CHANGING DYNAMICS OF THE NEW YORK GENERAL HOSPITAL POPULATION: A CASE OF TOO MUCH GOVERNMENT INTERFERENCE?

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ABSTRACT

This paper explores the effect of government regulations on mortality of health care organizations. Specifically, we study the effects of two government regulations, the Emergency Medical Treatment and Active Labor Act and the Certificate of Need Regulation, on the growth and mortality rates of hospitals in New York State. The hospital system in New York has gone through dramatic ecological changes as a result of both federal and state mandates. However, these regulations have negatively affected hospitals' growth and their mortality. The current literature on organizational ecology does not adequately explain the potential unintended negative consequences of government regulation. We used a population ecology approach to organizations to investigate this phenomenon.

INTRODUCTION

The long-term success of hospitals is significantly influenced by factors that are often beyond the control of these organizations. Consequently, hospitals are often affected by their operating environment (Nyham, Ferrando, & Clare, 2001). A seemingly endless wave of acquisitions, closures, consolidations, mergers, and regulations has helped craft the landscape of hospitals in the United States today. These fundamental and often structural changes have important implications for hospital patients, employees, and the communities they serve.

Government-imposed hospital regulations have existed for nearly as long as hospitals have. Popular wisdom endorses the notion that the intentions behind such regulations are positive, aiming to rectify or at least mitigate perceived social problems (Morgan, 1980). Regulations targeted at controlling overall medical costs or promoting equal access to care regardless of the patients' financial well-being seem beneficial on the surface. However, despite the well-intentioned rationale behind hospital regulations, unintended negative consequences have emerged as a side effect.

This paper addresses two important government regulations in the hospital industry, specifically, the Emergency Medical Treatment and Active Labor Act (EMTALA) and Certificate of Need Regulation (CNR). In New York State, these two regulatory acts have contributed to a loss of hospital revenue as a result of uncompensated care, led to the closure of general hospitals, and served as a catalyst for the growth of specialty hospitals.

This study contributes to the literature by testing the organizational ecology theory on the general hospital industry. This is of vital importance from a policy-based standpoint; the continued mortality of general hospitals in New York will endanger the health care safety net and reduce hospitals' overall ability to provide care for vulnerable populations.

Additionally, this paper bridges the gap in the literature in terms of unconventional research in organizational scholarship (Bamberger & Pratt, 2010). While traditional for-profit firms have been studied extensively from an organizational perspective, organizations like hospitals have received little attention in the literature. The present research fills this gap in the literature by chronicling these underrepresented organizations.

In the first section, we present an overview of the literature on organizational ecology, EMTALA, and the CNR. In the second section, we document our hypotheses and data. The final section concludes with our directions for further research.

LITERATURE REVIEW

Organizational ecology is a theoretical and empirical approach that examines the evolution of organizations. Of primary concern is assessing how the external environment affects organizational founding, growth, and mortality (Hannan & Freeman, 1987). New organizational forms maximize their exploitation of the environment to fill niches. General hospitals occupy wide niches, while specialist hospitals occupy unsatisfied and narrow niches (Carroll, 1985). Organizations with the same form depend on the same resources, and together, they form an organizational population (Lazzeretti, 2006).

Specialist hospitals serve as new entrants into a mature industry, and because of this status, they play an important role in the industry's renewal and growth (Abernathy & Clark, 1985). They have established a new organizational form that adds to the diversity of general hospitals (Hannan & Freeman, 1987). Specialist hospitals also compete with general hospitals for their patients and possess more focused organizational forms (Hannan & Freeman, 1984; Rao & Singh, 1999; 2001; Scott, 1995).

The existing literature on organizational ecology suggests that other industries have experienced a similar decline as that seen in the New York hospital industry. Carroll (1985), Freeman and Lomi (1994), and Powell (1985) offered detailed perspectives on organizational populations in the book publishing, newspaper publishing, and music recording industries. In these instances, market dynamics and not government regulations were the primary cause of declining growth.

In New York, the organizational form of hospitals is not driven by competition or expertise, but rather by regulations. Such regulations make general hospitals with emergency rooms less competitive. Specialists hospitals, which lack emergency rooms, have a competitive advantage since they do not fall under the jurisdiction of EMTALA.

EMTALA covers any hospital that receives compensation from the federal government through health care programs, such as Medicare or Medicaid, and has an emergency room. Additionally, this regulatory act also applies to on-call physicians (Bagley, 2015). These emergency rooms provide medical screening exams, stabilizing treatment if necessary, or a transfer to an appropriate health care facility for any patients who present themselves. The act mandates that services must be provided to individuals regardless of their financial status.

The goal of EMTALA was to prohibit the denial of patient care for purely economic reasons (Stricker, 1992). EMTALA "required hospitals to provide emergency care on credit and prohibited them from delaying treatment to inquire about insurance status or means of payment" (Mahoney, 2015, p. 713). The penalties for violating EMTALA are quite strict, including monetary fines ($50,000 per violation); civil actions; negative influence on a hospital's Joint Commission

on Accreditation of Healthcare Organizations accreditation status; and suspension, revocation, or denial of a hospital's license by the state's department of health (Ringholz, 2005).

The CNR was first introduced in the early 1960s as a measure to help control health care costs in the United States. The primary motivation for this legislation was to create a mechanism that could be used to standardize the capital expenditures of American health care providers. As a result of the CNR, prior approval of health care investments over certain dollar limits became mandatory, although the threshold varies from state to state (Rivers, Myron, & Jemima, 2010).

Despite being created with good intentions, these two regulations have had their share of criticisms. While EMTALA was designed to protect the financially vulnerable from being denied treatment, the final act does not refer to patients who are destitute (Weiss & Martinez, 1999). The constitutionality of EMTALA has even been questioned on the basis of violating the Fifth Amendment's Takings clause by requiring hospitals to render emergency medical services without receiving just compensation (Morreim, 2015). Furthermore, while access to care may have expanded, there is little evidence to suggest that the CNR has improved the overall quality of patient care (Conover & Solan, 1998).

Hospitals and emergency physicians currently face a financial crisis from all sides, including cutbacks to Medicare, lower payments from health insurance plans, and medical liability exposure. These factors threaten emergency physicians' ability to continue to provide high quality care to their patients. Even more problematic is the inadequate coverage of the uninsured. Hospitals and physicians are left alone to carry the financial burden for the uninsured, incurring billions of dollars in uncompensated care each year. The American College of Emergency Physicians (2009) gave the following estimates:

> Fifty-five percent of emergency care goes uncompensated, according to the Centers for Medicare & Medicaid Services. Health care costs for both the full-year and part-year uninsured will total $176 billion dollars this year—$86 billion of which will be incurred when they are uninsured.
> In the past, hospitals shifted uncompensated care costs to insured patients to make up the difference. However, cost shifting no longer is a viable option because managed care and other health plans have instituted strict price controls, leaving little margin to shift costs. More than one-third of emergency physicians lose an average of $138,300 each year from EMTALA-related bad debt, according to a May 2003 American Medical Association study. (p. 5)

The creation of specialist hospitals since the passage of EMTALA is a method of circumventing its regulations. These specialist hospitals compete more efficiently than general hospitals, as the latter are required to provide unreimbursed care to the uninsured and the underinsured who present at their emergency rooms. Specialist hospitals serve a specific market—patients who can afford to pay for their care. These facilities possess cost advantages, such as no loss in revenue due to uncompensated emergency care, that allow them to compete successfully against general hospitals (Herzlinger, 1997; Skinner, 1974). The emergence of specialized providers and uncoupling of these services from the general hospital may push general hospitals into a marginal role as providers of ever-diminishing acute inpatient services (Robinson, 1994).

The emergence of populations of specialist organizations in other industries has been previously studied in the literature. Such research has been based on three viewpoints: niche

formation, density dependence, and resource partitioning. These viewpoints have been used to explain the founding of new specialist organizations (Swaminanthan, 1995).

Niche Formation

An ecological niche is the space of N-dimensional resources in which a population of organizations can exist (Hutchinson, 1957). The width of a niche is determined by the "range of the environmental dimensions across which a population exists" (Carroll, 1985, p. 1266). Generalists, as is the case with general hospitals, have a wider fundamental niche because they operate in several fields simultaneously. Specialist hospitals function with a narrower range of environmental resources or conditions (Carroll, 1985).

Environmental uncertainty or changes can lead to the formation of a new niche (Abernathy & Clark, 1985; Swaminathan, 1998). The emergence of new niches can also occur as a result of forces that are exogenous to the industry (Delacroix & Solt, 1988), such as changes in technology or consumer taste (Tushman & Anderson, 1986). It becomes apparent when a niche market is more profitable than the general market. Firms have an incentive to discontinue services that are unprofitable or costing the organization money. In the New York health care market, the unprofitable services are emergency rooms.

Delacroix and Solt's (1988) explanation of the formation of niches holds for most industries; however, it does not characterize the hospital market in New York. These researchers argued that new niches may become available for a given type of organization with the advent of new technologies to perform old tasks or the emergence of new methods of obtaining resources from the environment.

Density Dependence

The density dependence model was introduced in Hannan's (1986) study, in which he described the demographic regularities perceived in the expansion of different organizational populations. According to Aldrich (1990, p. 11), "Density dependence refers to the dependence of population processes on the size of the population itself." If the maximum number of competitors remains constant over time, then the population growth of a new form of an organization is restricted when the density level is low. This is attributable to the novelty and rarity of that form. In the early stage of a population, increasing density can be seen as a sign of society's approval. This emboldens entrepreneurs to venture into the market, leading to an increase in the number of organizations being founded. Lomi (1991) postulated that as density varies over time (perhaps due to exogenous forces such as EMTALA and CNR), the way density is related to legitimation and competition may be too complicated to predict with the density dependence theory.

The density dependence model has received mixed support in the literature, primarily because the non-monotonic relationship between organizational founding and density has been supported in several organizational populations. Examples include industrial and craft unions (Hannan & Freeman, 1987; 1989), newspapers in Argentina (Carroll & Hannan, 1989), American life insurance (Lomi & Freeman, 1990), and breweries (Carroll, Preisendoerfer, & Swaminathan, 1989; Carroll & Wade, 1991). Studies that failed to support the density dependence model suggest that if the right control variables are introduced, the effect of density on the founding rate can be eliminated (Aldrich, 1990).

Resource Partitioning

The resource partitioning model seeks to explain the birth and mortality rates of specialist organizations in environments with varying degrees of generalist concentrations (Carroll, 1985). The theory argues that specialist and generalist organizations occupy different resource spaces, and as such, they can coexist without negatively affecting one another. Resource partitioning theory distinguishes between organizations depending on their niche (Boone, Carroll, & Witteloostuijn, 2002).

Resource partitioning theory hypothesizes that a positive relationship exists between market concentration and specialist organizations' founding. In industries where scale advantages exist, organizations compete to increase their customer base (Carroll, 1985). In general, organizations will offer their products and services to the mass market. However, general hospitals are required to service all of their patients, including those who can pay for services and those who cannot. This is in contrast to specialist hospitals, such as New York's Hospital for Special Surgery, which offers services based on the organization's specialty (Hannan & Freeman, 1977). Policymakers have proposed that specialty hospitals' access to the market must be restricted (Berenson, Bazzoli, & Au, 2006; Iglehart, 2005; Mitchell, 2007; Shactman, 2005). However, supporters of specialty hospitals argue that they provide fiscal efficiency, superior quality of care, and services that are more patient-focused, making them able competitors for general hospitals (Casey, 2004; Dobson & Haught, 2005; Domrzalski, 2002; Herzlinger, 2004; Walker, 1998).

In other industries, generalists seek to dominate the market and occupy the center of the resource space. This market concentration leads to the founding of specialist organizations that benefit from this newly unoccupied peripheral space (Boone et al., 2002). However, the concept of generalists dominating a market does not hold in the New York hospital industry; specialist hospitals do not have to provide unprofitable emergency room services and thus can proliferate.

HYPOTHESES AND DATA

Specialist hospitals develop a competitive advantage over general hospitals because they do not have emergency rooms or the loss of revenue associated with uncompensated care from managing them. Thus, we posit the following hypothesis:

H1: Specialist hospitals are more profitable than general hospitals.

Ruef, Mendel, and Scott (1998) used an ecological perspective to describe specialist hospitals:

> In a distinction applicable to the health care sector, ecologists distinguish between generalists and specialists. Specialist hospitals, relative to general hospitals, for example, usually employ a smaller range of occupational groups, offer a narrower range of products and services, and operate in fewer markets. (p. 779)

The purpose of specialist hospitals is to provide focused medical care to patients with specific needs. Such specialization allows each respective facility to offer expertise services; the end result is the delivery of important health care services in an efficient manner. Under this framework, cost-savings are not a primary goal. Consequently, specialist hospitals have an economic incentive to focus on high-margin services while eschewing low-profit services.

Specialist hospitals also have a financial incentive to avoid patients that are uninsured or underinsured, leaving fewer options for vulnerable members of society (Guterman, 2006). This sample-selection bias ultimately creates a two-class system of access to care; patients of means have the resources to seek treatment at specialist hospitals, while less fortunate individuals are relegated to obtaining medical services at general hospitals. As a result, general hospitals receive a disproportionate amount of uninsured or underinsured patients.

These dynamics impact the financial well-being of health care organizations, leaving general hospitals to shoulder the financial burden of uncompensated care. According to Rosko (2001, p. 353), "The viability of hospitals that continue to provide substantial amounts of uncompensated care may be compromised." In the long run, general hospitals that provide substantial amounts of uncompensated care are at risk of closure. Conversely, the challenge of managing uncompensated care is not a predominant issue for specialist hospitals.

By their nature, specialist hospitals operate at an advantage compared to general hospitals. In New York, the advantage afforded to specialty hospitals has influenced the landscape of the industry. Facing financial and regulatory pressure, general hospitals have experienced attrition even as specialty hospitals have grown. Moreover, while EMTALA regulations disproportionately affect the operations of general hospitals, they do not pose as severe a burden on specialty hospitals. Therefore, we postulate the following hypotheses:

H2: As the birth rate of specialty hospitals increases, the death rate of general hospitals also increases.

H3: The birth rate of specialty hospitals increases as government regulations increase.

The Commission on Healthcare Facilities in the 21st Century was established to assess the state of health care in New York. In particular, this commission examined the availability of services and resources possessed by facilities during the 1983–2006 time period. Data collected by the commission is particularly useful as it encompasses a significant period of time since EMTALA regulations went into effect in 1986.

Examining the data from the standpoint of general hospital closures post-EMTALA yields interesting findings. Since the establishment of the EMTALA regulation, 59 hospitals in New York have closed (Commission on Healthcare Facilities in the 21st Century, 2006). All of these 59 hospitals were general hospitals providing emergency room services to patients. These hospital closures affected urban and rural areas alike.

To differentiate between geographical location types, we used the county population as a deciding metric. If a hospital was located in a county with a current population greater than 300,000, it was considered urban, while hospitals located in counties with a population of less than 300,000 residents were considered rural. The sizable number of hospital closures, irrespective of location type, during periods when EMTALA regulations were in effect indicates that the viability of general hospitals has been diminished. Between 1986-2006, 35 hospitals closed in urban areas, while 24 hospitals closed in rural areas.

We argue that the competitive advantage of specialist hospitals was a contributing factor to the mortality of these 59 general hospitals in New York between 1986 and 2006. The restrictions caused by EMTALA regulations can, in part, explain these closures. As the death rate of general

hospitals increased during this period, one cannot help but notice the proliferation of specialty hospitals.

There are currently 222 hospitals in New York. Of these, 189 are general hospitals that provide emergency room services, and 33 are specialty hospitals with no on-site emergency room (New York State Department of Health, 2019). These specialty hospitals are mostly concentrated in urban areas. Using the same location-based metrics, 21 specialty hospitals are located in urban areas, while specialty hospitals are located in rural areas.

Of the 33 specialty hospitals currently operational in New York, 12 have opened or merged into their current entity since EMTALA regulations took effect in 1986. Hospital openings and mergers are considerable; they require a tremendous amount of resources and directly affect patients' access to care. The birth rate of specialty hospitals stands in stark contrast to the death rate of general hospitals, 59 of which closed during the 20-year post-regulation time period. Support in the data gives credence to the argument that regulations were, in part, responsible for changes within the organizational population.

DIRECTIONS FOR FURTHER RESEARCH

This paper has outlined how increasing growth in specialty hospitals in New York began after the implementation of EMTALA and CNR regulations. There is consistent evidence that the growth in specialty hospitals and decline in general hospitals are attributable to these regulations. Because of these regulations and the accompanying loss of revenue from uncompensated care, general hospitals are unable to modernize and afford other efficiencies.

Government regulations have contributed, in part, to the numerous specialist hospitals that are not required to provide emergency room services. The structure of specialist hospitals allows these organizations to circumvent the EMTALA regulations. Specialist hospitals are able to compete more efficiently than general hospitals are since they are not required to provide unreimbursed care to the uninsured and underinsured. Specialist hospitals often occupy different niches than general hospitals do. They serve a specific market, particularly patients who can afford to pay for their care, and have a more specialized organizational form (Hannan & Freeman, 1984; Rao & Singh, 1999; 2001; Scott, 1995).

Despite this comprehensive analysis, there remain several limitations to this paper. First, causality cannot be inferred from a simple interpretation of the data. A more extensive dataset spanning multiple states is required to prove that the discussed regulations were the cause of the general hospitals' closures. In addition, this paper did not consider the effect of demand-side variables, real income per capita, population, or the percentage of the population over 65 years of age.

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