

The Sickly State of Public Hospitals

By Sam Vaknin, Ph.D.

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There are many types of hospitals but the most well known are the Public Hospitals. What sets them apart is that they provide services to the indigent (people without means) and to minorities.

Historically, public hospitals started as correction and welfare centres. They were poorhouses run by the church and attached to medical schools. A full cycle ensued: communities established their own hospitals which were later taken over by regional authorities and governments - only to be returned to the management of communities nowadays. Between 1978 and 1995 a 25% decline ensued in the number of public hospitals and those remaining were transformed to small, rural facilities.

In the USA, less than one third of the hospitals are in cities and only 15% had more than 200 beds. The 100 largest hospitals averaged 581 beds.

A debate rages in the West: should healthcare be completely privatized - or should a segment of it be left in public hands?

Public hospitals are in dire financial straits. 65% of the patients do not pay for medical services received by them. The public hospitals have a legal obligation to treat all. Some patients are insured by national medical insurance plans (such as Medicare/Medicaid in the USA, NHS in Britain). Others are insured by community plans.

The other problem is that this kind of patients consumes less or non profitable services. The service mix is flawed: trauma care, drugs, HIV and obstetrics treatments are prevalent - long, patently loss making services.

The more lucrative ones are tackled by private healthcare providers: hi tech and specialized services (cardiac surgery, diagnostic imagery).

Public hospitals are forced to provide "culturally competent care": social services, child welfare. These are money losing operations from which private facilities can abstain. Based on research, we can safely say that private, for profit hospitals, discriminate against publicly insured patients. They prefer young, growing, families and healthier patients. The latter gravitate out of the public system, leaving it to become an enclave of poor, chronically sick patients.

This, in turn, makes it difficult for the public system to attract human and financial resources. It is becoming more and more destitute.

Poor people are poor voters and they make for very little political power.

Public hospitals operate in an hostile environment: budget reductions, the rapid proliferation of competing healthcare alternatives with a much better image and the fashion of privatization (even of safety net institutions).

Public hospitals are heavily dependent on state funding. Governments foot the bulk of the healthcare bill. Public and private healthcare providers pursue this money. In the USA, potential consumers organized themselves in Healthcare Maintenance Organizations (HMOs). The HMO negotiates with providers (=hospitals, clinics, pharmacies) to obtain volume discounts and the best rates through negotiations. Public hospitals - underfunded as they are - are not in the position to offer them what they want. So, they lose patients to private hospitals.

But public hospitals are also to blame for their situation.

They have not implemented standards of accountability. They make no routine statistical measurements of their effectiveness and productivity: wait times, financial reporting and the extent of network development. As even governments are transformed from "dumb providers" to "smart purchasers", public hospitals must reconfigure, change ownership (privatize, lease their facilities long term), or perish. Currently, these institutions are (often unjustly) charged with faulty financial management (the fees charged for their services are unrealistically low), substandard, inefficient care, heavy labour unionization, bloated bureaucracy and no incentives to improve performance and productivity. No wonder there is talk about abolishing the "brick and mortar" infrastructure (=closing the public hospitals) and replacing it with a virtual one (=geographically portable medical insurance).

To be sure, there are counterarguments:

The private sector is unwilling and unable to absorb the load of patients of the public sector. It is not legally obligated to do so and the marketing arms of the various HMOs are interested mainly in the healthiest patients.

These discriminatory practices wreaked havoc and chaos (not to mention corruption and irregularities) on the communities that phased out the public hospitals - and phased in the private ones.

True enough, governments perform poorly as cost conscious purchasers of medical services. It is also true that they lack the resources to reach a substantial segment of the uninsured (through subsidized expansions of insurance plans).

40,000,000 people in the USA have no medical insurance - and a million more are added annually. But, there is no data to support the contention that public hospitals provide inferior care at a higher cost - and, indisputably, they possess unique experience in caring for low income populations (both medically and socially).

So, in the absence of facts, the arguments really boil down to philosophy. Is healthcare a fundamental human right - or is it a commodity to be subjected to the invisible hand of the marketplace? Should prices serve as the mechanism of optimal allocation of healthcare resources - or are there other, less quantifiable, parameters to consider?

Whatever the philosophical predilection, a reform is a must. It should include the following elements:

Public hospitals should be governed by healthcare management experts who will emphasize clinical and fiscal considerations over political ones. This should be coupled with the vesting of authority with hospitals, taking it back from local government. Hospitals could be organized as (public benefit) corporations with enhanced autonomy to avoid today's debilitating dual effects: politics and bureaucracy. They could organize themselves as Not for Profit Organizations with independent, self-perpetuating boards of directors.

But all this can come about only with increased public accountability and with clear measuring, using clear quantitative criteria, of the use of funds dedicated to the public missions of public hospitals. Hospitals could start by revamping their compensation structures to increase both pay and financial incentives to the staff.

Current one-fits-all compensation systems deter talented people. Pay must be linked to objectively measured criteria. The Hospital's top management should receive a bonus when the hospital is accredited by the state, when wait times are improved, when disrollment rates go down and when more services are provided.

To implement this (mainly mental) revolution, the management of public hospitals should be trained to use rigorous financial controls, to improve customer service, to re-engineer processes and to negotiate agreements and commercial transactions.

The staff must be employed through written employment contracts with clear severance provisions that will allow the management to take commercial risks.

Clear goals must be defined and met. Public hospitals must improve continuity of care, expand primary care capacity, reduce lengths of stay (=increase turnaround) and meet budgetary constraints imposed both by the state and by patient groups or their insurance companies.

All this cannot be achieved without the full collaboration of the physicians employed by the hospitals. Hospitals in the USA form business joint ventures with their own physicians (PHO - Physicians Hospital Organizations). They benefit together from the implementation of reforms and by the increase of productivity. It is estimated that productivity today is 40% less in the public sector than in the private one. This is a dubious estimate: the patient populations are different (sicker people in the public sector). But even if the figure is incorrect - the essence is: public hospitals are less efficient.

They are less efficient because of archaic scheduling of patient-doctor appointments, laboratory tests and surgeries, because of obsolete or non-existent information systems,

because of long turnaround times and because of redundant lab tests and medical procedures. The support - which exists in private hospitals - from other (clinical and nonclinical) personnel is absent because of impossibly complex labour rules and job descriptions imposed by the unions. Most of the doctors have split loyalties between the medical schools in which they teach and the various hospital affiliates. They would tend to neglect the voluntary affiliates and contribute more to the prestigious ones. Public hospitals would, therefore, be well advised to hire new staff, not from medical schools, share risks with its physicians through joint ventures, sign contracts with pay based on productivity and put physicians in the governing boards. In general, the hospitals must shrink and re-engineer the workforce. About half the budget is normally spent on labour costs in private hospitals - and more than 70% in public ones. It is no good to reduce the workforce through natural attrition, mass layoffs, or severance incentives. These are "blind", nondiscriminating measures which affect the quality of the care provided by the hospital. When compounded by work rules, seniority systems, job title structures and skewed grievance procedures - the situation can get completely out of hand.

The government must contribute its part. Public hospitals cannot comply or compete with the demands of national, publicly traded HMOs with political clout and the capacity to raise capital to finance hyper-sophisticated marketing. Public policy must be written to support "safety net" institutions. They must be allowed to organize their own MCOs (Managed Care Organizations of patients), to insure patients and to market their services directly to groups of potential consumers. This way they will save the 20% commission that they are paying HMOs currently. If they become more efficient and reduce utilization, they will absorb the full benefits, instead of ceding them to contracting groups of patients and insurance companies or even to the government's medical insurance plans. The hospitals will thus be able to construct their own networks of suppliers and share their risks with their physicians or with the insurance companies as best suits their objectives.

An example: a Public Hospital with its own healthcare plan is likely to make use of all its specialists and facilities, increase capacity utilization and profits - whereas today only its primary care, less lucrative, services are used by independent HMOs.

The government can limit the total number of healthcare plans available, so that the one propagated by the public hospital will stand out and not be swamped by hundreds of other plans. Such a public hospital plan could also be declared the "healthcare plan of default" - anyone who has not selected a plan will be automatically referred to and included in the public hospital plan.

Not every hospital can start an HMO plan. Only the big ones can support the necessary insurance payments, the reserve requirements and the marketing and administrative costs. The paradox is that big public hospitals are already committed to HMOs, insurers, other patient groups, or government-sponsored MCOs. These resist the inclusion of hospitals which own competing healthcare plans - in their networks. This is natural: a hospital with a plan - is a direct competitor of a private provider of healthcare management and insurance. Another obstacle is that governments are very reluctant to encourage the public sector on account of the private one. This is definitely out of fashion nowadays.

So, an alternative strategy looks more viable:

Public hospitals can act as direct contracting networks. They can team up, pool their resources, exercise political lobbying, relegate administrative and audit functions (data processing, claim processing, payment system, accounting, legal services) to a common centre. This will eliminate the need for middlemen like the HMOs. These joint networks will be able to negotiate contracts with other contractors: physicians, pharmacies, specialized laboratories and so on. This will assist the public hospitals to preserve a loyal and stable (low churning) patient base.

Finally, public hospitals are large employers with political muscle. All they lack is the will to exercise it. They should do it to force governments to adopt some unpopular decisions: offer incentives to HMOs which will refer patients to public hospitals, require HMOs to use all the range of services (both primary and speciality), compensate public hospitals directly for nonpaying patients.

But the public hospitals must begin to behave as public entities: they must open their decision making processes and make them community-oriented. They must shift from relying on contractual language to relying on administrative law (regulations) - except when it comes to employment. In a nutshell: they should be business oriented, on the one hand - and publicly accountable on the other.

There is the little matter of Public Relations and advocacy. Public Hospitals have a terrible image and they are doing very little to change it. They do not even collaborate with researchers trying to establish a factual fundament concerning "safety net medical and social care". In a world where images count more than realities this may well be the public hospitals biggest mistake.

Eight Ways to Improve the Operation of Public Hospitals

A public hospital can lease physical space or temporal slots, or computer equipment or any other equipment which suffers capacity underutilisation - to their physicians for private practice.

The lessee physicians will undertake to pay the hospital - either in the form of fixed fees or in the form of participation in the income (franchise arrangements).

They will also commit themselves to provide community-oriented, non profit services in return for the right to use what is, essentially, community property.

Another method of using the excess capacity is to sell it, rent it, or lease it to entrepreneurs who are not members of the hospital staff. There are many such possibilities: small laboratories, speciality medical services, primary care and specialist practitioners. All these would love to use the superior infrastructure of the hospital. The right to use this infrastructure can be given in the form of a concession, a franchise, a rental arrangement, or any other arm's length mode of collaboration. Professionals are likely to jump on the bandwagon when they realize that the hospital provides them with a "captive market" of patient. This is very much like the relationship between an "anchor" in a shopping mall and the small retail shops surrounding it. The small shops

benefit from the business diverted in their direction from the big "anchor" outlets.

The next logical step would be to sell products and services to the community on a commercial, competitive basis. The hospital does not have to limit itself to the sale of medical goods and services. It can also sell medical legal services, use its print shop to offer print jobs, organize its social services as a profit centre and sell them to the community or to individuals, offer medical consultancy on a fee per service basis, even sell food from the hospital kitchen through a catering service or data to researchers from its archives. A natural extension of this approach would be "internal privatization".

A hospital is a collection of small (to medium) size businesses operating under one organizational roof. Laundry, cleaning, kitchen, the provision of television sets and telephones to patients, a business centre for the hospitalized businessmen - these are all profit or loss generating centres.

Internal privatization entails the transformation of the hospital into a holding company. This holding company will own and operate a host of corporations. Each corporation will constitute a separate contractor which will provide the hospital with a service or a product. Thus, all laundry will be done by a corporation which will charge the hospital for its services. The same will go for the kitchen, the printshop, the legal services and so on. These corporations will employ the former staff of the hospital. This way, the knowledge and experience accumulated within the hospital will not be lost. The corporations owned by the former employees will have a "right of first refusal" in the first five years following the transformation. The employee-owned corporations will be allowed to match the best offers in yearly tenders that the hospital will conduct for the services that they are offering.

These corporations will also be allowed to offer their services to other clients. Thus, they will reduce their dependence on one employer, the hospital. They will become truly entrepreneurial entities, competing for profits in a market environment.

A part of the re-engineering process is to determine which of the functions that the hospital fulfils are "core functions", indispensable functions without which the hospital will cease to exist or will change its identity to such an extent that it will no longer will be recognizable as a hospital. All other, "noncore", functions should be tendered out (a concept called "outsourcing"). They should be awarded in a tender to the most competitive bidders, regardless of their identity and previous allegiance. The hospital is likely to benefit from the transfer of functions, in which it has no relative competitive advantage, to outsiders whose expertise these functions are. This is somewhat akin to international (free) trade, where each nation optimizes its resources and passes the (beneficial) results of this optimization process to its trading partners.

To control this kind of transformation, medical information management systems need to be introduced. Many are available and they improve both the quality and the quantity of data available to the management of the hospital and, as a result, the decision making process. This will make it easier for the management to pinpoint which areas require doing what. For instance: the management of the hospital will be able to determine what kind of incentives should be provided to which members of the staff, where could costs be cut and where and how could productivity be improved.

Finally, a novel concept is emerging. Universities and hospitals are two important repositories of human knowledge and experience. Virtually every hospital somehow collaborates with an academic institution, or with a medical school.

There is symbiosis between hospital and medical and social researchers.

Hospitals should actively encourage this. It improves their image, it contributes to their ability to provide quality services. But should not do it for free. They should be contractual partners to the commercial exploitation of the results of research conducted within their premises or with their co-operation. There is a vast field for pharmaceutical, medical, genetic and bioengineering research - and a lot of opportunities to make money for the benefit of the entire community. By not getting commercially involved - hospitals give up money which really is not theirs to give up.

Sam Vaknin is the author of "Malignant Self Love - Narcissism Revisited" and "After the Rain - How the West Lost the East". He is a columnist in "Central Europe Review", United Press International (UPI) and ebookweb.org and the editor of mental health and Central East Europe categories in The Open Directory, Suite101 and searcheurope.com. Until recently, he served as the Economic Advisor to the Government of Macedonia.

His web site: <http://samvak.tripod.com>

Healing Promised

By Joyce C. Lock

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Problem: Many are weak and sickly among you, and many sleep.

How many people do you know that can't stand on their own two feet spiritually, that seem to be sick the entire winter every year, or that haven't shouted, "Amen!" since 1958?

Cure: If we would judge ourselves, we should not be judged, I Co. 11:30-31.

All our righteousness is as filthy rags, in comparison to God's way of thinking. His ways are higher than ours are. Understanding that, it seems odd when people go into a state of shock, being offended that another would even think they weren't perfect, when all God wanted to do was to set them free.

It takes a person maturing in their walk to be able to consider thoughts that might not be lined up with God's, without their pride or low self-esteem kicking into overtime.

When we allow ourselves to be introspective with ourselves, to see if any part might be in error, we accomplish what the Bible said. If people judge themselves, they shouldn't be judged.

When our insides begin to go haywire, instead of pointing to a person or circumstance, we can look inward and upward, asking God, "What is it about me that crumbles whenever this happens? Where does this feeling come from when I get angry over such little things? Why do I always fall apart in like circumstances? Why can't I trust You with my needs instead of taking matters into my own hands? Why do I expect the worst and get offended at people when I only presume to think I've seen their heart?"

Spiritual and literal healing is promised for those who are willing to examine themselves. It is a process of restoration, becoming free from ways of thinking that Satan planted.

When our thinking doesn't line up with God's, it isn't our thinking at all - but Satan's lies. For, we wrestle not against flesh and blood ... and if we do, we're going to become weak, sickly, or asleep (missing God's blessings), I Co. 11:30.

Once we get a glimpse into that, whenever anything makes us feel anxious, worried, insecure, or any other negative feeling - we can continue to take those things to God so we can find our way to more areas of inner healing.

Learn to protect your mind. Take Satan by force (cleaning the inside of the cup) and the outside will take care of itself.

God is very pleased when His people consider that there is more to knowing Him. For those who dare take the journey through the refiner's fire, no doubt, God has some special purpose for you. Doing so makes one a purified vessel that God can both teach and use.

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In addition to being a published author and poet, Joyce C. Lock created the religion column, "Christianity Made Simple" for Peru Daily Tribune, continues to write inspirational articles for area newspapers, and shares further in online and e-mail ministries.

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