



To market, to market: Corporatisation, privatisation and hospital costs

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Abstract

The Australian political arena echoes with calls for the privatisation of health care institutions, the contracting-out of health care services and the introduction of various marketing strategies into hospital management. These calls are justified by asserting that the market, rather than the public sector, can provide better services, greater productivity and increased efficiency. The National Health Strategy (1991, p 17) provides a good example. Noting that Australia is copying American investment trends for hospital 'chains' rather than for independent small establishments, the strategy dismisses any concern over changes in ownership, pointing instead to a 'process of rationalisation' that is to be 'welcomed'. Using evidence from the United States, United Kingdom and Australian hospital sectors, this paper examines claims for the greater efficiency of market processes.

Introduction

In a 1980 editorial in the *New England Journal of Medicine*, Relman identified the formation of the new medical-industrial complex which he defined as ‘a large and growing network of private corporations engaged in the business of supplying healthcare services to patients for a profit – services heretofore provided by non-profit institutions or individual practitioners’ (pp 996–7). In the same editorial, Relman also pointed out that the basis of this complex was the corporate ownership of hospital chains.

In the late 1970s, corporate investment in hospitals and hospital services arrived in Australia. Before this, the hospital sector had been characterised by a ‘cottage industry’ of small private hospitals – often owned and run by doctors and family members (cf Morley, Taylor & Opit 1982) – and encircled by large public institutions run by State governments with Commonwealth funding. The entry of sizeable corporations such as Mayne Nickless and Dalgety Farmers into the hospital sector, and the interest of foreign hospital operators, such as American Medical International and Hospitals Corporation America, introduced the phenomenon of cross-ownership among private hospitals and built financial alliances between hospitals, hospital services, health care suppliers, health insurance companies and investors of financial capital. By the 1990s, another innovation had arrived onto the scene. Private hospitals, previously offering only limited services, began to expand their range and build premises adjacent to the large public hospitals (cf Peers 1991, p 14). These new private hospitals sought to capitalise on the proximity of doctors, medical trainees, and facilities for attracting patients (now known as consumers). Along with this new practice, the state sold a number of its ‘public’ hospitals to the private sector; encouraged the investment of private capital for the creation of public infrastructure; and allowed the private sector to build, and manage, ‘public’ hospitals (cf Collyer 1996a).

The introduction of these marketing strategies is, according to scholars such as Relman, completely at odds with the appropriate provision of health care services in modern societies. Health care services have previously been protected from market forces for a number of reasons. First of all, because access to health care is considered to be a right of all citizens. Secondly, because public funds are allocated to health care (for research costs and the education of practitioners) and it is felt that this public provision ‘distorts’ the market and allows speculators to benefit. Thirdly, because the sick are not in the position of the classical consumer, and are thus unable to be prudent, shop around and compare services, price is often irrelevant in the context of need. Lastly, patients are unable to decide on the services they might require, but must be guided by a doctor (Relman 1980, pp 996–7).

These often-articulated rationales underlying the *primarily* public provision of hospital services have been profoundly shaken by the recent surge in economic rationalism and the incorporation of economic models into the health policy arena. The largely uncritical acceptance of this value system by powerful members of the bureaucracy and key political parties has relegated social policy to second place behind economic policy. It has also brought with it an ideological doctrine that asserts, with little substantiation, the virtue of the market as pre-eminently capable of providing for greater efficiency and productivity. Concomitant with this assertion has been a systematic denigration of the public sector. In a clear reversal of political discourse, the state is now largely portrayed as inefficient, incompetent, inflexible, secretive and tardy (Wettenhall 1987).

Until recently, claims for the virtue of the market have been difficult to challenge, given the lack of comparability between the Australian public and private hospital sectors (where private, not-for-profit, and public hospitals offered quite different services) and given the very different health financing systems of Australia, the United Kingdom and the United States. However, with the entry of private investment into the traditionally 'public' health care service sectors in each of these countries, comparisons can now be made. For example, spurred on by the privatisation of the Port Macquarie Base Hospital by the previous Liberal Coalition Government, the New South Wales Labor Government has introduced a system of data collection among 'peer' hospitals, that is, hospitals (both privately and publicly owned) with similar casemixes and functions. This system bypasses some of the previous difficulties of comparison, allowing hospitals to be assessed on a range of indices, including infection rates, discharge outcomes and the cost of administration and services (Collyer 1996b).

Corporate efficiency: Fact or fiction

The purposeful introduction of market strategies such as privatisation into health policy and planning rests upon a number of claims. One of these is that the 'unfettered' market provides a 'discipline' lacking in the public sector. For example, the National Health Strategy asserts that private hospitals have a greater incentive to implement efficiencies, and that allowing a small number of corporate operators to control the private hospital market will result in more effective use and better management of private hospitals (1991, p 117). Another claim is that a competitive market economy generates an output that is in equilibrium and therefore efficiently allocates resources (Stilwell 1993, p 31). A third claim is that market principles, rather than government interventions, enable enterprises and organisations to operate more efficiently (for example,

Beesley & Littlechild 1983). And a fourth claim is that larger, private sector corporations (including hospitals) with central planning, management and marketing, and economies of scale, can produce goods or services with a lower price per unit, and can raise the standards of services (for example, Senate Select Committee 1987).

These claims all use the economic concept of *efficiency* as a measure of the 'success' of the marketing strategy. Though originally defined as the effective use of resources or energy, the concept is now more commonly used in a narrower sense to refer to the reduction of the costs associated with production, services and performance. Given the common usage of the term, it can be argued that enterprises and institutions can respond to 'cost efficiency' not with one, but with a variety of practices and policies (cf Light 1995b, p 145). The variety of responses to 'cost efficiency' enables enterprises or institutions to remain competitive, but as this paper demonstrates, not all responses are equally desirable.

Efficiency: A reduction in cost

At least three types of 'cost efficiency' responses can be noted in the hospital sector. The first type of response is to aim for a reduction in the cost of providing services by, for example, eliminating duplication; cutting practices that are 'wasteful' of time or resources; increasing productivity through changing work practices; or perhaps introducing a new technology.

Unfortunately, there is little evidence to suggest that cost reduction of this type has been achieved in the hospital sector without reducing either access to services, the number or type of services provided, the number of employees engaged to perform the work, the conditions of workers, or the quality of work performed. For example, the British health care system introduced this type of 'cost efficiency' into its hospital sector during the 1980s and reduced the length of stay for all acute services by 28 per cent, increased the throughput per bed by 46.8 per cent, and decreased the costs per acute inpatient case by 10 per cent. However, this involved the closure of 17 per cent of its acute beds and 24 per cent of all beds (Light 1993, p 285).

The situation in California shows a similar 'cost efficiency' response. Melnick and Zwanziger (1995) examined health care expenditure under two policy approaches, competition managed care (that is, free market) and state government regulation. They compared California – a state with pro-competitive policies – with the United States average, and with four states that had established regulation programs, between 1980 and 1991. They found some startling

differences in regard to the cost of health care service delivery. While the real capital expenditures on health for the United States grew by 54 per cent, the rate of growth in California was only half this, at 27 per cent. Similarly, real per capita expenditures for physician services and drug expenditures in the United States grew by 82 per cent and 65 per cent respectively, while in comparison Californian rates increased by only 58 per cent and 41 per cent. On the basis of these findings, the authors concluded that competition plays a significant role in controlling health expenditures in the United States (Melnick & Zwanziger 1995, p 1391).

A closer examination of the Californian situation, however, reveals that these 'cost efficiencies' have been achieved at the expense of access to health care services. Melnick and Zwanziger's study examines only insured individuals. Given that California has a 60 per cent higher rate of uninsured in comparison with a population-weighted average among the regulated states (Health Insurance Corporation of America 1993), less people in California have the capacity to use the health services, and it is this which can reduce overall cost. In short, the decision not to provide services for the uninsured is a common 'cost efficiency' response in a market without a universal health insurance scheme. Californian hospital services have also been made 'cost efficient' through reducing the length of hospital stay. The average length of stay in Californian hospitals is four days less than in comparable hospitals in New York (Health Insurance Corporation of America 1993).

Other examples of 'cost efficiency' responses in the United States hospital sector have been to provide only 'profitable' services to paying patients; offering uncomplicated surgery and leaving emergency cases, patients with chronic illness or social problems to the public sector (Shiel 1995, p 30); eliminating services to areas of low population density and low socioeconomic status; and reducing services (Mulner & Hadley 1984, p 150). This last response is in direct contradiction to the view held by scholars such as Gayle and Goodrich (1990) that market forces will provide an expanded range of services.

In the United Kingdom, where there is a universal health system, the private sector has recently been invited to tender for business. In this 'secure' market, one 'cost efficiency' response – by the National Health Service – has been to introduce outsourcing of functions, particularly in the allied services of catering, cleaning, maintenance and security. The impact of the contracting-out of services, which has been under way since the introduction of competitive tendering in 1983, has been assessed by the National Health Service. A report released in 1990 found that private contractors held between 72 per cent and 90 per cent of domestic service contracts over this period, and that the expected

savings of £120 million had led to a decline in standards and service (Joint National Health Service Privatisation Research Unit 1990). Another United Kingdom study on privatisation strongly linked a rise in infection rates in hospitals with the poor domestic cleaning performances of private contractors (Bach 1989).

Efficiency: A shifting of costs

A second type of 'cost efficiency' response in the hospital sector has been to reduce the costs for one particular player, and to shift these costs onto others. This type of response occurs most prominently in the United States, where the cost of health care services are transferred to the patients (and their employers) in the form of escalating insurance premiums (Light 1991).

This response is not peculiar to the United States, however. In an Australian example, the New South Wales Liberal Coalition Government sought to achieve 'cost efficiency' through privatising the Port Macquarie Base Hospital (Hannaford 1992). This was the first *public* hospital in Australia to be constructed, owned and managed by the private sector. With this privatisation strategy, the New South Wales Government expected to save \$46 million over 20 years by allowing the private sector to build and run one of its 'public' hospitals (Collyer 1996b).

The finance for construction and development of the hospital came from two foreign banks, Hambros and NatWest. The hospital operator, Health Care of Australia (a subsidiary of Mayne Nickless), has a mortgage agreement with the banks as well as a contract with the New South Wales Government to manage the hospital, providing services to both public and private patients. The impact of the privatisation of Port Macquarie Base Hospital has been a significant transfer of funds from the public sector into the private sector, without securing *additional* services. This revenue is going to the banks and to the hospital corporation (Collyer 1996b, p 10). At the same time, there has been a shifting of costs onto the health insurance companies (estimated at \$35–45 million over 20 years), which have to pay higher premiums to the private hospital than are paid to comparable public hospitals for private patients (Public Accounts Select Committee 1993, p 64). Ultimately, these increases are passed on to the membership in the community in the form of higher fees for private health insurance.

Efficiency: A delaying of cost

A third type of 'cost efficiency' response in the hospital sector has been to reduce costs in the short term, delaying the costs to the current generation of taxpayers, even though the costs over the long term may be significantly higher. This is the type of strategy currently in use by several Australian State governments in the hospital sector. It can also be illustrated by the case of Port Macquarie Base Hospital, where the State government has, according to the New South Wales Auditor-General, paid for the capital cost of the construction of the hospital twice. First of all via the annual availability charge paid to the private operators over the 20-year period and, secondly, through the set fee-for-service arrangements under which the State pays an amount for public patients equivalent to the top-cover private health insurance rebate. This rebate is calculated to reimburse private hospitals for all hospital costs, including the construction costs of the hospital (New South Wales Auditor-General 1996, Appendix 4). To make matters worse, the State government will own neither the building nor the land after the 20-year period, and is subject to the threat of litigation from the management company when it has attempted to control annual costs. As a consequence, the government recently gave in to demands from Health Care of Australia for a further \$3 million to provide ongoing services to public patients (Downey 1997).

Similar arrangements for delaying costs have been employed by other State governments. Rather than constructing hospitals from public funds, governments have been entering into arrangements with the private sector to build public infrastructure. The government is then liable for future lease payments and operational funding. The cost of these periodic payments, over the total life of the contract, may, however, be significantly higher than it would have been if the hospital had been constructed with public funds. This is because the periodic payments include an amount on top of the patient cost to allow companies to recoup their capital investment in building construction and equipment.

Many examples of this type of arrangement can be found. For example, the South Australian Government entered into several contracts with the private sector for the construction of hospital services in Mount Gambier and Port Augusta. In the case of the Mount Gambier Health Service, the contract includes the construction of a new 100-bed hospital which will be privately funded and leased to the government for a period of 25 years. Similar contractual arrangements have been made for an 87-bed facility at Port Augusta. The South Australian Health Commission and the Department of Treasury and Finance have provided evaluations of these projects, indicating that the private sector funding arrangements result in a net additional cost to government of

approximately \$4 million and \$2.5 million respectively (Auditor-General 1996, p 33).

Efficiency: Enlarging the business

A fourth type of 'cost efficiency' response in the hospital sector has been to increase and diversify the 'business' of hospital care in order to strategically increase the size of throughput and demand. This strategy escalates the cost of care. It also reveals the fundamental contradiction between market forces and the delivery of low 'cost efficient' health care services. This fourth response to 'cost efficiency' is not a cost reduction program, but a competitive strategy for increasing patient volume and stimulating the demand for services. It is an economic growth strategy, and it drives the development of increasingly complex and elaborate treatments, therapies and products. As Light argues, while the demand for more services continues to rise and services continue to be highly valued, *less costly* services are unlikely to emerge within a competitive market (1995a, p 146).

This fourth 'cost efficiency' response is amply illustrated by the United States hospital sector, where the large hospital conglomerates have driven up health care costs through over-servicing, increased use of diagnostic tests, the expansion of services and the introduction of new technologies – even though many will not necessarily contribute to better health. Hospital chains have higher patient charges per admission as well as higher operating costs, and it is clear that any cost-savings deriving from the economies of scale of owning several hospitals are not passed onto the patient (Relman 1983, p 371).

Another example of this fourth strategy can be found in a study comparing 53 non-profit, non-chain community hospitals with 53 corporate-owned chain hospitals, in the states of California, Florida and Texas. Lewin, Derzon and Margulies (1981) found that charges per admission were 17 per cent higher in corporate-owned hospitals and that operating costs per admission were slightly higher in the investor hospitals. Furthermore the investor-owned hospitals generated higher revenues from ancillary services such as radiology, supplies and drugs. The general service costs were 13 per cent higher in the corporate chains, mainly because of higher administration and general costs.

Further evidence is provided by Pattison and Katz (1983), who studied 280 hospitals in California. These included 114 voluntary (non-profit) hospitals, 35 public hospitals, 53 national chain investor-owned hospitals and 78 investor-owned hospitals. All the hospitals were comparable, non-teaching hospitals, of moderate complexity, in urban and suburban regions, with similar bed sizes.

They found that admission charges were 24 per cent higher in investor-owned chains than in the comparable voluntary hospitals. The increased revenue of the chain hospitals was attributed to higher ancillary costs, and the increased use of clinical laboratories and pharmacies. As Wohl (1984, p 90) commented: 'the chaining of hospitals under corporate umbrellas has actually led to an escalation of health costs rather than a cutting down'.

In Australia, private hospitals also have higher costs. The Australian Health Ministers' Advisory Council commissioned an analysis of the financial position of private hospitals and found that costs 'were higher in publicly listed and chain hospitals due in the main to interest charges and corporate overheads' (Sheraton 1990, p 9). Despite the rhetoric about the greater efficiency of the private sector, administrative costs in this sector are not lower. Even in the Port Macquarie Base Hospital, where a private company manages the public hospital, administrative costs have been assessed as higher than comparative 'peer' hospitals.

In Australia, we have not experienced the escalating costs of the United States system, and demand for hospital services has been relatively contained and managed – despite the noisy public debate about the 'crisis' in public hospital care in the daily press (cf Davis 1993, p 119). The suppression of costs can largely be attributed to the universal Medicare system and the extensive coverage of the public hospital system. Unlike the private insurance companies, Medicare has not been as easily manipulated by the economic growth strategies of the private sector. However, recent innovations in this system, particularly privatisation and the contracting-out of services to the private sector, threaten the integrity of this system. The private sector is vitally dependent on the state sector for the provision of investment infrastructure. In a United States study, decreasing public sector involvement in the provision of public infrastructure growth was shown to have led to a decline in the profitability of the private sector (Gayle & Goodrich 1990, p 4). Another study demonstrates that the escalation of demand and cost in hospital services in the United States did not occur until the inception of Medicare. Lindorff argues that, by the late 1980s, most hospitals in the country were essentially dependent on Medicare for their very existence, and that Medicare provided more than half the revenue for many hospitals (1992, p 22).

One lesson to be learned from this is that *without a public sector insurance scheme* that provides care for a significant portion of the population, and which allows the private sector to rely upon the 'public purse' for a steady supply of 'business', the hospital chains and the corporate investors are unable to fully utilise the market strategy of increasing demand and costs to increase the productivity of their capital.

A second lesson is that the shrinking of public sector involvement in health care services and the undermining of the Medicare system by corporate strategies aimed at economic growth rather than the betterment of the population's health are likely to have a significant effect on the health of the population. A study by Elola, Daponte and Navarro (1995) contrasted health care systems organised around a national health system (that is, public) and those financed through national health insurance systems (that is, private). They found that, overall, the countries did not differ in infant mortality, potential years of life lost, or life expectancy. After controlling for the effect of gross national product and health care expenditure, however, infant mortality was found to be lower in countries with national health systems. This is because publicly run systems are more likely to result in an even regional spread of services, and access to these services is the most important factor in infant mortality rates (Shi 1994). Similarly, countries that place an emphasis on providing strong infrastructure for primary care services achieve better health levels for a variety of health indicators across the age span (Starfield 1995, p 1350). Access to primary services, mortality and morbidity are clearly linked to measures of equity in society. The more equitable the distribution of wealth, the healthier the population (Wilkinson 1990). Equality, equity and access to primary care make for a healthier population.

Conclusion

The use of market strategies aiming for 'cost efficiency' in the United Kingdom, the United States and the Australian hospital sectors has been proceeding apace. Uncritical acceptance of the notion that only the market can offer efficient use of resources has fuelled these trends. Studies of the impact of market strategies, however, do not support the assertions of pro-marketeers. The introduction of hospital 'chains', corporately owned and/or managed, offering to deliver 'cost efficient' services for both public and private patients has enabled direct comparison of hospital costs. The evidence gathered to date clearly refutes these claims. In the United States, hospital costs are increasing for employers, for consumers and for governments. In Australia, hospital costs are increasing for the consumer, for health insurance companies and for governments. The 'winners' have been the hospital corporations and the financial institutions. The 'losers' can be counted in terms of the reduced access to quality care, the reduction in services, the deteriorating working conditions of the hospital workers, and the next generation of the Australian public who will have to service the 'delayed' debts. In the light of the experiences of the United Kingdom, the United States and Australia, any claim that a move towards market-based hospital care will provide more 'efficient' services should be very carefully weighed.

References

- Auditor-General 1996, *Report of the Auditor-General* for the year ended 30 June 1996, Auditor-General's Department, South Australian Parliament, Government Printer, South Australia.
- Bach S 1989, 'A study of competitive tendering for domestic services in the NHS', Warwick Papers in Industrial Relations, No. 25, Industrial Research Unit, University of Warwick.
- Beesley M & Littlechild S 1983, 'Privatization: Principles, problems and priorities', *Lloyds Bank Review*, July, 149, pp 1–20.
- Collyer FM 1996a, 'Measuring privatisation: An overview of methodological approaches', *Just Policy*, 7, August, pp 24–34.
- Collyer FM 1996b, 'Who really pays for the provision of private hospital services? The privatisation of the Port Macquarie Base Hospital', The Australian Sociological Association Annual Conference, 4–7 December, University of Tasmania.
- Davis A 1993, 'Economising health', in S Rees, G Rodley & F Stilwell (eds) *Beyond the market: Alternatives to economic rationalism*, Pluto Press, Australia.
- Downey M 1997, 'More public hospitals to be run privately', *Sydney Morning Herald*, 21 March.
- Elola J, Daponte A & Navarro V 1995, 'Health indicators and the organisation of health care systems in Western Europe', *American Journal of Public Health*, 85, pp 1397–1401.
- Gayle D & Goodrich J 1990, 'Exploring the implications of privatisation and deregulation', in D Gayle & J Goodrich (eds) *Privatisation and deregulation in global perspective*, Quorum Books, Westport, pp 1–24.
- Hannaford J 1992, 'Putting profit into public hospitals', *Directions in Government*, April, 21–2.
- Health Insurance Corporation of America 1993, *Source Book of Health Insurance Data*, Washington.
- Joint National Health Service Privatisation Research Unit 1990, 'The privatisation experience: Competitive tendering for NHS services', NHS Privatisation Research Unit, London.

- Lewin L, Derzon R & Margulies R 1981, 'Investor-owned and nonprofits differ in economic performance', *Hospitals*, 1 July, pp 52–8.
- Light D 1990, 'Bending the rules', *The Health Service Journal*, 100, pp 1513–15.
- Light D 1991, 'Role protection in an era of accountability' in J Blau & N Goodman (eds) *Social roles and social institutions*, Westview, Boulder, Colorado.
- Light D 1993, 'Escaping the traps of postwar western medicine', *European Journal of Public Health*, 3, pp 281–9.
- Light D 1995a, 'US report: Report from America,' *Medical Sociology News*, 20, 3, pp 36–7.
- Light D 1995b, 'Homo economicus: Escaping the traps of managed competition', *European Journal of Public Health*, 5, 3, pp 145–54.
- Lindorff D 1992, *Marketplace medicine*, Bantam Books, Sydney.
- Melnick G & Zwanziger J 1995, 'State health care expenditures under competition and regulation, 1980 through 1991', *American Journal of Public Health*, 85, 10, pp 1391–6.
- Morley J, Taylor R & Opit L 1982, 'Patterns of private hospital ownership in Victoria', *Community Health Studies*, 6, 1, pp 25–9.
- Mulner R & Hadley J 1984, 'Interstate variations in the growth of chain-owned proprietary hospitals, 1973–82', *Inquiry*, 21, pp 144–51.
- National Health Strategy 1991, *Hospitals services in Australia: Access and financing*, Issues Paper Number 2, Department of Health, Housing and Community Services, Canberra.
- New South Wales Auditor-General 1996, *NSW Auditor-General's report for 1996*, Volume 1, Auditor-General, NSW Government.
- Pattison R & Katz H 1983, 'Investor-owned and not-for-profit hospitals', *New England Journal of Medicine*, 11 August, pp 347–53.
- Peers M 1991, 'Healthy push for private hospitals', *Financial Review*, 15 March.

Public Accounts Select Committee, NSW Parliament 1993, *Report of the Select Committee Upon The Port Macquarie Base Hospital Project Into The Funding of Health Infrastructure in New South Wales* June, Phase Two, New South Wales.

Relman A 1980, 'The new medical-industrial complex', *New England Journal of Medicine*, 303, pp 963–70.

Relman A 1983, 'Investor-owned hospitals and health-care costs', *New England Journal of Medicine*, 309, pp 370–2.

Senate Select Committee 1987, *Private hospitals in Australia*, Report by the Senate Select Committee on Private Hospitals and Nursing Homes, April, Commonwealth of Australia, Australian Government Publishing Service, Canberra.

Sheraton B 1990, 'Private hospitals – A financial analysis', *Hospitals and Health Care*, 21, 10, pp 8–9.

Shi L 1994, 'Primary care, speciality care and life chances', *International Journal of Health Services*, 24, pp 431–58.

Shiel A 1995, 'The economics of privatisation', *New Doctor*, 64, pp 29–30.

Starfield B 1995, 'Health systems effects on health status – Financing vs the organisation of services', *American Journal of Public Health*, 85, 10, pp 1350–1.

Stilwell F 1993, 'Economic rationalism: Sound foundations for policy?' in S Rees, G Rodley & F Stilwell (eds) *Beyond the market: Alternatives to economic rationalism*, Pluto Press, Australia.

Wettenhall R 1987, *Public enterprise and national development*, Royal Australian Institute of Public Administration (ACT Division), Canberra.

Wilkinson R 1990, 'Income distribution and mortality: A "natural" experiment', *Sociology of Health and Illness*, 12, pp 391–412.

Wohl S 1984, *The medical industrial complex*, Harmony Books, New York.