HEALTH CARE

The Wal-Mart of hospitals

Columbia, America's largest hospital chain, gobbles up nonprofits, slashes basic services and raises prices.

By Sean Cahill

As the number of uninsured Americans grows, the health care industry is raking in record profits. That money flows into the pockets of a handful of corporate giants now asserting dominance over the field. Every three days, there is another hospital merger or acquisition—often of a nonprofit gobbled up by a for-profit. According to Public Citizen, 447 community hospitals were objects of mergers or acquisitions in 1995, and 58 nonprofit hospitals converted to for-profit status in that year alone.

The exigencies of managed care are driving the hospital-merger mania. Hospitals merge to increase size and market power, and thus cut costs, enhance their ability to negotiate with insurers and better compete with health maintenance organizations. According to *Modern Healthcare*, the amount of money hospitals spent on care for the poor dropped in 1994 for the first time in more than a decade, even as profits jumped 17.3 percent to a record high of $13.8 billion.

For-profits currently comprise 15 percent of the nation's hospitals, and a 1996 Coopers & Lybrand study estimates that for-profits will own one in four hospitals by the turn of the century. Columbia/HCA, the nation's largest for-profit hospital chain, is leading the charge. Columbia owns 10 percent of the nation's hospitals, including about one-third of Florida's hospitals and 80 percent of Utah's hospital beds. This $20 billion giant owns a total of 350 hospitals and 133 outpatient surgery centers in 38 states. Columbia's game plan is to vertically integrate in order to provide "one-stop shopping"—owning everything from the hospital to the insurance company, the home health care provider and the local pharmacy.

The company says it brings private-sector efficiency to flabby nonprofits, cutting health care costs while improving patient care. A growing legion of opponents, however, sees things differently. They argue that Columbia and other for-profit hospital chains are buying up the country's health care infrastructure at far less than these institutions are worth, creating quasi-monopolies. They then slash basic services like trauma care—which too many uninsured patients use, making it unprofitable—and jack up the price of services across the board to boost profits. For-profit hospital executives and shareholders are making out like bandits. Columbia founder and Vice Chair Thomas Frist made it onto the 1996 *Forbes* list of the 400 richest Americans, amassing a net worth of $1.1 billion. Meanwhile, consumers, the uninsured and the employers who pay for higher health care costs end up footing the bill.

Gobbling up nonprofit institutions like Pac-Man, Columbia has merged with or acquired more than 340 hospitals since 1987. In 1995 alone, the company negotiated 27 deals to purchase nearly three dozen nonprofit hospitals. The chain pays bargain-basement prices for community-built institutions that have been subsidized for decades by taxpayers. Unlike for-profits, which are owned by and accountable to their shareholders, nonprofits are usually owned by a university, religious institution or municipal government, and are incorporated as charitable trusts. The bylaws of these nonprofit hospitals usually empower the board of directors to sell the hospital, sometimes by a simple majority. In recent years, many have sold due to an increasing inability to compete in the managed-care marketplace.

Despite the nonprofits' community mission, institutionalized mechanisms rarely exist for community review of the sale decision. In nearly all cases, the only party with legal standing to intervene in a transfer or sale of charitable assets is the state attorney general. Furthermore, because the sales

of nonprofits to for-profits are usually inside deals, and because nonprofit hospital administrators and managers may benefit from higher salaries or shares in the for-profit institution, the sale price is often less than the fair market value of the hospital.

The Internal Revenue Service requires that proceeds from the sale of charitable assets stay "in the charitable stream," so usually the proceeds of any sale must be reinvested in another charitable entity, such as a free-care pool. Golden parachutes are one way of diverting money from the charitable stream to board members' pockets. Ohio Attorney General Betty Montgomery sued last year to block Columbia's purchase of the nonprofit Blue Cross/Blue Shield of Ohio, in part because of the $15 million in severance pay offered to three of the Blue Cross officials who approved the deal. "Fifteen million dollars in severance packages for three officials of an organization founded as a charity, and operated to help the sick and needy, strikes me as both inappropriate and excessive," she said. Montgomery is also trying to block the $300 million purchase of the insurer on the grounds that it would leave consumers with little choice and less power to negotiate costs; pose an insurmountable barrier for uninsured people seeking proper care; and increase the cost to business of providing health care to employees.

Columbia's incursion into San Diego's health care market offers an example of the perils of these sorts of deals. In November 1995, Columbia offered to pay $195 million for half—and controlling—interest in Sharp HealthCare, an operator of four hospitals and a medical group in San Diego County. Last November, California Attorney General Dan Lungren launched a civil investigation into the proposed merger. Lungren threatened to sue to block the deal, charging that it "threatens the value of the charity and the charitable services provided to the community" and "would breach the trust under which Sharp operates."

Deputy Attorney General James Schwartz, who monitors nonprofit corporations for the state, charged that Columbia's offer "grossly undervalued" the facilities, pointing out that two other for-profit hospital chains submitted significantly higher bids than Columbia. Schwartz vowed to sue "to hold the Sharp directors who voted to approve the transaction personally liable."

Columbia's goal is to turn a profit—at least 20 percent per hospital per year—regardless of the effects on patient care. The company's modus operandi is to buy up several hospitals in a city or region, close some down and consolidate services in fewer locations in order to increase the capacity and the profitability of other hospitals they own in the area. For example, Columbia purchased Seminole Hospital and Women's Center and Pinellas Community Hospital near Tampa, Fla., on March 18, 1996. Three days later, Columbia closed the two hospitals, eliminating 318 jobs. Although the chain denied it had acquired the properties to close them and reduce competition, Columbia/HCA Tampa Bay Division President Bill Hussey admitted to the *St. Petersburg Times* that the company had done just that in the case of other acquisitions.

Since 1994, Columbia has closed approximately 20 hospitals nationwide, leaving rural communities even more isolated from medical care. In Gilmer, east Texas, Columbia closed the town's only hospital, leaving residents more than 20 miles from the nearest hospital. Columbia gave the city of Destin, Fla., only three days' notice when it closed Destin Hospital in May 1994. Columbia's Chief Operating Officer David Vandewater explained, "You just can't have a hospital on every corner," even though the nearest hospital is now 45 minutes away.

Columbia's relentless pursuit of profit has also led to massive layoffs. After acquiring Henrico Doctors' Hospital, in Richmond, Va., Columbia laid off 65 workers, mostly registered nurses, in early 1996, allegedly replacing them with part-time nurses, nurse technicians or other unlicensed professionals. Elsewhere, Columbia's layoff numbers are even higher: Columbia-HealthONE in Denver laid off 169 people in November 1995 and another 139 in March 1996; Wesley Medical Center in Wichita, Kan., laid off 204 in early 1996; and Good Samaritan Health System in San Jose, Calif., laid

Friends in high places

Columbia/HCA has enormous political clout. The chain has more than a dozen registered lobbyists in Washington, who lobby Congress on Medicaid, Medicare and health care reform.

Republican Sen. Bill Frist of Tennessee, whose brother, Thomas, is Columbia's founder and vice chair, owns $13.9 million in Columbia stock. Sen. Frist sits on several key committees, including Banking, Budget and Labor, where he has influence over legislation that affects Columbia. Last year, Sen. Frist worked behind the scenes to hold up a bill requiring a minimum 48-hour hospital stay for new mothers, even though he is listed as a co-sponsor of the bill.

Columbia's influence is even greater at the state and local level, where it has 86 lobbyists in 19 states. In Florida, Columbia's Good Government PAC was the state's largest PAC contributor in 1994, donating $216,676 to Florida legislative races. After receiving $116 million in state funds to relocate from Kentucky to Tennessee in 1995, Columbia managed to kill a bill requiring all Tennessee hospitals to report the amount of community benefits they provide. The Tennessee attorney general also quietly dropped his antitrust investigation into Columbia. — S.C.

off over 500 people in 1996.

Reports of labor abuses are widespread, too. These include charges of intimidation and coercion against hospital workers seeking to unionize, as well as threats of job loss and facility closure. After Columbia closed Palm Beach Regional Hospital in Florida in 1995, the nearest emergency room was at Columbia's JFK Medical Center. JFK Medical Director Dr. Michael Barfield was fired four days after complaining to Columbia that the overflow from the closed hospital, with ambulances lined up outside and an overworked staff, "endangers patients' lives." Last spring the National Labor Relations Board ruled that Columbia Audubon Regional Medical Center in Louisville, Ky., had defeated a labor drive among its registered nurses through an illegal campaign of intimidation, and ordered Columbia to bargain with the union representing the nurses.

These cutbacks affect patient care. In June 1996, the Indiana State Department of Health fined Columbia Women's Hospital of Indianapolis $25,000 for failing to have enough nurses on duty. Columbia's Blake Medical Center in Bradenton, Fla., was fined a record $55,000 in 1995 for denying emergency medical care to two patients. Columbia CEO and President Richard Scott asks, "Do we have an obligation to provide health care for everybody? Where do we draw the line? Is any fast-food restaurant obligated to feed everyone who shows up?" Co-founder Richard Rainwater evidently shares his partner's idea of what health care is all about: He proudly compares his company to McDonald's and Wal-Mart.

Clearly, health care advocates have good reason to fear that for-profits will eliminate medical services for the poor and reduce or eliminate other areas of health care that are not big money makers, like neonatal intensive care, AIDS care and burn and organ-transplant services. Two studies in Georgia and Tennessee conducted by the law firm of Parker, Hudson, Rainer and Dobbs in 1994 lend credence to suspicions that for-profits like Columbia are "cream-skimming" profitable patients, leaving nonprofits to handle indigent care. The studies found that in both states, nonprofits provided a disproportionate amount of care for the poor, even as they charged paying patients less for services than did the investor-owned hospitals.

State health officials in Columbia's home state of Tennessee also found that nine of the company's hospitals there provided noticeably less care to the poor than nonprofits and even other for-profits. In North Carolina, the attorney general's office put a hospital sale on hold because Columbia would not agree to maintain emergency medical services and indigent and charity care "at the same level currently provided." The sale went through when, in a compromise, Columbia agreed to provide "sufficient" indigent care.

In regions of the country where Columbia and other for-profit hospital chains dominate the market, including Florida and El Paso, Texas, studies document price increases for hospital services. In Florida, Columbia has asked on 10 occasions for state health care budget increases, and has appealed the Florida Health Care Board's rejections four times. A 1994 study of Florida hospitals documented that for-profits charged 13.7 percent more than nonprofits.

Citizens and government officials are organizing in response to the concerns created by for-profit takeovers of nonprofit hospitals. Labor unions like the Service Employees International Union and doctors groups like Physicians for a National Health Plan are working to expose Columbia's abuses. In 1996, Nebraska became the first state in the country to require full public disclosure and state approval of for-profit purchases of nonprofit hospitals. Massachusetts and California are considering similar laws. In Massachusetts, where Columbia owns two hospitals and has bids in for two more, state Rep. Patricia Jehlen has introduced a bill that would block for-profit hospitals from buying any more facilities in the state. New York state law bans investor-owned for-profits from owning hospitals there.

"Health care should be about prevention and treatment of disease based upon need, not about profit and corporate greed," says Kathryn Mulvey, executive director of the Boston-based corporate watchdog group INFACT, which is investigating Columbia. "The two are fundamentally incompatible. Trends such as the for-profit takeover of health care are not inevitable, but only occur because we allow them to, and because corporate lobbyists and campaign contributions block sensible regulations which enjoy widespread public support." ◀

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LABOR

White coats with blue collars

Squeezed by HMOs, doctors are starting to form their own unions.

By Annette Fuentes

For 10 years, Dr. P. has practiced the kind of medicine he loves at a major medical center's outpatient clinic in New York City. Like his fellow physicians, he was drawn by the center's excellent reputation for urban health care. But his labor of love began to sour in 1995 when hospital administrators, worried about falling revenues, put the squeeze on doctors to increase their productivity. They hired efficiency experts who followed staff around with clipboards, timing patient visits like cars coming off an assembly line.

"They set a specific target for how many patients you should see per hour at four," says the doctor, who prefers to remain anonymous. "They went to an incentive program, cutting our salaries by 10 to 20 percent, which could be restored if you met the productivity levels."

Without physicians' input, the bean counters started changing the roles of clinic employees to the detriment of quality care. Ancillary staff, including social workers, translators and medical-records personnel, was slashed. Medical assistants, who used to take blood pressure and weight, were required to draw blood, a job previously performed by lab technicians. By the spring of 1996, their backs to the wall, the clinic's physicians decided there was only one thing to do: organize a union. The United Salaried Physicians and Dentists, a 500-member union based in New York City, is working with them.

Dr. P. says it may take a couple of years for his core group of 20 doctors to reach a critical mass for unionizing, because many fear being fired or blacklisted. But these union activists see organizing as the only long-term solution to their problems.

They are certainly not alone. Union talk has caught fire among physicians across the nation, as they've seen their authority, professionalism and incomes diminish with the rise of managed-care health delivery and the economic competition it engenders. Health-maintenance organizations and insurance companies are intervening in the practice of medicine—both at hospitals and in private practices—in ways that doctors and patients alike think compromise quality health care.

For patients, legislative remedies—such as recent laws that ban HMOs from limiting hospital stays for maternity and mastectomy patients—offer at least a piecemeal response to HMOs' profit-driven excesses. For physicians, however, old-fashioned labor organizing may be the best way to safeguard jobs and, not incidentally, to defend quality health care—an issue likely to unite doctors and their patients.

"Doctors are being aced out of decision-making by nonmedical people and are trying to deal with the conditions affecting them. Collective bargaining is still the best model," says John Ronches, executive director of the Committee of Interns and Residents, a 40-year-old New York union whose members work in public and private hospitals and other health facilities. With 10,000 members in New York, New Jersey, Massachusetts, Washington, D.C., Ohio, Florida and California, CIR is the largest union of employed physicians. In 1996, it grew by 50 percent, says Ronches. That figure includes 950 resident doctors in a Florida hospital who voted by a 4-to-1 margin to join CIR in the largest union vote ever by doctors.

Doctors' burgeoning interest in unions can be attributed in part to the way managed-care health delivery, by turning doctors into employees at an ever increasing rate, is radically reshaping the medical profession. According to a 1995 survey by the American Medical Association, a record 40 percent of the country's 720,000 physicians now work as salaried employees of hospitals, clinics, HMOs and group