BURNING THE SEED CORN
Healthcare Forum Journal (March/April 1996): 19-22.

California's Metropolitan Healthcare markets are often seen as a bellwether for the rest of the nation, perhaps the purest test we have of a market model in health services. But healthcare executives and scholars have not yet solved one of the enduring puzzles about California: How is it that its major markets have resisted reductions in hospital capacity in the face of managed care? In both Northern and Southern California, metropolitan hospital occupancy rates are in the low forties, and yet hospitals have not closed in significant numbers.

As a 15-year market observer, I believe the reason for this puzzling phenomenon is that a significant fraction of California's excess hospital capacity is being propped up by multi-hospital systems, which now control most of the bed stock. The failure of these systems to rationalize capacity should provide a warning to the rest of the country: In concentrated managed care environments, hospital-based systems may not be the solution.

Over the past 20 years, multi-hospital systems have formed and grown on the operative premise that systems were capable of doing things individual institutions were not. Those things included eliminating duplication, reducing overhead, rationalizing capital investment, investing in technology and new clinical services on a community-wide basis, and, most recently, assuming and managing capitated healthcare risk.

As managed care has grown, the capacity of health systems to realize their potential is being critically tested. And as economic risk is shifted onto systems by managed care, an increasing number are collapsing under the weight. A few examples may help illustrate the problem

Three systems in trouble

The San Francisco Bay Area contains several major multi-hospital systems, which were formed at least in part to respond to the competitive challenge of Kaiser, the dominant actor in the region's healthcare system. Several of these systems -- California Pacific Medical Center, Mills-Peninsula Medical Center, and Good Samaritan Health System (formerly Health Dimensions) were built upon the strength of a dominant tertiary institution, but they serve multiple, and in some cases competing, medical communities. All three of the named systems participated, to some degree, in the physician integration movement and have been active in trying to organize their physicians to compete more effectively in the managed care market.

Each system is burdened with the need to support the remnants of a dying hospital: Children's in San Francisco, Mills Medical Center in San Mateo, and San Jose Hospital in downtown San Jose. Left to the vagaries of the market, these three troubled hospitals would have closed. Instead, they have been rescued by stronger institutions and their boards under the premise that the whole would be greater -- and more economically viable -- than the sum of the parts. The likely price of these altruistic decisions may ultimately be expenditure of several hundred millions of dollars in institutional reserves.

Today, all three systems are, in varying degrees, in serious trouble, All have suffered declines in their collected revenues, undergone major staff reductions, and struggled to consolidate clinical services and rationalize capacity against the real prospect of further revenue declines. Their physicians are simultaneously struggling -- in some cases drowning -- in an increasingly adverse economic climate.

Each system has struggled valiantly to reprogram its "problem campus," searching for the right mix of ambulatory and subacute services to fit within the shrinking revenue envelope. Two of the systems, after many years and millions of dollars in consulting expenditures, have arrived at an armed truce with their physicians to permit the reprogramming. And as of this writing, the third (Good Samaritan and its medical staffs) remains deadlocked over the details of a modest scaling back of its tertiary programs at the San Jose Hospital campus, even as the system runs out of cash.

Mills-Peninsula and California Pacific recently announced plans to merge with Sutter in Sacramento and several other Bay Area providers into a gargantuan, as yet unnamed, provider system. Good Samaritan was acquired by Columbia/HCA in January 1996.

If one can learn any lessons from the agony of these three systems, it is that the whole may be less than the sum of the parts, and that the economies of scale and coordination that exist in multi-hospital systems in theory may be unachievable in fact. Or, if they are achievable, it may be only when the systems have run completely out of cash and debt capacity, and are incapable of further development.

Four reasons

Why has it been so hard for these systems to create a sustainable business in the face of managed care growth? I can identify four reasons:

1. Professional franchises are stubbornly entrenched. This problem is the most intractable. While one might view the hospital as a business, it may be more realistic to see it as a collection of semiautonomous professional franchises that use the hospital to support their practices. Achieving economies of coordination requires shrinking, reporting, or eliminating professional franchises.

Closing a campus or consolidating clinical services may mean eliminating whole clinical franchises-pathology, radiology, cardiology, anesthesiology as well as markedly reducing employment of cadres of nonphysician professionals such as nurses, pharmacists, physical therapists, technicians. It also may mean rearranging the logistics of medical practice by compelling competing specialists to share the same operating suites, catheterization laboratories, and the like.

As hospitals and physicians became more closely intertwined during the Eighties and early Nineties, hospitals began supplying physicians an increasing percentage of their incomes through medical directorates, stipends for providing ER or trauma center call coverage, and the like. This trend markedly accelerated with the movement toward practice acquisitions, or creation of physician foundations, which put hospital systems directly into the business of employing physicians or subsidizing their practices *en masse*.

Thus, multi-hospital systems have unwittingly become the economic buffer that protects physicians from the declining market value of their own time. While these arrangements are sometimes referred to as "partnerships," invariably the "system" assumes virtually all the physicians' downside economic risk. Eliminating services or closing hospitals -- something systems must do if they are to remain viable -- directly threatens physician franchises and incomes.

2. *Institutional identifies die hard.* Even dying institutions have substantial community constituencies, not merely because they employ the community's citizens but because they have helped thousands of families in hours of desperate need. Closing hospitals or changing their missions threatens historical institutional identities in which boards are emotionally invested.

For those trustees who are the keepers of the community flame to accept the reality of their institution's redundancy is exceptionally difficult. The path of denial leads board members to seek other institutions that would fuel the flame in future years. The result, as with the savings and loan industry, has been to burden the strong institutions with the losses from their weaker partners.

3. The market for hope is large and lucrative. Merging and consolidating hospitals is a major business for a whole class of "transaction brokers" who profit from creating larger and less wieldy enterprises. Consultants, attorneys, systems integrators, and investment bankers (to name only four handy examples) do not profit from institutional closures. Mergers (and increased complexity), on the other hand, mean major economic opportunities. They not only create the illusion of action for the client, they also lead to major downstream revenue opportunities for the broker.

Few of these advisers are cynical enough to admit that the ensuing institutional paralysis and multiple administrative changes are highly profitable. Yet for transaction brokers, the multibillion-dollar healthcare "enterprise" is really like the whale that washes up at the foot of the proverbial Alaskan village-enough food for an entire winter.

There isn't much of a market for advice that says: "This franchise has no future; find a graceful but rapid way to shut the doors." Boards and managements just don't want to hear it. The market for hope-for perpetuating unsustainable dreams through claimed synergies, "market leverage," and economies of scale-is both vastly greater and much more lucrative.

4. Boards and managements are unable to weed their gardens. The weak link in the chain is the inability of trustees to husband scarce resources against the focused claims of institutional stakeholders: physicians, unions, vendors, and others who depend on the hospital for their incomes. Many trustees sought their roles to perpetuate community traditions; they did not become trustees to take things away from people, let alone to fight their cardiologists or anesthesiologists over money.

In a 30-year period of prosperity, the reflexes and values needed to husband scarce resources never really developed in system board members because they weren't necessary. Trusteeship was really about how to allocate new capital. Weeding the garden, let alone plowing it under and planting new crops, was not required. It is not surprising, then, that trustees find it easier to write checks to fund operating losses than to manage the strife and conflict associated with taking resources away from powerful constituencies.

The invisible losses

The tragedy of all this is that there are invisible "opportunity costs" of perpetuating dying franchises (hospital and physician). Opportunity costs are the alternative uses that could have been derived from money spent for a particular purpose.

What are the opportunity costs of system funds used to prop up dying franchises or to preserve physician incomes? The list is long and depressing: care for those without health insurance, non-medical but nonetheless essential services for youth or the elderly; investment in new, not-yet-developed services such as genetic screening and therapy, preventive care for high-risk populations, or information technology to help rationalize clinical decision-making and improve quality; and, eventually, replacement of the core physical plant and technology of the surviving institutions.

Funds spent on postponing the inevitable will not be available to invest in the future, or to serve those in greatest need (the only viable justification for not-for-profit status). The problem is that decisions to fund system losses are almost never examined in an opportunity-cost framework. And by the time the system has run out of cash, the opportunities to benefit the community have been largely exhausted.

A tattered fig leaf

Some not-for-profit systems have made tough decisions to reduce capacity in concentrated managed care markets. For example, the Sisters of Providence agreed in 1992 to exit Oakland's crowded hospital market by merging Providence Hospital with Merritt-Peralta to form the Summit Healthcare System.

The Sisters of Mercy of Farmington Hills, Michigan have closed three hospitals with two more in process. These two examples suggest that having a mission larger than simply delivering healthcare may help religious sponsored organizations make decisions that lay organizations cannot.

Other not-for-profits contemplate the ultimate bail-out: selling their franchises outright to an investor-owned company. Not-for-profit boards in many communities in and beyond California are looking at sale to investor-owned companies as a face-saving strategy for abandoning their community trust. The assumption of the system's debt and the creation of a new "foundation" from sale proceeds provides the board of a failing institution a tattered fig leaf behind which to hide their own lack of resolve or the consequences of poor strategic choices.

Some board members and healthcare executives have justified acquisition by investor-owned companies on the basis that their traditional sources of capital have been exhausted. And why is this? Seeking acquisition as a source of new capital begs the question of why the capital was needed in the first place, If it is used merely to purchase market share via physician practice acquisitions or to fund operating losses, the relevant question should be: Are these appropriate uses of capital from the community's point of view?

The new capital brought to the community by the acquisition, the corpus of the foundation (in Good Samaritan's case, some $56 million), as well as the assumption of the acquired system's debt, are not gifts from the acquiring firm. This new capital is an investment. And if it is to be a viable investment, the acquiring firm must generate the 20 percent return on invested capital to sustain its current equity valuation.

That return cannot be generated through subsidies from less competitive markets without diluting the long-term earnings of the firm. Rather, it must be generated inside the community itself.

In many markets, the return may be generated by closing surplus facilities, but also by raising rates to the non-managed care segment of the payer community (a strategy no longer available in much of California), as well as through purchasing of physician practices and layoffs of hospital employees. All of these actions represent costs to the community. The return on capital, on the other hand, is aggregated on a company-wide basis to be reallocated across national holdings, based on overall firm demand for capital, rather than the community's needs.

Whether for-profit companies will ultimately prove any more adept than nonprofit systems at reducing physician incomes or. consolidating professional franchises remains to be seen. In its first two markets, El Paso and Miami, Columbia/HCA showed a refreshing lack of sentimentality in closing acquired institutions. The grease for these consolidations was providing physicians equity in the combined franchises, a strategy clouded by recent changes in federal fraud and abuse laws. Those bold moves, which are several years old, have been followed by extensive blustering and dithering in more demanding markets (Houston and Chicago, to name only two).

One major handicap the investor-owned firms face is that they remain harnessed to medical staffs to whom previous owners communicated the message: "Let's get rich together under fee-for-service." This *modus operandi* is, to put it mildly, a big problem under managed care, because it has resulted in adversely selecting the income-maximizing subset of the specialty physician community-the last people you would want as partners in a capitated payment framework. Wholesaling hospital services over the dead bodies of one's specialists doesn't seem to be a very attractive business.

Squandering the community's money. The failure of not-for-profit systems to husband the community assets they hold in trust is an indictment of contemporary health services trusteeship. Institutional reserves spent to prop up physician incomes or to perpetuate a redundant hospital allegedly belong to the community. And the role of trusteeship is to maximize the benefit to the community of the use of those funds.

But in reality, institutional reserves belong to no one. Spending even large sums of other people's money is depressingly easy. If ordinary citizens in our communities really understood how much money was being squandered, and that it actually belonged to them, they would be outraged.

Directors of a company are far less willing to tolerate waste, because they will be sued by shareholders or barbecued by institutional investors for not maximizing their returns. And as private individuals, trustees would never simply squander their own funds on purposes that produce no measurable benefit. By failing to maximize the community benefit to be derived from use of system dollars, healthcare trustees have failed a fundamental test of their trusteeship. And in the unforgiving healthcare marketplace of the next ten years, the dollars they are wasting will never be seen again.

The shaking out of excess capacity in our healthcare system is inevitable; healthcare is the only major sector of the American economy that has not experienced a significant reduction in force in the past 20 years.

If we can learn anything from what has happened in other sectors, such as the automobile or steel industry, the shaking out is going to hurt. Thirty years of prosperity have left the unfortunate legacy of a very low institutional pain threshold in healthcare organizations.

The most difficult challenge trustees face is sorting out the weak from the strong claims on community resources, and steeling themselves against the cries of those who simply do not want to change or to see their incomes or prerogatives reduced. The large number of unmet needs in our healthcare system demands no less.

To our readers: You are invited to respond online to this article by joining a lively debate on "The Jeff and Joe Show" (Jeff Goldsmith of Health Futures and Joe Flower of The Change Project). The current topic of this ongoing conversation: "Is For-Profit Medicine Inevitable?" Address: http://www.healthonline.com.