What price for-profit hospitals?

Donald H. Taylor Jr.

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Fast-tracked article

The vast majority of hospitals in North America are organized as private, not-for-profit institutions. In Canada, 95% of all hospitals are so owned. In the United States, around 10% of all hospitals are for-profit institutions, whereas 70% are not-for-profit hospitals and the balance are public institutions (generally run by counties or municipalities). These shares have been remarkably stable over time, but in recent years for-profit hospitals have been increasingly owned by large chains.[1]

Debate about whether for-profit hospitals should be allowed in Canada is loaded with symbolism and much rhetoric. Underlying this is an important public policy choice. On the one hand, those opposing for-profit hospitals in Canada suggest that attention to the bottom line will come at the expense of patient care and may signal the beginning of an unravelling of the health care system that Canada has much to be proud of. Advocates suggest that for-profit hospitals will interject a free-market panacea into a system that is publicly financed, if not publicly run. In this issue (page 1399),[2] P.J. Devereaux and colleagues contribute some evidence to this debate that shows that in the United States for-profit hospitals have a higher adjusted mortality rate compared with not-for-profit hospitals.

Their meta-analysis included 15 papers (only one was not peer reviewed[3]) that studied mortality following admission to hospital as a major outcome variable. The period of time over which mortality was assessed ranged from in-hospital mortality (outcome was discharged, dead or alive)[4–6] to a 90-day postadmission follow-up.[3] Thirteen of the 15 studies assessed mortality among elderly patients who were insured by fee-for-service US Medicare. This fact increases the study's relevance to health care in Canada. Individuals enrolled in Medicare health maintenance organizations in the United States (about 15% of patients) are excluded from Medicare claims data and, therefore, from the studies included in the meta-analysis. Thus, a limitation for those using Medicare claims data to understand the situation in the United States actually works to the advantage of this meta-analysis, because it ensures that the patients studied were covered by a fee-for-service, tax-financed, single payer.

The magnitude of the mortality difference is important, with patients treated in for-profit hospitals having a 2% higher adjusted mortality rate, on average, compared with those treated in not-for-profit hospitals. Some might be surprised that the difference was not greater. The ever-changing nature of hospital ownership in the United States may serve to dilute the true effect of both not-for-profit and for-profit status on mortality. Although studies that analyzed hospitals that changed ownership status were excluded from the meta-analysis, the admissions to hospital that were studied took place at a time when hospitals were characterized by a variety of forms of ownership. Some were long-term not-for-profit hospitals, some long-term for-profit hospitals, some were about to convert, some had just converted, and so on. This information is not characterized or controlled for in the studies included in the meta-analysis. The dilution of the "true effect" of ownership type is likely to bias findings of relative mortality comparing not-for-profit and for-profit hospitals toward no difference. Thus, the mortality difference found is likely to be a conservative estimate.

Finally, allowing for-profit hospitals in Canada raises an entirely new set of issues: Would hospitals be sold or leased? Who would determine a fair price? How would the proceeds of a sale be distributed? For what purpose? Who would control them? In the United States, the proceeds of such a sale are generally placed in a not-for-profit foundation that is meant to serve some public interest. It is fair to note that in an in-depth study of 10 conversions in North and South Carolina for-profit hospitals were found to have paid a reasonable price or perhaps even too high a price for several not-for-profit hospitals.[1] The cases in which the local community appeared to get the worst financial deal were when nearby teaching or governmental hospitals bought or leased struggling not-for-profit hospitals. In such cases, communities perceived that they had received substantial non-price incentives such as a reduced likelihood of outright hospital closure when they sold or leased their facilities as they did, instead of selling to a for-profit hospital chain. To say that the details surrounding hospital conversion from not-for-profit to for-profit are messy is an understatement.

The Canadian health care system has many positive attributes as well as problems — just like all health care systems in developed nations. For-profit hospitals in the United States have been found to have worse mortality rates than not-for-profit hospitals. This finding in conjunction with the myriad of legal and administrative issues likely to be faced by allowing for-profit hospitals into

Canada make it unwise for Canada to add this variable to an already complex health care system.

Dr. Taylor is Assistant Research Professor of Public Policy, Terry Sanford Institute of Public Policy, Center for Health Policy, Law and Management, Duke University, Durham, NC

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Correspondence to: *Dr. Donald H. Taylor, Terry Sanford Institute of Public Policy, Center for Health Policy, Law and Management, Box 90253, Duke University, Durham NC 27708, USA; fax 919 684-6246; dtaylor@hpolicy.duke.edu*

The decline of family medicine as a career choice

Walter W. Rosser

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In 2001 less than 28% of medical students made family medicine their first choice for a career, continuing a steady decline from 40% in the early 1990s. Having a family doctor has been accepted as a core value in Canada, a value now threatened. The traditional 50:50 ratio between specialists and family physicians in Canada is beginning to erode. To reverse this trend, an understanding of the complex causes feeding the loss of interest by medical students in family medicine is required.

During the 20th century the role of physicians underwent many dramatic changes. At the beginning of the century physicians provided comfort and support with little more than a trusting relationship to offer the patient. Over the subsequent 100 years scientific knowledge exploded. Medicine responded by dividing into increasingly narrower subspecialties. The accelerated pace of this change in the 1950s and 1960s led to a prediction of the demise of the generalists. In Canada, and in many other developed countries, organizations supporting general practitioners began to focus on a new role that saw family doctors emphasizing the support of the person through health and illness, rather than on specific ages, organs or disease.[1] In recent years the respect for this new discipline of family medicine has waned, in part because of real changes that have affected the practice of medicine and in part because of myths.

The reality is that, as the volume of medical information increased and technology flourished, the prestige spotlight in medical schools focused on subspecialists and their research. Academic family physicians were left with the less glamorous chores of teaching interview and basic clinical skills. Teaching these clinical skills affords little opportunity to describe any of the disciplines of family medicine to students. Since family medicine is mostly community based, there is little visibility of family doctors in teaching hospitals, where the "real action" is for medical students. The result is that the unique methods used by family doctors to approach diagnosis are not well understood, both by students and by their subspecialist colleagues. The scientific basis for watchful waiting — a strategy to separate common nonspecific complaints from significant disease — is rarely discussed in medical schools.[2] Thus most medical students buy into the myth that family medicine is an amalgam of all specialties and is impossible to practise competently given the overwhelming information load. These misunderstandings lead to negative comments about family physicians and their style of work.[3] Although academic family medicine has led much of the educational innovation in medical schools, research has not evolved as rapidly in family medicine as it has in most specialties. University promotion policies that favour research over teaching leave large departments of family medicine with few full professors or associate professors.

Students hear complaints from family physicians themselves about physician shortages, excessive workloads, increased difficulty "keeping up" and declining financial re-