

## **Outlook for Hospitals: Systems are the solution**

*Harvard Business Review* (September/October 1980).

*Given that the freestanding hospital may not survive the tightening health care market, which large hospital system the not-for-profit or the investor-owned management company should dominate?*

*Like all industries, the health care industry under goes change. A fragmented system of isolated, free-standing community hospitals is undergoing rapid consolidation into large multihospital corporations and systems. If the history of other industries is any guide, this consolidation will accelerate as the nation instills greater economic competition in the health marketplace. In the future, say the managers of two very different hospital networks, large multihospital systems will predominate. Two big questions, then, are: Should these systems be proprietary or voluntary? And how should they go about meeting people's changing health care needs?*

*These interviews with the physician founders of two multihospital Organizations, Hospital Corporation of America in Nashville and Rush-Presbyterian-St. Luke's Center in Chicago, focus on these organizations' contrasting corporate strategies and on the mechanisms that able them to survive shakeout in the industry. The differences between the two systems are linked to the philosophies founders, who disagree about how and where patients will get the best treatment.*

*Thomas I. Frist, Jr., MD and James A. Campbell, MD  
Interviewed by Jeff C. Goldsmith*

*Dr. Frist has been president and chief operating officer of HCA since 1977. Before the establishment of HCA in 1968, he served as a flight surgeon in the U.S. Air Force.*

*Dr. Campbell is president and chief executive officer of Rush-Presbyterian St. Luke's Medical Center in Chicago. He joined the clinical staff of Presbyterian Hospital in 1948, and in 1971 founded a new medical school based in the core hospital.*

*Additional data on HCA and Rush-Presbyterian-St. Luke's can be found in the ruled inserts.*

*Mr. Goldsmith is the director of health planning at the University Chicago Medical Center and lecturer at the Graduate School of Business, University of Chicago. This is Mr. Goldsmith's third article in HBR. His Book Can Hospitals Survive? The New Competitive Market for Health Care, was recently published by Richard D. Irwin, Inc.*

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Interview with Dr. Thomas J. Frist, Jr.

### **Mr. Goldsmith: Could you tell us something about the beginnings of Hospital Corporation of America?**

Dr. Frist: The company was founded in 1968 by Jack Massey, my father, and myself. In the beginning we had no end of grief. People would say that because Jack was the man who bought Kentucky Fried Chicken, we must be putting together a chicken system. Dad -- who is a doctor and who used to practice 15 or 16 hours a day, giving 100% all the time -- was worried. He was afraid of what his patients would think, and he was worried about his reputation among his peers.

So we started out with Jack's financial strength and reputation in the business world, Dad's reputation in the medical community and his well-known concern for high-quality care, and my youth and enthusiasm.

We have never compromised our standards to make an extra buck. We have worked hard to build a good reputation and be a responsible part of the health care delivery system.

### **Does your being a physician influence how you run the HCA system?**

In our early years, my medical degree was a tremendous plus in dealing with physicians and hospital personnel. I spent a lot of time explaining to communities what HCA was about and how we could help them. I could empathize with their problems and, when I saw abuses within the system, speak with knowledge and confidence that a layperson wouldn't have. As the company

grows, my medical background is becoming less important. Today I consider myself a professional manager who happens to have a medical degree.

**Where did you train in management?**

I have my "MBA" from some of the best businessmen in the world: Jack Massey, who was HCA's first chairman; John A. Hill, who was president of Aetna Life and Casualty and who brought both expertise and credibility to this company when he joined us in 1971; and Donald McNaughton -- our present chairman-who was chairman of Prudential.

**The growing presence of hospital management companies like HCA in a traditionally not-for-profit industry has stirred quite a controversy. In a New England journal of Medicine article last fall, Dr. Arnold Relman warned of a new "medical industrial" complex that, in pursuit of profits, would increase health care costs. How do you respond to these charges?**

It is not unusual for people who try to innovate in an established industry to be attacked by that industry's entrenched interests. That's what's happening here. The entry of large hospital management companies has been a healthy stimulus to a complacent, obese, and fragmented industry. Costs and productivity are the two most important issues facing the health care industry right now, and we have made a major contribution here at HCA to solving them and to forcing the industry to reexamine itself.

**What evidence do you have to support that claim?**

We have been watching very closely some key indicators of our prices relative to our competitors' in our major markets. For example, in Florida the cost per hospital admission in HCA hospitals is lower than that of our competitors-in some cases, much lower. In Texas, Tennessee, and Georgia, we have been able to keep the cost of care in our facilities very competitive with that of other hospitals, even after absorbing the taxes and higher financing rates we pay because we are a for-profit operation. We take the concept of productivity very seriously.

**What are the differences between your operation and that of a regional nonprofit multihospital group?**

Unlike some of the other investor-owned hospital companies, a third of the hospitals that we manage are nonprofit. But I don't want to overemphasize the distinction between for-profit and not-for-profit; the issues of economies of scale and financing are far more important. For example, FICA recently acquired an investor-owned company, with eight hospitals and about \$130 million in revenue, that was striving to do its very best. However, as a result of the merger we'll be able to reduce its costs by between \$7 million and \$11 million.

**How will you do that?**

We will immediately eliminate \$2 million in corporate overhead by folding the hospitals into our divisional structure. Then, by insuring the hospitals through our captive insurance company, Parthenon (which handles casualty, malpractice, and workers' compensation for our institutions), we'll generate substantial savings, up to \$600,000 per year. We can provide the computer systems we've developed at a cost of 95 cents per patient day. Similar programs developed in-house or bought from external sources would cost the small company \$2 to \$3 per patient day. And our computer systems are not only accounting and financial tools but are also the basis of our management system.

**What about improving productivity?**

We can achieve substantial savings there too. HCA has many skilled specialists who do nothing but work on management systems for nursing, housekeeping, materials management, and dietary services. We have rigorous staffing and productivity guidelines that we expect our administrators to follow.

**You mentioned that you have a financial advantage over your competitors. What do you mean?**

We are the only hospital company that has an "A" rating on its commercial paper. Consequently, during the last 18 months of interest rates we have borrowed \$100 million to \$ 125 million, not at prime but at 2% to 3 % over prime. Smaller for-profit companies might have to pay 2% to 3% over prime, if they can get it. In many parts of the country where we operate, the capital just isn't there. The local tax base is fully committed. The nonprofit foundations can borrow, but their ability to generate cash from, say philanthropy, is much diminished from years past. All they can really do is leverage the systems have; and that probably isn't going to take them very far. Last year, when we needed money we sold \$87 million of stock to raise equity. This year, we sold \$125 million in convertible debentures at 8 3/4%. A not-for-profit group simply can't touch these kinds of resources. HCA is able to tap major capital source in the world from tax-exempt long-term bonds to Eurodollars.

**How would you compare the soundness of your debt with that of a hotel chain with 190 units?**

Two things distinguish our financing from that of a typical "real estate loan." First, federal cost reimbursement formulas (under Medicare, for example), where interest and depreciation are recognized costs, back our loans. Second, the planning laws protect our hospitals from competitors who might build new facilities and take our market. We know what the market for a particular institution is going to be like 5 or 10 years down the road. Another important difference is demand for our services is not subject to cycles in the economy. These factors make us a far better credit risk than a large hotel chain.

**Are differences in scale and access. capital the only differences between your organization and a not-for-profit system?**

No, there are differences in accountability and structure that are important as well. We are a publicly owned company with 15,000 shareholders throughout the United States and the world to whom we must be accountable. We have to make a quarter-by-quarter accounting of our progress, not only to our board of directors and stockholders but also to the financial community and the general public. And because we are a growth company, we have to plan not just for the 1980s but for the 1990s as well. Then, too, the larger multihospital nonprofits are loosely knit organizations held together by affiliations or management contracts, which are of limited value.

**Why do you say that?**

They're better than nothing, but you can't control enough variables through affiliations or contracts to make the hospital efficient. Besides, there's little profit in managing hospitals for other owners. one-third of our hospitals take at least a third of our management time, maybe more, but contribute less than 1% of our pretax earnings. If we manage a 200-bed hospital with revenues of \$20 million a year and charge a fee of \$200,000, that might represent a 25% profit, or approximately \$50,000 per year. When we put in a labor productivity system or a computer system and implement other cost-saving systems, we might save \$1 million to \$2 million for the hospital, but HCA's profit remains \$50,000. If we expend the same resources on a hospital we own, all savings would accrue to HCA. And because our human resources are more limited than anything else, we must weigh our commitments to nonequity projects very carefully.

**Then why are you involved in contract management to the extent that you are?**

For us, it's a marketing tool. It lets us test a new state or region at almost no risk. If it's going to be a good marketplace and the hospital we've managed is interested in selling to us, we will acquire that hospital or look for other hospitals in the area. The typical large, nonprofit system is usually limited to narrow geographic regions. Even the larger non-taxpaying hospital groups are not likely to extend their equity commitments outside a certain region. They really can't compete on a national and international scale. It makes sense for us to broaden our market while staying within the area we know best-hospital management.

**You made a point earlier that I want to get back to. What did you mean when you said that government regulation has actually strengthened your financial position?**

Federal and state health planning laws have erected formidable barriers to entry into the hospital industry by creating literal monopolies for physicians and hospitals. If the health Planning laws state that a community can have only one. cardiac surgery program, they might as well give the physician who performs that surgery an exclusive franchise. It's the same for hospitals. And

although there is a lot of talk about deregulation, it's not clear that deregulation would necessarily be best for large health care providers like HCA.

At the same time, though, I'm not sure that businesses that are monopolies are more productive than they would be if they were part of a competitive system. And monopolies frequently breed more regulation and bureaucracy. Under the current ground rules, the strong are going to get stronger and the weak, weaker.

**But it seems like the financing and market advantages you talk about would position you to compete very effectively in a deregulated environment.**

We are in an ideal situation now. If Congress and the new administration do decide to lift some of the regulations, we have the resources and large base to compete effectively. If President Reagan decides to tighten up on health care reimbursement, we have the flexibility to move quickly to maximize our opportunities. Regardless of the way the government moves, HCA should prosper in a survival-of-the-fittest sense. But I am not sure that significant deregulation will occur or that the Congress is ready for it yet, even though some changes may be in the best interest of the consumer.

**Where does your analysis leave us? Can government take the kind of action necessary to bring real economic competition to the health care market?**

I think the industry itself must look for ways to bring meaningful competition to this market, not just wait for government. That is why HCA is a proponent of developing alternative health care delivery mechanisms. There's an example of that kind of competition right here in Nashville, across the street from HCA's corporate office. Some physicians there have developed a freestanding ambulatory surgical unit. If they hadn't built that surgery center, more than likely HCA's Parkview Hospital and the nearby Baptist Hospital would not have been as quick to develop their own outpatient surgery programs. That's competition, and I think it's healthy. In the hope of forestalling additional regulation, HCA is taking a long-range approach to these developments. Through the Center for Health Studies-our research and educational arm-HCA is continually examining the merits of such alternatives as HMOs, primary care centers, home health care, "lifecare" centers, and industrial medicine programs. As a large organization, we can afford to experiment and take risks that smaller units cannot. Some of these alternative delivery systems may be appropriate for HCA, and some we will encourage others to develop.

**Is this type of competition going to bring costs under control?**

There are divergent views on how well it is working, but I believe that alternative delivery systems can provide a powerful impetus to hospitals and other providers for greater efficiency. A successful HMO will help make other providers in a given market more responsive to consumers, as well as more cost conscious. And large, publicly owned hospital management companies, including our own, have to demonstrate that they can be efficient providers and still give high-quality care -- or their long-term outlook is not going to be very bright.

**Some observers have speculated that not only HMOs and local health care plans but also the public health care programs like Medicaid will begin putting services to their enrollees out to bid and will require hospitals to compete over price. Do you think this would be a positive development?**

No, I don't. I think insurers need to do a better job of monitoring what they are buying on behalf of the consumer. But the margin in most for-profit or nonprofit hospitals isn't big enough to permit that type of competition without really hurting the quality of care. That would be a false economy. Real economies occur when medical staffs and administrators go out and work with industry leaders to show them that working together can prevent unnecessary admissions, eliminate, overuse of certain diagnostic tests, and reduce lengths of stay. Through the use of ambulatory vices, we can cut down on total health care expenditures. Physicians and hospitals must be accountable for efficiency as well as quality.

**Major insurance companies like Blue Cross and Prudential are beginning to finance and operate HMOs. Is it possible that, with their enormous capital bases, these companies themselves resent a competitive threat to the hospital industry?**

I don't worry about it. The possibility of a threat is something that FICA has just reexamined, and I honestly wonder if HMOs offer an ultimate saving to the consumer. HCA recently encouraged and assisted Prudential in starting an HMO in Nashville, where we have five hospitals. Because Prucare, Prudential's health plan is willing to subsidize its HMO for 5 or 10 years to get it off the ground, its initial pricing is directed toward market penetration instead of short-term profit. But once Prucare establishes its market, things will change. Just as the ambulatory surgery center I referred to earlier started out with low prices, Prucare's HMO's rates will gradually creep up to the competition's level.

**How do you respond to some nonprofit hospital advocates who charge that hospital management companies engage in "cream skimming"? The specific accusations are that hospital management companies will come in and do a cost analysis of the various programs in the hospital, find out that, for instance, obstetrics is losing money, and say: "Let's close it."**

We couldn't do that. That's ridiculous. For instance, more than 50 of the hospitals that we own are sole or primary hospitals in a community. When you own the only hospital in South Carolina—where the population is 50% minority and poor—you have to provide a full-service hospital that works closely with all the other care agencies. When you're in Erin, Tennessee (with a population of 1,500) and you have the only hospital, you must provide obstetrics and care for the indigent. Of course, I can speak for HCA only, but we're trying to run a quality operation that meets the needs of the communities we serve. The accusations of cream skimming directed toward HCA are, at best, cop-outs.

**With the acquisition of Hospital Affiliates, your gross revenues will have nearly tripled in three years. How does the Affiliates acquisition change your corporate strategy?**

The Affiliates acquisition certainly advanced our growth several years beyond our projections, but it hasn't altered our basic strategy. That strategy called for steady acquisition of 300 or so hospital beds per month and for steady growth in net income, which has been doubling every three years. Basically, we want to get as many hospital beds under our umbrella as we can and to remain predominantly a hospital management company. By 1985, we expect to have revenues of approximately \$6.5 billion and to control between 425 and 450 hospitals. With Affiliates, we saw an excellent opportunity to exert industry leadership, and we capitalized on it.

**Obviously the strategic options open to a \$6.5 billion company are much broader than those open to a \$1 billion company. Do those options include integrating backward?**

We have elected not to build up a supply arm of this company. What we want to do is use our purchasing power to get a better price for the things we need. We want to leave something on the table for our suppliers so they can stay profitable and render us the services we require. Most of the supply companies are high-volume, low-margin operations that require real expertise and organization to achieve adequate profits. Look for a minute at the economics. If a hospital computer company sells computer systems for \$1.50 per patient day to nonprofit hospitals, their cost of providing them is probably about what ours is. It wouldn't make much sense for us to acquire that company to reduce costs.

Besides, just because a company is vertically integrated doesn't mean it is more efficient. If you have your own supply operation and 80% of its business comes from your company, it may not have the same incentives for cost containment or service as a freestanding operation. Incentives are very important in this system.

**If you don't begin to develop a presence and management competence in areas other than hospital management (whether in ambulatory surgery, nursing homes, or HMOs), are you going to be out of the action in new growth segments of the health care industry?**

In the first place, through our Center for Health Studies we try to stay up on everything that is happening in health care. So much can be done and the opportunities are so great in the hospital management area that we must discipline ourselves not to divert our resources from our primary line of business. Our approach to new forms of care is "Let's study them and see if we are able to develop new profit centers within our hospitals."

For instance, if renal dialysis looks promising, we'll look at the hospitals we own to see if we need 20 or 30 renal dialysis units rather than develop freestanding units. If inhalation therapy looks

promising, we won't just go out and buy an inhalation therapy company. Instead, we will develop inhalation therapy systems for HCA hospitals.

We have a tremendous base. Forty percent of the health care dollar is spent through hospitals. As I mentioned, regulation severely restricts new hospitals from entering our markets. Therefore, if we keep looking for opportunities to meet the needs of the communities we serve in areas such as ambulatory care, surgery centers, and new technology, we will have ample internal growth during the coming years.

**One of the factors that may limit your growth is access to managers. We also know that in areas of the country where you are a major presence, it is becoming very difficult to get nurses and doctors. What are you doing about these problems?**

Before I get to the subject of nurses and doctors, let me address the problem of hospital administrators. In our early years, many schools of hospital administration didn't want students to fulfill their residency requirements in HCA hospitals or through our corporate office program. Today that has changed, and we have many fine relationships with master's degree programs that provide a pipeline of capable managers (with varying levels of experience) to meet our needs. This past year we brought approximately 65 controllers and 65 administrators into the HCA organization.

Frequently, we take the individual who has four, five, or six years of experience and put him or her in our system. After an orientation period, we move these people around quickly, stretching them at a faster pace than you could in a single hospital. A manager will start at a 50-bed hospital, go on to a 100-bed hospital, and then move on to the corporate offices, the Center for Health Studies, or our international offices.

We can give the manager a little rope, expecting that there will be some mistakes. A division vice president monitors and counsels each manager, which is a great opportunity and challenge for a young professional-and something he or she wouldn't get in many companies. We have a decentralized management system that rewards the innovator and self-starter.

**What happens to the administrators of the hospitals you acquire?**

We retain the majority of them. Most of them are not bad managers, they just have not had access to the expertise and resources of HCA. We retrain them to work effectively in a complex and increasingly regulated environment. I would say that probably 60% of these administrators and 40% of the controllers can shift to our system.

**What about physicians and nurses?**

As I mentioned earlier, we have been very active in recruiting doctors. In the past 12 months, the corporate office helped relocate 100 doctors to towns of 20,000 or less.

**How do you do it?**

We tell our story. We tell them we have a modern, well-equipped hospital in which we practice high-quality medicine, that management and employees have developed a climate in which practicing high-caliber medicine is enjoyable. We tell doctors about the advantages of the small town to them and their families and how more and more physicians have come to appreciate small-town living. Finding nurses has been the toughest problem, one which federal policymakers have worsened.

**What are you doing about it?**

About three years ago we recognized that the shortage of nurses in the United States was developing into a critical problem. In concert with HCA's international recruiting department, the Center for Health Studies made an investment recruiting and training nurses in the Philippines. Not only did we carefully screen them when they graduated, we also set up intensive training programs there to prepare them for the U.S. exams as well as for life in America. This program, which taps our other international recruiting offices around the world, has been a great help to our hospitals and is one of the benefits of being a large, international health care provider.

## **Interview with Dr. James A. Campbell**

**Mr. Goldsmith: As the chief executive officer of a \$220 million not-for-profit health care organization, how do you view the entry into the health care market of the large national hospital management companies?**

Dr. Campbell: When you compare for-profit management companies with not-for-profit institutions like Rush-Presbyterian-St. Luke's in Chicago, you're talking about apples and oranges. Besides the fact that we both need to generate positive net incomes for our respective corporate purposes, I'm not sure that we are in the same business. If we were in the health care business to make a profit, we wouldn't be engaging in the amount of research and training of health manpower that we are. Neither of these is a profitable undertaking.

### **Hospital Corporation of America**

While 38 companies were involved in hospital management in 1980, five large corporations - Hospital Corporation of America, Humana, American Medical International, Hospital Affiliates International (a subsidiary of INA Corporation), and National Medical Enterprises - controlled over 60% of the market. With the acquisition of Hospital Affiliates International in 1981, HCA is indisputably the largest hospital management company in the world - with anticipated revenues of \$2.3 billion in 1981.

HCA was founded in 1968 by Dr. Thomas Frist, Sr., then chief executive officer of the Parkview Hospital of Nashville, Tennessee (the core hospital of the HCA system); Dr. Frist's oldest son, Thomas Jr. (also an MD); and Jack Massey, a successful Nashville entrepreneur who founded and developed Massey Surgical Supply, Inc. In 1978, Donald McNaughton, former chairman and chief executive officer of Prudential Insurance Company of America, became chairman of the board of HCA and oversaw HCA's major expansion program. In 1980, the company acquired the General Care Corporation and General Health Services, Inc.

By the end of 1980, HCA owned or managed 188 hospitals. And with the acquisition of Hospital Affiliates, it owned 175 and managed 159. In 1980, HCA generated \$1.428 billion in revenues, with a net income of nearly \$81 million. For the same period, Hospital Affiliates had after-tax earnings of more than \$28 million on revenues of \$564 million.

### **The U.S. hospital industry**

In 1980, approximately 7,000 U.S. hospitals employing around 3.8 million people expended close to \$100 billion in rendering care to patients. Of the 7,000, approximately 5,900 are community hospitals. Within this group, state and local governments own more than 1,800; over 3,300 are not-for-profit private institutions; and the rest are investor owned. The remainder are state mental institutions, federal hospitals (such as veterans hospitals), and the like.

Of the 5,900 community hospitals, around 30% are part of some larger system. By mid-1980, investor-owned hospital management companies owned or managed 862 hospitals and over 100,000 beds. Regional not-for-profit "multihospital" systems (public and private) owned or managed approximately 190,000 beds.

The largest of this latter group is the Kaiser Health Plans, which operates 29 hospitals and 6,235 beds in connection with its large prepaid health plans. The second largest not-for-profit system is the Sisters of Mercy Hospital System of Farmington Hills, Michigan, which operates 22 hospitals and 5,461 beds. There are 44 Catholic hospital systems in the United States and 45 secularly affiliated nonprofit systems, as well as 29 Protestant and 13 municipal hospital systems.

Not all investor-owned hospitals in the United States are operated by the hospital management companies. Many are freestanding units owned by physicians or by groups of local investors. In 1980, hospital management companies owned or managed 64% of 1,351 proprietary hospitals, up from 41% of 1,161 in 1975. The hospital management companies increased their total "portfolios" of owned or managed hospitals by 80% from 1975 to 1980. If the present rate of growth in these companies continues, by 1985 they will own or manage one-fourth of the nation's community hospitals.