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FINANCING STRATEGIES FOR NONPROFIT HOSPITAL SYSTEMS

by Donald Wegmiller

Prologue: When Congress enacted the Social Security Amendments of 1983 and President Reagan signed them into law April 20th, the federal government moved another step down the philosophical road of dealing with the health care system as a business. For the first time in a significant way, the federal government agreed in the context of the Medicare program to provide hospitals with a financial incentive to provide less rather than more medical care. The intent of Congress is to compel hospitals through financial reward that inure to the institution, not the patient, to give more weight to the cost of medical care. But government action bolstering the likelihood of a more aggressive entrepreneurial spirit in health care is hardly the only place one finds such attitudes. It abounds as well in hospital systems, both those organized to generate a profit and those structured on a nonprofit basis. What is the difference between these organized hospital systems? In this article, Donald Wegmiller, president of the Minneapolis-based Health Central System, argues the differences are fewer rather than greater and they are likely to diminish in the future. Wegmiller has been chief executive officer of the Health Central System since 1978. Health Central owns, operates, or leases twenty-three hospitals in six states, but it is rapidly evolving into a vertically integrated, diversified health services corporation. Wegmiller is a moderate Republican who shares many of the philosophical beliefs of Minnesota’s senior senator, David Durenberger, with whom he consults on a regular basis. Wegmiller, for example, favors a limited role for government; government as stimulator rather than owner and operator. In his philosophical model, the Veterans Administration would not operate 172 of its own hospitals, but rather would contract for those services with private institutions, making certain in the process that the special needs of veterans are met. Wegmiller also advocated the competitive principles of the marketplace as the basic resource allocator. He is positioning Health Central to play in Durenberger’s competitive marketplace, that is, should the system evolve into a structure where consumers shop with a voucher for comprehensive medical services, Health Central’s diversified operation will be prepared to provide them.
The topic of financing the delivery of health care has captured much attention in hospital literature, seminars, and legislative discussion during the past several years. The role of emerging multi-hospital systems in this complex arena has been of particular interest. This article addresses some of these financing issues and the strategies, both operating and capital, proposed by the not-for-profit systems in order to compete within these arenas during the eighties and beyond. We are going to see more similarities than differences between the investor-owned and the not-for-profit systems in many areas, and I think that will be the case in both operational and capital financing. The markets that we will operate in—not only the financial markets but also the product markets—are clearly changing. How individual systems will grow, and what mechanisms they will use are already apparent in the diversification and restructuring activities of the not-for-profit systems. These goals are essentially summarized in the following paragraph.

By design, not-for-profit systems are going to grow beyond their current regional boundaries and become national in their scope and scale of operations. As they do so, both their operational and capital financing strategies will shift to take the changes into account. The alliances of not-for-profit hospitals or systems, such as Associated Hospitals Systems and Voluntary Hospitals of America, already represent some nationally based activities that will be excellent building blocks for these new financing strategies. Acquisition of hospitals or small systems and consolidation of systems will also be mechanisms used by not-for-profits for both marketing and improving financing opportunities.

What are some of the goals of the not-for-profit systems in developing operational financing strategies? They are very similar to some of the investor-owned system goals; we are in the same industry and have many of the same needs. Obviously, given the same set of parameters, it is difficult to have a different set of goals. Certainly, our goals are to include an increased cash flow. It is going to be necessary to meet all of the operational needs as reimbursement changes or prospective payment plans emerge. We must also, perhaps even more than others, separate our cost-based services from our market rate services. By doing so, we also intend to achieve an improved management focus. We will identify and strengthen each of the independent lines of business rather than operate with the more global or integrated umbrella-type approach that has been prevalent in the not-for-profit systems for some time. The goals will also have to include the sheltering of some existing sources of revenues and profits from either recapture or other deterioration imposed by grossly inadequate reimbursement structures. Finally, but most importantly, we must concentrate on achieving improved total margins on the entire enterprise, whether that be the traditional hospital or the hospital plus all of the subsidiary operations that the not-for-profit systems are moving
into so rapidly.

**Financing Strategies**

I want to identify six of the strategies that the not-for-profit systems will use to attempt to achieve these goals. The first strategy is stronger cost control and leaner operating management. Margins can be increased in the existing lines of business (primarily acute hospital services) through decreased personnel-to-occupied-bed ratios, significant improvements in plant operations, and energy savings. The existing emphasis on the price or cost of acquiring materials will be replaced by a strong concentration (stronger I think than the not-for-profit sector had ever exerted) on the logistical and distributional aspect of materials management. Finally, improved management engineering systems are being implemented in most of the not-for-profit systems as evidence of the trend for cost control and stronger operations management.

A second strategy is to improve significantly the revenues of the existing lines of business—the acute care activities. The prospective payment plans that are being discussed are important to this strategy. Some analysts observe that the not-for-profit systems have a great opportunity for gain if this system were to come about, since our personnel ratios are able to tolerate reductions without affecting the quality of our service. Return on equity is also a major element in a strategy to improve revenues for not-for-profit systems. Whether it is contained in the prospective payment plan, within the existing cost-reimbursement system, or through direct payment plans negotiated with business or industry, return on equity will definitely be included by the not-for-profits as a cost of doing business. The not-for-profit sector clearly needs the return on its equity and I believe the not-for-profits will achieve this return in the near future.

Aggressive pricing strategies, much more aggressive than in the past, must be adopted. Prices will be set to take into account provisions for the return on equity, greater margins, and the costs of capital acquisitions. These policies are being set in place at this time. You will begin to see, as a result, improvements in the operating margins in the not-for-profit systems.

Reimbursement maximization is also a part of this improved revenue flow strategy. During this period of reimbursement transition, the not-for-profit systems will accentuate efforts to achieve a full or maximum reimbursement from the less-than-cost-based payers. Thanks to the efforts of the investor-owned companies during the 1970s, a great body of skills and knowledge in reimbursement has been developed in this area. I think many of our reimbursement specialists are alumni of the investor-owned companies so that we have been able to take advantage of the training ground and the learning curves they have provided.
A third strategy in the area of operational financing is to change the mix of services. All of the existing services in the not-for-profit systems are under review at the present time. First, an evaluation will take place of the capital intensive services that have low volumes and low margins. This change may be achieved by some consolidation of these services in local and regional systems, and the selling, trading, or transferring of these services to other organizations. Whatever the mechanism, I am confident that the low-volume, low-margin, but capital intensive services will not be as much of our makeup as they have been in our past. We will be glad to share that burden with a number of other providers. We certainly need to, and will, reduce the proportion of less-than-cost-based payers as a percentage of the total revenue of the not-for-profit system. Two strategies probably will predominate in this area: the denominator strategy, in which the total volume of revenues will be increased with more charge or market rate services, such as mental health and chemical dependency services (thereby diluting the proportion of less-than-cost-based revenues); and the numerator strategy, in which the volume of less-than-cost-based patient services will be decreased through mechanisms I described above.

The fourth strategy in operational financing is to increase substantially the revenues and profits from health-related and other subsidiary operations. This is the purpose of diversification and the restructuring strategies that are increasingly widespread in the not-for-profit sector now. Many not-for-profit systems are restructuring their organizations to separate their provider activities from their nonprovider activities as part of this financing strategy. This is being done to prevent the recapture of the existing profits by Medicare and rate revenues which hurt many not-for-profit systems with traditional structures. By preventing this, restructuring is also going to allow the not-for-profit systems greater opportunities in the pricing of acute services: by removing the appropriate revenues and costs from current hospital operations, the new structures allow greater latitudes in dealing with some of the cost limitations and therefore maximize the profits from these subsidiaries. Also important to the strategy of increasing revenues and profits from the subsidiaries is to isolate each line of business and to focus management efforts on new areas, such as insurance. For a long time, not-for-profit systems have been content to contract for many of these services. This is changing rapidly. The Health Central System, for example, has owned and operated its own insurance company for the last six years; we have recently expanded that company to include some nine types of insurance which we will now offer hospitals outside our system as well. Equipment leasing companies with arrangements back to the not-for-profit systems will increase. Mobile diagnostic services, professional reference laboratories as well as occupational health and industrial medicine programs that serve not only hospitals in the parent system and the not-for-profit sector, but also others,
are just a few of the kinds of the subsidiary companies within the member systems of Associated Hospital Systems.

A fifth financing strategy is the development of more sophisticated marketing plans and efforts. Not-for-profit systems have been very aggressive in developing shared services. We are now beginning to use that network of relationships as a very effective marketing effort for leasing, acquisitions, and contract management of hospitals. Consulting activities with other not-for-profit groups as they are formed by independent freestanding hospitals is another part of this strategy. Our particular organization, Health Central, has greatly enjoyed the opportunity to consult recently in the Southeastern United States. Management contracting is clearly being seen by the not-for-profit systems as a profitable business in itself and as an important means to further leasing, acquisition, and contract management of hospitals. Finally, there will be an even greater amount of direct marketing activity like that which you see in many systems already.

A sixth and final area in operational financing is a more aggressive move into the less restrictive, although highly competitive, international hospital consulting, managing, and ownership market. As domestic manpower supplies increase and become adequate, or in some cases, develop a surplus, we will be able to meet some of the developing needs and now have the management structures to be able to put them in place: As an example, we recently signed our third international hospital consulting contract in a third country and our first management contract will be signed soon. So changes in this area by not-for-profit systems are occurring rapidly.

Capital financing is obviously a concern to all hospitals. There are not, at least to our knowledge, any magic potions that are going to create capital and solve the problems. There are, however, a number of goals that the not-for-profit systems need to achieve in the capital financing area just as there are in the operational area. First, we must increase the number of sources of capital available to not-for-profit systems. We have to improve access to the existing sources and become more competitive in gaining the scarce capital that is going to be made available from those sources. Second, we must lower the overall cost of acquiring capital, increase our concentration on balance sheet strategy and balance sheet management, and on this aspect of the business operation. Third, we in the not-for-profit sector must shelter our existing assets from erosion through less-than-cost-based reimbursement programs. And finally, we will more closely relate capital use to its productivity in our businesses—a discipline that has not been fully developed, but will be during the 1980s.
What are six methods to achieve those goals in capital financing? First, we will improve the existing balance sheets so that we can improve the attractiveness and security of investing in not-for-profit systems. We hope, therefore, to insure better access to the limited sources now available. It is clear from looking at any investment banking studies that the systems—whether they be investor-owned or not-for-profit—do have an edge in achieving access to capital. Our efforts have to focus increasingly on reducing the percentage of debt in our capitalization, and improving our debt coverage ratios. Those efforts are underway in many systems.

A second strategy is to institute the use of permanent equity capital within our capital structures. Restructuring our organizations will, in some instances, allow the use of permanent equity so that the acquisition of permanent equity becomes another reason for corporate reorganization efforts. It is already beginning to show initial successes: subsidiary companies such as laboratories, diagnostic services, insurance companies, and equipment and building leasing are but a few early examples of where and how that permanent equity is being acquired and put to use within an overall not-for-profit structure.

The third strategy is the pooling of assets among systems. Associated Hospitals Systems has pioneered in that effort. We will soon be putting forth, on a fairly limited trial basis, our initial pooling program.

A fourth strategy is the consolidation of assets and the net worth of freestanding hospitals that are not being directly acquired. This increasingly used tool provides the not-for-profit system an immediate gain of the independent hospital's net worth without many of the costs of an acquisition. This strategy is obviously more readily available to the not-for-profit systems than it might be to the investor owned. The low acquisition cost has made this a very active strategy. Health Central has just completed one consolidation which achieved a net worth increase of $5.8 million. A second is under discussion which would yield another $4 million of net worth increase with a very low capital cost.

A fifth strategy is a strong emphasis on philanthropy. Some are pessimistic about this, but I believe that we could take the posture of Everett Dirksen, when he used to say about the federal budget, “A billion here, a billion there, pretty soon you have some real money.” That's the kind of approach that I think not-for-profit systems are going to take with regard to philanthropy. It is, in fact, a very good source and, in many regards, the best source of equity capital that systems have neglected in large part. The systems, in particular, will devote considerable energies to fund raising. In fact, a series of highly localized, very personalized, and professional foundations that are effective in raising relatively low-cost equity already are operating.
A sixth strategy is the purchase of proprietary hospitals or small investor-owned systems through for-profit subsidiaries. This strategy provides the not-for-profit system continued access to equity capital; however, it is much more competitive than the consolidation of not-for-profit hospitals into our balance sheets. But competition is the name of the game and the nonprofit systems will be there competing.

In summary, issues of operational and capital financing are among the most significant long-term challenges facing the entire hospital industry. Not-for-profit hospital systems are addressing the challenges directly with some innovative and nontraditional strategies. They will compete with investor-owned chains for capital and with other providers for both operational funds and for market share. The systems’ success in implementing these finance strategies will largely determine their future overall success and growth.