Special Report

COLUMBIA/HCA AND THE RESURGENCE OF THE FOR-PROFIT HOSPITAL BUSINESS

(First of Two Parts)

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HOSPITALS, surprisingly, have emerged as a prime growth industry attractive to entrepreneurs. Seemingly, a legacy of overbuilding combined with competitive cost-cutting pressures should reduce the earnings of nonprofit and for-profit hospitals alike, making them unattractive investment candidates. Yet in the 1990s, for-profit hospital chains on a buying binge have outpaced the stock market. Conversions of nonprofit to investor-owned hospitals have accelerated, reaching a level of 58 in 1995, up from 34 in 1994.[1]

This two-part article addresses the medical, ethical, and public-policy issues posed by the resurgence of for-profit chains and their acquisition of nonprofit community hospitals. The prime case in point is Columbia/HCA Healthcare Corporation, the largest and most aggressive of the for-profit chains, the product of three large and several smaller mergers. With 340 hospitals, 135 outpatient-surgery offices, and 200 home health care agencies in 38 states, Columbia/HCA now controls nearly half the for-profit beds, and 7 percent of all hospital beds, in the United States. The company's gross earnings exceed 20 percent of revenues, and its 1995 profits were just under $1 billion, with $20 billion in assets.[2,3] It is now the nation's 10th largest employer, with 240,000 employees.

There are four broad explanations for the surprising profitability of the proprietary chains. First, the chains, as claimed, are generally more cost-conscious than voluntary and public hospitals, which have goals outside the market. Second, in their business strategy, for-profits tend to avoid unprofitable services and unprofitable patients, displacing these costs onto the rest of the health care system. Third, for-profits sometimes "re-engineer" or downgrade their staffing, administration, and supplies. Finally, large for-profit chains offer financial incentives for doctors to use their hospitals, even though competing hospitals may actually have lower costs and charges.

Columbia/HCA, for example, invites doctors to become shareholders in its local ventures, which often include several hospitals, ambulatory surgical centers, diagnostic facilities, a home care affiliate, and rehabilitation and physical therapy facilities. The company invests heavily in medical data systems that are available at both the hospital and the doctor's office. In many localities Columbia/HCA offers convenient office space at competitive rents. All these efforts are intended to make the doctor a partner (or happy captive) and an enthusiastic source of patients.

This strategy builds a powerful referral network and a source of market power. In addition, by bringing the doctor into an integrated network, Columbia/HCA neatly sidesteps ethical and legal conflict-of-interest constraints. Under the ethical guidelines of the American Medical Association, as well as federal and state anti-kickback laws, a doctor (with some exceptions) may not refer a patient to a facility in which he or she has a direct financial interest. Under federal "safe harbor" regulations, however, the most notable exception is a hospital or integrated delivery system owned by a public company worth at least $50 million in which the doctor is a shareholder.[4] A clinical laboratory to which a doctor-owner cannot legally refer patients becomes a legal referral facility if it is part of a large, integrated entity in which the doctor holds stock. Though this maneuver creates a legal loophole, the ethical issue of whether self-referral distorts clinical judgment remains. (One pending Texas lawsuit, brought by James Thompson, M.D., alleges that Columbia/HCA provides some services to doctors below cost, as disguised referral fees, which would be illegal.[5])

RECENT HISTORY

After a near-demise in the late 1980s, for-profit hospital chains are in a second phase of robust growth. In the 1920s, proprietary hospitals, often founded by local doctors, were a fixture of the health care system, accounting for some 36 percent

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of U.S. hospitals.[6] With the rise of voluntary and public hospitals after World War II, however, the proprietary sector dwindled. Shareholder-owned chains date only to 1960, when American Medical International (AMI), a West Coast laboratory company, purchased its first two hospitals.[7] Investor-owned chains grew rapidly after most people became insured with the enactment of Medicare and Medicaid in 1965. By 1971 there were 38 for-profit chains.[8] At their postwar peak in 1986, for-profit companies owned 838 hospitals and 107,000 beds, or about 14 percent of general acute care hospital facilities in the United States.[9]

In the late 1980s, shareholder-owned chains seemed likely to become casualties of cost-containment, overbuilding, and scandal. Reimbursement according to diagnosis-related group for Medicare patients and the rise of managed care undercut the economics of cost-plus billing. The two largest for-profit chains, Hospital Corporation of America (HCA) and Humana, stumbled in their attempt to operate both hospitals and health maintenance organizations (HMOs). HCA, after expanding to encompass more than 200 hospitals and launching a managed-care company, sold off 104 of its hospitals in 1987 to the newly created company Healthtrust (owned by former HCA executives). Humana, then the largest chain, launched its HMO subsidiary, Care Plus, in 1983 but was soon whipsawed between doctors and competing HMOs. Physicians affiliated with Humana Care Plus chafed under the constraints of managed care and would not reliably patronize Humana hospitals, whereas rival HMOs avoided them. Humana's hospitals were then spun off to the newly created Galen Health Care Corporation. Galen, in turn, was absorbed by Columbia/HCA in 1993.

Another major chain, National Medical Enterprises (NME), was fined $379 million on criminal charges that its psychiatric hospitals had paid for referrals and kept patients incarcerated until their insurance ran out. NME then raised over $3 billion in junk-bond and bank financing, bought AMI, and was reborn as the Tenet Corporation. Republic Health Corporation, in bankruptcy after overborrowing, reorganized, bought Safecare Corporation, and was renamed OrNda, allegedly an Iroquois word meaning "well-being." All these surviving chains now seek to expand further, either by merger or joint venture with other health care companies or by the purchase of nonprofits.

Remarkably enough, the instability, bankruptcies, and falling profits of the 1980s have given way to a new wave of lucrative consolidations in the 1990s. In 1995 alone, there were 447 community hospitals in play in takeover negotiations, as well as several hundred more that had been sold in four large corporate mergers.[10,11] In a sense, this process is not unlike the reorganizations of the steel, airline, and banking industries, in which well-capitalized entrepreneurs buy underperforming assets, consolidate, increase market power, cut costs, restore profitability, and reap the rewards. Richard L. Scott, the 43-year-old chief executive and architect of Columbia/HCA, has written that "free market, competitive forces should be the driver" to reform the health system.[12]

ETHICS, CROSS-SUBSIDIES, AND MARKETS

A hospital is not, of course, a pure creature of free markets. In medical care there are disparities of information and bargaining power between "seller" and "consumer."[13] A doctor is, in one sense, a small business par excellence. But since the physician also has privileged knowledge and authority vis-à-vis patients, professional ethics dictate that the doctor not opportunistically base clinical decisions on personal reward. By the same token, although nonprofit hospitals must at least break even, historically they have embraced a social ethic, serving uninsured patients, taking Medicaid losses, not insisting that every admission or procedure be profitable, and spending money on research, teaching, and public health as part of a broader mission of service to the community. In economic terms, these are cross-subsidies.

Entrepreneurs, by directly imposing market principles on hospitals, overturn the explicit and implicit understandings that have allowed doctors and hospitals to balance professionalism, profitability, and service. Conceiving of a hospital as just another business undermines the service mission by eliminating the tacit cross-subsidies. In the logic of the marketplace, each investment must pursue profit. Temporary losses are defensible only as investments in future profits, so cross-subsidy must be avoided. Thus, in a purely for-profit enterprise or system, there is no place for uncompensated care, unprofitable admissions, research, education, or public health activities — all chronic money losers from a strictly business viewpoint. By definition, the value of public goods is not recognized by profit-maximizing private markets. Disdaining a public health mission, David Vanderwater, chief operating officer of Columbia/HCA, has said, "We are not in the health care business. We are in the sick care business."[14]

Furthermore, by weakening the professionalism that has traditionally served as a counterweight to the profit motive in medicine, the investor-owned chains risk undercutting clinical care as they relentlessly pursue cost savings. In theory, the competitive marketplace prevents any deterioration in quality, because dissatisfied customers are free to take their business elsewhere. But the health care system is rife with well-known asymmetries of information and "customers" who are essentially captive. By attracting the doctor and the insurance plan or HMO, the for-profit chain brings along the patient. Insofar as the investor-owned chains initiate a cost-cutting "race

to the bottom" among hospitals, effective consumer choice is precluded, because rival hospitals pursue essentially similar economies.

COLUMBIA/HCA

Leading the race is Columbia/HCA, the result of a merger of two of the most aggressively entrepreneurial companies. At its zenith in the mid-1980s, HCA, the older and larger of the two companies, owned 250 hospitals and had contracts to manage 200 more. Columbia's founder, Richard Scott, bought his first two hospitals in El Paso, Texas, from Healthtrust in 1988. From a base of 12 hospitals in 1991, Columbia acquired Basic American Medical (1992, 8 hospitals), Galen (1993, 71 hospitals), HCA (1994, 97 hospitals), Medical Care America (1994, 96 ambulatory surgical centers), and the rest of Healthtrust (1995, 117 hospitals) after a bidding war with NME. Strikingly, both large spinoffs of the 1980s — HCA's sale of nearly half its hospitals to Healthtrust and Humana's sale of all its hospitals to Galen — have wound up with Columbia/HCA. In 1995 alone, Columbia/HCA acquired or negotiated joint ventures with 32 nonprofit hospitals.[2,15-17] Its spectacular success is clear from the numbers shown in Table 1.

Columbia/HCA's basic plan has been to acquire hospitals at the lowest possible cost, invest in upgrading where necessary, close or consolidate duplicative facilities, cut staff, increase administrative efficiencies, take advantage of economies of scale, integrate vertically and horizontally, and develop powerful local referral networks. The company's era of very rapid growth through the wholesale acquisition of other large for-profit chains is probably over. If Columbia/HCA attempted to merge with any of the other surviving large chains, such as Tenet or OrNda, it would probably face antitrust action.

Columbia's strategy differs strikingly from that of Humana and HCA in the 1980s. It does not, for the most part, build new hospitals. Rather, it buys existing hospitals cheaply, upgrading some acquisitions and closing or consolidating others. Despite the gradual shift to full capitation contracts with managed-care payers (in which hospitals are paid a flat fee), Columbia/HCA resists such contracts, except in markets where it can trade them for very substantial volume. Columbia will also buy new business from payers by pricing below its average cost, then seek compensating ways to raise charges. Unlike some of its competitors, purchasing physicians' practices has not been central to Columbia/HCA's strategy of creating alliances with doctors. Nonetheless, Columbia/HCA has absorbed over 1400 doctors' practices merely through its acquisitions of other corporations and occasionally buys practices to complement a local market strategy.[18] The company's strategy is instead to rely on its referral networks to attract patients, despite the fact that it is often not the low-charge provider. If it controls enough market share in a given locale, insurers have no choice but to deal with Columbia/HCA. And, as hospital reimbursements are squeezed, its control of an integrated network gives the company access to profitable outpatient venues to treat patients. Recently, Columbia/HCA has moved to enter the insurance business itself, as will be discussed in the second part of this article.

Columbia/HCA is extremely aggressive with vendors, offering all its business to the supplier who offers the best deal. Scott has claimed that his negotiating tactics save Columbia/HCA $300 million a year on supplies. General Electric, for example, has a five-year contract as the sole supplier and repairer of all the company's high-technology diagnostic equipment. In return for a favorable price, Columbia/HCA buys all its computed tomographic scanners and magnetic resonance imaging units from General Electric.

The company has targeted and achieved a formidable corporate goal of a 20 percent gross return on revenues. I was told by a Columbia/HCA executive that chief executives of company hospitals who fall short of this goal are regularly called to corporate

TABLE 1. THE GROWTH OF COLUMBIA/HCA, 1988–1995.*

VARIABLE	1988	1989	1990	1991	1992	1993	1994	1995
No. of hospitals	4	4	11	12	24	115	207	332
No. of admissions	7,022	20,884	32,925	48,950	74,630	1,158,400	1,565,537	1,744,793
Gross revenue (thousands of dollars)	45,260	153,130	290,322	499,427	819,302	10,252,000	14,543,000	17,646,000
Net profits (thousands of dollars)	1,704	6,258	9,848	15,202	25,875	507,000	814,000	988,000
No. of licensed beds at year end	511	833	2,130	2,542	42,245	42,237	59,595	61,347

*Data are from Columbia/HCA Healthcare Corporation (for 1995) and Columbia Hospital Corporation (for 1988 to 1994) annual reports.

headquarters in Nashville to explain and are ordered to redouble their efforts. Further economies at the local hospital usually follow.

Columbia/HCA markets aggressively. It advertises that a disproportionate number of Columbia/HCA hospitals have received accreditation with commendation from the Joint Commission on Accreditation of Healthcare Organizations and that 29 of its hospitals were included in the 1995 top-100 ranking by HCIA, Inc., and William M. Mercer Company (six of whose eight criteria are financial). Columbia/HCA advertisements claim that "The Examiners of the Malcolm Baldridge National Quality Award have recognized Columbia/HCA Healthcare Corporation's Ambulatory Surgery Division. . . [for] Continuous Efforts to Improve Quality Through Process Improvement and Performance Measurement." In reality, Columbia's ambulatory facilities had worked with the Commerce Department on a pilot program to develop quality indicators and criteria for future awards. Columbia/HCA won no special recognition, much less the prestigious Baldridge Award. The Commerce Department wrote to the company requesting that it cease the misrepresentation, to no avail.[19]

Columbia/HCA has waged strident campaigns to discredit nonprofits, as HCA did before it. Columbia/HCA has hired research firms to show that when the value of tax exemption and uncompensated care are aggregated, for-profit companies return more to the community than nonprofits. A 1995 report for Columbia/HCA by Healthcare Management Decisions, Inc., characterized five of six nonprofits that compete with the company in central Florida as providing "negative community benefits" and creating a "net community burden," because the value of their tax exemption exceeded that of their charity care.[20] In a 1994 Virginia study financed by HCA, Nancy Kane, on the faculty of the Harvard School of Public Health, calculated that nonprofit hospitals provided more than double the free care provided by for-profits (3.7 percent of revenues vs. 1.7 percent) and contributed 1.1 percent of their revenues to medical education, as compared with effectively nothing in the case of for-profits. But Kane concluded that when the cost of tax exemption (8.4 percent of operating revenues) is included, for-profits return more, on balance, to society.[21] Her method, however, assumes that tax payments to federal, state, and local government are equivalent to direct outlays for health care.

COMPARING FOR-PROFIT AND NONPROFIT HOSPITALS

Researchers who systematically studied for-profit chains in the 1970s and 1980s generally found that the for-profits had slightly higher average costs and charges than nonprofits, that they provided below-average rates of uncompensated and charity care, and that their clinical outcomes were not significantly different from those of comparable nonprofits.[22-24] But enormous changes have occurred in the hospital sector over the past decade. For-profit chains are no longer buying mainly independent proprietary hospitals or merging with each other: they are now acquiring community nonprofit hospitals. Cost-cutting pressures have intensified. Most important, hospitals are no longer paid predominantly on a fee-for-service basis, so profits must be made by cutting costs and services, not by increasing them.

The latest wave of for-profit consolidations and acquisitions is too recent to have been the subject of similar comprehensive studies. However, scattered evidence suggests that for-profits still provide relatively less charity care than their public and nonprofit counterparts and that they "cherry-pick" profitable admissions. One recent study, relying on data from the Health Care Financing Administration, concluded, "In summary, Columbia/HCA hospitals served fewer Medicaid patients, treated more complex cases, offered fewer services, incurred lower salary expenses per discharge, and had fewer occupied beds than local competing hospitals."[25] Florida's Agency for Health Care Administration, in a review of admissions at Victoria Hospital, a Columbia-owned facility in Miami, found that Medicare patients referred by Columbia-affiliated doctors stayed an average of 8.48 days. Patients sent by the same doctors to other area hospitals stayed 13.5 days. This pattern maximizes Columbia's profits, because of the system of Medicare reimbursement based on diagnosis-related groups. The Florida agency, in a draft report that was never officially released, concluded that the statistics "point to the possibility of cream-skimming," as well as "the possible adverse effects on a market of physician ownership in a hospital."[26,27] A report by the Georgia State Health Planning Agency found that in 1993, nonprofit hospitals contributed about twice as much charity care per bed as for-profits. This overstates the contribution of for-profits somewhat, because their charges are higher.[28]

In one of the most comprehensive tabulations of comparative charges, VHA, Inc. (formerly Voluntary Hospitals of America), used inpatient claims data supplied to the Florida Agency for Health Care Administration to compare for-profits and nonprofits. The VHA study found that investor-owned hospitals in 1994 were 13.7 percent more expensive on a charge basis than nonprofit and public hospitals. Charges by nonprofits, the report calculated, would have been even lower if the nonprofits had not been absorbing a disproportionate share of Medicaid and charity care. Medicaid patients accounted for 12.3 percent of the case mix among nonprofits, as compared with 6.3 percent among for-profits.[29] A VHA

study of Virginia hospitals calculated that investor-owned hospitals were 30 percent more expensive on a charge basis than public and nonprofit hospitals.[30]

Similar tabulations by the firm of Parker, Hudson, Rainer and Dobbs, with the use of publicly collected data from state authorities, found that Florida for-profit hospitals, which accounted for 56 percent of institutions and 34 percent of licensed beds, supplied just 8 percent of charity care and 20 percent of uncompensated Medicaid care.[31] In Tennessee, the for-profits, with 44 percent of hospitals and 35 percent of beds, provided only 3 percent of charity care, according to a Parker study.[32] Similar disparities were found in Georgia.

The trouble with these dueling consultants' reports is that all the parties are self-interested. The comparisons by the Parker firm and by VHA are based on public data and are seemingly accurate. But the question of the comparative performance of nonprofits and for-profit chains cries out for a second wave of disinterested scholarly research to examine such issues as charity and uncompensated care and costs and charges.

An even thornier question is whether the for-profits, in a much more stringent cost-cutting environment than the 1980s, are degrading clinical care. Although Columbia/HCA prides itself on scoring well on formal paperwork evaluations, and although it insists that its commitment to quality includes, above all, patient care, it is also strongly committed to reducing staff costs and outlays for equipment. In general, for-profits have continued to have a slightly lower overall ratio of staff to patients than nonprofits.[9] Although in part, this reflects laudable "delayering" and economies of scale, Columbia/HCA has also been bitterly criticized by some of its own staff members for replacing licensed personnel such as registered nurses with "multi-skilled" employees trained by the company, for "short-staffing" nursing shifts, and for introducing inferior supplies.

At the Good Samaritan system, a recently acquired four-hospital group in Santa Clara County, California, nurses (who are in a collective-bargaining dispute with Columbia/HCA) have complained not only of patient overloads, but also of poor-quality equipment. According to nurses with whom I have spoken, surgical gloves supplied by Columbia are thinner and more likely to break than those used previously, alcohol sponges are smaller, and a new chest drainage tube substituted by Columbia/HCA has a valve that does not indicate whether it is on or off. Nurses also allege more errors in medication but less frequent reporting of them.

Columbia/HCA, like other hospital operators, cuts costs by replacing many registered nurses and licensed practical nurses with lower-skilled and unlicensed people for many tasks once done by nurses, such as taking vital signs, changing sterile dressings, and some charting. According to nurses I have interviewed, staff cuts at some Columbia/HCA hospitals put nurses in the position of supervising unlicensed personnel, providing less direct patient care themselves. In fairness, "re-engineering" is pervasive among hospitals, and nurses' groups have objected to essentially similar staffing changes at public and voluntary hospitals.

In the further pursuit of economies, Columbia/HCA has merged traditional departments such as social work, which are seen as cost centers, with discharge planning. With the growing shift to Medicaid HMOs and the competition for Medicaid managed-care contracts, as well as increasing pressure for cost containment from other payers, the temptation will be great to further ratchet down staffing and, perhaps, care.

THE MARKET SPEAKS

For-profit chains are ultimately accountable to shareholders, not to communities. And the stock market is certainly bullish on Columbia/HCA, whose stock price since 1990 has risen at more than twice the rate of the Standard and Poor's 500. Despite its far-flung acquisitions, Columbia/HCA has maintained a prudent debt-to-capital ratio of 45 percent, well below that of its competitors Tenet and OrNda. Its debt is considered investment-grade, and Columbia has no difficulty raising capital. Most of its acquisitions are financed from its prodigious cash flow, which was $4.3 billion in 1995. Columbia's average cost of debt is 7.1 percent, and it is one of just four U.S. corporations in the past four decades to have successfully issued 100-year bonds.[2] When it buys a hospital or hospital chain with a shakier balance sheet, Columbia/HCA refinances the target hospital's debt at its own more favorable interest rates, producing an instant savings. Leading financial analysts currently rate Columbia's stock as a "buy."

Some critics in the hospital industry argue that Columbia's expansion strategy is a kind of Ponzi scheme that works only as long as Columbia/HCA keeps acquiring underperforming hospitals. Its very high profit rate is driven in part by the creation of one-time economies that are not repeated year after year, except through the acquisition of other new hospitals. Yet with nearly 5000 nonprofit and public hospitals in the United States, many of them reeling from the financial pressures of managed care, there is no shortage of targets. Columbia/HCA gains plenty of market power with a local market share of 20 to 30 percent and only rarely bumps up against antitrust problems. Richard Scott has talked about ultimately owning 500 to 1000 hospitals, and he plans 35 to 50 acquisitions a year. Columbia's cash flow is sufficient to maintain this pace without either worsening its debt–equity ratio or watering its stock. Thus, as long as its stock price holds up, it should

be able to continue expanding — unless it meets substantial resistance.

The only real cloud on Columbia's horizon is that such resistance is growing. In the past, Columbia went into communities with stunning speed and often negotiated binding letters of intent with the boards of nonprofit hospitals before communities could consider whether the local hospital should be sold. Lately, however, several deals have been rejected, and state attorneys general have begun asserting jurisdiction, questioning whether charitable assets are being sold too cheaply and whether insiders are, in effect, bribed to consummate the transaction. In the second part of this article I will focus on the legal and public-policy questions raised by Columbia's conversions and examine the effect of the for-profits on the behavior of the besieged nonprofits.

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CORRECTION

Columbia/HCA and the Resurgence of the For-Profit Hospital Business

Columbia/HCA and the Resurgence of the For-Profit Hospital Business . On page 364, in Table 1, the number of licensed beds at year end for the year 1992 should have been 4938, not 42,245, as printed.