

Book Reviews

Marketplace Medicine: The Rise of the For- Profit Hospital Chains

David Lindorff

*Bantam Books, New York City, 1992,
320 pp., \$22.50*

MORE THAN TWO CENTURIES AGO, WHEN Benjamin Franklin helped found Pennsylvania Hospital, the first voluntary hospital in the United States, he established the precedent of setting prices for paying patients (charging a substantial markup above costs). This was the beginning of marketplace hospital services, a new development among hospitals worldwide. He also coaxed a grant from the Commonwealth of Pennsylvania, the government's first involvement in financing community hospitals in this nation. Franklin's unique blend of voluntary, governmental, and marketplace initiatives to support a sometimes-murky social mission has characterized the U.S. hospital and healthcare systems ever since. Currently, however, marketplace and government initiatives appear to have eclipsed voluntary initiatives.

A quarter of a century ago, for-profit chains emerged at the same time that government was becoming the dominant force in financing and regulating hospitals. Nurtured by favorable government treatment, the for-profit chains grew rapidly in carefully selected markets, especially in the South and Southwest. As entrepreneurs and stock traders made and lost enormous sums of money during this period, for-profit hospitals' behavior and healthcare outcomes were not markedly different from those of the more entrepreneurial not-for-profit hospitals.

What will the future bring? Will investor-owned hospital chains become the dominant element in healthcare delivery? Are they likely to hinder healthcare reform? In his passionate book

Marketplace Medicine: The Rise of the For-Profit Hospital Chains, prize-winning journalist David Lindorff answers yes to these questions. He details the phenomenal growth and recent setbacks of the investor-owned chains and concludes, "The long-term trend assuredly is for further growth and consolidation." At the same time, Lindorff is extremely worried about the consequences if they "are allowed to grow at the expense of public and community hospitals."

Lindorff believes "national health care [based] on the Canadian or Swedish model . . . is clearly the best solution for America too." But the political power of the investor-owned chains and other special-interest groups rules out such innovation in the foreseeable future. Accordingly, Lindorff recommends a variety of "mechanisms to ensure the proper behavior of private hospital companies. . . . Market incentives alone cannot do this." He advocates revitalized Health System Agencies with augmented authority; stronger licensing, including licensing of trustees and chief executive officers (CEOs); stronger antitrust enforcement; and an end to the Joint Commission on Accreditation of Healthcare Organizations with substitution of stronger state or federal regulation. If these steps fail, he would treat hospitals as a public utility, controlled by a state or federal agency.

Lindorff builds a strong case—but not convincing to me—that the investor-owned healthcare chains have played the leading role in the following major developments in hospitals: aggressive marketplace competition, advertising, raising of capital, involvement of physicians in management, growth of multi-hospital systems, active involvement in politics, avoidance of unprofitable services, managed care, integrated financing and delivery, and much more. Unfortunately, Lindorff does not consider the possibility that in most—if not all—of these activities one or more aggressive not-for-profit hospitals was there first, with the investor-owned

enterprises following.

Lindorff tells how bottom-line-oriented entrepreneurs dream of creating the General Motors (GM) of healthcare. His point is especially poignant now as investors are turning away from GM. Today, business analysts are looking at more than the bottom line. They favor companies that emphasize service, mission, and continuous quality improvement. Recently, Sr. Irene Kraus, DC, (until recently president of the St. Louis-based Daughters of Charity Health System), Henry Ford Health System CEO Gail Warden, and other CEOs of not-for-profit hospital chains have come to be regarded as symbols of successful healthcare managers, more so than the CEOs of for-profit corporations such as Humana and Hospital Corporation of America.

In my hometown, the initiative is clearly with the not-for-profit hospitals. Within the decade, a not-for-profit, inner-city, teaching hospital used tax-exempt bonds to buy a suburban investor-owned chain in order to provide the margin to support its social mission. Subsequently, this not-for-profit chain was bought up by a more affluent, mission-oriented, not-for-profit chain. In my town, within the decade, more investor-owned hospitals have been absorbed by not-for-profit chains than vice versa.

The recent sale of a not-for-profit medical school complex in our town is especially telling. I have always believed that a profit-oriented medical school located in the United States has to be any entrepreneur's fantasy, given the amount of money that so many wealthy families still spend on educating their children—at any price—at for-profit medical schools of marginal quality in foreign countries. Ironically, a not-for-profit hospital chain was the successful bidder for the first not-for-profit medical school to be sold in the United States. The investor-owned chains are still only buying teaching hospitals, and not many of those.

Lindorff follows the lead of Arnold Relman, editor-in-chief emeritus of the *New England Journal of Medicine*, in the mistaken analogy to President Dwight D. Eisenhower's warning about the military-industrial complex. But he understands that the continuing corporatization of medicine is inevitable, and that corporations can be governed to serve public and professional interests. What is required are strong incentives to encourage healthcare corporations—private, public, and voluntary—to put social mission ahead of financial margin, just as almost all healthcare organizations do now with respect to the quality of patient care.

Lindorff does not give much attention to either the social or antisocial initiatives of the not-for-profit hospitals, which continue to dominate the field. If the not-for-profit hospitals really are as passive as Lindorff treats them, then his analysis and his prescriptions for the future are probably right on the money. But from my perspective, most not-for-profit hospitals are still much more vital—either in pursuing the public interest or in supporting private interests—than Lindorff implies. From this point of view, the future of our healthcare system depends less on what happens to the investor-owned hospitals (which, according to the American Hospital Association, account for only 10 percent of community hospital expenditures) and more on the future of the not-for-profit hospitals (which account for more than 70 percent). The real questions are: Will not-for-profit hospitals committed to an explicit social mission win out over those with narrower institutional and entrepreneurial interests? What incentives—positive and negative—can best encourage more not-for-profit hospitals to reflect the public interest effectively? If these hospitals do reflect the public interest more effectively, is it possible that some of the for-profit hospitals will follow?

Lindorff spent seven years tracing the role of for-profit hospital chains in mar-

ketplace medicine. He has gathered so much information that one can only hope he will do a sequel on the role of the voluntary and governmental hospital chains. Given his investigative skills and his clear commitment to the public interest, such a book would be another

valuable contribution to the healthcare reform debate.

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BOOK BRIEFS

Health Care Management: Strategy, Structure and Process; Physicians and Management in Health Care; Health Care Marketing Management; Human Resource Management in Health Care; Health Care Financial Management; Nursing Management: Issues and Ideas

Montague Brown, editor, Aspen, Gaithersburg, MD, 1992, \$34 (each), \$154 (series) (paperback)

Each volume in this series reprints articles from the past six years of the journal *Health Care Management Review*. For example, *Physicians and Management in Health Care* presents 23 articles on physician-hospital relations, organizational issues, practice issues, team building, and physician executive leadership. As with the journal, these books contain many charts and tables, as well a preface by Montague Brown (the journal's editor) and an index.

Grand Rapids, MI, 1992

Progressive Health Care Management Strategies, Donald N. Lombardi, American Hospital Publishing, Chicago, 1992

Recovering Catholics: What to Do When Religion Comes between You and God, Earnie Larsen and Janece Parnegg, Harper Collins Publishers, San Francisco, 1992

Renewal in Late Life through Pastoral Counseling, James N. Lapsley, Paulist Press, Mahwah, NJ, 1992

So You're on the Hospital Board! 4th ed., Richard J. Umbdenstock, American Hospital Publishing, Chicago, 1992

Spiritual Direction and the Encounter with God: A Theological Inquiry, William A. Barry, Paulist Press, Mahwah, NJ, 1992

Successful Management Strategies in Cardiovascular Services, Philip L. Ronning, John W. Meyer, and Charles W. Franc, American Hospital Publishing, Chicago, 1992

What Has Government Done to Our Health Care? Terree P. Wasley, Cato Institute, Washington, DC, 1992

A World of Change: A Book of Portraits Lynda Greer, Longstreet Press, Atlanta, 1992

BOOKS RECEIVED

Life, Death, and In Between: Tales of Clinical Neurology, Harold L. Klawans, Paragon House, New York City, 1992

Life on the Line: Ethics, Aging, Ending Patients' Lives, and Allocating Vital Resources, John F. Kilner, Wm. B. Eerdmans Publishing,