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The nation’s teaching hospitals are highly regarded, complex enterprises, but the public knows very little about their operations and their funding. Recently, Nancy Kane of the Harvard school of Public Health, under contract to Boston’s commissioner of health and hospitals, prepared a report that was critical of the city’s private teaching hospitals in a variety of ways. In an effort to illuminate our readers about the matters at issue, we invited Kane to prepare a brief discussion of those matters. Following Kane’s essay is a report that represents the collective response of seven Boston teaching hospitals to the original Kane report released in May 1993.

The Financial Capacity Of Nonprofit Hospitals
by Nancy M. Kane

Over the past decade policy analysts have developed an interest in measuring hospitals’ financial performance, which has ramifications for health care access, cost, and quality. More recently, some cities and states have attempted to assess the financial capacity of hospitals to provide more community services. This paper summarizes the findings and policy implications raised by such an assessment of the twelve non-specialty teaching hospitals in Boston.

Judith Kurland, former commissioner of health and hospitals in Boston, commissioned me to prepare a report on the hospitals’ financial resources. She was concerned that hospitals and neighborhood health centers serving economically disadvantaged areas were underfunded. Meanwhile, private, nonprofit hospitals affiliated with Boston’s three major medical schools were engaged in capital investments on an unprecedented scale. The report, released in May 1993, has sparked continuing public debate over the priorities and distribution of resources among the city’s hospitals.

Policy questions. Four key policy questions have emerged. (1) Why did the report have such an explosive impact, given that its findings were all based on publicly available information (audited hospital financial statements and Internal Revenue Service [IRS] 990 forms filed by hospital affiliates)? What does this suggest about the public accountability of private, nonprofit hospitals in Boston? (2) How much discretionary cash is reasonable for hospitals to accumulate? Over the period 1984-1992, the twelve Boston hospitals generated $3.6 billion in cash after meeting operating expenses. At the end of 1992, $1 billion in cash remained in the hospitals and their parent affiliates; this money was available for discretionary purposes (unrestricted by donors). (3) Who was “minding the store” when the hospitals were issued $1.8 billion in debt and invested $2.2 billion in duplicative facilities? (4) Are the health care needs of disadvantaged populations a high enough priority to the
hospitals with the greatest resources and the greatest likelihood of survival in a competitive marketplace?

Public Accountability

I noted two obstacles to a broader public awareness of hospital finances in my report: hospitals’ complex organizational and reporting structures, and hospitals’ aggressively conservative accounting practices. These obstacles may explain why the report’s findings took many in the city by surprise.

While corporate accounting standards increasingly require the consolidation and full disclosure of related affiliates, the same is not true of hospital accounting. The existence, assets, and composition of major fund-raising, investing, and operating entities related to hospitals are not disclosed in hospital financial statements. Moreover, the IRS 990 forms submitted by hospital affiliates often are not readily available or are not filed in a timely manner.

Entities related to Boston’s twelve teaching hospitals accumulated assets worth $1 billion, none of which was reported in the hospitals’ financial statements. Affiliates of Children’s Hospital alone amassed close to $500 million. Six other hospitals also retained significant assets in their affiliates. The affiliates consisted of a mixture of fund-raising organizations and operating subsidiaries (for example, outpatient surgery centers and home health agencies).

In addition to the complex organizational structures, aggressively conservative accounting practices helped some hospitals to accumulate large cash reserves while claiming low profit margins. Hospital accounting guidelines allow a large degree of managerial discretion in calculating revenues. Nonprofit hospitals also lack self-interested investors to “police” financial statements. What is needed is a public forum where hospitals fully disclose their financial performance and that of all affiliated entities. Public meetings with large purchasing alliances or state monitoring agencies established by health care reforms, for example, might constitute such a forum. The validity and usefulness of hospital financial information could be evaluated for rate negotiation and other purposes.

Cash Accumulation

The aggregate unrestricted cash balance as of 1992 exceeded $1 billion, after allowances for industrystandard “working capital” cash reserves equal to twenty days of operating expenses. This “discretionary” cash totaled almost 63 percent of the hospitals’ long-term debt. In the debate over the reasonableness of such cash balances, a number of standards have been proposed. Most fail to consider the attendant costs to taxpayers and premium payers.

One hospital financial expert proposed that the appropriate standard should be average cash balances at the level of university-affiliated hospitals with an “A” bond rating, or ninety days of operating expenses. Most hospitals, as well as most corporations, do not maintain cash balances at this level. The Standard and Poor’s 400 Industrial median value for days of operating cash during this period was between fifteen and twenty days. Another expert suggested that cash balances should be equal to 50 percent of the replacement cost of a hospital’s entire investment in plant and equipment. This is a ludicrously expensive proposal. It also ignores the fact that hospitals borrow (on a taxsubsidized basis) 80 to 90 percent of the costs of acquiring plant and equipment. Another “standard” proposed was that hospitals accumulate every dollar of cash that they can in order to survive in an uncertain payment environment. While this proposal may make sense from an institutional perspective, it is an expensive proposition for premium payers.

The mentality that hospitals should accumulate large discretionary cash reserves has contributed to Massachusetts’s high per capita health care costs. Discretionary cash has been used for competitive purposes rather than to make health care more accessible and affordable. For instance, the wealthier hospitals have purchased physi-
cian practices and satellite facilities in higher-income communities and have acquired duplicative “state-of-the-art” technology. These purchases have increased health care costs because hospitals seek to recover the acquisition costs through patient charges. Capital purchases also enable already wealthy hospitals to draw patients away from more affordable community hospitals and community health centers.

A more reasonable, affordable standard for discretionary cash balances is needed. Some states, for instance, have allowed rates that permitted the accumulation of cash balances equal to a fixed percentage (such as 20 percent) of the costs of replacing “needed” buildings and equipment.

Levels Of Debt And Capital Investment

Debt represents a significant financial risk for Boston hospitals. The twelve non-specialty hospitals raised $1.8 billion in long-term debt (as of 1992) to fund capital expenditures totaling $2.2 billion. Most of the dollars were spent upgrading inpatient buildings and equipment during a period of declining inpatient admissions. A quarter of the debt, or $454 million, was incurred in 1992 alone and by only four hospitals. Capital costs (depreciation and interest) grew 10 to 25 percent per year, well above the growth rate of noncapital costs. How did this happen?

Given hospitals’ large cash balances, which in some hospitals exceeded total long-term debt, it is easy to understand why the $1.8 billion was lent. Wall Street faces high demand for tax-exempt “paper.” Investors generally will finance any tax-exempt project that looks viable from the bondholders’ perspective. Meanwhile, the state’s certificate-of-need (CON) program has lacked the political will to say “no” to hospitals requesting permission to build new facilities. Especially during the deep recession of the past four to five years, creating jobs has taken precedence over containing health care costs. Massachusetts tax and premium payers will pay for this policy over the next twenty to thirty years.

Some hospital executives have claimed that their capital development plans were made a decade ago and could not be altered as inpatient overcapacity became evident in the mid-to-late 1980s. This argument is simply not credible. Inpatient overcapacity is a systemic problem of which the hospitals were well aware. The institutional response to this problem has been to upgrade and renovate facilities in order to compete for a declining patient base. The same phenomenon occurred in California in the early 1980s. From the perspective of the community and health care payers, this “capital arms race” is a gross misallocation of health care resources. As health reform considers containing health care costs, stronger, more centralized measures to contain the capital arms race must be considered.

Hospital Priorities

Several private hospital executives have suggested that Boston City Hospital (BCH)—the city’s main provider of care to the uninsured, minorities, and the economically disadvantaged—should be closed. BCH lost paying patients to private teaching hospitals during the 1980s and faces an uncertain future. The private hospital executives say that BCH patients could be treated at their hospitals.

Community advocates and city leaders, however, have expressed skepticism about the willingness of the teaching hospitals to provide unprofitable, unglamorous services to a population with special needs. As if to prove the point, just after the report was issued, two hospitals discontinued unprofitable programs in acquired immunodeficiency syndrome (AIDS) screening and substance abuse. Clearly, the research, teaching, and tertiary care missions of the strongest Boston hospitals suggest a set of priorities different from those of much of the community. Are competitive pressures reinforcing economic priorities over social needs?

Several policies have been proposed to address the community needs issue. One
proposal under consideration in Massachusetts and already enacted in Texas is to redefine tax-exempt status. Nonprofit hospitals would be required to provide a minimum level of community services (as defined by the community, not by the hospital alone). Another proposal is to tax private, nonprofit hospitals; revenues would be earmarked for city hospitals and community health centers. Still other proposals call for the redistribution of philanthropic resources from wealthy hospitals to hospitals and other providers that serve economically disadvantaged communities.

Whatever policy is settled upon, it must link health care resources to community needs. Gathering the political will to implement such fundamental policy changes may well be the greatest challenge.

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NOTES

Boston Teaching Hospitals’ Response To The Kane Report

A recent study, commissioned by the Boston Department of Health and Hospitals and Boston City Hospital and authored by Nancy Kane of the Harvard School of Public Health, raised questions about financial reporting by Boston’s teaching hospitals and their efforts to serve the community. Unfortunately, this report (now known as the “Kane report”) went well beyond a factual review of financial data (that have always been available to the public) to a set of misleading and biased conclusions. The following response provides information critical to a discussion of the roles and responsibilities of Boston’s teaching hospitals.

In determining whether Boston teaching hospitals have acted responsibly with regard to “the community,” it is important to understand their mission and their many communities. Not only do these hospitals provide a tremendous amount of high-quality care to Boston residents, they also serve a broader need in patient care and lead the nation in teaching and research. The more than 2,000 resident physicians in training at any given time at these institutions go on to serve the medical needs of Boston and the nation. The almost $300 million spent annually for research by the nonpublic hospitals included in the study is critical to Boston’s economy. Moreover, this research has resulted in discoveries that have changed the practice of medicine. These hospitals also serve as worldwide referral sites for complex cases of serious illness.

Each of the private teaching hospitals has demonstrated a profound commitment to addressing the needs of the local community. In fiscal year 1992 they collectively provided $121 million in care for the poor, for which they received no reimbursement. In fact, approximately two-thirds of the in-

This report was prepared by staff of seven Boston teaching hospitals in response to Nancy Kane’s May 1993 report: Beth Israel Hospital, Boston University Medical Center, Brigham and Women’s Hospital, Children’s Hospital, Massachusetts General Hospital, New England Deaconess Hospital, and New England Medical Center.