effect is akin to the arrival of anesthesia 150 years ago.”⁹ MIS is now used throughout the body system, including gynecological surgery, neurosurgery, cardiac surgery, and urologic surgery. The article points out that heart mitral valve repairs used to involve foot-long incisions followed by the breaking of the breastbone in order to access the heart valve. Hospital stays lasted 5–6 days with a 2-month recovery time. MIS for the same problem involves a 2-inch incision, use of miniature cameras and instruments, a 2-day hospital stay, and a 2-week recovery.¹⁰ The brave new world of medicine is upon us, and for managers the changes will be enormous. As we learned in Chapter 1, we will need fewer beds for more people, more and better equipment, and certainly people with different training than before. For consumers, we will see a quicker return from the sick role and hopefully a better quality of life.

FRAUD AND ABUSE

Although the subject of fraud and abuse will be dealt with extensively in later chapters, I do want to introduce it here because it represents such an important new development in the health care field. Although sleaze has

⁹“As tools of surgery shrink, training expands,” *The Boston Globe*, June 27, 2002, p. E1.

¹⁰*Ibid.*

always existed, the availability of huge reservoirs of insurance and government funds has taken corruption in the health field to a new level. The following articles and commentary provide a glimpse of this problem.

- **Fighting fraud in Boston:** The big picture about fraud in the health industry was presented in a page 1 *Boston Globe* article stating that amongst federal prosecutors, Boston lead the way on fighting fraud.¹¹ The statistical chart presented with the article illustrates that in 2000 the National Medical Corporation settled the government's suit against them for a variety of charges, including kickbacks and unnecessary tests and therapies for the sum of \$486 million. Additionally, four executives were convicted of conspiracy to defraud the government. In 2001, the fraud unit settled with TAP Pharmaceutical for \$855 million. In this instance TAP had been involved in illegal marketing and pricing of Lupron, a drug used for prostate cancer. In 2003, two drug giants, Bayer and GlaxoSmithKline, settled with the government for more than \$350 million. In both instances they had intentionally overcharged the government for medications.
- **Illegal marketing:** Another drug giant, Parke-Davis, is in trouble with the government for the alleged illegal marketing activities of its epilepsy drug Neurontin.¹² In this case, the drug manufacturer allegedly provided illegal marketing trips and tickets to physicians under the guise of educational programs. The government's case will be based on the company's conduct, thought to be an illegal inducement to prescribe its drugs. Part of the problem with this activity is that the government says it was an inducement to use the drug for various ailments, such as bipolar disorder, rather than the ailment for which the drug was initially designed. Such so called "off-label" uses have a significantly positive impact on the drug company's bottom line. The line between aggressive and legal marketing and illegal marketing activities is still not clear, and until it gets well-defined we can anticipate many more similar government lawsuits.
- **Faulty medical device for treating aneurysms:** As reported in the June 13, 2003 edition of *USA Today*, a medical

¹¹"Prosecutors here lead in health fraud cases," *The Boston Globe*, May 13, 2003, p. 1.

¹²"U.S. filing backs suit against drug firm," *The Boston Globe*, May 25, 2003, p. D1.

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manufacturer, EndoVascular Technologies, agreed to pay a fine of \$92.4 million and plead guilty to “covering up thousands of incidents in which the device malfunctioned and might have led to 12 deaths and 57 emergency surgeries nationwide.”¹³ In this instance, the company’s balloon-like device had been approved by the FDA in 1999 and suspended in 2001 after some anonymous tips about problems. Aggressive marketing activities, including covering up the details of the problems, led to the criminal charges. Once again one must wonder whether less attention to sales goals and more attention to quality of the product would have been in the company’s long-term interest. Additionally, one must raise the issue of surveillance systems for new medical devices—after all, but for the anonymous tips the defective products might still be on the market!

- Poor patient care leads to divestiture: An Albany, New York, nursing home company was required to divest itself of its eight nursing homes after state investigators found that it had falsified its business records and provided substandard care to the home’s residents.¹⁴ The owners are not only being forced to sell but also to pay over \$1 million in fines and penalties. Nursing homes are among the most regulated sectors of the health system and, because of their large volume of Medicaid and Medicare business, come under both federal and state scrutiny. In recent years, many states have become increasingly aggressive in using significant penalties in order to change the behavior of nursing home owners and operators. As this case illustrates, the penalties can even include driving an owner out of business.
- Nonprofit medical center not exempt from problems: Even distinguished, world-famous institutions such as Massachusetts General Hospital (MGH) fall under scrutiny for fraud and abuse issues. For example, on June 19, 2003, it was reported by the *Boston Globe* that MGH would “pay the federal government \$75,000 to settle allegations that it defrauded the Medicare program by billing for neurological services when no senior physician was present.”¹⁵ According to the article, there were instances where Medicare was billed for a

¹³“Medical firm fined \$92M in coverup,” *USA Today*, June 13–15, 2003, p. 1.

¹⁴“Operators must divest themselves of eight nursing homes,” *Adirondack Daily Enterprise*, June 1, 2003, p. 2.

¹⁵“Hospital to pay \$75,000 settlement,” *The Boston Globe*, June 19, 2003, p. B2.

physician's services while the doctor was away in Bermuda. For a health care manager, this raises the simple question: How does this happen? Unfortunately, too often, personnel appear to be on automatic pilot and impute information when it is missing . . . and this is where the trouble begins. For example, I was once investigating a woman's complaint about the care her father was receiving in a nursing home. In reviewing the chart I noticed that the nurses were consistently reporting the same dietary intake and status each day despite the facts that the man had lost a significant amount of weight (also recorded) and the daughter stated he had no appetite. What was occurring was that the nurses, at the end of their shift and hurrying to leave, made similar entries on this man's records as well as on every other person's record on the unit. The lack of attention in this case led to the man's hospitalization, as well as not only a subsequent change of staff on the unit but also a significant amount of in-service reeducation. If a lawsuit had been filed, those medical records would not have served the cause of the nursing home!

- Executives' problems: Two unrelated articles demonstrate the problems that both cause and result from the issues of fraud and abuse. In the first, a HealthSouth financial executive joined 11 other company executives in pleading guilty to a variety of charges about financial irregularities in the company.¹⁶ The case itself, involving a chain of rehabilitation hospitals, began with investigation of illegal behavior in 1996 and by the summer of 2003 was far from resolved. The second article is equally troubling. Even though Jeffrey Barbakow was the executive who was brought in to clean up and run Tenet Healthcare in 1990 after it ran afoul of the government, he could not survive a new set of regulatory problems and subsequent loss of investor confidence.¹⁷ This article reminds us that once an organization is stained by fraud and abuse, that stain has a way of affecting everyone, even the clean-up brigade. As will be shown in the chapters on corporate compliance, both an organization's reputation and the reputation of those that work there are best served by ethical and honest behavior.

¹⁶Former executive at HealthSouth pleads guilty [electronic version], *The New York Times*, (May 6, 2003) retrieved December 8, 2004.

¹⁷"Troubled Tenet Outs Chairman Barbakow," *The Boston Globe*, June 28, 2003, p. D2.

HEALTH SYSTEMS AND QUALITY

The standard model for examining quality in health care involves a three-part analysis: structure, process, and outcome. This model assumes that optimal care will be achieved when the proper structure exists. For example, to deliver quality radiology services it is necessary to have the right equipment, staff, and physical facilities. Process examines how that care is delivered. Were appropriate laboratory tests ordered for the likely problems? Were the tests done in a timely fashion? Were the results properly recorded and transmitted to the appropriate people? Were the tests properly done? Last, we have the true issue: outcomes. What were the expected clinical outcomes? Were they attained efficiently and effectively? We are now in a period of heavy government and foundation investigation into the area of outcomes research. This research is leading to clinical protocols and a potential standardization that could have some positive benefits. One issue that will likely be on the board for decades is inequity of care due to socioeconomic status. As one of the following articles indicates, the gap between the poor and wealthy is still with us.

- Quality of care: Perhaps one of the most significant articles on quality of care was a research report published in 2003 in the *New England Journal of Medicine*.¹⁸ The authors of this study of the medical care of 6712 adults found that “participants received 54.9% of recommended care.”¹⁹ There was considerable variation, depending on both the mode of care and the condition. For example, if good-quality care dictated medication, then 68.6% of the people received that care. However, if good care recommended counseling or education, only 18.3% received that care.²⁰ The article also reported considerable variations with clinical conditions. If the condition was senility, cataracts, or breast cancer, the patients received the quality of care they should have approximately 75% of the time. On the other hand, many common conditions fell below 50%: diabetes mellitus (45.4%); urinary tract infection (40.7%); dyspepsia and peptic ulcer disease (32.7%); atrial fibrillation (24.7%); hip fracture

¹⁸E.A. McGlynn, et al., “The quality of health care delivered to adults in the United States,” *New England Journal of Medicine*, 348 (2002), 2635–2645.

¹⁹Ibid., p. 2641.

²⁰Ibid., p. 2642.

(22.8%); and alcohol dependence (10.5%).²¹ All of this suggests that there is considerable work to be done for both consumers and managers. The managerial responsibility is to ensure that the organization's staff provide the best quality care possible and that the organization has the resources to ensure that that quality is provided. While most organizations have internal quality control protocols such as "quality assurance committees," few organizations raise the bar to include the boards in quality discussion. Some years ago, as part of a program I was taking in England on the British health system, I visited one of the London teaching hospitals. In a discussion with a medical professor I raised the issue of quality review. My frame of reference was the United States' hospital quality review "system," consisting of a series of committees such as medical records, tissue, and credentials. The professor answered me by saying they had no need for such committees because of their continual daily oversight of each other. Frankly, I did not buy that answer then and still believe in the adage that foxes cannot guard chicken coops. As this article points out, despite the assumed best intentions of practitioners they do not deliver the best quality care in a significant percentage of the time. Management that sees its role as central to quality can make an impact on this problem.

- The burden of poverty: For those health professionals working with impoverished clients, there is a special challenge associated with the connection between economic status and health. This connection was highlighted in a Massachusetts Department of Public Health study reported upon in the *Boston Globe*. It found that two of Massachusetts's poorest communities, Lynn and Lowell, were dramatically less healthy than the affluent communities of Newton and Brookline.²² The primary statistic used in this report was the premature death rate: Newton's was half that of Lynn. This finding is neither atypical nor unexpected. The poor have fewer dollars to spend on health care and generally have less access to that care. The clinical problems, behavioral issues, and other barriers that the less economically fortunate deal with make it imperative that the health

²¹Ibid., p. 2643.

²²"Report underlines burden of poverty," *The Boston Globe*, May 28, 1903, p. B1.

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system respond to these needs in a more efficient and effective way than it has done to this point. My own experiences with impoverished communities in New York and New Orleans, particularly prison inmates, suggest that we can and must do better.²³

- The pharmacist's role: The health system is certainly not merely about doctors, nurses, and administrators. In fact, billions of dollars are spent on self-medication. Everyone from massage therapists to faith healers and grandparents provide advice on health issues. Pharmacists are major-league providers of advice and dispensers of nonprescription remedies and, certainly, prescription drugs. In Hollywood, Florida, a local pharmacy tests for bone density, cholesterol, and hypertension. The pharmacist is well known for his suggestions on everything from snoring to menopause. He typically suggests a range of herbal remedies and usually has quite satisfied customers. With regard to prescription drugs he, like most pharmacists, is available for consultation, but the bulk of the information comes in the labeling. For example, a prescription medication from Walgreens comes with an information sheet that includes the medication, directions for use, ingredient name, common uses of the drug, information on how to use the drug, cautions, and side effects. In New York state, the role of the pharmacist has been taken to a new level. Rather than merely being required to ask a patient whether he or she has questions about a drug, they will now have to meet with every patient about a new prescription. In this counseling session they will "talk to every patient about the name, description and purpose of each drug. They will also discuss the dosage, any special precautions, techniques for self monitoring, storage requirements" and a host of other matters.²⁴ Fortunately for New Yorkers, a practice is now in place that will no doubt increase drug compliance and will likely result in better quality care. As this section illustrates, quality is a complex issue, and one that requires teamwork from all components of the system. The physician can write the prescription and usually give the patient a very short commentary on the medication. The pharmacist, though, is in the best position to

²³S.B. Goldsmith, *Prison health: Travesty of justice* (New York: Prodist, 1973).

²⁴"New rules for N.Y. pharmacists enacted," *Adirondack Daily Enterprise*, July 1, 2003, p. 9.

offer substantive information and help the patient in using the drug most effectively. It is unfortunate that the pressures on the health system are such that it requires state or federal regulations to get professionals to do what they have trained for.

- Medicaid and quality: On July 7, 2003, the *New York Times* reported on a U.S. General Accounting Office study that found that 11 of 15 states were operating suboptimal quality Medicaid programs with the funding and blessing of the federal government.²⁵ Quality assurance under the Medicaid program is a state responsibility that operates with federal rules and guidelines. Unfortunately, quality is something that happens at the grassroots level, and no level of inspection can ensure true quality. A quote from Professor Rosenbaum of George Washington University captures the essence of the quality dilemma: “States prepare good plans of care for Medicaid recipients, but there’s no follow-through to see if people get the care. States assume that home and community care will save money, without realizing that it takes real money to monitor the quality of care.”²⁶

FINANCES

In Chapter 1, I provided an overview of health finances from a national perspective. In this section, a summary of articles will examine how money is affecting providers and beneficiaries of care. The inherent dilemma presented in these articles is that money is the fuel oil of the system and must come from somewhere, business or government. It is obviously easier to find the money in a good economy. But in a bad or uncertain economy, costs must be controlled, and health care expenditures are not sacred cows.

- Health costs slowing: In a page 1 article, the *Wall Street Journal* provided an analysis that suggested health care costs are slowing down because of a shift to generic drugs, increased substitution of outpatient surgery for inpatient (and, by definition, hospital) surgery, and decreased health benefits.²⁷ The article goes on to raise the most

²⁵“Report criticizes federal oversight of state Medicaid,” *The New York Times*, July 7, 2003, p. C8.

²⁶Ibid.

²⁷“Rate of increase for health costs may be slowing,” *The Wall Street Journal*, June 11, 2002, p. 1.

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common argument/analysis; that is, if people are responsible for their own health care costs through copayments and deductibles, they will be more careful about health expenditures. Perhaps the question to ask is: Why does the *Wall Street Journal* put health care finances on its front page? The answer is that health expenditures are a significant part of any organization's budget, and controlling expenditures is a prime function of management. In my CEO days I, too, was faced with the problem of health benefit expenditures. Although I would have loved to provide Lexus-level benefits to each employee, I had to compromise with the budget and provide Ford Escort level benefits (at least I avoided going to the used Yugo level).

- Hospitals in deep trouble: The first few years of the 21st century have not been kind to many large health care providers. For example, in the nursing home industry, five of the eight largest nursing home companies have filed for bankruptcy. HealthSouth, a large chain of rehabilitation hospitals, with various fiscal and regulatory problems, was another company heading toward bankruptcy in 2003.²⁸ The stain from these bankruptcies has spread throughout the health industry, eroding public confidence in investing in this sector of the economy, which further weakens the industry. Hospitals also have not fared well in this economy. The problems in Massachusetts were presented in an article reporting that many hospitals were in deepening financial straits because of both lower patient volume and poorer insurance coverage for treated patients.²⁹ One aspect of the problems for many hospitals nationwide is the fiscal problems that the states are facing. Inevitably, state budget cutters look to Medicaid payments to balance their accounts, and that balancing often takes a toll on nursing homes, hospitals, and clinical providers of care. Another aspect is simply that of disease. As the article stated, a hospital in the resort area of Cape Cod saw a decline in its revenues because of a mild flu season.³⁰ In a related piece, the *Boston Globe* reported that Waltham Hospital, after serving that

²⁸"HealthSouth bankruptcy could come this summer," *The New York Times*, April 30, 2003, p. C2.

²⁹"Weakening bottom lines worry hospitals," *The Boston Globe*, May 14, 2003, p. C1.

³⁰*Ibid.*, p. C6.

community for 117 years, was expected to close.³¹ Unfortunately, a few months later, the hospital did close, and developers were in the process of using the land for housing and perhaps some type of medical office building and surgicenter. Although Waltham Hospital is one of hundreds of hospitals that have closed throughout the country, others have survived by downsizing or merging. Sometimes it takes years before a community knows what will happen to a closed institution. For example, in Miami Beach, St. Francis Hospital stood essentially vacant for years as discussions continued about turning the building into a geriatric facility, a medical office building, housing, and so forth. Eventually, close to a decade later, the hospital was razed to make way for an upscale housing development. In New York City, Mount Sinai Hospital was reported to be having its share of financial problems, with a 2002 deficit of \$72.5 million.³² By contrast, in 1997 the hospital had a profit of \$30 million. A consultant's analysis of the problems at Mount Sinai found "flawed billing systems cost Mount Sinai tens of millions of dollars, even as it pursued ambitious expansion and building plans and paid its top executives salaries, detailed in tax records, that many experts say were unusually high for a struggling nonprofit institution."³³ Everything was complicated for Mount Sinai because of its relationship to its medical school and a merger with New York University's Medical Center. Finally, what is perhaps most disheartening about the Mount Sinai saga is that it was managed by some of the most talented executives in the country and had a board comprising many people who are considered the senior financial "geniuses" of New York City.

- Hospital desperation in troubled times: Calling an airline or hotel for a rate is a challenging experience. With the airlines, it's the 21-day advance, 14-day advance, 7-day advance, 3-day advance, restrictions, no restrictions, and so forth. At the hotel, it's the rack rate, then the discounts: AAA, AARP, corporate, government, frequent hotel user, and so forth. With hospitals we also have a discount structure, with

³¹"Waltham Hospital to be closed," *The Boston Globe*, May 14, 2003, p. C6.

³²"How a venerable hospital helped undermine its own fiscal health," *The New York Times*, April 2, 2003, p. A19.

³³Ibid.

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bulk purchasers, usually HMOs, getting the best price. The fiscal problems facing hospitals has caused them to charge the uninsured a full price with no discount and then to aggressively pursue collecting those charges. This practice has come under increased public and governmental scrutiny and resulted in the hospital trade association, the American Hospital Association, urging its members to review their practices and “stop using harsh bill-collection tactics that reflect poorly on the industry.”³⁴ Unfortunately, some of those who bear the greatest burden of the financial woes in the industry are employees who see their health benefits being constantly eroded. This area will be examined next.

- Employee health benefits and health costs: Health benefits are often an area of major payroll expenditures for any business. It is frequently said that the an automobile’s manufacturing costs include more expenses for health benefits than for steel. This concept has industry reexamining the entirety of the health benefits and puts health benefits on center stage for any negotiations. At General Electric, the union declared victory when it was able to maintain the employee’s contribution to health insurance at 18% for the first year of the contract rather than the 30% desired by management.³⁵ With estimated costs of \$6,500 per employee, the difference is a contribution of \$1170 per year versus \$1950 per year. For the company, not getting its way involves a \$13 million bottom-line expenditure that it had hoped to transfer to employees. A different strategy employed by industry is to promote healthy employees. One group of employers announced that they would fight obesity because, as the medical director of Ford Motor Corporation noted, it takes “an amazingly large portion of the \$3 billion” that the company spends on health care.³⁶ National estimates by the director of health care management at Ford are that employers are spending \$13 billion annually on weight-related problems, including disease and

³⁴“Hospitals urged to end harsh tactics for billing uninsured,” *The Wall Street Journal*, July 7, 2003, p. A9.

³⁵“G.E. union cites deal to curb workers’ share of health costs,” *The New York Times*, June 18, 2003, p. A16.

³⁶“Employers plan obesity fight citing \$12 billion-a-year cost,” *The New York Times*, June 18, 2003, p. C2.

lost productivity.³⁷ Another strategy used by industry is the limitation or elimination of health benefits for retirees or disabled employees. In Massachusetts, NStar, the energy public utility, cut back on health benefits to retirees as a strategy to eliminate some of its \$20 million increase in its health care expenses.³⁸ In another Massachusetts situation, a lead article in the *Wall Street Journal* focused on the Polaroid Corporation's decision to fire employees who were on disability and thus save the costs of providing them health care.³⁹ What was perhaps most shocking about the article is that more than 50% of 723 large companies surveyed would fire an employee after some period on disability; indeed, 27% dismiss them immediately after they go on disability.⁴⁰

In this chapter, as well as in Chapter 1, I have provided both a data-driven and a human-focused overview of the health system and its issues. It is now time to narrow the focus of this book on management and the health industry by examining in the next two chapters a managerial view of the health care industry and the beginning of all managerial efforts; that is, setting objectives for what we do.

³⁷Ibid.

³⁸"Healthcare for life, with exclusions," *The Boston Globe*, June 27, 2003, p. C1.

³⁹"To save on health-care costs, firms fire disabled workers," *The Wall Street Journal*, July 14, 2003, p. 1.

⁴⁰Ibid.