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Rural Healthcare Facilities: Monopolies to Cooperatives

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Abstract

U.S. Legislation around the turn of the 19th Century was created to prevent large companies from influencing prices. This net loss to society came in the form of misallocated resources and increased prices. Notwithstanding the societal costs of a monopoly structure, some monopolies are government mandated, such as rural electric and water service. Monopolies have benefits (and are sometimes the only business structure that will work) especially in rural America. In rural healthcare, the monopoly structure is sometimes the only business organization that effectively serves a community or rural area and makes sense. A healthcare monopoly can have the same negative characteristics associated with the monopoly-structure, like increasing costs and misallocation of resources. A cooperative is a viable alternative to monopoly. The rural community would participate in the monopoly profits and decisions. A self-imposed tax could be levied on the area the rural healthcare facility would serve offset by charitable donations; thus, making the community stakeholders in the healthcare facility. The people who make up the tax base would be benefactors for the facility's profits and the whole community would benefit from access to expanded services otherwise unavailable to underserved areas.

Monopoly

From Distrust to Support

The Clayton Antitrust Act of 1914 and the Sherman Antitrust Act of 1890 were created to prevent the formation of large companies wielding sufficient market power to influence prices of goods; and, thus, creating a net loss to society [1]. Nevertheless, some companies are actually mandated monopolies, such as public utility companies (electric, water, and telephone companies with fixed telephone lines), where high investments of physical infrastructure are required. AT&T dominated the fixed telephone service for many years until the Governmental antitrust authorities broke-up AT&T in 1986 into eight smaller, independent telephone companies, known as the Baby Bells (Sutherland, 2006). Then, testifying to the cost advantages of the larger, combined organization, and increased competition in the fixed telephone market, AT&T merged with Bellsouth in 2006 [2].

Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA of 2011) required healthcare facilities to provide care at fixed and reduced rates. This contributed to the mad desire to acquire, merge, and form partnerships both vertically and horizontally with other companies to reduce costs to improve quality and make operations more efficient [1,3-5].

Payment for services rendered and changes brought on by the PPACA encourage and, possibly, obligate the majority of M&As (merger and acquisition), partnerships, and consolidations due to the amount of capital required to compete and the desire to reduce costs [1,4-6].

Mergers, Acquisitions, Partnerships, and Consolidations

Operating cost is the largest challenge facing all healthcare facilities [3]. Monopoly hospitals in large, metropolitan markets are the biggest driver of costs [7]. Mergers and Acquisitions (M&A) make sense to lower costs and make operating more cost effective [3]. Cosgrove (2016) states "size enables systems to purchase supplies at a much lower cost, to handle regulatory compliance more handily, and to find and share new efficiencies across the whole spectrum of operations…. So far, Cleveland Clinic supply chain initiatives and joint purchasing efforts have saved the Akron General system over $5.3 million" (para. 4).

There has been a rash of planned healthcare facilities (hospital, urgent care, provider networks, etc.) mergers in 2015 and 2016.Hospitals negotiate prices with health insurance

companies individually, and this is one of the reasons there is an expansive range in healthcare spending for the privately insured [7].

Hospital groups look for the size and influence necessary to negotiate with insurance companies; but, more importantly, they are preparing for monetary changes in which they assume financial risk for the costs of caring for [uninsured] patients [6]. While many of the recent acquisitions involve hospitals combining with other hospitals or specialized facilities, future M&A activity may involve adding mobile clinics or even acquiring digital health companies to specialize in bringing healthcare to remote or rural locations.

Antitrust Issues with Healthcare Monopolies

The FTC (Federal Trade Commission) challenged the 2007 merger of nonprofit Chicago hospitals four years after the merger was consummated because they found convincing evidence the newly formed entity had increased prices 'substantially' [1,8]. Emphatically stress the fact that "nonprofit hospitals are not immune from the temptation to raise prices when they are in a position to do so" (p. 9). However, the Massachusetts state legislature directed the State's Attorney General to analyze and report on the causes of rising health care costs. The AG concluded that "prices for health services are uncorrelated with either quality or costs of care but instead are positively correlated with provider market power" (p. 11). [1] do admit that all hospitals' insured patients subsidize treatment for the uninsured patients, even though they disagree with the value of the monopoly power conferred. Using the 2007 census data, they found that almost 38% of America's uninsured, those treated free-of-charge or at reduced rates, come from the middle class, that is, households making more than $50,000 a year; and, 20% of households making more than $75,000.

PPACA propagates healthcare market consolidations

The PPACA reinforces and emboldens hospitals and healthcare professionals to merge and acquire other players in the healthcare market to form an organization dominating the local market, a.k.a. monopoly [4]. The new law also reduces competition in the insurance market; hence, the expansion of monopoly power is not a result of free-market forces. Public policy deliberately establishes monopoly power with the expectations of subsidizing indigent and emergency care with the higher revenues [9].

Medicare payment rates support established general hospitals and discourage less expensive specialty facilities. Policies, at the state level, prevent competition from taking root by using certificate-of-need (CON) laws to prevent the construction or expansion of facilities by potential competitors [4].

Prices increased due to inefficiencies and the cost of doing business at nonprofit and for-profit hospitals alike. In 2012, 79% of community hospitals in the US were either government-owned or not-for-profit facilities [4]. Inflated hospital incomes tended to be consumed across a plethora of medical personnel, auxiliary staff, and suppliers; but, also, wasted on unused capacity. Small local markets accentuate precisely this problem, as an empty hospital bed costs approximately $75,000 a year, so, raising occupancy from 59% to 79% could reduce hospital operating costs by 9% [4]. In some cases hospital mergers can indeed increase efficiency by eliminating duplicative overhead, reaping economies of scale in procurement, or shifting to a greater volume of specialized procedures. Mergers can prove beneficial to consumers yielding average price reductions [4]. Emphasizes these hospital M&A would likely continue in a truly competitive market, and those mergers would produce consumer benefits in the form of quality and access improvements as well as price reductions.

The savings from this M&A activity would likely be greatest for small hospitals because for larger hospitals in more populated areas M&A tend to inflate costs and is desired to increase pricing power [4]. Peer-reviewed economics literature illustrates a clear consensus that prices tend to increase by at least 20% following hospital mergers in concentrated markets.

Pope (2014) outlines some suggestions to correct the situation: remove the shackles placed on health care competition, and appropriate the necessary funds through subsidies and tax breaks to the individual and away from institutions; allow patients to shop for less expensive options; and abolish required healthcare insurance benefits that the insured do not need, thus creating captive markets for providers regardless of value.

Special Consideration for Rural Providers

Some rural hospitals receive special lump sum payments based on geographic location. The 1997 Balanced Budget Act designated hospitals as rural "critical access hospitals" (CAHs), and modified Medicare payment rules to reimburse the CAHs according to costs claimed rather than services provided. Pope (2014) continues with prevalence and dominance of Medicare payments to CAHs explaining Medicare patients account for 65% of inpatient days. There is, however, requirements accompanying the CAH designation, such as requiring hospitals to provide a broad range of inpatient, lab, and ER services, impose restrictions on patient length of stay, and limit facilities to 25 patient beds. Prior to 1997, only 15 percent of rural hospitals had fewer than 25 beds, but, by 2004, 45 percent did; thus, taking advantage of the CAH special lump sum payment. This, in itself, reduces competition, even though the majority of them are less than 25 miles from another facility [4]. As a result, these rural market providers have inflated costs and have the most overcapacity, as illustrated in empty beds and unused services.

Special Consideration for Rural Consumers

Rural Americans experience significant health issues different from urban dwellers such as a higher incidence of

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chronic disease and disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering because the rural population tends to be older, poorer, and have fewer physicians to care for them [9-11]. Getting timely healthcare is a problem for rural people versus their urban counterparts. Emergencies can also pose a serious risk, and the convenience of routine checkups and screenings are often delayed [10]. Rural Health Concerns (2016) indicate rural areas oftentimes have fewer doctors and dentists, and certain specialists might not be available at all, health problems may get out of control and be more serious by the time they are diagnosed. People in rural areas of the United States have higher rates of chronic disease and have higher rates of certain types of cancer, from exposure to chemicals used in farming; and, this could be compounded by geographic isolation, lower socio-economic status, and poor overall health [10,11]. Hall and Owings (2014) indicate from the list of 2010 National Hospital Discharge Survey Data some very telling points.

I. Sixty percent of the 6.1 million rural residents who were hospitalized in 2010 went to rural hospitals; the remaining 40% went to urban hospitals.

II. Rural residents who remained in rural areas for their hospitalization were more likely to be older and on Medicare compared with those who went to urban areas.

III. Almost three-quarters of rural residents who traveled to urban areas received surgical or nonsurgical procedures during their hospitalization (74%), compared with only 38% of rural residents who were hospitalized in rural hospitals.

IV. Many rural areas are medically underserved due to physician (especially specialist) shortages.

V. Rural hospitals often are small, with a low volume of services, and have difficulty remaining financially viable under the regular hospital prospective payment system (PPS).

VI. Special Medicare hospital payment categories have been established so that rural residents have access to hospital care without traveling to urban areas.

VII. About one-half of rural residents hospitalized in rural hospitals were aged 65 and over (51%), compared with 37% of those hospitalized in urban hospitals.

VIII. No significant difference was observed in the percentage of hospitalized rural residents under age 45 who were in rural hospitals compared with urban hospitals.

IX. Twenty-four percent of rural residents hospitalized in rural hospitals were aged 45–64 compared with 32% of those hospitalized in urban hospitals.

X. Reflecting the larger percentage of hospitalized rural residents aged 65 and over in rural hospitals, more than one-half of these patients had Medicare as their principal expected source of payment (53%), compared with 44% of those who were hospitalized in urban hospitals.

XI. Rural residents hospitalized in urban hospitals were more than three times as likely to have three or more procedures as rural residents hospitalized in rural hospitals, thus influencing cost of care through the availability of expensive equipment, such as CT Scans, MRI, and colonoscopies.

XII. Regardless of where rural residents were hospitalized, 2% of them died during their hospitalization, which was due to their age and health.

XIII. Research by analysts of the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) has confirmed that these categories are meaningful for analyzing health data [9-11].

Cooperative Healthcare Facilities

Currently, the IRS enables Cooperative Hospital Services Organizations. From the IRS website, these organizations provide certain specified ancillary support services on a cooperative basis to two or more hospitals described in IRC 501(c)(3).

The Cooperative Hospital (TCH) members include area hospitals supplying a rural area of the US. The Hospital Cooperative is made up of 16 hospitals throughout Southeast Idaho and West Wyoming [12]. The ownership of TCH, and thus the profit distribution, is the membership of 16 hospitals, not the members of the various communities making up the service area. There is a Cooperative of American Physicians established in California to help protect against malpractice. It is a group established "By Doctors, For Doctors" [13-15]. This is a cooperative of physicians formed to pool resources to fend against Medical Malpractice, which is used in lieu of traditional medical malpractice insurance.

Population Finance for Membership

For a company to distribute profits to owners, the shareholders have to own a part of the company by investing their own income. If a government financed the construction of a healthcare facility then distributed its profits to the surrounding community, this would amount to another type of income redistribution system or welfare system.

A bond issue could be implemented then all bondholders would receive a dividend (interest) payment. The profits of the healthcare facility would only be distributed to the people with enough disposable income to participate and own the bond. This would defeat the purpose of a cooperative hospital sharing profits with the community it serves.

The only way a Cooperative Hospital would work is for the community to participate in establishing the healthcare facility. Increasing taxes would increase the shareholder base, but should be participatory, that is, the affected areas should vote on an

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increase in taxes for this specific project. Taxes would be raised for the areas affected and, thereby, obligating an investment to finance the construction of some type of healthcare facility. This would allow the income to be distributed to every tax payer in the service area of this facility. To help finance the cost, charities and nonprofit organizations could help by lending monetary support, and, thereby, lowering the amount needed from taxes.

Prices for health services could not, however, be effectively lowered because nothing would prohibit or hinder other people from surrounding states or areas from utilizing the lower cost healthcare services. The prices would have to remain competitive. Nevertheless, another possibility would be to charge a "membership fee" to members of the local community to help keep prices low for members only, which is fully refundable when the person or family leaves the area or dies.

Summary

Benefits of a Monopoly Structure

Monopolies are valuable in some industries where high infrastructure and investments are required and the product or service is a social need, like a public utility. Monopolies are valuable in Healthcare servicing rural communities, which sometimes is the only business structure that makes sense. There is a need for monopolies or government mandated monopolies for healthcare companies (not including health insurance companies) serving a smaller market, that is, rural area, with a more unhealthy population. Rural healthcare facilities cannot cover the costs of doing business in competitive markets, as the numbers of paying patients are spread between too many organizations, that is, low demand to support competition. There is a duplication of resources, that is, the same expensive equipment at more than one location, which cannot pay for itself for lack of sufficient demand. There may be a shortage of healthcare workers available in small rural towns. Nevertheless, a monopoly structure is known to increase prices unnecessarily and cause inefficiencies in resource usage.

Healthcare Cooperative

The benefits and perils of a monopoly are the reason a cooperative structure based on a monopoly-type structure is proposed. The monopoly profits would be disbursed to its primary customers, the same rural town's people, or rural area citizenry, who use the facility.

The closest example for our discussion is the Galle District Co-operative Hospital in Sri Lanka. It was first established on June 14, 1962 as a small dispensary through a joint effort by the Sri Lanka Government and private investment [13,14]. In 1972 the Galle District Co-op was formed into a hospital, which expanded further in 1982 with the addition of a three story hospital building. In 2012, a seven story hospital with 65 residential rooms was built to serve both foreign and national patients. Notwithstanding the success of the Galle District Co-operative Hospital in Sri Lanka, it is a government supported investment with private investors, which is not exactly the business structure needed in rural America.

A Healthcare Cooperative nonprofit is a good business structure that could be combined with the benefits of a monopoly to supply healthcare to the rural community and distribute the profits to the same community thus helping the local economy. A cooperative would facilitate the on-going concern of the business while keeping prices reasonable and competitive for the region. In the United States, a cooperative healthcare organization would be developed through a community voted, self-imposed, tax offset by donations used to invest in the construction of a local healthcare facility with the public sharing the benefits of quality healthcare, reasonable prices (subsidized through membership), and possibilities of a dividend if the organization is profitable.

Conclusion

The options available for a business are Sole Proprietorship (one person takes responsibility and reaps the profit or loss), Partnership (more than one person takes on the responsibility and reaps the profit or loss), and Corporations (an entity separate from its owners and the profits or losses are shared with stakeholders).A partnership and corporation can be classified as either for-profit or non-profit. A sole proprietorship can only be classified as a for profit business. The three forms of business organization classification are for taxing purposes of the Internal Revenue Service (IRS).

Government run facilities and nonprofit corporations still fall under the partnership or corporate classification. A government corporation is an organization either wholly or partly held by a government Non-profit organizations do not have shareholders but must make enough money to cover costs to stay in business.

The cooperative is run like a nonprofit where the profits are distributed to the owners or members. It is possible to create or establish some form of hospital cooperative in rural areas where the community is the owner and has a stake in seeing the hospital succeed. In the United States, a cooperative healthcare organization would be developed through a community voted, self-imposed, tax, offset by donations, used to create a local healthcare facility with the public sharing the benefits of quality healthcare, reasonable prices (subsidized through a membership), and may receive a dividend if the organization is profitable.

Reference

1. Havighurst C C, Richman BD (2011) The Provider Monopoly Problem in Health Care. Oregon Law Review 89(3): 847-884.
2. Sipress A, Goo S K, Drezen R (2006) AT&T completes BellSouth takeover. Washington Post Staff Writers.
3. Cosgrove T (2016) Merging Hospitals Makes Sense. Consult QD: Cleveland Clinic.
4. Pope C M (2014) How the Affordable Care Act Fuels Health Care Market Consolidation.

How to cite this article: Kent A. Rural Healthcare Facilities: Monopolies to Cooperatives. Organic & Medicinal Chem IJ. 2017; 1(5): 555575. DOI: 10.19080/OMCIJ.2017.01.555575

5. Wood D (2013) Hospital Mergers and Acquisitions Increase, Benefiting Communities. Healthcare News.

6. Abelson R (2015) Health Care Companies in Merger Frenzy. NY Times, New York, USA.

7. Roy A (2011) Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About. Forbes: The Apothecary.

8. Healthcare mergers and acquisitions in 2015 (2015, Dec 21) Healthcare Finance.

9. Hall M J, Owings M F (2014) Rural Residents Who Are Hospitalized in Rural and Urban Hospitals: United States, 2010. NCHS data brief 159.

10. Rural Health Concerns (2016) NIH: U.S. National Library of Medicine (Medline plus).

11. Rural Health Disparities (2014) HHS: Rural Health Information Hub.

12. The Hospital Cooperative (2017) .

13. Cooperative of American Physicians (n.d).

14. Co-operative Hospital, Galle in Sri Lanka (n.d).

15. Havighurst C C, Richman BD (2011) The Provider Monopoly Problem in Health Care. Oregon Law Review 89(3): 847-884.

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