

The Impact of Various Accounting Approaches on U.S. Healthcare Reimbursement Systems: Ethical and Managerial Implications

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Health care delivery has been impacted over the last sixty years as reimbursement methods evolved from a cost-center to a profit-center to an investment-center approach. The consequences of these changes have been viewed by many to be detrimental to the quality of care for the patient and by many lawmakers to be detrimental to public interest. Exploring the role of accounting for health care costs and the allocation of scarce resources beginning in the 1950's through present day, we show these accounting changes led to resource allocation issues with direct managerial and ethical impacts that were relative to all stakeholders.

INTRODUCTION

Good afternoon, ladies and gentlemen. This is your pilot speaking. We are flying at an altitude of 35,000 feet and at a speed of 700 miles an hour. I have two pieces of news to report, one good and one bad. The bad news is that we are lost. The good news is that we are making excellent time.

Anonymous

Undoubtedly, the above anecdote [DuHon, 1988, p.3], as well as similar humor published in the introductions of other recent books and articles, appeared because they provided funny, thought-provoking metaphors to draw attention to the serious and intricate dilemma of the direction and delivery of healthcare in the United States. The evolution of healthcare delivery in the U.S. is fast approaching crisis and there seems to be no compromise on the horizon. In an effort to find our way in the future, we believe it is important to assess how the system has evolved and arrived at this current location.

The last sixty years have been a time of drastic change in the U.S. health care industry. Federal and state governments fostered a turbulent health care environment with diffused focus, erratic direction, and non cohesive policy. Then, as the private sector took the lead with a strong profit motive and specific market mechanisms, a powerful defacto policy in health care delivery resulted. The primary motivator for private sector leadership is profit and, as might be expected, such a focus can stimulate intended *and*

unintended results, as well as foreseen *and* unforeseen consequences. Because certain groups who collectively represent a minority of the population (*e.g.*, executives, managers, the rich, professionals whose livelihood often depends on the profit in the healthcare industry, and unionized labor) enjoy an advantaged socio-economic-political position, and other groups, who collectively represent a majority of the population (*e.g.*, children, the poor, the elderly, the self-employed, the uninsured, the under-employed) are disadvantaged, current health care policy may be viewed as contrary to the public interest, at least for the approximately 50 million U.S. citizens who have no health insurance [The Institute of Medicine, 2009]. Further exacerbating the problem is our current political environment which seems to be operating on the idea of polarization of two extremes with no seeming desire for compromise or balanced allocation of resources.

Both individuals and institutions play critical roles in accounting for health care costs, and thus a critical role in the allocation of scarce health care resources within the U.S. health care system. While seemingly value neutral, accounting has been shown to be, at best, non-neutral and, at other times, extremely biased toward profit objectives and/or advantaged stakeholder groups. (See Chua and Preston, 1994; Davis, Menon & Morgan, 1982; Tinker, 1985; and Lehman and Tinker, 1987)

The purpose of this paper is to explore the role of accounting for health care costs and the allocation of scarce resources in the evolution of the U.S. health care system, both in the past and in the future. Noting that all stakeholders – managers, patients, physicians and insurance companies are directly or indirectly impacted, first, the role of hospitals in the U.S. health care system is presented in an evolutionary framework: the 1950s (when hospitals were “accountable as revenue centers”), the late 1970s and early 1980s (when hospitals were “accountable as cost and profit centers”), and the 1990s and 2000s (when hospitals have become “accountable as investment centers”). Next, we look to the future and the fast changing role of electronic information to determine how accounting practices are evolving to meet the needs of the U.S. health care system. Finally, conclusions are drawn as to the responsibility of accounting (as a process, a business, and a profession) and the accountant (as a practitioner, a citizen, and a professional). The objective of this “flight into accounting” is to moderate the “speed of the plane,” become oriented to its current position, set a reasonable course, and resume the speed that had been achieved prior to the loss of direction.

A BRIEF HISTORY OF U.S. HEALTH CARE: 1950S TO PRESENT

Since the early 1900s, the U.S. health care system has been serving the public primarily with four types of hospitals: proprietary, religious, private-charitable, and local-government served by health care professionals employed by the hospital and self-employed physicians who were granted practice privileges. While these classifications endure today, there has been a changing emphasis on their relationships to the patient served and, equally as important, in the relationships of the hospitals to the physicians and nurses in service therein.

The facts are that the United States is the only developed nation on Earth that does not guarantee healthcare to its people and is “nearly alone among developed nations in our failure to commit healthcare as a human right” [Riedel, 2009]. Our healthcare industry is rooted in the industrial revolution when businesses and unions began providing sickness funds to employees. Since that time the insurance industry has ballooned while numerous presidents have tried unsuccessfully to find a way for the government to step in and provide healthcare either as a direct pay or through national insurance to all citizens. Some government programs have provided coverage for segments of the population that seem to be deserving to the general population such as Medicare for the aged, Medicaid for the indigent, and the VA system for military veterans, but little has been done to help the majority of the population [Riedel, 2009].

Perhaps the values of our nation, individualism and self-determination as well as a general distrust of government and reliance on the private sector to provide social help are to blame for the disconnect on healthcare responsibilities [Riedel, 2009]. Perhaps political interests have so distorted the message with one-line quips and biased analysis [Gitterman & Scott, 2011, Gorin, 2011] that the people don’t know,

THE HOSPITAL AS REVENUE CENTER: 1950S THROUGH THE 1970S

Third-party insurance, especially group hospitalization, have been around since the 1930s and 1940s; however, only with the increased availability of insurance as a work benefit in the 1950s and 1960s, did insurance begin to shape how and what health care services would be offered and/or provided by a given hospital. The growing number of potential patients with an ability to assure payment of hospital services via health insurance encouraged hospitals to “respond to the market incentives of increased demand by providing more, more expensive, and better care” especially of those services where they were most likely to be reimbursed by third party insurers [Stevens, 1989, p. 256].

Total expenditures of short-term nonfederal hospitals rose steadily from \$2.1 billion in 1950 to \$5.6 billion in 1960 and on to \$9.1 billion in 1965, the year of Medicare legislation—a more than fourfold increase in fifteen years. [Stevens, 1989, pp. 256-257]

The reason for this, in economic terms, is very easy to understand. Until the U.S. Congress passed Medicare and Medicaid legislation, the primary forms of payment for health care services were self-payment and third-party insurers. By 1965, private insurance for hospital care covered most of the working population. This insurance also covered most of the costs of a hospital stay and payment was fairly automatic and much more rapid than in the past. With the introduction of Medicare for the elderly and Medicaid for the poor in 1965, hospitals were then able to charge two major classes of the population for services which the hospital previously had provided for free or for types of health care that had not previously been sought from the hospital system [Kronenfeld, 1993, p. 96]. Since costs *and* a profit factor were passed on directly to third-party payers (*e.g.*, insurance companies and the federal government), there was no incentive for hospitals to control costs. Further, insurance, the government, or employers who were paying for that insurance were now responsible for payment. The insured patient, no longer burdened by cost, then began seeking more treatment with little regard to actual need or cost. Throughout the 1960s and 1970s, this lack of incentive to control costs led to a staggering rise in hospital costs well beyond the fourfold increase noted above.

The increase in hospital costs is inevitable, according to Trevor Gambling [1987], who argues that even without the inefficiencies in the system; one could expect the costs to rise at a rate higher than the average national inflation rate. He bases his arguments on a theory proposed by the economist, W.J. Baumol, who suggested that certain industries—the health care industry being an example—should

...expect their costs to rise consistently at a greater rate than any general measure of price inflation. This was because they were unavoidably labour-intensive, so that they could not achieve the enhanced productivity of manufacturing industry or agriculture. Those increases in productivity are reflected at least partially in real increases in the general level of wages; unless the workers in labour-intensive industry are prepared to accept wages very much below that level, exponential growth in costs may be expected. Those industries tend to be extensively subsidised, usually by the State, since there is inevitably a gap between their costs and what their consumers are minded to pay for their services. [Gambling, 1987, pp. 47-48]

This gap between service costs and consumer remuneration is sometimes referred to as “Baumol’s Disease”; and, while Baumol used the performing arts as his reference point, both the theory and the descriptive title for the gap can be applied appropriately to the U.S. health care system. Starr [1982] points out that in the 1970s, the politics of American health care generally passed through the same three phases as American politics in general.

1. A period of agitation and reform in the first half of the decade, when broader entitlements to social welfare and stricter regulation of industry gained ground in public opinion and law.

2. A prolonged stalemate, beginning around 1975, when the preoccupation increasingly became coping with inflation, doubts arose about the value of medical care, and initiatives such as national insurance were set aside.
3. A growing reaction against liberalism and government, culminating in the election of President Reagan in 1980 and the reversal of many earlier redistributive and regulatory programs. [Starr, 1982, p. 380]

With inflation running at 15.5%, Preston observed that Medicare and Medicaid were obvious targets for “fiscal responsibility” [1992, p.92]. The 1980s showed that to be the case.

In the 1980’s we see a move to introduce cost control into the system and more control of the health care system being exercised vis-à-vis the system of accountability as Rhodes (1985) points out.

Ultimately those who pay, whether government or private insurance agencies, want to know just what it is they are paying for. They then want to know in greater detail what is going on in each consultation, what advice is being given and why, what resources are being employed to carry out treatment, and how much it will all cost. (p.175)

THE HOSPITAL AS COST AND PROFIT CENTER: 1980S TO EARLY 1990S

The movement toward containment of health care costs was initiated in the late 1970s by the federal government, due to the rapidly rising rates of expenditure for Medicare and Medicaid. Medicaid expenditures, for example, had risen at a rate of 15.6% per year between 1973 and 1979. Solving the problem of such rapidly inflating rates of expenditure was made more complex by the political realities that prevailed during that decade. In the case of Medicaid, the simplest means available to the federal government to reduce costs would have been to limit the number of citizens eligible for the Medicaid program. Such an action, however, would only have shifted the costs of care for those citizens to individual states and cities and may have, in fact, increased the total health care costs for these patients due to the inefficiencies that also were created by this shift.

Because some level of government has to serve as provider or payer of last resort for these populations, changing the Medicaid eligibility rules was perceived as unlikely to reduce costs and quite likely simply to shift fiscal burdens from a higher level to a lower one. [Holahan and Cohen, 1986, p. 6]

One also could expect the same impact from the Medicare sector. Current arguments using Massachusetts as an example directly argue the shifting of medicine to state control. Thus, the cost containment movements in the 1980s led to varying attempts to focus on controlling health care expense on a “per episode” basis. This led to the concept of reimbursement by Diagnostic Related Groups (DRGs).¹ Many factors needed to be quantified in order to develop a credible system—such as the “case-mix” as it relates to general health (*e.g.*, indigent versus wealthy) or a more complex “diagnostic case-mix” (*e.g.*, elderly versus youthful).“ For example, an urban teaching hospital might receive \$3,000 per hernia whereas a suburban non-teaching hospital might receive \$1,500 per hernia” [Easthaugh, 1981, p. 302]. The situation was complicated further because the direct costs of providing episodic services to the patient were usually unknown and many “overhead” costs were allocated. Charges to the patient were often used to approximate costs, but not without associated problems.

Therefore, hospital charges emerged from policies based on maximizing a hospital’s benefit (revenue) from their particular mix of patients and payers, and frequently have little to do with the cost of a patient’s care....charges are often reported because hospitals generally do not know even the direct costs of a particular patient’s care. Therefore,

charges are not selected because they are a good proxy for costs but because they are available. [Oakes L.S., Considine, J. & Gpi; d. S., 1994, pp. 34-35]

The unknown direct implementation of the DRG system of cost control or performance measure at the beginning was very difficult indeed. The calculation of the DRG reimbursement for hospitals was driven mostly by the *estimated* average-length-of-stay in the hospital for a particular case-mix diagnosis and a predetermined “bundling” of usual and expected costs for services relevant thereto. Thus, a patient with a hernia (using Easthaugh’s example) might require an average of four in-hospital treatment days at an urban teaching hospital where a large proportion of patients are indigent and/or present more complex medical cases; whereas, at a hospital located in an urban, upper middle class area, that same hernia patient might only require two days of in-patient treatment. So a hospital would expect to make a profit if it was able to maintain its length-of-stay (l.o.s) average; and that hospital would expect to increase its profit if it was able to reduce its actual “l.o.s” below the average. Conversely, a hospital might expect to incur a loss if its “l.o.s” exceeded the calculated average. Such circumstances led to the hospital-as-profit-center for those patients whose episodes were reimbursed by DRGs.²

Because the profit calculation held revenue constant and only allowed the hospital to improve profits by controlling costs, hospitals adopted many different cost-control strategies—some of which can be considered sub-optimal, especially with respect to patient care—and the “l.o.s.” (sometimes referred to as “DRG days”) evolved from an *average* to an *absolute* in the minds of many hospital administrators. The hernia patient in the above example would be discharged two days following surgery because his DRG days were “used up”, although the incision might be infected and require a continuing high level of medically expert attention. The resulting development of the “quicker-and-sicker-syndrome” (where the pre-defined average discharge date of all patients in a category led to premature discharge of sicker patients in that same category) caused additional challenges for balancing the provision of medical care (the hospital’s professional purpose) with the management of a profit center (the hospital’s administrative goal). A patient was admitted and administered to under an initial DRG code throughout the provision-of-care-process, which meant that all costs were charged to that DRG. Therefore, some patients were discharged from the initial DRG code and physically left the hospital, then immediately readmitted under a new DRG code for continuing care of the original or complicating circumstances. As Stevens observed,

The DRG system provided incentives to discharge elderly patients as quickly as possible, but no equal incentive to provide them with an appropriate place to go.... In December 1984, the American Medical Association published the results of an informal survey conducted in thirty-eight states.... Administrators, it was claimed, were encouraging doctors to discharge patients for a primary condition and then to readmit them for a second, thus being able to charge for two DRG episodes; there was pressure to release patients prematurely, evidenced in rising rates of readmissions within seven days.... [Stevens, 1989, p. 326]

Some hospitals also attempted to assign the DRG code with the highest revenue potential rather than capture the most relevant diagnosis. For example Columbia/HCA Healthcare Corporation, a profit making hospital chain that operates approximately 350 hospitals across the United States, treating nearly 125,000 patients per day has been identified as one of the biggest offenders of this practice.

HCA, as well as KPMG, settled with the federal government after years of litigation that involved numerous cases of financial fraud allegations.

Under the terms, HCA would pay \$630 million in fines and penalties to resolve all outstanding civil litigation with the Justice Department. An additional \$250 million would be paid by HCA to the Medicare program to resolve expense claims submitted by the company to the government.

Combined with previous settlements HCA has negotiated with the government involving fraud investigations in 200 to plead guilty to 14 felonies – the company will be paying a total of more than \$1.7 billion in civil and criminal penalties... [Eichenwald, 2002, p. 1]

Of course, HCA argues that they do not *inflate* the diagnosis but are merely more efficient in assigning the *correct* diagnosis. Dafney (2003) reported after observing changes in DRG rates, but not in hospital costs, that hospitals did, in fact, respond to these changes by “up-coding DRG codes”.

“...associated with large reimbursement increases, garnering \$330 – 425 million in extra reimbursement annually,... these findings suggest that, for the most part, hospitals do not alter their treatment or admission policies based on diagnosis-specific prices; however, they employ sophisticated coding strategies in order to maximize total reimbursement. (p.1)

Other consequences arising from DRGs were that hospital services were “unbundled” so that they fell under differing schedules of payments within the total reimbursement system. As a result of this DRG gamesmanship, some hospitals declined to accept indigent patients (*i.e.*, practiced patient dumping); while other hospitals terminated provision of services and procedures which analysis of past history indicated would lead to an *unprofitable* DRG. Many of these practices were either directly outlawed (*e.g.*, patient dumping) or became less problematic as the reimbursement system evolved and developed refinements (*e.g.*, the unbundling of charges for payment).

A major dilemma for administrators in the DRG system was the independence of the relationship between the hospital and the physicians whose patients were admitted. Tension heightened between physicians and the hospitals participating in the DRG reimbursement system because the doctors had “hospital privileges” to admit and treat their private patients at a particular hospital, but those doctors were not employees of the hospitals. DRGs were used to reimburse the hospital, not the physician. Later, payment schemes called RBRVS (resource based relative value systems) would be developed to control physician reimbursement. Easthaugh provided an interesting summary of the reimbursement-under-DRGs dilemma.

...the physician can prosper as the hospital loses money because physicians control the admission and discharge process. No hospital administrator has the power to discharge patients at the economically rational point, that is, when the hospital payment per DRG covers costs. One would hope that...physicians recognize the financial health of their hospital as a component in their utility function, and discharge patients more efficiently.... [Easthaugh, 1981, p. 301]

However, as was later to become evident, while unable to discharge patients, hospital administrators were able to track the “efficiency” of individual physicians in adhering to DRG guidelines and to deny them renewal of privileges to practice at the hospital if they were deemed to be outside the acceptable economic parameters. These “tensions”—while hidden from the patient—were very deep-seeded and found in most health care systems.

As we see in our example in the U.S., this contrast consists of what at times can be diametrically opposed objectives and goals between the physicians and the hospital. DRGs have come under scrutiny from many diverse sources such as consumer advocates and health care policy makers. In a review of the literature on measures and indicators, Van Peurse, Pratt & Lawrence [1995] discussed accounting researchers who have critiqued the use of performance measures including DRGs. Even with the critics, DRGs and/or the basic concept of DRGs have been adopted by American managed care providers (HMOs) and health providers in other countries such as Great Britain and Australia.

The performance (cost control) measure used to measure physician performance is Resource-Based Relative Value Scale (RBRVS). Like the DRG it is a control system that is tied to the cost of production.

In a statement to the Subcommittee on Health of the U.S. House of Representatives Ways and Means Committee, Dr. Jane M. Orient noted the problem of relying on RBRVS, thus DRG:

...the RBRVS is flawed in practice because it cannot accurately calculate the cost of production. The tables of cost are derived from subjective evaluations by a small panel, using data that may be completely inapplicable and arbitrary extrapolations. The tables disregard variations in cost due to location, type of practice, individual abilities, and training of the practitioner, and individual complexity of the patient's case, and uncontrollable fluctuations for goods and services. [Orient, 1995, p.1]

Cost Control

Twenty years of research by Dr. John Wennberg and Dr. Elliot Fisher of Dartmouth University found large differences in the amounts that Medicare spends on patients. These differences are related to geography. For example, patients in Manhattan and Miami receive far more aggressive care than patients in Rochester, Minnesota and Salt Lake City, Utah [Mayer, 2007, p. 28]. Wennberg and Fisher made adjustments to their data to account for differences in regions due to race, age, sex, as well as the overall health of each community studied.

Wennberg and Fisher also found that patients that received more aggressive care were no better off, and in some cases worse off, than patients who received conservative care [Mayer, 2007, p.28]. For example, Wennberg and Fisher reported that medical patients who were aggressively cared for were more likely to die in an intensive care unit than patients who received conservative care. Part of the reason for this is that patients who receive aggressive care were more likely to be the victim of a medical error; or they were more likely to develop an infection during their hospital stay [Mayer, 2007, p.28]. Higher-spending regions need to replicate practices and processes in lower-cost regions [New York Times, November 25, 2007]. Wennberg and Fisher estimate that this could result in across-the-board health care savings of twenty to thirty percent. Halverson advocates creating price leverage between regions:

“(This) would create a very direct price competition impact because the lowest price in each market would set the benefit level for that service in each market. So under that approach if there is an \$80 office visit price at one clinic and \$100 at another, the benefit payment made by the coverage plan for all patients at either clinic would be \$80 – the local price for that service. Any patient who went to a higher-priced provider would have to pay the cost difference between the two fees.”[Halverson, 2007, page 191]

The Congressional Budget Office reports that good evidence supporting the effectiveness of specific medical treatments exist in less than half of the medical treatments provided [New York Times, November 25, 2007]. Better information is needed to determine which treatments are effective for specific patients. Specifically, information is needed to discern if the benefits from specific treatments outweigh the costs. This information could be used to determine if certain treatments need to be scrapped; or possibly refined at a lower cost.

Herzlinger [2007] advocates transparency in information for consumers. Herzlinger [p. 232] reports that more than 70 percent of patients would like to see online evaluations of physicians (i.e.: there is a website, <http://ratemds.com>, that evaluates physicians, but it is somewhat limited). Herzlinger also cited a report in Health Information Online that reported that 95 million people use the Internet to search for medical information, with 6 million using the Internet daily [p. 231].

Cost accounting techniques from industry can also be effective in reducing healthcare costs. Eldenburg, Schaefer, and Zulof [2004, p. 242] advocate using target costing systems in the healthcare environment. With target costing techniques, new services can be offered at a price that will increase volume. The service would have to be offered at the target cost; allowing hospitals, physicians, and other health care providers to practice effective cost containment.

If systems such as target costing are to be effective, the physician will need to have a central role in reducing costs. McGlaughlin and Kalamzy [p. 202] note that physicians have a “central role in making and controlling key decisions that affect the provision of health services.” They note that it is important for the physician to identify area where targeted cost savings can occur, without reducing the level of service to the patient.

Information technology is a critical element in cost control. In a hospital setting, the goal of an effective information technology function is to improve patient care and services, strive for better organizational performance, and reduce costs [Glaser, 2006, p. 66]. Many hospitals have invested in patient care information systems. These systems are designed to reduce medical errors. Dick, Steen, and Detmer [1997] reported that these systems allow for health care professionals and patients to have access to real-time patient data along with corresponding medical information. These systems should lead to better decisions and treatments for patients. Caution must be exhibited with these systems; Ash, Berg, and Coriera [2004, p. 104] found that these systems frequently have two different types of errors -- errors in the process of entering and retrieving information and errors in communicating and co-coordinating specific medical events. A heightened awareness is needed by designers of these systems to reduce these errors.

Grimson [2001] believes that the next generation of medical records will be available on-line, and will include all medical information from infancy to death. Grimson [p. 111] states that “the next generation of records... will be a longitudinal cradle-to-grave active record readily accessible and available via the Internet, and which will be linked to clinical protocols and guidelines to drive the delivery of healthcare to the individual citizen.” Grimson further states that post-genomic research will be part of this database – and the database will thus contain data relating to genetics, diseases, medical treatments, and the environment. Sittig [2004, p. 1379] believes new information technologies, currently used sporadically, will be available for routine clinical use. These include real-time clinical decision support systems, wireless monitoring devices (both invasive and non-invasive), and large integrated databases with data mining analysis tools. These tools should improve patient well-being, as well as improve the organizations offering these technologies but at what cost to individual privacy? And, should that matter?

Activity-based costing can also be used for cost control. Similar to the ABC systems that are used in manufacturing; a two step process would have to be utilized. First, hospital costs are assigned to various cost pools (such as administer CAT scan” or “perform blood test.). These costs could then be charged to a cost object such as a patient or a department [Upda, S.,1996, p. 84].

THE HOSPITAL AS INVESTMENT CENTER: 1990S AND BEYOND

As hospitals instituted controls over costs by means of DRGs and physicians were controlled by similar reimbursement plans (RBRVS), the concept of the hospital and its role in society began to change in the United States. With beds utilized less, due in part to shorter lengths of patient occupancy, and with a reduction in the numbers of procedures being performed by physicians, many hospitals faced financial difficulties in the 1990s. As a result, hospitals engaged in many different arrangements in an effort to successfully control their environment. Certain hospitals closed, unable to meet the demands of the efficient/effective medical services market. Acquisitions became commonplace as when larger private hospitals purchased smaller, weaker hospitals. Mergers of two or more hospitals with varying distinctive competencies were common. Hospitals formed alliances with third-party insurers in an attempt to corner the market for their subscribers. Physicians, especially specialists, received more and more pressure to affiliate with only one hospital rather than two or three as had been the practice previously.

“As health insurance costs rose during the 1970’s and 1980’s – driven both by improving medical technology and by the growing inefficiencies of the health care system – health maintenance organizations, which had been around since the beginning, began to proliferate, along with other managed-care schemes. Like the Blues, HMO’s became

victims of their own success. Initially they were mainly non-profit, but once again businesses spotted an opportunity and for profit HMO's displaced non-profit HMO's." [Noah, 2007, p 2]

Approximately 12 percent of the market was for profit in 1981 and by 1997 the for-profit market share was around 65 percent; over a five-fold increase. It is not surprising that, as more focus is placed on the bottom line for corporate profits, that HMO's are more aggressive. With the proliferation of HMOs, which required a patient to obtain a referral from their supervising general practitioner for each visit to a specialist or hospital, the general practitioner became more important to hospitals as the patient's case manager in assuring a steady supply of patient referrals and admissions. Hospitals began to follow one of two strategies. Either they would hire general practitioners and set up clinics in various areas of their service community, or they purchased existing private practices with agreements that the physicians would send their patients to the purchasing hospital for needed treatment. In addition, physicians themselves started forming groups with the intention of becoming strong enough in their geographical locations to be able to demand *en force* higher reimbursements for services. National companies (*e.g.*, Coastal) also were purchasing physician practices and national for-profit chains (*e.g.*, Humana) were purchasing hospitals. Hospitals were also forming buying groups in order to be able to purchase large quantities of drugs and supplies at a cheaper rate.

The management of hospitals also changed. No longer are doctors likely to practice part of the day and administer at a hospital on a part time basis. Currently, hospital administrators are more likely to be educated (MBA or MHA) business people who have little, if any, medical training or expertise. Most often trained to focus on the "bottom line", current hospital administrators work with Boards of Directors that not only understand the hospital's need to be financially viable in order to operate successfully but also expect the hospital administrators to accomplish a reasonable rate of return (profit) for the assets under their control.

While for-profit ownership has been argued to have a negative impact on health care costs, others argue that more efficient management offsets these higher costs.

Some experts argue that for-profit hospitals increase total health care costs by exploiting any inadequacies in the system of paying for care and by earning higher dollars for a similar procedure than would a different facility. Others argue that the general business knowledge of private sector management may be applied in the for-profit sector and allow those hospitals to provide care more efficiently. [Kronenfeld, 1993, p. 99]

To date, available studies are inconclusive and the matter continues to be the focus of research in a number of areas.

Stevens [1989] raised questions as to the future role of hospitals, arguing that while the U.S. does not have a formal national health care system; it does have a *de facto* national health care system through the structure of its hospitals. She concludes that hospitals in the U.S. are in a state of turmoil and change [pp. 352-353]. Kronenfeld provides a nice summary of this change.

Hospitals in the United States have long represented values of science and have carried important cultural weight of that reason. They have also represented charity and caring, particularly in the non-profit sector.... Earlier in the century, they also represented forces for social order. All of these values are shifting, with a greater emphasis on hospitals as businesses. Moreover, more and more advanced care is now occurring outside of hospitals. Will they become only a collection of specialized workshops? [Kronenfeld, 1993, p. 100]

As usual, there is disagreement on where health care is headed. Columbia University's Eli Ginzberg [1997], whose study of the health care industry has spanned forty years, believes that managed care

cannot sustain its current growth and industry dominance. Costs will continue to rise due to technological innovation, and despite the current strong market forces. The first big wave of baby boomers will be reaching age 65 in 2011, resulting in the HMO enrollees being older, sicker, and less profitable to the HMOs and their profit-driven bottom lines. HMOs could possibly attempt to cut health care expenditures further but we have already seen resistance by the public, and by state and federal legislators.

Public concern, discontent, and distrust have grown as enrollees have become increasingly aware of the more egregious profit-oriented practices of their managed care plans....policies... providing bonuses to physicians who cut back on referrals to specialist... and deliberately delaying the authorization of costly treatment without which the patients health, and in some cases survival, may be compromised...[Government] will use their regulatory powers to ensure that plans do not engage in practices and policies detrimental to enrollee's health. [Ginzberg, 1997, pp. 1013-1020]

SUMMARY

The U.S. health care system, and the role that accounting and accountants play in that system, has been explored by means of a critical perspective. First presented was how, over the last sixty years, cost controls such as DRGs have transformed the hospital from a revenue-center to a cost/profit-center to an investment-center. Also discussed were the behavioral changes associated with these changes, behavior that usually would be considered sub-optimal relative to the quality of patient care. The resulting obsession with cost control and managed care was found to be a very powerful and disturbing element in the overall health care delivery process in the United States. The debate over where the U.S. health care system is headed continues today as evidenced in the October 3, 2012 presidential debate. Compromise seems unlikely at this point as all the critical players continue to see the problem from their own perspective. In the interim costs continue to rise as do profits and yet general health care does not improve. Cost control and managed care:

...could have the unintended consequences of lowering quality, reducing access to care for the uninsured, disrupting continuity of care for all patients, and undermining the financial stability of such important institutions as academic health centers, with implications for future research, technological innovation, and medical training. In short, managed care is unlikely to be a panacea for improving performance of the health care system [Davis, 1996, p. 3]

ENDNOTES

1. Preston, et al., [1997] provides an excellent description of the political process surrounding DRGs and the rationing of health care to the elderly.
2. At first, this only applied to Medicaid and Medicare, but the DRG concept was quickly adopted by third-party insurers to cut costs.

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