

*from*  
**Ministry  
to Market**



*Catholic*

*Healthcare Can*

*Survive in*

*An Age of*

*Commercialization*

Cathie Bleck

In the fall of 1994, when Congress rejected measures that would have provided medical insurance for all its citizens, the United States decided in effect to leave healthcare to the market. Since then, large, for-profit healthcare corporations have come to dominate hospital and physician services in many parts of the nation.

Healthcare, which once was a *ministry*, a means of providing aid or service, is today becoming an *industry*, an opportunity to make money. In saying this, I do not mean to imply that the profit motive is inherently wrong, or that for-profit healthcare organizations necessarily provide substandard services. I would argue, however, that for-profits are under unrelenting pressure to produce profits, and that such pressure can lead them to engage in questionable, even clearly illegal activities. I would argue also that for-profit organizations are unlikely to provide much care for the poor.

### QUESTIONABLE BUSINESS PRACTICES

In November 1995 Dennis C. Vacco, New York's attorney general, described some problems with for-profit healthcare in prepared testimony before the U.S. Senate's Committee on Aging: "A significant trend is the merger, acquisition, consolidation, affiliation, and joint venture of health care corporations as a cost-saving business practice. The result is that business judgments are overriding medical practice. . . . We are [also] beginning to see this in the form of self-referrals. Couple this with greed, unregulated businesses, and big government dollars, and it equals disaster."<sup>1</sup>

Vacco's warning has been reinforced by news stories about various for-profit healthcare organizations:

- In July 1994, National Medical Enterprise, Inc., officials admitted they had broken the law in their efforts to acquire psychiatric patients. In settling the case, the hospital chain agreed to pay \$379 million to the federal government and sev-

eral state governments.<sup>2</sup>

- In June 1995 officials of Caremark International pleaded guilty to charges that they had defrauded federal healthcare programs by making improper payments to physicians and other healthcare professionals to induce them to refer patients to the corporation. Caremark agreed to pay \$161 million in criminal and civil fines.<sup>3</sup>

- In his testimony, Vacco cited the case of National Medical Laboratories, Inc., whose officers pleaded guilty to Medicaid fraud.<sup>4</sup> The president was sentenced to prison, and the company paid more than \$110 million in settlements and fines.

- In May 1994 a Braintree, MA, rehabilitation hospital owned by Continental Medical Systems (CMS) admitted that it had submitted false Medicare claims and paid a \$1.6 million fine. Later that year, U.S. justice department agents visited more than half of CMS's other 37 rehabilitation hospitals and questioned employees about the chain's billing practices in Medicare cases.<sup>5</sup>

- In the spring of 1995 the federal government announced plans to ban ABC Home Health Services (now known as First American Health Care) from the Medicare and Medicaid programs. The government alleged that the homecare firm, one of the nation's largest, had submitted more than \$800,000 in false claims, seeking reimbursement for (among other things) maid service, utility bills, and country club fees for the company's owners.<sup>6</sup>

- In 1995 a Corpus Christi, TX, physician filed a lawsuit against Columbia/HCA Healthcare Corporation, alleging that it paid kickbacks to physicians to get referrals to the chain's hospitals.<sup>7</sup>

I may seem to be blaming an entire industry for the illegal or unethical behavior of a few of its executives. That is not my intention. It certainly

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**Summary** Large, for-profit healthcare corporations now dominate hospital and physician services in many parts of the nation. Such organizations are under unrelenting pressure to produce profits; news stories show that these pressures can lead for-profits to engage in questionable, even illegal activities. Also, for-profits are unlikely to provide much care for the poor and uninsured.

Unfortunately, Catholic providers have several disadvantages when competing with for-profits, and one is the fact that they do provide care for the poor. Catholic providers are handicapped also by:

- Problems with their geographic locations
- Difficulties in creating partnerships with physicians

- Lack of access to capital
  - Loss of political influence
- On the other hand, Catholic healthcare providers have several advantages over for-profits. Among them are:

- A reservoir of public goodwill
- Experience in forming networks
- The potential for prudent growth
- A common vision
- Access to Church pulpits
- The influence of women and men religious

Given these advantages, Catholic health ministry leaders could boldly restructure their own organizations, and, in doing so, mitigate the commercialization of healthcare in the United States.

is true, however, that the production of profit is the *raison d'être* of a for-profit enterprise. Such an enterprise expects its employees to produce profit, rewards them if they do so, and punishes them if they do not. I suggest that such enterprises may not be suited to the delivery of healthcare—that we may be making a mistake in replacing a ministry with an industry.

#### WHO WILL SERVE THE POOR AND UNINSURED?

Catholics do not see healthcare as a business. As Card. Joseph Bernardin puts it, paraphrasing Pope John Paul II, "Healthcare by its nature is not a mere commodity. . . . Healthcare—like the family, education, and social services—is *special*. It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities."<sup>8</sup>

Catholic healthcare organizations have as their purpose serving all people in need, *especially* poor people. Unfortunately, although such a commitment is noble, it may also be self-destructive, given the commercialization of healthcare. If for-profit organizations assume an increasingly large share of care for the wealthy and insured while Catholic organizations are left with the poor and uninsured, the future of Catholic healthcare will be bleak.

For several reasons, Catholic facilities now find themselves at an economic disadvantage. Many were founded by nineteenth-century women and men religious who wanted to bring care to the needy. And, even today, such facilities are often found in poor urban and rural communities. As of 1990, 497 Catholic hospitals allocated an average of 14 percent of their gross annual revenue to the care of the poor; many devoted as much as a third of their revenue to the poor.<sup>9</sup>

In a 1991 study the Catholic Health Association (CHA) classified the financial health of its members according to six categories ranging from "consistently sound" through "adversely affected" to "closed" and "no longer Catholic."<sup>10</sup> The number of facilities in the "adversely affected" column had grown by 16 percent in 1989-90. In a 1992 report CHA said such facilities were typically located in areas that "had significantly greater levels of poverty, lower average per capita income, more unemployment, greater proportions of nonwhite and Hispanic residents, higher dependency ratios, and greater welfare enrollment."<sup>11</sup> The report showed that some "adversely affected" Catholic hospitals in Chicago were located in neighborhoods where the infant mortality rates were higher than the 1990 national average.

Contrast such Catholic facilities with those owned by for-profit corporations. In 1995 a *Wall*

*Street Journal* article about healthcare in Florida noted that

many private hospitals cater to the most profitable patients, including retirees who are insured or covered by Medicare, leaving public hospitals with the bulk of poor and indigent patients. The chains also keep things lean and mean, while public and not-for-profit hospitals, which tend to be the biggest, bear the burden of providing high-cost services such as burn centers, trauma centers and neonatal intensive care units. Of the 30 hospitals that spent the least per patient last year, 15 belonged to [Columbia/HCA].<sup>12</sup>

And the for-profits live up to their name, generating eye-popping financial results. The *Wall Street Journal* article continued: "Dallas-based Tenet Healthcare Corp., with 12 hospitals in the state, posted a 1994 operating-profit margin of 10.9 percent at its Florida hospitals, compared to 10.7 percent for Columbia and 2.7 percent for the industry statewide. Tenet hospitals have focused, among other things, on treating cardiovascular ailments, which with cancer treatments is one of the more profitable services hospitals provide."

A profitability rate of more than 10 percent may not strike some readers as particularly impressive. The six most profitable Florida hospitals—all part of for-profit systems—posted profits of more than 20 percent in 1994. HCA Medical Center Hospital—Largo, a Columbia/HCA-owned facility that, at 256 beds, is about the same size as the average Catholic facility, earned a profit of 24.8 percent, making it the third most profitable hospital in the state that year. In 1991, the most recent year for which we have data, the average margin for 485 Catholic hospitals was only 3.8 percent.<sup>13</sup> Could the management of for-profit hospitals be so dramatically much better than that of Catholic institutions? That seems unlikely.

What, then, explains the difference in margins?

#### STRATEGIC DISADVANTAGES OF CATHOLIC HEALTHCARE

Catholic healthcare has several inherent disadvantages, including several related to the ministry's mission and values. Although essential to carrying out Jesus' healing mission, these factors affect the strategies Catholic healthcare must adopt to survive.

**Commitment to the Poor** Because for-profit organizations will not compete with each other to capture poor and uninsured patients, such patients will increasingly turn for their healthcare to

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Catholic and other not-for-profit organizations. This will add to the financial burdens on not-for-profit healthcare providers, especially if, at the same time, they lose paying and insured patients to the for-profits.

**Geographic Problems** Catholic healthcare facilities are typically dispersed over wide geographic areas. CHA noted that, in 1991:

The average distance between a Catholic hospital and its sponsor's main office was 250 miles. . . . Nearly 10 percent of the hospitals were located over 700 miles from their sponsor. Many U.S. cities have numerous different Catholic sponsors responsible for the area's Catholic healthcare facilities. For example, there are 13 different sponsors of the 19 Catholic hospitals in St. Louis, and over a dozen other sponsors of Catholic long-term care facilities and other human service organizations.<sup>14</sup>

What is more, the sites for many Catholic healthcare facilities were selected in the last century and do not often correspond to the prime markets favored by today's purchasers of healthcare services. These prime markets are usually major cities and their suburbs (such as Dallas-Fort Worth) or populous state regions (such as eastern Massachusetts). Big purchasers prefer to contract with a healthcare organization—usually a system—capable of providing services throughout the market area. For example, in a press release of September 22, 1995, Columbia/HCA announced it had agreed “to acquire three Houston hospitals. . . . These facilities will join Columbia's 16 other hospitals and nine outpatient surgery centers in Houston's largest healthcare network.”

The surviving healthcare systems of the future are likely to be those which can cover an entire market. Unfortunately, many Catholic systems tend to be either too dispersed, on one hand, or overlapping, on the other.

**Partnering with Physicians** Big purchasers of healthcare especially like to contract with integrated delivery networks, which include physicians. Physicians are currently experiencing economic problems. Many specialists, for example, are seeing their referral bases dwindle. And many primary care doctors are learning that, no matter how much they value their independence, they can earn more as employees of large organizations. Both specialists and primary care physicians are finding that their office expenses are increasing while their reimbursement rates are declining.

Because of this economic crunch, physicians are increasingly willing to sell their practices to for-profit corporations. An August 1994 news

story noted, for instance, that Caremark International had recently purchased an 180-member physicians' network in La Habre, CA, a 165-physician clinic in Houston, and a 100-physician network in Oklahoma City.<sup>15</sup>

Unfortunately, physicians are increasingly reluctant to become associates or employees of not-for-profit hospitals or systems, especially those which are Catholic. They may fear that such organizations will not be competitive in the new age of commercialized healthcare. (Another reason some physicians may be reluctant to associate with a Catholic organization is because they fear that Church-related limitations on reproductive services could cost them patients.)

**Access to Capital** Not-for-profit healthcare institutions have traditionally issued tax-exempt bonds to raise the capital they needed. Although bonding services such as Moody's and Standard & Poor used to consider such investments relatively risk free, they have frequently downgraded them in recent years.<sup>16</sup>

Downgrading has been the result of increased pressure on not-for-profit organizations by for-profit competitors, reduced payments from the employers who purchase healthcare for their workers, and reduced government reimbursements for Medicare and Medicaid. Because they have been downgraded, tax-exempt healthcare bonds are not as attractive to investors as they were.

At the same time, cash-strapped state governments are seeking ways of raising revenue without alienating voters, as tax increases would. Toward this end, states may begin to discourage tax-exempt debt and modify hospitals' traditional tax-exempt status. Since for-profit healthcare currently enjoys easy access to debt and equity financing, state moves of this kind could greatly add to not-for-profit healthcare's economic disadvantages.

The ability of Catholic and other not-for-profit organizations to secure capital financing may be severely limited in the future; late last year a news story indicated that the “smart money” believes this to be so. The story noted that VHA Inc., an alliance of 1,200 not-for-profit facilities, had invested in a new company that plans to arrange access to capital for some not-for-profits by transforming them into for-profits. “We have been strong advocates of community ownership,” said C. Thomas Smith, VHA's president and CEO. “But we recognize that in some institutions the need for capital is so great, it's going to be difficult to sustain the traditional model.”<sup>17</sup>

**Reduced Influence on Government** In 1993-94 Catholic healthcare was generally enthusiastic about the Clinton administration's healthcare reform plan



(although ministry leaders disagreed with the plan's positions on reproductive issues). The November 1994 elections literally changed the face of Congress, however. A branch of government that had been dominated by Democrats for most of the previous 60 years suddenly became Republican.

The current Republican majority does not appear to share the Catholic health ministry's view that healthcare is a human right. What is more, victors tend to look unfavorably on supporters of their defeated opponents, as the president of the American Nurses Association (which backed the Clinton plan) learned last year when she found it impossible to arrange a meeting with the Republican senators from her own state.<sup>18</sup> Republican leaders very likely see Catholic healthcare as quaintly out of step with the market thinking now dominant in Washington, DC, and many state capitals. Catholic healthcare leaders have less political influence now, and this situation will probably not change until there is a change of leadership in Congress.

#### STRATEGIC ADVANTAGES OF CATHOLIC HEALTHCARE

Although it has weaknesses, Catholic healthcare also enjoys some strategic advantages over for-profit care.

**A Reservoir of Public Goodwill** According to a December 1995 Harris Poll, most Americans see the trend toward for-profit healthcare as a "bad thing."<sup>19</sup> A deep reservoir of goodwill exists for Catholic healthcare. There could be a public

backlash against those who are currently turning hospitals into for-profit organizations. By the same token, the public may soon seek healthcare leadership from those who chose not to profit.

**Catholic Healthcare Systems** Catholic healthcare was organized in "systems" long before the term became fashionable. There are 680 Catholic hospitals today in the United States, and they are the nation's leaders in average number of beds, admissions, and annual expenditures (see **Graphs**). Of these, 460 are organized, along with 100 long-term care facilities (LTCFs), in 58 systems. The systems range in size from one that has 2 hospitals and a single LTCF to another with 47 hospitals and 5 LTCFs. The average Catholic system consists of 6 hospitals and an LTCF.

Many of these Catholic systems have decades of experience in sharing services, enjoying the advantages of economies of scale, and balancing the needs of local communities with those of central management. Such skills are not learned quickly. Experience of this kind is an asset in itself.

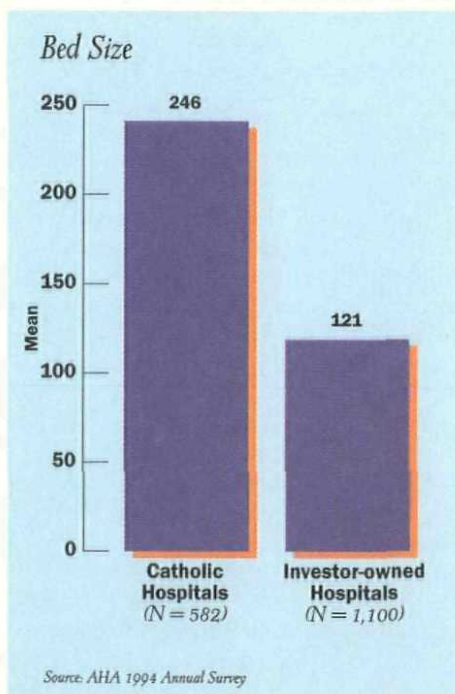
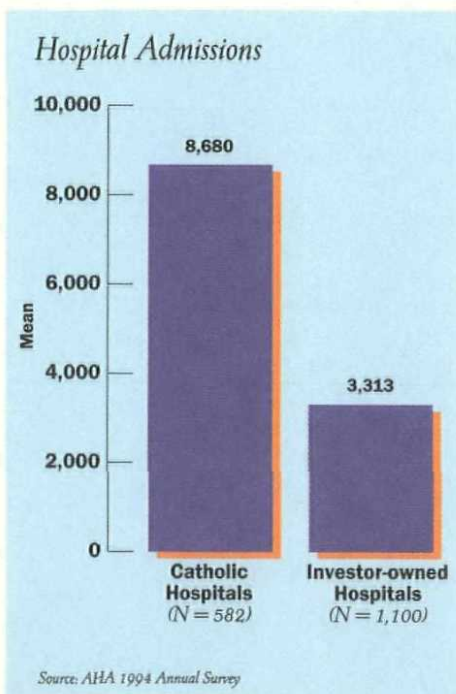
Contrast this with the experience of Columbia/HCA, the United States's biggest for-profit healthcare corporation, which acquired 325 hospitals in just eight years. Expansion of this kind is likely to lead to difficulties down the road. Consider, for example, the case of Durham, NC-based Coastal Physician Group, Inc., once the nation's largest operator of physician services. Coastal Physician recently announced that, because of a series of financial reverses, it might have to sell part or all of its company.<sup>20</sup>

Catholic and other experienced not-for-profit organizations are unlikely to make mistakes of this kind.

#### The Potential to Expand Networks

Catholic systems are poised to make the *right* kind of growth. Although most Catholic hospitals are in systems today, some 150 are not, and many of these would be financially strengthened by joining one. A 1990 CHA study of members' financial stability showed that around 25 percent of system-affiliated facilities were consistently sound, compared with only 10 percent of nonaffiliated facilities.<sup>21</sup>

And Catholic healthcare could expand in still other ways. The nation has another 200 religious hospitals and some 2,600 community hospitals; many of these have values compatible with Catholic



values. If all these hospitals were to affiliate, they would make up by far the largest healthcare network in America.

**A Common Catholic Vision** Catholic hospitals and LTCFs are a mix of urban and rural, teaching and community, stand-alone and system, financially sound and struggling. These differences could be a source of conflict. But Catholic organizations also have a consistent vision, which guides their planning and public policy efforts. As described in CHA's vision statement, the ministry is "anchored in Jesus' healing mission."

Commonality of purpose binds Catholic healthcare together. Not all associations can make that statement. Because of declining funds, healthcare providers are increasingly pitted against each other—which is the essence of competition. But, unlike for-profit organizations, Catholic providers continue to work for the common good.

**Access to the Pulpit** The reforms congressional leaders are planning for Medicare and Medicaid have generated a good deal of confusion. If the leaders of Catholic healthcare were given access to the 23,685 Catholic pulpits in the United States, they would have a unique opportunity to clear up this confusion for 59 million people. If, moreover, *all* faiths were to agree that we should ensure equal access to healthcare to everyone who needs it, that message could be spread from 358,194 pulpits to 156 million people.

**Religious Women and Men** The dwindling number of religious women and men in Catholic healthcare is considered by some people to be a disadvantage. I disagree. As of 1992, 81 percent of Catholic hospital CEOs and 51 percent of Catholic system CEOs were laypeople.<sup>22</sup> The significant fact is that Catholic healthcare has adapted quite well to the transfer of management to lay professionals—so well, indeed, that we should consider it an advantage, rather than the opposite.

More important, a number of religious can exert a very strong influence on healthcare providers. Hospitals, systems, and CHA itself are profoundly shaped by the presence of religious women and men. Efforts such as the Sister Visitor program of the Franciscan Sisters of Christian Charity can be very effective. Sister Visitors are retired women religious who are assigned as volunteers to the congregation's hospitals. Their presence, which can be felt throughout the hospitals, is a power that no for-profit facility can match.

## A STRATEGY FOR CATHOLIC HEALTHCARE

Catholic healthcare must develop a strategy to ensure its own viability, so that it can continue to

## The Elements of a Successful Strategy

The developers of a strategy for the survival of Catholic healthcare will:

- Reorganize their systems to compete with others for insured patients
- Create their own physicians' network
- Aggressively pursue Medicare and Medicaid contracts
- Aggressively pursue private managed care contracts
- Be slow to launch their own HMOs
- Exert their influence on public opinion
- Reinvigorate philanthropic efforts
- Be patient

provide excellent services for all, especially the uninsured and the poor. Of what elements should such a strategy consist?

**Reorganize Catholic Systems to Compete with Other Systems for Insured Patients** For leaders of such systems, this would include the following actions:

- Examine your current market. Is your organization the dominant provider? Is it holding its own with competitors? Or is it merely a minor participant?

- Decide whether to stay in a market that may be adequately served by other organizations. If your facility is but a minor market participant, and one or more of your competitors also has a religious sponsor, this question will be especially pressing.

- Consider trading facilities with another sponsor to improve both organizations' effectiveness in their respective markets.

- Convene meetings of the like-minded organizations in your market, with forming a new network as the goal.

- Remember, however, that such a realignment may cause organizational confusion similar to that experienced by rapidly growing for-profit networks. Pay close attention to your organization, especially to management's insecurities, and you may be able to reduce this confusion.

- Integrate your new network tightly. Loose affiliations are easier to form (which may make them a good starting point), but they are also more difficult to manage. Such organizations will have trouble competing with more centrally controlled systems.

- Be prepared, once the new network is formed, to see improvement in your organization's bond ratings and its ability to borrow.

**Create Your Own Physicians' Network** This would entail the following:

- Recruit physician leaders who share your mission, and build your network around them.
- Place these physicians in important manage-



ment positions and invest in their management education.

- Acquire primary care physicians' practices. Try to avoid arrangements that fall short of *complete* acquisition, however. Otherwise, in future negotiations you may find yourself forced to offer ever more generous terms, or else risk losing physicians to competing organizations.

- Acquire selected specialists' practices. You will need them to provide your network with sophisticated inpatient services. Primary care physicians are currently in high demand, but specialists are not, and thus are more ready to discuss new arrangements.

- Use your primary care residency program to build your primary care network. If you have no primary care residency program, start one now. There is likely to be funding for it.

**Aggressively Pursue Medicare and Medicaid Contracts** Such contracts will help you provide care for uninsured and poor patients. They will also help you fund the preventive care that is needed in your area.

**Aggressively Pursue Private Managed Care Contracts**

**Do Not Rush into Launching Your Own HMO** Insurers, who tend to see provider-owned HMOs as competitors, often retaliate by signing exclusive contracts with other providers.

**Exert Your Influence on Public Opinion** You can do this by:

- Mounting public information campaigns
- Enlisting men and women religious to speak on behalf of Catholic healthcare from the pulpit
- Enlisting the aid of the National Council of Catholic Bishops
- Carrying out a consistent dialogue with legislators

**Reinvigorate Philanthropic Efforts** If the federal and state governments reduce their funding of healthcare for the poor, your organization will not be able to make up the difference by itself. In that case, your sponsor may need to seek private donors to help your organization fulfill its mission—which is how Catholic healthcare began in the first place.

**Be Patient** Eventually, the public may well decide it does not want healthcare to be commercialized. Until then, Catholic care will be there to serve the public good.

### A TIME FOR BOLDNESS

The transformation of healthcare from a ministry into an industry will probably slash the amount of care available to Americans. It could also seriously destabilize Catholic providers. But this transformation is a reality, and it must be accommodated, at least for the time being.

In some ways, Catholic providers are prepared for the great transformation that U.S. healthcare

is currently undergoing; in other ways, they are not. In any case, it is inconceivable that Catholic healthcare would ever abandon the poor, the uninsured, and the underinsured simply to ensure its own survival.

As I have suggested here, Catholic healthcare enters this new era with both disadvantages and advantages. We can develop a strategy that will mitigate the impact of commercialization, but it will require bold action and sacrifice. In particular, our new strategy will require some sponsors and CEOs to share—perhaps even give up—control of their institutions so that new healthcare organizations can be born. □

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Our new strategy will require some sponsors and CEOs to share—perhaps even give up—control of their institutions.