Healthcare's Catch-22

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Abstract

Over the decades, hospitals have slowly evolved from humanitarian foundations to business ventures and the impact of this dramatic shift can be seen in modern day healthcare. In the United States, hospitals typically establish arbitrary pricing methods, instruct staff to offer the highest priced services, and demand intense labor from residents without offering a fair compensation. These changes in vision and action have resulted in an ample number of Americans in tremendous medical debt. Incorporating evidence from reviews, personal anecdotes, and research journals, this manuscript demonstrates that hospitals are run with the intention of generating the most profit and revenue rather than with the noble purpose of philanthropy from which the idea of hospitals were first conceived. It argues that hospitals have long benefitted from generous tax breaks, there is a need for an intervention of checks and balances from policymakers, and for more reasonable compensations for hospital staff's strenuous labor.

Healthcare Providers or Profiteers?

In the minds of many, hospitals are places entrusted with the care of those infirm or injured when needed. They are entities of mercy and purveyors of medical care entrusted by all to serve the public good. However, hospitals are motivated by profit. They have brought about

changes in the economic landscape that have made access to healthcare nearly unattainable for many. These questions remain: how did this happen and how did we get here?

Trusted Establishment: The Origin of Modern Healthcare

Most hospitals in the United States started as an extension of church support systems across the country, evident through the early establishment of hospitals with titles such as "Baptist, Mercy, Methodist, Trinity, Presbyterian, and Mount Sinai." (Rosenthal, 2018) The nation further developed, and Medicare coverage was eventually introduced in the 1960s (De Lew, 2000). According to Elisabeth Rosenthal, "Between 1968 and 1980 the number of Americans under sixty-five covered by good private insurance was at its peak (about 80 percent, compared with about 67 percent in 2007)" (Rosenthal, 2018). With most Americans leaving hospital bill payments in the hands of private insurance companies as opposed to paying for bills directly out of pocket, many hospitals saw this as an ample opportunity to charge more money for their work and dispensation (Bai & Anderson, 2015). An interesting phenomenon about hospital care is that there are no set standards for how much money the goods and services the hospital offers should cost (Song et al., 2017). Without price ceilings or regulations to keep institutions in check, hospitals saw charging high prices on commodities and labor as the ideal way to go because for the most part, private insurance companies had no problem paying for the entirety of it. The tremendous cash flow for hospitals created the need for those skilled in business and finances to manage. Once people in business and financial gurus dominated hospital administrations, decision-making was directed by whichever option made more money, such as instructing doctors and nurses to offer the more expensive services to secure maximum income. Some hospitals began to do away with paying their physicians a salary and adopted a

new form of payment that was based on how much profit a physician would reel in throughout the month. The method for determining the price or valuation of a given procedure or service involves the assigning of relative value units or RVU's by hospitals (Baadh et al., 2015). The more a doctor delivered services with higher RVU, the more they would be paid. Several hospitals employ this method of paying their physicians, such as "the Harvard-affiliated Partners HealthCare, the Henry Ford Health System, Duke Health, and Baylor Scott & White Health" (Rosenthal, 2018). Not to mention, according to Elisabeth Rosenthal, "In 2015, 71 percent of physician practices supplemented salary with productivity bonuses. Bonuses can motivate doctors, just as they do bond traders" (Rosenthal, 2018). Thus, when physicians begin to receive monetary perks for effective work done in the hospital, hospitals begin on a path of inclination to ensure income is reliable and ample which many hospital goers have felt the repercussions of for decades.

The Effect by Exorbitant Hospital Bills

Everyone has been impacted by the profit-driven over-pricing of hospital services; however, some groups have endured disparate and disproportionate harm. People often subjected to high hospital bills are those diagnosed as obese and, in turn, ordered to undergo elective bariatric surgery. In response to the heightening obesity rates in the US, medical technology companies constructed new equipment to combat the trend, which caused a boom in bariatric surgery (Lee & Almalki, 2017). Hospitals saw this rising trend as a moneymaker and invested capital into new bariatric lifts, beds, and wheelchairs to accommodate patients undergoing surgery. Sadly, medically classified overweight individuals were not the only ones who fell victim to these profit-seeking ventures by hospitals. More often, hospitals made efforts to purchase new

machinery with the intent of financial gain instead of purely out of adequacy or necessity. One example of this is high-energy proton beam machines (Bortfeld and Loefller, 2017). Individuals who suffered from tumors in their eyes were most affected by the high cost of high-energy proton beams present in many hospitals across the US. The reason why so many eye tumor patients are affected by these high costs is that the manufacturers of high-energy proton beam machines purposefully designed these machines to be worth well over $100 million dollars and included information on how much tests using these machines should be priced. The pushback against the use of these machines was enormous. According to the *Wall Street Journal*, "The National Cancer Institute and the American Cancer Society tried unsuccessfully to tame the frenzy with science, to no avail, even though one study of thirty thousand patients with prostate cancer found that "proton beam therapy provided no long term benefit over traditional radiation therapy, despite far higher costs." (Rosenthal, 2018) Pragmatism lost the battle to profit in the continued utilization of these machines. The prevailing wisdom of unabashed trust in one's doctor had been weaponized by hospitals against unsuspecting patients. Soon, doctors in training would begin to feel the sting and communities would begin subsidizing hospital profits with tax breaks. Currently, individuals with obesity and any individual in need of a medical remedy involving "new" and "groundbreaking" technology placed in hospitals are the most vulnerable to high hospital bills which sadly also happens to mostly be not only the most medically vulnerable populations in the United States but also the most socially vulnerable as well.

Societal and Economic Impacts

One societal impact of exceptionally high hospital bills is the toll it has taken on hospital workers themselves. This is especially the case for residency workers in hospitals. There have

been ongoing debates on where the money for training residents should come from and how much it should be (He et al., 2020). It is not uncommon for residents in hospitals to be seen as no more than honorable volunteers. In her book, Rosenthal goes on to state, “The residents are the primary teachers of the medical students assigned to their wards, relieving hospital staff of that burden.”

Additionally, residents provide much of the hospital’s on-the-ground medical workforce by seeing patients in the ER, assisting in the OR, and drawing blood, to name just a few of their duties. They are learning, yes, but are also effectively low-wage labor.” (Rosenthal, 2018) Statistics themselves can back up the claim that hospital residents are severely underpaid in proportion to the amount of work. The average cost to pay a hospital resident in 2013 was $134,803. However, research has shown that the value of the labor each resident gives annually is closer to $232,736. This inequitable pay affects the economy by creating a more significant gap in classes that perpetuates wealth growth in hospital administrators while providing less opportunity for hospital residents to climb out of a lower socioeconomic status. Another penalty hospitals impose on the economy is the amount of money received in tax breaks compared to the amount of money spent on assisting the communities around them (Zare et al., 2021). According to the California Nurses Association, 196 hospitals were given $3.3 billion in tax exemptions. They spent somewhere near $1.4 billion on charity which leaves a gap the size of $1.9 billion in the wallets of hospitals. This apparent misappropriation of community resources and lack of accountability by hospitals has sadly in mass gone mostly unnoticed and continues to remain unaddressed by policymakers in the United States.

Assuaging the Harm

The high cost of hospital care has taken a toll on healthcare consumers around the country. Efforts to help alleviate this toll on citizens include holding hospitals accountable through government action (Pross et al., 2017). Attempts have been made to prevent harm through government action such as Mayor Ravensthal's lawsuit against the University of Pittsburgh Medical Center for not giving enough to charity and using state and federal tax exemptions for personal gain (Simpson, 2016). However, the lawsuit was eventually dismissed by a judge. An example of successful government intervention is the Charity Care Ordinance passed by San Francisco in 2001 (Kurani, 2017). The reasoning behind this city ordinance was that the city officials were skeptical that California Pacific Medical Center, a major hospital in the area, was not providing as much assistance as it could, based on the size of the hospital. How the ordinance worked was that it established a mandatory review of the amount of funds hospitals poured into charitable budgets in conjunction with "approval for new hospital construction." (Rosenthal, 2018) This mandate proved effective against the inequitable actions of California Pacific Medical Center and established a means of keeping other hospitals in check by pressing all of the hospitals in the City of San Francisco to spend more resources on charity. Efforts from the government like this can help prevent hospitals from abusing community resources only to be used on expensive and unnecessary machines, decorations, and bonuses to administrators. The City of San Francisco discovered a means of cutting through the red tape to provide benefits to those affected by high hospital bills. The same can be done nationwide if local, state and federal government officials address these issues by taking action.

Personal Anecdotes of Unreasonably High Hospital Bills

Argurably, all have been impacted directly or indirectly by the rising costs of healthcare due to the rising cost of medical insurance. During my co-researcher and I's lifetime, the expense to medically insure us amounts to approximately $110,000 each. When adjusting for inflation, this dollar amount equates to approximately $200,000 today. That amount invested in the S&P 500 for 24 years would equate to nearly $1.3 million. My parents have invested a significant amount of money towards my healthcare through medical insurance in my lifetime. After reflecting on my lifetime, it has occurred to me that I have not encountered the issue of high hospital bills because I have never been hospitalized. However, I am being affected by the high price of healthcare in regards to dental care currently. I do not have insurance which means I would have to pay out of pocket entirely to visit my dentist I have seen for years and get my wisdom teeth removed, which I am putting off until I have insurance again. This, however, is nowhere near my best example of remotely being affected by high hospital bills. My good friend and roommate Salvador, along with his girlfriend, were in a dangerous car accident and were rushed to the hospital by another friend of ours. By the grace of God, Sal and his girlfriend did not have any severe injuries but ended up having some minor contusions and bruises from the accident. Sal has mentioned to me that the hospital had him and his girlfriend go through various X-Ray exams and CAT scans to see if either of them had retained any "sequestered injuries." They asked for an itemized receipt before leaving and a couple of days later, Sal and I looked through the charges, and we were astonished at how extravagant his bill was. The charge alone for just being admitted into the emergency room was well in the thousands of dollars. The hospital had counted his CAT scan as two different CAT scans: one done on his head and one done on his body. Each scan was well over $2,000. They had even charged both of them for a

physical therapy evaluation which never actually occurred. Sal and his girlfriend were both extremely grateful to have insurance that covered almost all of the bills, but I can only imagine the stress those two would be in if they did not have insurance and were forced to go into medical debt to pay their bill. This brings light to those less fortunate who end up hospitalized without the financial capability to pay their bills. May efforts be made to prevent socially and medically vulnerable individuals situations like this in the future.

Further Examination of Hospital Bill Inflation Upon Additional Research

Despite analyzing the process of how hospitals calculate patient bills, there is still much to be considered in regarding the reasoning behind why hospital bills can be so high and the toll these hospitals can take on physicians and hospital workers. High prices of healthcare from hospitals continue to fluster the general public, but it was not until further digging and reflecting that the following reality became clear: healthcare in the United States is a greedy business model. This is the reason why more money was not spent on raising pay for valuable workers like nurses and residents. Not to mention a lack of funds poured into reducing list prices for the patients. Efforts such as these would not bring in more revenue but would instead overall reduce it, which is a nightmare hospital administrators do not want to make become a reality. Another noteworthy takeaway from studying Rosenthal's text was the value of residents in hospitals and how little they are compensated for their output.

After much inquiry regarding healthcare workers in hospitals, I have gained substantially more respect for the nurses, physicians, and residents who endure so much to assist those in need and less respect for the individuals who turned hospitals into a money-making business only to profit off of those in need. Hospitals fall more in line with the business category than the

community-assisting non-profit category and should be held more accountable to assure that healthcare workers are fairly compensated and that endeavors are being made to price services fairly.

Closing Discussion

The hospital system in the US is responsible for overcharging the wealth of generations and altering the landscape of the entire economy. They intentionally used the trust between doctors and their patients to manipulate profit margins and pass exorbitant medical expenses to insurance companies. Those costs were eventually passed off to the patient through increased medical insurance costs. Hospital residents have bore some of the burden by working for menial wages while hospitals earned enormous profits from their work. The blame can be placed on lack of regulation in the marketplace, on the greed of hospital administrators, the willingness of doctors to look the other way or all of the above. This broken system begs the need for change because if nothing changes, then our children and grandchildren will continue to carry the burden of inflated healthcare costs and essentially rob them of their future financial wellbeing.

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