Guest Editorial

Accounting issues in health care

A number of factors have led to the increased national attention on health care issues in the United States during the past three decades. Principal among these was the rapid escalation in public and private health care costs. For example, real per capita national health expenditures rose from about 8.9% of the Gross Domestic Product from 1970–1980 to about 13.7% in 1993 (see Smith et al., 1999, Exhibit 1, p. 87). More pertinent to the public was the fact the annual rate of increase of payments by consumers for private health insurance decreased from 15.7% in 1970–1980 to 13.1% in 1990, and declined further to 3.2% in 1997 (Smith et al., 1999, Exhibit 1 p. 87). Some economists attributed the rapid escalation in health care costs of the 1980s to a perceived key weakness in the health care system – the insulation of the recipients of medical services from the financial responsibility which were borne by third party payers (Leibowitz, 1994, pp. 2, 3; Shelby, 1997).

In response to this rapid escalation in costs, a general movement towards more reliance on managed care has taken place. In general, three types of managed-care programs have emerged: Health Maintenance Organizations (HMOs), Independent Practice Associations (IPAs), and Preferred provider Organizations (PPOs). The economic theory underpinning the emergence of these plans is that the plans can price-shop for consumers by entering into contracts with providers for lower prices (Edgmand et al., 1996, Ch. 5). Employers, conscious of the opportunity for significant reductions in employee health insurance costs, have tended to embrace these plans by offering strong incentives to their employees to enroll. (Edgmand et al., 1996, Ch. 5). As of 1998, Hilzenrath (1998) reports that health insurance was dominated by the managed-care industry.

It is believed by many that the marked deceleration in the rate of increase in health care premiums is largely attributable to this dominance by the managed-care industry, although the evidence supporting this belief is mixed (see Maquis and Long, 1999, p. 76 for a review of the literature). However, the decrease in the annual growth in private health insurance costs from the 1980s to the

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1 For example, the number of employees of large firms who were enrolled in prepaid medical care plans increased from 14% in 1984 to 50% by 1993 (Maquis and Long, 1999, p. 76).
mid-1990s is remarkable – from the high of 15.1% in the 1970–1980 period to a low of 3.2% in 1997 (Smith et al., 1999, Exhibit 1 p. 87). Unfortunately, this downward trend may be already beginning to reverse, with the premium rate increases projected for 1999 and 2001 at 7.7% and 8.4%, respectively (Smith et al. 1999, Exhibit 1 p. 87). The reasons for the expected upward spike in health insurance costs over the coming years vary. Arguably, managed-care programs may have matured, may be operating on thin margins and, thus, may need to raise prices (see the discussion in Armour, 1998; Hilzenrath, 1998). It is also possible that employers may have achieved most of the potential savings by changing from traditional insurance to managed-care plans (see the comments in McGinley, 1998).

Thus, despite the early optimism that managed-care or national health care programs could provide a way to solve the health care crisis, neither appears to be a panacea. Consequently, the search for additional ideas or potential contributions that can be made by other disciplines must continue.

Current issue of the journal

In recognition of the importance of health care as a topic in discussion on national policy, the editors of this journal decided in 1996 to devote a special issue of the Journal of Accounting and Public Policy to the topic. In a guest editorial, I noted that I would serve as Special Associate Editor and I called for submission of papers on the topic (Mensah, 1996). In that guest editorial, I outlined some areas where research was needed to show what role accounting may have played and how it can also help in resolving the health care crisis (Mensah, 1996). The four papers in this special theme issue in which I have served as Special Associate Editor have not necessarily been all limited to the areas I identified in the call for papers. Nevertheless, they all make unique contributions toward our understanding of the role of accounting in the health care context.

In “Adoption of Costing Systems in US hospitals: An Event History Analysis 1980–1990”, Hill (2000) traces the evolution of hospital costing systems in response to external stimuli in the decade from 1980 to 1990. Using data generated from a mail survey, she found evidence that the introduction of the Prospective Payment System (PPS) by Medicare forced many hospitals which did not have any costing management system in place to adopt such systems. Moreover, as the rate of revenue constraints increased, so did the rate of adoption of costing systems.

In a research note entitled “The Effects of Changes in Cost Allocation on the Assessment of Cost Containment Regulation in Hospitals”, Eldenburg and Kallapur (2000) examine the extent to which the results of prior studies of the effect of regulation on cost containment may have been affected by not
considering possible changes in cost allocation practices. Consistent with results from their prior study (Eldenburg and Kallapur, 1997, p. 33), when inpatient full costs were compared to outpatient full costs, the former appeared to have decreased relative to the latter after Medicare PPS reimbursement system was introduced in 1983. However, when inpatient direct costs (i.e., excluding cost allocations from common cost pools) were compared to outpatient direct costs, the former had increased relative to the latter. This differs from previous studies which found decreases in inpatient costs after the introduction of PPS and interpreted such decreases as indicative of the effectiveness of the PPS system.

In “The Impact of Medicare Capital Prospective Payment Regulation on Hospital Capital Expenditures”, Barniv et al. (2000) examine how the introduction of the Medicare PPS system affected the capital expenditure decisions of hospitals. They found a statistically significant decline in capital expenditures (without any changes in relative aggregate operating expenses) in the years following the adoption of the PPS system. This suggested that the PPS system did induce behavior changes among hospitals. In particular, high-cost hospitals decreased their expenditures after the passage of the PPS systems.

In the final paper in this issue, Watkins (2000) considers the ability of financial ratios calculated from the financial statements to fully capture all relevant dimensions of the hospital’s operation. Entitled, “Hospital Financial Ratio Classification Patterns Revisited: Upon Considering Non-Financial Information”, this article presents evidence that, at least for the purpose of replicating hospital bond ratings, non-accounting information provides incremental explanatory power over and above that provided by the financial ratios.

Areas for further study

The first three studies in this special issue offer a historical perspective and some insight into how the introduction of the PPS influenced the development of internal accounting systems. They also offer insight into how hospitals and other health care institutions responded to the external stimuli provided by the introduction of the PPS systems.

These findings by Hill (2000) and Eldenburg and Kallapur (2000) are of importance because they establish that non-profit health care institutions can be motivated to change their accounting systems and the data generated by such systems as the occasion demands. This is consistent with the evidence reported by Mensah et al. (1994a,b) indicating that health care organizations are not immune to the compulsion to tinker with the information generated by their accounting systems. The Barniv et al. (2000) article shows that some real effects (such as reduced capital spending) can be induced under different regulatory regimes. Finally, Watkins (2000) shows that non-accounting
information has an incremental role in the proper evaluation of the credit-
worthiness of hospitals.

These studies provide an interesting starting point for further studies. Among the areas open for further studies, the following general areas identified in the original call for papers (Mensah, 1996, pp. 374, 375) are still in need of research consideration. First, additional research on methods for assessing the efficiency and effectiveness of hospitals is needed. Effectiveness assessment ties in with the renewed interest in measuring and reporting outcomes for non-profit entities. Second, research on plans that provide the appropriate incentives to health care employees (including physicians) are needed. Furthermore, given the current public debate on whether managed-care incentive plans create inherent conflicts for physicians, empirical studies examining this issue would contribute to a better understanding on which plans might work and under what circumstances. Third, research into benchmarking practices in hospitals would be worthwhile. Finally, additional research into financial reporting and evaluation models and practices in the managed-care industry as well as other sectors of the health care sector is needed.

Given the continuing debate on the proper role of physicians vis-à-vis the administrators of managed-care plans as well as the predicted re-escalation of health care costs, additional studies on the role of accounting in the health care arena should continue to be of interest to the readership of this journal.

References


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