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Financial pressure threatening U.S. hospital care

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Health care systems are one of many institutions under financial strain worldwide, providing health care to people who cannot afford it.

In comparison with Europe, the United States does not have a state welfare system as such. Instead, uninsured people rely on charity for medical care. The bulk of this service is taken on by hospitals that act as providers of last resort, also known as the safety net. These are usually government hospitals, teaching hospitals and those located in poor areas. Traditionally these hospitals part-fund their charity health care through a complex system of cross-subsidies.

In her working paper, "Responding to Financial Pressures: The Effect of Managed Care on Hospitals' Provision of Charity Care," IESE economics professor Núria Mas explores the implications of changes to the health care insurance market in the United States, and how the delicate equilibrium that exists there is increasingly under threat in the current competitive and changing environment.

The rise and rise of managed care

A key reason behind these changes, Mas suggests, is the shift in the U.S. health care market from traditional insurance to managed care contracts. The percentage of Americans who have a managed care contract has risen from 27 percent in 1988 to 93 percent in 2001.

The managed care umbrella covers a variety of health insurance contracts, but they all have

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some aspects in common: they involve a controlled form of financing and delivering health care based on cost control and a measured use of health care services.

Unlike traditional health insurance plans, managed care systems control the choice of providers: they, not the customer, pre-select the providers of their network of hospitals and clinics. A patient's choice is, therefore, limited to the network.

Managed care has fundamentally altered the way the health care market works in the U.S. - in the services offered, how much the doctors are paid and how the patients are reimbursed. Meanwhile, the number of uninsured in the U.S. keeps rising, from 31.8 million in 1987 to almost 46 million in 2007.

To illustrate the impact of this dramatic rise in managed care, Mas analyzes a sample of 894 hospitals, categorizing them into four types: teaching hospitals, government hospitals, hospitals in poor areas and other, non-safety net hospitals, which are used as a benchmark.

More managed care, fewer safety nets

The analysis shows that in areas where managed care enrollment is strong, there are significantly more closures of safety net hospitals, especially government hospitals and hospitals in poor areas. Other hospitals also suffer, but not as much. The only exception to this rule is when the safety net hospital is the only one of its kind in a poor area and is, therefore, forced to remain open.

The main cause for these closures is financial pressure: Revenues to part-fund charity services are declining, while the level of care these hospitals provide for the uninsured remains the same.

In the case of hospitals within a network, revenues drop because patients in managed care contracts pay less in premiums. This is because managed care organizations can negotiate down pricing as well as service levels.

Meanwhile, hospitals outside the network also see a drop in the number of patients and, therefore, revenues, since patients are forced to choose from the network only. In any case, these hospitals have to reduce prices in line with the lower price a managed care dominated market brings.

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Managed care reduces services available

Unsurprisingly, the result of all this is that hospitals suffering most from cost pressures react by dropping the services most commonly used by non-paying patients. These tend to be emergency rooms and obstetrics, compulsory under U.S. regulations, as well as treatments for alcohol- and drug-related conditions.

Indeed, the research shows that a rise in managed care enrollment corresponds to a drop in hospitals offering ER, obstetric units and inpatient centers for alcohol and drug treatments. Compared with the benchmark, this is notably the case with government hospitals and hospitals in poor areas.

Outpatient alcohol and drug treatment centers do not follow the pattern - quite the reverse. Some 46 percent of hospitals that closed their inpatient center for patients with alcohol and drug problems already had an outpatient center. Therefore, there is a tendency for hospitals to substitute inpatient care with an outpatient service.

These results have important implications for uninsured patients? access to care. The reduction in the number of safety net hospitals, and the curtailing of the services they use most, mean uninsured patients have to travel longer distances to obtain medical care.

Future research should focus on the ultimate impact of managed care on the access and quality of care for those who can least afford it.

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