

# PRIVATIZING PUBLIC HOSPITALS

## STRATEGIC OPTIONS IN AN ERA OF INDUSTRY-WIDE CONSOLIDATION

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### EXECUTIVE SUMMARY

A veritable revolution is occurring in the way that health care is provided to the indigent and uninsured. Because of industry-wide consolidation pressures, it is unlikely that 10 years from now governments will find it strategically desirable to directly operate their own public hospitals and clinics—more cost-effective choices are becoming available.

Besides dwindling public resources, the main force driving this change is vigorous competition for treating the poor from private for-profit and nonprofit hospitals. In most communities, even those on public assistance now have a choice of providers. The advent of HMOs is leading to a fundamental restructuring of the whole health care system. One offshoot of this is a declining need for hospital beds.

In response to these developments, more and more governments are exploring privatization options for public hospitals and clinics. Depending on the nature of a jurisdiction's present system and the external market in the area, there are several options for governments exploring privatization of hospitals and health clinics.

- **Sale.** A sale produces a large cash payment up front, which can be used to retire debts and to establish a trust fund for community health care. Example: When the public hospital in Conroe, Texas, was sold to Healthtrust for \$104 million, the profits were used to establish a community health care foundation to meet the ongoing needs of the community.
- **Lease.** An alternative to selling the hospital outright is to lease the hospital, clinics, and equipment to a management firm. Example: Austin, Texas, has a 30-year lease with Seton Health Care Network to run

its public hospital. All indigents have access, but the subsidy for indigent care is capped at \$17 million annually.

- **Joint Operating Agreement.** The government turns operation of the hospital over to the private sector but retains a measure of influence by appointing a portion of the board members to the new joint-venture entity. Example: the state of Oklahoma will transfer operation of the state's teaching hospitals to Columbia/HCA Healthcare Corporation under a 50-year contract. The state of Oklahoma and Columbia will each appoint five directors to the board of directors of the new jointly operated hospital..
- **Joint Venture.** Government sells a portion of the public hospital assets for cash, retaining power to appoint a portion of board members. Example: in 1997 California's Sequoia Healthcare District netted \$30 million in cash by affiliating with Catholic Healthcare West. The new CHW management of Sequoia Hospital staged a successful turnaround from previous losses.
- **Service Shedding.** Depending on local market conditions, the location of the hospital, the condition of the physical plant, the image of the hospital, and other factors, a facility may not be needed as a hospital at all. In such a case it may make sense for the government to get out of the hospital business and sell the hospital for the value of the facility or of the land that lies underneath the buildings.
- **Community-wide Public-Private Partnership.** After shedding its public hospital(s), government purchases from local hospitals and clinics the bed days it needs for indigent care. Example: Orange County, California, no longer owns or operates any hospitals. Instead, it contracts with 28 local hospitals to provide indigent care on a cost-effective basis.
- **Comprehensive Outsourcing.** Public hospitals are increasingly contracting out everything from their information systems to business offices to clinical services. Example: Nassau County Medical Center in New York contracted out orthopedic services to a local physician practice group, slicing almost \$1 million in salaries and benefits from the county payroll.

Privatization can raise cash, reduce debt, and create a better system for serving indigents. But transitioning from operating the public hospital to a privatized system means crossing a mine field of regulations, selecting the best structural arrangement to meet local goals, negotiating the best deal possible, and handling union and public opposition.

## Part 1

# Introduction

*Safety-net (public and nonprofit) hospitals will be caught in a major budget squeeze, as tax subsidies dry up and capitated Medi-Cal (Medicaid) patients choose a variety of HMOs and hospitals; up to half of the traditional safety-net hospitals may close or be converted by the year 2005.*<sup>1</sup>

—California Healthcare Association

Across the nation, public hospitals are facing serious challenges.<sup>2</sup> Fundamental consolidation and restructuring is affecting all hospitals, especially the so-called “safety-net providers.”<sup>3</sup> The focus of this report is specifically on the safety-net subset of government-operated, public hospitals, because the options available to these facilities through privatization, if executed intelligently, can improve services to indigents and reduce payments by taxpayers.<sup>4</sup>

The force behind hospital-industry restructuring is unprecedented market competition. This change results from a revolution in the way health care is being delivered. At center stage is the growth of managed care, which itself is a product of competition between public and private purchasers of health care.<sup>5</sup> Managed care is a series of purchasing techniques that employers have applied to reduce the cost of their employees’ health benefits. Managed-care plan administrators bargain with individual hospitals and primary-care centers for low cost and high quality on behalf of large groups of employees who are typically required to use a selected set of providers.

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<sup>1</sup> “California Health Care 1996 to 2005,” California Healthcare Association, p. 5.

<sup>2</sup> For a concise overview, see Jerome P. Kassirer, M.D., “Our Ailing Public Hospitals,” *New England Journal of Medicine*, November 16, 1995.

<sup>3</sup> The term “safety-net providers” refers to health care providers that are legally obligated to provide care to persons who cannot afford it. Such providers typically include public university teaching hospitals, federally funded community health centers, and city and county health departments. Safety-net providers also include nonprofit hospitals that provide uncompensated care as part of their community benefit obligation. (The obligation itself arises due to tax breaks and federal funding these hospitals receive to treat indigents, although all hospitals, including for-profits, must treat all patients needing help in their emergency rooms regardless of ability to pay). Debra J. Lipson and Naomi Naierman, “Effects of Health System Changes on Safety-Net Providers,” *Health Affairs*, vol. 15, no. 2.

<sup>4</sup> “Privatization” means to change responsibility for hospital operation from a government to a private corporation, either nonprofit or investor-owned. It may also refer to a government closing a public facility and contracting for indigent-care services from private-sector firms. “Conversion”, a term also used throughout this report, refers to any change in ownership status, but in the hospital industry the term recently has become associated with the trend of nonprofit facilities to convert to for-profit, investor-owned, status through purchase, long-term lease, or joint-venture restructuring.

<sup>5</sup> Three-quarters of U.S. workers are now in managed-care plans, compared with just over half in 1993, according to the latest survey by Foster Higgins (a consulting firm). See “Perspective: Why Health Costs Really Fell,” *Investors Business Daily*, March 5, 1997, p. B1.

Competing for managed care contracts broke a 40-year barrier to price competition among hospitals, which have responded by forming larger organizational units to strengthen their bargaining power.<sup>6</sup> These integrated delivery networks have transformed old cottage hospitals into corporate systems that are nationwide in scope and highly sophisticated. Public hospitals have responded by becoming more competitive, converting to nonprofit status, or partnering with investor-owned or nonprofit hospitals (see Table 1). In 1995, there were 447 buyouts, mergers, or acquisitions of hospitals in the United States (see Table 2).

	1975		1995		Change		% Change	
	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
Non-profit	3,339	658,000	3,092	610,000	-247	-48,000	-8%	-8%
For-profit	775	73,000	752	106,000	-23	33,000	-3%	45%
State/Local Govt.	1,761	210,000	1,350	157,000	-411	-53,000	-30%	-34%
Federal Govt.	<u>1,177</u>	<u>519,000</u>	<u>1,071</u>	<u>144,000</u>	<u>-106</u>	<u>-375,000</u>	<u>-10%</u>	<u>-260%</u>
Totals	7,052	1,460,000	6,265	1,017,000	-787	-443,000	-13%	-44%

Source: California Healthcare Association, *California Health Care: 1996–2005: A View of the Future*.

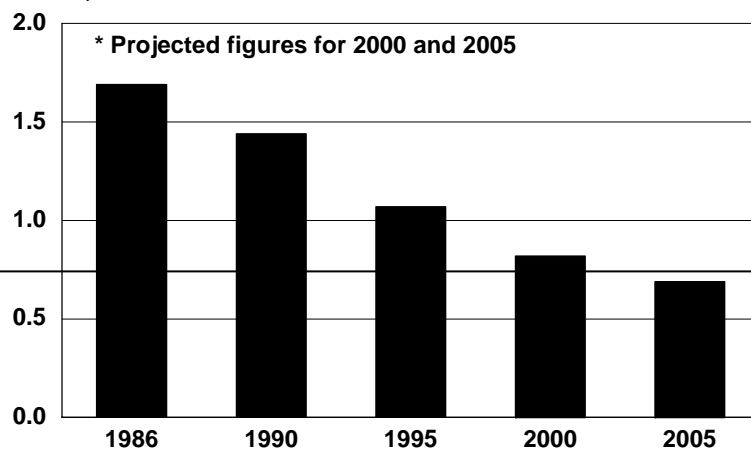
Jurisdiction	Type of Privatization
<b>Completed</b>	
• University of Cincinnati Hospital	Conversion to nonprofit.
• Oklahoma Medical Center	JOA between State and Columbia/HCA
• Spalding Regional Hospital	Sale to Tenet; 15 year option buy-back
• Boston City Hospital	Conversion to nonprofit
• Washington, D.C. General Hospital	Conversion to nonprofit
• Northwest Mississippi	
• Regional Medical Center	Lease to Health Management Associates
• Wake County Medical Center, NC	Sale and conversion to nonprofit
• Brackenridge Hospital, TX	Long-term lease to Seton Health Care
• Desert Hospital, Palm Springs, CA	Conversion to nonprofit; subsequent sale to Tenet and conversion to for-profit.
• Edge Regional Medical Center, Troy, AL	Sale
• Northwest Health Care, Amarillo, TX	Sale to Universal Healthcare Systems
• Sequoia Hospital, Redwood City, CA	Joint Venture Agreement with Catholic Healthcare West
• Fallbrook Hospital, Fallbrook, CA	Leased (30 years) to Columbia/HCA
• West Contra Costa Health Care District, Richmond, CA.	Sale to Tenet.
• Conroe Regional Medical Center	Sale to Health Trust/Columbia
<b>Proposed (or in progress)</b>	
• Eden Medical Center, Castro Valley, CA	Joint Venture with Sutter Health (to close 1/98).
• Parrish Medical Center, Titusville, FL	
• Los Angeles County (2 hospitals)	
• New York City (2 or 3 hospitals)	
• University of California (San Francisco teaching hospitals)	

<sup>6</sup> David F. Drake, Ph.D., “Managed Care: A Product of Market Dynamics,” *Journal of the American Medical Association*, February 19, 1997, pp. 560–563.

Hospital firms are prospering because they are cutting costs and winning managed-care contracts by consolidating functions, achieving economies of scale, and eliminating redundancies. Media attention has focused on the rapid growth of Columbia/HCA, and recently, on its problems. Unreported, however, is the parallel development of huge nonprofit corporate systems, which are fueled by the same economic consolidation. Catholic Healthcare West, for example, has quadrupled in size in four years and is currently in negotiations seeking several additional acquisitions (see Table 3 for industry leaders). Ten years from now we will have fewer, more-efficient, and better-integrated hospital care networks than today. (Figure 1 illustrates the decrease of hospital beds in the next 10 years.) The change will help indigents as well as taxpayers because productivity improvements will mean that the system treats more patients at less cost.

<b>Table 3: Hospital Industry Leaders</b>	
<b>For-profit</b>	
• Columbia/HCA	338 hospitals
• Tenet Healthcare	127 hospitals
• Health Management Associates	30 hospitals
<b>Nonprofit (selected sample)</b>	
• Daughters of Charity	40 hospitals
• Catholic Healthcare West	39 hospitals
• Mercy Health Systems	37 hospitals
• Intermountain Health Care	22 hospitals

**Figure 1: Occupied Number of Beds per 1,000 Californians from 1986 to 2005\***



Source: California Healthcare 1996-2005, California Healthcare Association, 1996.

## Part 2

# Why Communities Are Turning to Privatization to Meet Health-Care Needs

**T**he public hospital has been a fixture of American life for decades. Many of these facilities were built in the Great Depression and have served the poor in their time of need. Public hospitals have been especially important to residents in the inner city and in hard-to-serve rural areas. But due to internal and external factors, public hospitals don't fit well into a consolidating health-care industry. In response, an increasing number of jurisdictions are exiting the business of running public hospitals.<sup>7</sup> There are seven principal reasons why this is occurring:

## A. The Drag of Bureaucracy

Slow government decision making, cumbersome procurement and personnel regulations, lack of a marketing orientation, multi-layered management, and excessive benefit costs—each constrain public hospitals from competing effectively in the rapidly changing health-care marketplace.<sup>8</sup> Most of these problems are difficult to correct due to union opposition and internal resistance. Writes Penelope Lemov in *Governing* magazine,

*The sunshine laws, procurement rules, civil service regulations, restrictions on raising capital, decision-making processes—. . . all the rules and regulations that government institutions must operate under—are dead weight for a hospital that has to act quickly and work efficiently to survive in the super-competitive and fast-changing health care market.*<sup>9</sup>

## Trends in Hospital Ownership in the United States

The number of public hospitals has been shrinking for twenty years. There were 1,761 public hospitals at the state and local levels in 1975 and only 1,350 in 1995, a decline of 23 percent.

<sup>7</sup> Jack Needleman et al., "Hospital Conversion Trends," *Health Affairs*, March/April 1997, p. 189.

<sup>8</sup> For a detailed look at the internal inefficiencies of the nation's largest public hospital systems, see Jeffrey L. Rabi, "How Public Health Care Got So Sick," *Los Angeles Times*, October 29, 1995, p. B1.

<sup>9</sup> Penelope Lemov, "Dumping the Public Hospital," *Governing*, September 1996, p. 44.

In recent years, public hospitals have been more likely than either nonprofit or for-profit hospitals to convert their ownership status. The favored conversion is from public to nonprofit status. For instance, between 1990 and 1993, 88 percent of public-hospital conversions were to nonprofit status. The vast majority of these conversions were “flips”, meaning no outside private affiliation or system consolidation is involved. The government simply converts the legal status of the public hospital to nonprofit status so that it can issue revenue bonds and escape “sunshine laws.” In some cases, the government still retains ownership title to the buildings and land, and leases these to the nonprofit entity it created to operate the hospital.

Although public hospitals are still more likely to become nonprofit than for-profit, there is a decided recent trend to for-profit status, if for no other reason than the tremendous access to capital enjoyed by such publicly traded firms as Tenet and Columbia (however, the latter’s stock price has plummeted since federal investigations started). But from 1990 to 1993 only nineteen percent of conversions were to for-profit status, and the for-profit sector still has a limited market share of the industry.

Nationwide conversions tend to be concentrated in those states that have highly developed managed-care competition (California, Arizona, Texas, Florida, Tennessee, Georgia, and, recently, New York). (See Table 4 below). In these states the conversion of a public hospital is often described as an effort to improve efficiency by freeing the hospital from civil service and hospital procurement rules, or a response to the unwillingness of local governments to provide continued tax subsidies.

The current ownership structure of hospitals breaks down as follows:

- **State and local public hospitals** make up some 22 percent of the nation’s 6,265 hospitals and contain approximately 157,000 beds. Approximately 30 percent are in inner cities. Many others are in rural and semi-rural health-care districts.
- **Federal government hospitals** make up 17 percent of all hospitals and account for 14 percent of all hospital beds.
- **Nonprofit hospitals** account for nearly half of all hospitals in the nation and 60 percent of all hospital beds.

State	1980–1990			1990–1993		
	# of Conversions	Conversion from Nonprofit	Conversion from Public	# of Conversions	Conversion from Nonprofit	Conversion from Public
Alabama	16	5	11	n/a	n/a	n/a
California	16	13	3	7	7	0
Florida	21	14	7	5	4	1
Georgia	18	3	15	n/a	n/a	n/a
Missouri	n/a	n/a	n/a	5	4	1
Oklahoma	11	6	5	n/a	n/a	n/a
Tennessee	11	1	10	n/a	n/a	n/a
Texas	28	19	9	7	5	2

Source: Jack Needleman, et al., “Hospital Conversion Trends,” *Health Affairs*, March/April 1997, p. 192.

## **B. The Poor Have a Choice of Providers: Hospitals Now Compete to Serve the Poor**

Historically, public hospitals developed mostly free from competition: the poor were served almost exclusively by the county, city, or district hospital. This no longer holds true. Private safety-net hospitals now compete against public hospitals for poor patients. In Los Angeles, occupancy rates in private hospitals have dropped so low that thirteen of them offered to provide cut-price treatment to County of Los Angeles

patients in order to help fill their beds, over half of which now stand empty.<sup>10</sup> “Competition is so tough that even the patients previously deemed not worth bothering with have now become attractive to private providers as Medicaid payments have risen and private payers have cut their rates,” says Anne Camper, a lawyer representing private safety-net hospitals.<sup>11</sup>

Public hospitals now must compete to attract and retain clients. Even those on public assistance have a choice of care in most communities. Patricia Gabow of the Denver Department of Health and Hospitals, explains:

*The fast eat the slow in this business. Running a public hospital is not like other government services. It's at risk in a competitive market. If people in your community don't like the police force, they don't go use the police in a neighboring community. If we're not operating our hospital well, our patients will go elsewhere.*<sup>12</sup>

### C. Public-Hospital Beds Are No Longer Needed

Occupancy rates at all community hospitals, including public, nonprofit, and for-profit, are already below 60 percent (below 50 percent in California (see Table 5)) and will continue to shrink. The rapid decline in occupancy rates of the last ten years will accelerate over the next ten—communities that now have twice the hospital beds they need soon will have *three times* as many beds as can be efficiently supported.<sup>13</sup> If all of these hospitals are kept open, there will be many adverse consequences on health-care patients. As Matthew Miller points out in *The New Republic*,

*Excess hospital capacity isn't benign. . . . Weak hospitals sap strong ones. Over capacity means insurers can buy unused beds at steep discounts; this drives down hospital earnings across the board, limiting their ability to invest in community-based primary care and disease prevention programs that are vital for improving public health (and cutting costs) in the long run.*<sup>14</sup>

Year	Licensed Gen. Acute-Care Hosp. Beds	Number of Occupied Beds	Percent Occupied	Total Population	Occupied Beds/1,000 Population
1986	85,031	45,836	53.9	27,052,000	1.69
1987	84,789	45,547	53.7	27,717,000	1.64
1988	83,862	44,603	53.2	28,393,000	1.57
1989	84,305	44,155	52.4	29,142,000	1.52
1990	83,644	43,132	51.6	29,976,100	1.44

<sup>10</sup> County supervisors declined the cut-price treatment offer. Duncan Moore, “California Public Hospitals Dodge a Bullet,” *Modern Healthcare*, October 21, 1996, p. 24.

<sup>11</sup> Quoted in “The Perils of Imitating Sweden: Los Angeles County’s General Fund,” *The Economist*, July 29, 1995, p. 16.

<sup>12</sup> Lemov, “Dumping the Public Hospital,” p. 43.

<sup>13</sup> California hospital beds are only 44.9 percent occupied. California is ahead of most states in the use of managed care. In California, HMOs cover nearly half the population, compared to only 20 percent nationwide. As a result, health care costs actually declined 5.2 percent from 1994 to 1995. Source: *The Economist*, November 9, 1996, p. 92.

<sup>14</sup> Matthew Miller, “Taking Our Medicine,” *The New Republic*, December 2, 1996.



1991	83,512	42,325	50.7	30,654,800	1.38
1992	82,530	40,391	48.9	31,306,200	1.29
1993	80,673	37,568	46.6	31,746,400	1.18
1994	79,353	35,697	45.0	32,140,000	1.11
1995	78,000	35,000	44.9	32,681,000	1.07
2000	68,800	29,252	42.5	35,590,000	0.82
2005	59,300	26,675	45.0	38,636,200	0.69

Source: California Healthcare Association, *California Health Care: 1996–2005: A View of the Future*.

## D. Managed-Care Plans, Competing For Medicaid Dollars and Members, are Bypassing Public Hospitals

Public hospitals are also caught in the middle of an undeclared war for Medicaid patients among public and private managed-care plans. Many states have allowed Medicaid patients to choose from competing public, nonprofit, and for-profit health plans. To date, the Federal Health Care Financing Administration (FHCFA) has approved competitive managed-care bidding processes in nine states: Arizona, California, Connecticut, Florida, Hawaii, Missouri, New Jersey, New York, and Rhode Island.<sup>15</sup>

The rapid growth of managed care in the Medicaid arena encourages competition among plans, which encourages cost containment, thereby moving care from hospitals into primary-care centers and creating more empty beds.<sup>16</sup> The trend also means that most HMOs can now choose private hospitals rather than the typically older (and often less appealing) public hospitals for their members' Medicaid care.<sup>17</sup> This puts even greater competitive pressure on public facilities.

The state of California has developed a “two plan” model of Medicaid (Medi-Cal in California) funding to *deliberately* create new competition between a *public* managed-care plan and a *private*, or commercial, managed-care plan in several major cities, including Los Angeles.<sup>18</sup> If the private Medicaid plan gains market share over its public rival, the public hospital will lose patients.

<sup>15</sup> Medicaid managed care is growing. As of June 30, 1995, 11.6 million Medicaid beneficiaries were enrolled in managed-care plans, representing 32 percent of the total on Medicaid. Managed-care enrollment is increasing at the rate of 50 percent per year. Source: Columbia Center for Medicaid and the Uninsured.

<sup>16</sup> Titles XVIII and XIX of the Social Security Act still favor the highly inflationary fee-for-service system, and states still must navigate a complex waiver process in order to “experiment” with managed care. Still, the number of recent waivers granted suggests that profound changes are occurring, especially in states such as California and Texas. Under these systems, plans providing benefit packages for the old or disabled (Medicare) and the poor (Medicaid) compete on quality and price.

<sup>17</sup> Some local governments are responding by creating their own public HMOs to refer to their own public hospitals. The jury is out on whether these public HMOs can compete by sending employees to hospitals that are generally seen by the public as undesirable.

<sup>18</sup> The Los Angeles County Health Services Department, in a controversial attempt to “save” its four remaining public hospitals (there are currently six hospitals in the system, with two of these slated for privatization), is responding to the challenge by developing its own HMO, called “L.A. Care.” This public HMO is attempting to enroll Medicaid members faster than its “commercial” competitor, Foundation Health. For public hospitals in Los Angeles to win this competition, they must attract Medicaid members, who have a choice of the health plan and hospitals they use. This is a competitive new world that public hospital administrators could not have imagined in their worst nightmares only five years ago. Telephone conversations with staff at L.A. Care indicate that their patients will be given a choice of private providers as well as public, thus continuing a trend away from public treatment.

## **E. Managed-Care Plans Prefer Private Providers That Can Contain Costs**

Investor-owned hospital chains have gained market share by successfully competing for managed-care contracts.<sup>19</sup> This competitive advantage has been garnered through such innovations as volume-purchasing systems, standardization of supplies, outcome-management systems, computerized case-management systems with cost-per-procedure variables among physicians performing the same procedures, physician practice management, technologically advanced patient care, national staffing, and management information systems. These innovations translate into better care at lower cost. Local governments often lack the tools and capital to compete on this level.

## **F. If a Public Hospital Can Internally Restructure to Compete Aggressively, That “Success” Can Push Other “Safety-Net” Hospitals into Bankruptcy**

When a community needs fewer hospitals overall, some must eventually close their doors. Competition is erasing the boundary lines between the traditional public and private hospital target populations. To avoid raising taxes for subsidies, public hospitals are seeking more privately insured patients to improve their payer mix. And as we have seen, the days of the poor being the exclusive domain of the public hospital are gone. Any patient needing a bed now becomes fair game.

Nonprofit safety-net hospitals can be at a competitive disadvantage in a “medical arms race” with local government competitors because governments have ultimate recourse to increase local taxes to support public systems. Nonprofit hospitals have recently started to sue public hospitals for venturing outside their turf and “unfairly competing” for privately insured patients.<sup>20</sup> While courts in California have backed public hospitals thus far, it is a battle that public hospitals may pay a severe price to win—loss of community goodwill.

## **G. Local Governments, Facing Limits on Their Ability to Raise New Taxes, Are Finding That Public Hospitals Are Taking More Than Their Share Of Limited Resources.**

Public hospitals are expensive, often costing \$1,600 per bed day. Local governments still involved in running these hospitals are finding that the hospital operations tend to absorb an increasingly disproportionate share of tax revenue, often robbing other public programs of needed support. Nowhere is this more apparent than in the County of Los Angeles, which still operates six public hospitals. The budgeted appropriations for these county-operated hospitals increased from \$351 million in fiscal year 1977/78 to almost \$2.2 billion in fiscal year 1995/96, an increase of 526 percent. If county public hospital

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<sup>19</sup> Peter H. Emich, in “Report on the Health Care Industry,” Alex Brown & Associates, January 21, 1997.

<sup>20</sup> Moore, “California Public Hospitals Dodge a Bullet,” p. 24. This article discusses the long-term war between the nonprofit community hospital in Ventura that sued the county hospital for “stealing its patients.” The suit attempted to restrict public hospitals from competition for insured patients, but it failed. Now the nonprofit hospital is trying to survive by attacking a county hospital expansion project.

appropriations had increased only as fast as inflation and the population of Los Angeles County, the appropriation would have been \$1.16 billion, an increase of 229 percent.<sup>21</sup>

Meanwhile, appropriations for preventive public health programs in Los Angeles County have actually declined 24 percent since 1992, prompting the *Los Angeles Times* to sound a warning in an editorial about an “inability to perform basic public health functions like monitoring epidemics.”<sup>22</sup>

## H. Geography is Making Public Hospitals Obsolete

Often the old geographical boundaries set by political jurisdictions work against public hospitals’ ability to compete. Private hospital chains now band their providers together into integrated-care networks to seek market dominance on a regional basis. The old political jurisdictions—city, county, and district boundaries—make little sense in this context.

For example, public hospital districts serving once semi-rural areas may now exist in overbedded, densely populated urban areas where the public now has a wide choice of hospitals. Beach Cities Health District in Redondo Beach, CA (Los Angeles area) and Sequoia Healthcare District in Redwood City, CA (San Francisco/Silicon Valley area) are examples of two California jurisdictions that privatized hospitals in part because the old geographic boundaries were obsolete in their market areas, making it impossible to secure the managed-care deals they needed to survive.

Conversely, in those areas of the nation that are still truly rural, districts can no longer operate tiny, independent, 50-bed hospitals in today’s market structure. Vic Biswell, President of the Association of California Healthcare Districts notes that several rural districts need to reduce costs by sharing an integrated management firm which can operate hospital services and negotiate managed care contracts for a wide regional area.<sup>23</sup>

Inner city hospitals also need to think regionally. They must be part of a viable, integrated, regional network in order to compete for managed care contracts.

Of course, local governments are still responsible for indigents and the uninsured within their geographic jurisdictions. It is simply more efficient for local government to obtain services from a regional integrated care network than from a stand-alone public hospital. The network will attempt to treat indigents in primary care (outpatient) centers close to home and then refer patients to the regional hospital only when necessary.

Integrated regional hospital and clinic networks are also starting to look a lot like HMOs. Sutter Health System in Northern California, which is involved in the privatization of Eden Medical Center (Castro

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<sup>21</sup> Steven B. Frates and Eric S. Norby, “An Analysis of Los Angeles County Government,” Howard Jarvis Taxpayers Association (Rose Institute: Claremont McKenna College, May 1996), p. 34. Note that the county’s current 1997–98 appropriation for the six hospitals increased again to \$2,214,519,000—an increase of \$17,435,000—despite efforts to reduce budgeted inpatient beds from 2,073 beds in 1996–97 to 1,690 beds in 1997–98 in order to qualify for \$536 million emergency federal funding to avoid bankruptcy. Source: David E. Janssen, *County of Los Angeles 1997–98 Proposed Budget*, April 1997, pp. 26.2–26.20.

<sup>22</sup> “L. A. County Health Services Still Falter Despite U.S. Aid,” *Los Angeles Times*, September 28, 1997.

<sup>23</sup> Telephone conversation, August 10, 1997.

Valley), has applied for an HMO license which would allow it to enroll patients over a wide regional area and be financially responsible for their care. Loma Linda University Medical Center and Cedars-Sinai Medical Center in Southern California, and their respective physician groups, are adopting the same strategy. This kind of geographic strategy is making the public hospital obsolete.<sup>24</sup>

## I. Picturing Consolidation Pressures

Figure 2, “Consolidation Pressures,” integrates much of what is discussed above.<sup>25</sup>

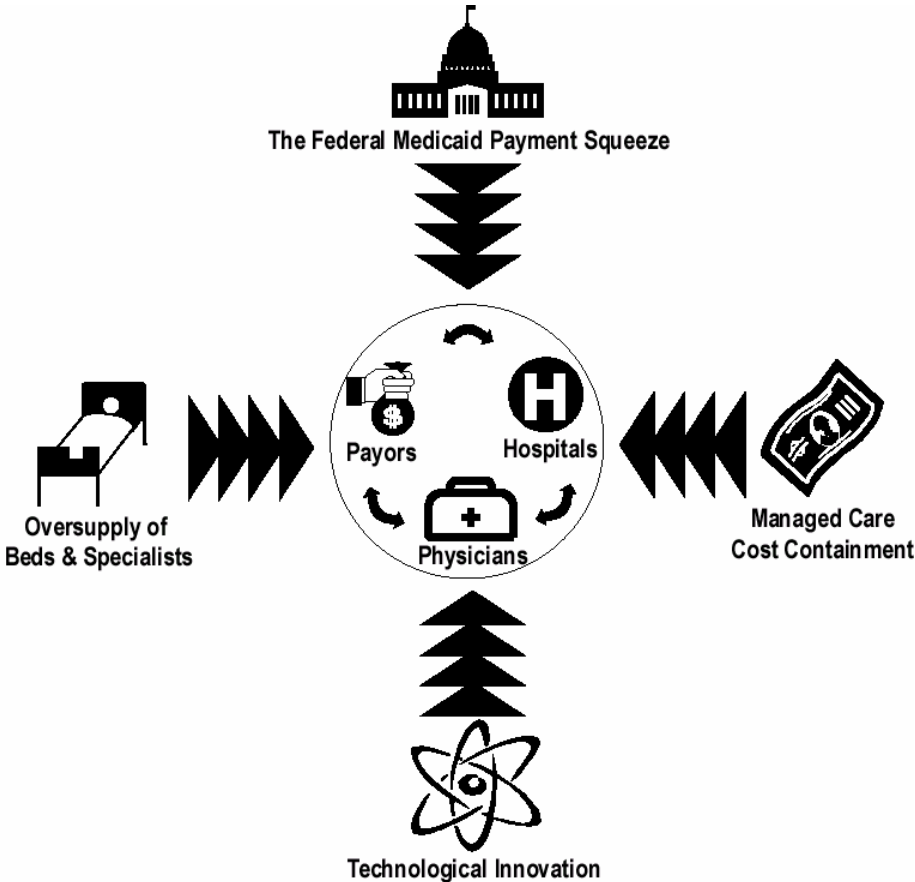
- Top: the federal government squeezes payments, through a shift in Medicaid, to managed care plans and other payment reduction measures.
- Bottom: new technology allows many surgical procedures to be performed solely on an outpatient basis, with no hospital stay needed.
- Left: the oversupply of beds, with the serious implications we have discussed at length.
- Right: managed care cost containment goes across the entire industry, putting private hospitals at risk as well as public hospitals.

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<sup>24</sup> George Wartzman, “Hospitals Start to Look a Lot More Like HMO’s”, *Wall Street Journal*, August 27, 1997.

<sup>25</sup> The chart has been modified from an unpublished presentation given by Steven R. Hollis of Cains Brothers at the Association of California Healthcare Districts Annual Meeting, May 29, 1997 in San Francisco.

Figure 2: Consolidation Pressures



## Part 3

# The Privatization Process

**T**he previous section was a general discussion of why the public hospital no longer fits into the evolving healthcare industry. This section provides a concise discussion of the necessary steps in a successful privatization. Part 4 then shows practical examples of how these steps work in structuring agreements that benefit the whole community.

## A. Undertake Careful Evaluation of the Public Hospital's Position in the Marketplace

Evaluate the hospital's market position, market share, customer base, competitors, internal organization and current financial and legal resources and constraints. This should occur before seeking a partner. This is not an analysis routinely performed by many public hospitals, especially those hospitals that serve as "providers of last resort", because until recently they had no competition. But now it must be performed and must become part of the hospital culture, whether or not the hospital ends up seeking privatization.

An outline for this process, crafting a strategic market management plan, is provided in the Appendix. Healthcare consultants are available to perform this kind of analysis, but the hospital must also involve its key stakeholders in the process so that it is not seen as a sterile planning exercise.

## B. Define the Goals of Affiliation

The most important first step in a successful privatization process is agreeing upon and setting the goals to be achieved. This means conducting a series of meetings with a mergers and acquisition specialist, reviewing the strategic market management plan (see above), and agreeing on what privatization should accomplish. Some steps to consider include:

**Refine the hospital mission statement.** This must be expressed precisely if the new partner is to be expected to follow it. The mission statement must answer the question: what is our hospital's purpose in this community? Each service area must be identified. If, for instance, affiliation with a medical school to train physicians and nurses is an important part of the core mission, this must be clear. Carefully note how your mission differs from that of your competitors. The most useful mission statements specify growth directions and thus have a very dynamic orientation. The development of a mission statement is an

**Box**

### Privatization Process—Key Steps

- ◆ Market Evaluation
- ◆ Define Partnership Goal
- ◆ Assemble an Expert Team
- ◆ Establish Criteria for the Private Partner
- ◆ Resolve Legal Questions

opportunity to consider many alternative strategies with stakeholders, without the associated detailed analysis.<sup>26</sup>

**Preserve or enhance indigent care.** The privatization agreement should try to guarantee delivery of *at least the same or a greater level of indigent care* as under public operation. If this principle is missing, the media, unions, and welfare rights groups will claim the deal “abandons the public mission of serving as the provider of last resort for the poor and uninsured.” *For this reason, the indigent care requirement today is usually written into the RFP as a prerequisite to doing business.*

The way government negotiates indigent care is also determined by the public hospital’s market position (see Appendix). If it has a high percentage of uninsured and indigents, government may need to continue a reduced subsidy after privatization. In this case, lowering the public subsidy by a target percent may be a reasonable goal that protects the level of indigent care delivered.

**Identify key services that must be continued:** Are there certain vital services that your partner must agree to continue after privatization? These may be expensive services such as cardiovascular, burn, and neonatal units that could be on the chopping block if not identified as priorities.

**Consider timing:** How much time is there to do a deal? What are the risks of doing nothing? Moving to privatize when the public hospital is still financially viable and before the surrounding market is fully consolidated is better than waiting until it’s too late.

**Discuss governance and control.** When privatizations fail, they typically do so because government leaders are unwilling to give up their control as a provider.<sup>27</sup> But how much influence does the district board or board of supervisors really need to retain in the hospital’s operation to protect the public interest? Indigent care and education can be achieved without direct operational control.

The best RFPs should encourage a full range of responses concerning the optimal ownership structure. Be aware that retaining government voting power on a new board will eliminate many opportunities, including all sales and most lease arrangements. And having direct voting rights only gives the illusion of power. If the private partner holds the management contract, that partner has the power. More important, voting power is not necessary to achieve public goals. Covenants in the sale and lease agreements can protect the public without giving up the extra cash and other benefits of a sale or lease.

**Consolidate operations, wherever possible, to reduce costs and increase productivity.** Virtually every regional hospital-services market in the United States suffers from severe overcapacity. All taxpayers and healthcare consumers pay for this inefficiency, either through taxes or insurance rates. This means that beds

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<sup>26</sup> David A. Aaker, *Strategic Market Management*, John Wiley & Sons, Inc., 1984, Chapter 2.

<sup>27</sup> View of Josh Nemzoff, a national mergers and acquisition consultant.

must be closed down and some entire facilities will cease to operate as hospitals. Nearly every effective privatization includes some consolidation.

Cost savings from consolidation can be dramatic. After consolidating, two inefficient hospitals running at 40 percent occupancy each can join to become one productive hospital running at 60 to 70 percent occupancy. Back office work (billing, medical records, reporting) that was done at two or more locations can be done at one location and with half the staff. There can be one, rather than two, labs, radiology units, and so on throughout the entire operational structure.

But this change, while dramatic, is painful and requires a strong management company with long experience at streamlining, consolidating, automating operations, and integrating organizational cultures. It requires experience in dealing with staff reductions. It requires making difficult and politically unpopular decisions for the long term good of indigents and the community. For this reason, we do not often see consolidation occur successfully within the public sector unless an outside partner is involved.

## **C. Assemble Your Team**

### ***1. Find a Mergers and Acquisitions Expert***

Governments considering privatizing something as complex as a hospital need to enlist the assistance of a mergers and acquisition (M&A) expert. You may be assured that the acquiring hospital or affiliation partner has full-time experts in M&A on tap. Government needs someone just as experienced in preparing and evaluating RFPs, preparing transaction criteria, and, negotiating agreements sitting on its side of the table.

Governments usually have a competent contracts staff, but they are often inexperienced with deals of this size and complexity. The top managers of the investor-owned chains, on the other hand, negotiate such deals frequently in order to grow their business. Public officials need someone looking after their interests who is in the same league. A mergers and acquisitions consultant interviewed for this report had personally represented nonprofit and public hospitals in 145 mergers totaling \$6 billion in value.

Inexperienced project management can lead to errors like missing documentation or incomplete transaction criteria. Such errors preclude adequate bids, and can mean having to reissue the Request for Proposal—an expensive and time consuming process that earns the hostility of potential partners who must redraft their proposals. Advice: appoint as project director an M&A expert who has put dozens of deals successfully to bed.

### ***2. Assemble a Team of Experts Under the M&A Project Director***

Most governments will want to have the following players on their privatization team:

- M&A Consultant: Project Director, lead negotiator.
- Investment banker: Handles hospital valuation and bond issues.
- Healthcare Consultant: Assembles the marketing plan and market bed demand projections
- Transaction Lawyer: Handles all transaction and due diligence details (your County/City Counsel does not have this specialized expertise).



- Antitrust expert: Required in certain consolidations.
- Human resources consultant: Transition plan, including outplacement arrangements.
- Public Relations Firm: Communications, media, community outreach.

## D. Criteria for Selecting a Partner

**Type of Partner.** The RFP should be open to all possible bidders: national or regional, for-profit or nonprofit.

*National chains vs. regional hospitals.* Both have advantages and disadvantages. National chains may have national influence but may not be as responsive to local needs. This means that local needs must be identified and written into the affiliation agreement. But national chains have unique advantages in purchasing, information processing, marketing, access to capital and other areas which should be considered.

On the other hand, a large, respected, nonprofit hospital which has been in the community for years has the advantage of community acceptance. This was a key factor in the 96 percent voter approval of Catholic Healthcare West's (CHW) partnership with Sequoia Healthcare District (south of San Francisco). Although CHW is considered a major chain operation (see table 3), its regional strength and established public trust won the contract.

*For-profit vs. nonprofit.* A large amount of literature, much of it very emotional, has been produced on the relative advantages/disadvantages of for-profit versus nonprofit structures for delivering hospital care. Leaving aside this overwrought debate, for most public officials the defining difference between the for-profit and nonprofit firms is the greater access to cash, for debt payments or capital investments, that for-profit firms bring to the table. They recognize that quality of care and access for indigents can be assured through thoughtful arrangements with either type of partner.

A nonprofit, on the other hand, may not bring cash to the partnership. Typically they have no cash other than a small amount of internally generated currency—to raid their balance sheet to buy a hospital would impair its balance sheet and add additional debt.<sup>28</sup> Instead, the nonprofit can only offer is to assume the public facility's debts.

For-profits, on the other hand, can more easily provide cash if needed. Selling stock is a more efficient way to raise capital than is issuing debt. Generating cash may or be not be government's most important criteria for affiliation, however. And there are large nonprofit chains that have proven the exception by coming up with considerable cash by pooling debt among all member hospitals (See case study on Sequoia Hospital and Catholic Healthcare West in Part 5).

**Willingness to hire displaced public employees.** Bidder may commit to give first priority to employing displaced public employees within its system.

**Financial strength.** The bidder has the financial capability to make capital investments necessary to secure a competitive advantage.

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<sup>28</sup> For a detailed discussion see Steven R. Hollis, "Strategic and Economic Factors in the Hospital Conversion Process", *Health Affairs*, March/April, 1997, pp. 131–143.

**A successful track record in consolidation/economies of scale.** Bidder demonstrates an ability to create cost savings by consolidating operations and reducing excess beds, and through economies of scale, e.g. purchasing at volume discount.

**Quality.** A bidder’s demonstrated track record of providing high quality care in an ethically responsible manner is also critical.<sup>29</sup> Means of assessing quality include site visits to other facilities recently acquired, peer interviews of nurses at these facilities, and communication with key medical staff.

## E. Columbia/HCA: the Most Successful; the Most Targeted

Stories about federal and state investigations of the ethical and billing practices of Columbia/HCA—the nation’s largest hospital chain, with 338 hospitals and revenues of \$20 billion dollars—were front page news during the summer and fall of 1997.

Columbia/HCA CEO Richard Scott, who built the company through aggressive acquisitions, was forced to resign by the company’s Board of Directors. Board Vice Chairman Thomas Frist Jr., M.D. took over as CEO and refocused the company on its internal operations, which means much slower, if not stagnant, company growth for some time.

As of December 1997, the results of the ongoing federal and state investigations were still unknown.<sup>30</sup> The State of Alabama did, however, give Columbia/HCA a clean report based on state audits conducted in August and September.<sup>31</sup>

News reports have focused on government charges of “unethical” practices—such as Columbia/HCA’s strategy of making doctors “partners” by giving them a share of the profits they produced. Depending on one’s viewpoint, these incentives are either classic free-market capitalism that drive efficiency improvements, or a conflict of interest. The point is moot now—Columbia/HCA’s board ordered the practice discontinued.

There have also been accusations that some Columbia/HCA hospitals put cost-cutting ahead of quality, thereby endangering patient care. Such accusations, which are almost entirely based on anecdotal information, run counter to more rigorous independent evaluations. For example, 23 percent of Columbia/HCA facilities are “accredited with commendation” by JCAHO, the independent hospital review agency, against a national average of only 4 percent at all hospitals.<sup>32</sup> Such a commendation rating demonstrates superior quality at these Columbia facilities.

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<sup>29</sup> The following is a statement used by a public hospital in a recent RFP that puts the burden of proof on the prospective partner: “Prospective partners are required to provide information regarding the quality of care provided at their facilities, including, but not limited to, JCAHO survey scores and patient, employee and physician satisfaction scores. A summary of your plans to maintain, augment, or expand the quality of care at the hospital should be provided.” “Request for Proposal,” *Transaction Criteria Item No. 30*, Parrish Medical Center, Titusville, Florida, June 3, 1997, p. 7.

<sup>30</sup> The company’s problems seem to be in select hospital operations, mostly in Florida and Texas.

<sup>31</sup> Federal agents are examining thirty-five facilities.

<sup>32</sup> “How Columbia/HCA Changed Health Care for Better or Worse”, *The Wall Street Journal*, August 1, 1997.

The other charges against Columbia/HCA fall into the class of “illegal” practices, such as “upcoding” the seriousness of illnesses of certain Medicare patients in order to garner higher reimbursement levels from the federal government. Columbia/HCA has the company of many other hospitals in being charged with upcoding and other criminal fraud. The extremely complex and confusing nature of the federal government’s reimbursement rules have made coding errors widespread in the industry. Several respected nonprofit teaching hospitals, for example, paid fines in the spring of 1997 for “upcoding” the “education” of residents, calling it “patient care” in order to be paid higher rates. In another case, a health-care administrator actually went to jail for classifying certain expenses as “outreach,” and therefore reimbursable, expenses that the government considered “advertising.”<sup>33</sup>

Many analysts believe the reimbursement system itself is more the problem than the individual hospitals. Writes James V. DeLong in the *Wall Street Journal*:

*“The medical system is particularly hit hard when disputes over the allocation of indirect overhead under arcane principles of cost accounting get escalated into criminal fraud. The world is full of paperwork errors and anyone can be indicted if an agency has a mind.”*

Regardless, Columbia/HCA has fired several reimbursement managers it believes were responsible for the disputed practices.

Despite Columbia/HCA’s troubles, the positive impact that for-profit hospital firms have had on the once sleepy and insulated hospital industry can’t be ignored. They have fundamentally changed the way health care is delivered in America. Nonprofit and public hospitals have been forced to become more cost conscious thanks to the competition that for-profits have injected into this market.

Moreover, some for-profits have introduced quality innovations into the hospital field. Tenet Healthcare, the second largest for-profit hospital company, has annual health care ethics courses for their employees, a toll-free number for whistle-blowers, and a ‘vision statement’ that has ‘integrity and honesty’ as its prime principles.<sup>34</sup>

The bottom line is this: Columbia/HCA, Tenet and other for-profit firms honor the terms of their contractual agreements. It is the responsibility of elected officials to ensure these agreements reflect the values of their community.

## F. Legal and Transaction Questions

### 1. Do you need to achieve fair market value?

State law in California and many other states requires that the sales price of a public hospital cannot be below “fair market value” in order to guard against a “gift of public funds”. This applies only to sales to for-profit firms—since nonprofits are “Public Benefit Corporations” under IRS Code Section 501C(3), they are not legally obligated to pay “fair market value.” As many recent news articles attest, determining the proper

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<sup>33</sup> James V. DeLong, “Just What Crime Did Columbia/HCA Commit?” *The Wall Street Journal*, August 20, 1997, p. A15.

<sup>34</sup> Ibid.

sale price of a hospital can be contentious, especially when the media and State Attorney General become involved, and concerns with “protecting public investments” are bandied about.<sup>35</sup>

Options	Benefits	Obstacles
1. Sell the hospital	<ul style="list-style-type: none"> <li>• Pay off public bonds.</li> <li>• Gain new capital for indigent-care trust fund.</li> <li>• Gain new capital for other public service purposes.</li> <li>• Reduce hospital liability costs.</li> <li>• Reduce salary and employee benefit costs.</li> <li>• Gain additional tax revenue for community.</li> <li>• Reduce local tax rate.</li> <li>• Increase care for indigents.</li> <li>• Expand primary care.</li> <li>• End government competition with private sector (“medical arms race”).</li> </ul>	<ul style="list-style-type: none"> <li>• Public-employee union opposition.</li> <li>• Possible community opposition to perceived loss of public institution.</li> <li>• Difficulty of determining “fair market value.”</li> <li>• Perceived loss of direct control.</li> <li>• Perceived reduced prestige for public officials.</li> </ul>
2. Lease the hospital	<ul style="list-style-type: none"> <li>• Reduced community opposition.</li> <li>• Up-front capital infusion. (Assumes 30- to 40-year lease.)</li> <li>• Retain some control. All other benefits apply.</li> </ul>	<ul style="list-style-type: none"> <li>• Some public-employee opposition.</li> <li>• Somewhat reduced amount of capital.</li> <li>• Reduced control.</li> </ul>
3. Form a joint-venture or JOA partnership	<ul style="list-style-type: none"> <li>• All benefits apply.</li> </ul>	<ul style="list-style-type: none"> <li>• May require special state legislation.</li> </ul>
4. Shed the service.	<ul style="list-style-type: none"> <li>• Re deploy land to its “highest and best use”.</li> </ul>	<ul style="list-style-type: none"> <li>• Public and union opposition; public hearings; competitive bids.</li> </ul>
5. Contract out: community-wide competitive bidding	<ul style="list-style-type: none"> <li>• Creates competition among providers to serve uninsured patients.</li> </ul>	<ul style="list-style-type: none"> <li>• No apparent obstacles.</li> </ul>
6. Restructure or outsource	<ul style="list-style-type: none"> <li>• Reduced salary and benefit costs.</li> <li>• Reduced tax rate.</li> <li>• Moderately streamlines bureaucratic structure.</li> <li>• May put private safety-net hospitals in jeopardy.</li> </ul>	<ul style="list-style-type: none"> <li>• Some public-employee opposition.</li> <li>• Public-employee opposition.</li> <li>• Retains slow government decision structure</li> <li>• Relatively simple to implement.</li> </ul>

There are two common approaches to calculating the value of a hospital. The approach most often used by non-profits is to obtain an objective third-party appraisal of the value of the enterprise. The appraisal will incorporate the price paid in similar recent sales in order to estimate the value of public hospital.<sup>36</sup> For-profit firms take a different approach, making their offers based on a multiple of last year’s cash flow.

## **2. Must there be a public referendum?**

In many states, 51 percent of the voting public must approve a hospital privatization, and many have been voted down. That is why it is important to focus energy and resources on public communication throughout the process. Columbia/HCA lost the public vote in Cookeville, Tennessee, despite its offer of \$113 million for a small rural hospital that was worth far less. Although the surplus would have allowed the city to treat

<sup>35</sup> “Not-for-Profits Should Act to Prove Value of Conversions”, *Modern Healthcare*, November 25, 1996, p. 30.

<sup>36</sup> High debt can kill valuation and spoil privatization. A highly leveraged public hospital may have no economic value at all. For example, the fact that \$147 million in existing bonded indebtedness would become due on sale is a key reason why no for-profit firm bid on the County of Los Angeles’s privatization attempts for Rancho Los Amigos Hospital. The world-renowned rehabilitation facility operates deep in the red. The county was in negotiations with Catholic Healthcare West, a nonprofit firm, for several months, but still faced a high barrier due to the debt-service expense.

indigents and reduce taxes, the public was emotionally attached to its hospital.<sup>37</sup> In contrast, the partnership proposal put together by the Sequoia Healthcare District in August, 1996 was approved by 96 percent of voters.

### ***3. Will you run afoul of antitrust laws?* [Ray-fix font of this subhead]**

The U.S. Department of Justice and the Federal Trade Commission are major stumbling blocks to privatization, especially in small communities with only two hospitals. The federal government sees consolidation as a restraint of trade and a threat of monopolistic pricing powers.<sup>38</sup> According to some, problems with federal antitrust regulators were the single most important factor in slowing the pace of privatization in some Southern states in 1997.<sup>39</sup> For areas with few hospitals, dealing with antitrust concerns is an area where transactions attorneys and M&A consultants can be invaluable. In large urban areas public hospitals can generally ignore antitrust problems and affiliate with any desirable partner because there are plenty of beds and providers to ensure competition.

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<sup>37</sup> Greg Jaffe, *Columbia/HCA Meets Resistance in Tennessee*, *Wall Street Journal*, February 21, 1997.

<sup>38</sup> Ironically, this is one area in which public hospitals have been given a legal advantage by the courts. The recent case of *Lee Memorial Hospital vs. F.T.C.* ended up with the U.S. Supreme Court affirming that monopolistic practices did not apply to public hospitals. Therefore, a public hospital could acquire the only private hospital in town to create a monopoly with no problem, but not the other way around.

<sup>39</sup> Telephone conversation, July 5, 1997.

**Part 4**

# Structural Options

**F**or local governments, continuing down the path of operating their own public hospitals ultimately is likely to mean being forced to raise taxes and to drive competing private, nonprofit, safety-net providers out of business. More attractive options are available.

Many municipalities are demonstrating that they can serve indigents more efficiently and more effectively without actually operating hospitals themselves. Governments have a menu of privatization techniques to choose from as they transition out of public hospital operation, including: sale, lease, joint-operating agreement, joint venture, service shedding, community contracting, and outsourcing. One cardinal rule should be followed when evaluating privatization techniques: Let bidders propose a structural solution that they believe best meets your mission and goals. Avoid setting structural limits in the Request for Proposals (RFP).

## A. Sale

A hospital asset sale is a complete government divestiture of the hospital's plant and property. The sale produces a large cash payment up front, which can be used to retire debts and to establish a trust fund for indigents. The sale agreement can even oblige the buyer to provide continuing indigent-care services over the long-run—sometimes at a level higher than the status quo.

Since 1994, over 100 charities have been formed from the proceeds of hospital sales.<sup>40</sup> These charitable foundations control as much as \$5 billion in assets. In South Carolina, the state's three largest charities were all established from hospital sales and conversions.

**[Ray, the line below is my idea for offsetting the case studies in some way. I don't want to box them, but In some cases the case study ends, and the text of the section it is embedded in continues, and it is confusing where that transition is. So I felt the need for some graphic-type trick to offset the case studies. If you have a better way, go for it.]**

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<sup>40</sup> Greg Jaffe and Monica Langley, "Fledgling Charities Get Billions from the Sale of Nonprofit Hospitals," *Wall Street Journal*, November 6, 1996, p. A1.

**Case Study: Conroe Regional Medical Center, Conroe, Texas**

*After several years of raising people’s taxes, we decided it was time to end the “medical arms race” and to sell our public hospital. As a result we got lower taxes, better treatment, and much more help for indigents.<sup>41</sup>*

—Rigby Owen, Jr., retired Montgomery County Hospital District board member

**Lessons From Conroe**

- The leaders had a desire to break the mold and try something new.
- Outside experts were used to evaluate the hospital’s value.
- The request for bids went out nationally. Both for-profits and nonprofits were invited to respond.
- Worker concerns were met.
- Needs of indigents were addressed.
- The press was kept informed.

The Conroe area, north of Houston, has a population of about 200,000. It was burdened by an ever-growing indigent population, so its public hospital was constantly requesting more money, which required repeatedly raising taxes.

Regional authorities had essentially two choices: (1) keep fighting for market share against the private hospital, a course which would require a significant increase in

taxes, or (2) sell the public hospital to the highest outside bidder willing to treat indigents. They decided to focus on meeting the needs of the disadvantaged rather than the business of operating a hospital.

The winning bidder to purchase the hospital was Healthtrust, which at that time owned the major private hospital in the area. (Healthtrust was later acquired by Columbia/HCA) The final sale price was \$70 million. The community realized a net “profit” of \$11.4 million after \$58.6 million in bond debt was paid off. The “profit” was used to establish a nonprofit Community Foundation to meet the ongoing health needs of the community.

Healthtrust closed its own private hospital (instead of the public hospital) to alleviate the surplus-bed problem in the area, and it transferred its staff to the public hospital, which was renamed Columbia Conroe Regional Medical Center. Columbia/HCA has since added another \$35 million in improvements to the hospital.

Through the privatization, the community is realizing increased revenue through new property and other tax payments by the hospital, which totaled \$2 million in 1995.

Indigents have fared best of all. The number of indigents served has gone up substantially—enrollment increased 11.7 percent from 1995 to 1996, and indigent outpatient services increased 36 percent. Indigent care costs Columbia \$10 million a year, of which the government reimburses only \$6 million.

The citizens of Conroe ended up with the very best in public-private partnerships. Columbia has become a part of the community, not just a buyer of a public hospital.<sup>42</sup>

<sup>41</sup> Rigby Owen, Jr., interview with the author, January 12, 1997.

<sup>42</sup> This was recognized nationally when the National Council for Public-Private Partnerships gave the hospital district its 1994 Project Award for its “Indigent Healthcare Assistance Program and Healthcare Foundation.”

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***Case Study: Northwest Texas Healthcare System, Amarillo, Texas***

In 1996, the Amarillo Hospital District released a request for proposals for the sale of its public hospital. The winning bid, from Universal Health Services, included the following:

- Creation of a \$200 million trust fund.
- Payment of \$13 million in bond debts.
- Elimination of Amarillo residents' annual ad valorem tax burden of \$8.5 million.
- Payment of property and other local taxes of \$3 million annually, producing a net annual gain to the community of over \$11 million (\$8.5 million plus \$3 million).
- Payment of ongoing hospital-related costs to indigents at both the hospital and the primary-care clinic.

Voters in the Amarillo Hospital District voted two to one to approve Universal Health Services' proposal. The sale of the public hospital gave Amarillo the best of both worlds: lower taxes and better services. "Without Universal's help, the Northwest Texas Healthcare System faced a difficult time due to increased competition. The results would have been an increase in taxes, a cut in services to indigents, or both," said one board member.<sup>43</sup>

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It is more efficient for local government to obtain services from a regional integrated care network than from a stand-alone public hospital.

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***Case Study: Griffin-Spalding County Hospital Authority; Spalding Regional Hospital, Griffin, Georgia***

Several board members of The Hospital Authority Board in Griffin, some 40 miles south of Atlanta, were skeptical about the benefits of privatization. The authority had sold its hospital for \$9 million in 1986 to an investor-owned company that in 1996 became part of the merger which formed Tenet Healthcare. Several board members, having second thoughts about the original sale, used the event of the merger to trigger its "first right of refusal" option clause in its original sales contract to explore new options, including assuming operation from Tenet or leasing the facility to Emory University, which was interested in the facility.

However, entering into a public dialogue with the citizens revealed that there was widespread appreciation for the positive changes that the private owners had brought to the hospital over the past ten years. Tenet had rebuilt the hospital from the ground up; it eliminated all tax subsidy and treated indigents well (no one entering its emergency room was turned away). Fifty new physicians had been recruited, and a number of new services started, including a heart unit, oncology service, and expanded outpatient services.

When the board went out to the community, they found that the public, the newspaper, and the employees were solidly behind Tenet continuing as the owner. The board negotiated a new long-term agreement with Tenet in which the company paid \$5 million upfront plus an additional \$1 million annually for fifteen years. The authority is using interest from the original \$9 million plus the new \$5 million payment to open an Indigent Care Clinic.

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<sup>43</sup> Sources: *Amarillo News-Globe* and Federation of American Health Systems.



This case of privatization has one of the longest track records in the nation. Tenet Healthcare made long-term investments in plant, equipment, and human services that paid off years later. The case shows government negotiators the wisdom of inserting a “first right of refusal” clause in all sales contracts. This is sensible as it means that the new owners cannot resell to an outsider which does not have the community’s interest at heart without the deal coming back onto the public agenda. Not only did the provision protect the public interest, it greatly enhanced the original sales agreement that had already proved its value to the community.

## B. Lease

An alternative to selling a hospital outright is to lease the hospital, clinics, and equipment to a management firm. This allows the government to retain title to the facility but frees a private firm to serve indigents without the employment restrictions, regulations, and bureaucracy that accompany public operation.

Hospital management firms prefer to purchase hospitals outright rather than lease them, but recognize that this is often not politically possible. Hugh Jack Stubbs, the administrator for the Coahoma Board of Supervisors in Clarksdale, Mississippi, who negotiated a long-term lease with Health Management Associates (HMA), an investor-owned firm, said: “[With a lease] we’ll at least have some input in the way they operate in the community, which we wouldn’t have had with a sale.”<sup>44</sup>

A lease generates the same kind of capital infusion as a sale. Most lease agreements today are “prepaid” leases that provide the government with money up front. In the Mississippi case, HMA paid \$30 million up front while retiring \$2 million in hospital debt. As a bonus, HMA will make \$15 million in capital improvements over the next five years. The interest on the \$30 million principal is being kept in a trust fund to be used for indigent-care projects.

The public hospital becomes a for-profit facility once the lease is finalized, just as if it were sold, meaning the investor-owned firm starts paying new taxes into the public general fund immediately.

Indigent care is typically a component of the lease. When the City of Austin signed a 30-year lease with Seton Health Care Network to run its public hospital, it priced the indigent subsidy to Seton at \$17 million per year. That means that Austin capped its exposure. If the cost or number of indigents rises, it is Seton’s responsibility, not the city’s.<sup>45</sup>

## C. Joint Ventures and Joint Operating Agreements

Both joint ventures and joint operating agreements (JOAs) have emerged as state-of-the-art privatization methods that allow governments to retain voting influence on the board of directors of the legal entity operating the hospital.

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<sup>44</sup> The assumption that government loses control when it sells is not valid, as we have seen with the Conroe case. The sale agreement can include many covenants and restrictions that retain government influence. However, the *perception* of lost control is a political fact of life that the lease option sidesteps nicely. Bruce Japsen, “For Sale or Lease: More For-Profits Opt for Leasing Route in Hospital Deals,” *Modern Healthcare*, February 6, 1997, p. 42.

<sup>45</sup> Lemov, “Dumping the Public Hospital,” p. 46.

Under a JOA, the public and private partners jointly operate the hospital, but the ownership of assets is retained by government. Under a joint venture, government and the partner each transfer their assets to the new company which operates the venture. Both government and the partner appoint board members in proportion to the value of assets transferred—usually, but not always, a 50/50 representation.

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### **Case Study: University of Oklahoma and Columbia/HCA Joint Operating Agreement**

*“The State of Oklahoma and Columbia are essentially entering into a partnership which is a promising example of how government can join hands with private business for the betterment of all Oklahomans.”*

—Oklahoma Governor Frank Keating.

*“This is a great deal with enormous synergy. But merging their culture with ours will be like merging the U.S. Postal Service with American Express.”*

—David Dunlap, President, Oklahoma Division, Columbia/HCA<sup>46</sup>

After years of rising red ink in the state’s university hospital system, Oklahoma Governor Frank Keating signed legislation on May 8, 1997, transferring operation of the state’s teaching hospitals to Columbia/HCA Healthcare Corporation under a 50-year lease. After legal protests, the deal was finally signed into place on February 5, 1998. It is one of the largest and most far-reaching public hospital privatizations on record. Under the new agreement, the State of Oklahoma and Columbia will each appoint five governors to the governing committee of a new joint venture operation.

There are a number of important features to the Oklahoma deal:

**Operational Consolidation.** Consolidation will be easy and potentially profitable as the three facilities involved all share a common campus. Columbia Presbyterian (367 beds) is literally next door to the two state hospitals: The University Hospital (278 beds) and Children’s Hospital (190 beds). One of the primary objectives of the Joint Operating Agreement is to improve the efficiency of operations in the state hospitals. All three have suffered financially due to shorter stays and lower reimbursement rates.

Several services lend themselves to consolidation without threatening patient care, including: administrative support, physician practice management, ancillary services, marketing and finance. Columbia has already been effectively consolidating these services within their division and market offices.

**Profit Sharing.** The deal includes a payment of \$40 million by Columbia to the State’s University Hospitals Authority. The joint operating agreement calls for combining the earnings of Presbyterian and the two University Hospitals. From these combined earnings, the Trust will receive an annual rent for 50 years of \$9 million, for a total of \$450 million. Columbia will receive the next \$30 million of each year’s profits (if any) and any profits thereafter will be split 70 percent to Columbia and 30 percent to the Trust. What this means

is that the State gets a large up-front cash infusion and an incentive—in the form of a share of profits from the JOA—to support improvements in efficiency.

#### **Box**

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<sup>46</sup> David Dunlap, interview with the author, May 15, 1997.

<b>Highlights of the Oklahoma/Columbia Joint Operating Agreement</b>	
Length of Lease	50 years
Up-front Payment to State	\$40 Million
Annual Rent	\$9 Million for 50 years
Profit split	70/30 (Columbia to Trust after first \$30M)
Indigent Care	State's share capped at \$26.5M ; Columbia's share is \$39M

**Increasing Indigent Care.** The new joint venture will protect the State by capping off its indigent care subsidy at \$26.5 million. Columbia is at risk to provide indigent care at minimum of 120 percent of the State's cap, which is expected to mean \$39 million worth of care in 1998. Columbia has agreed to provide up to 150 percent of the State's cap before it can take action to diminish the level of services provided for indigent services. This means that the public will receive more indigent care than before the consolidation. In addition, by reducing the cost of care through improved efficiencies, Columbia is committed to increasing units of service for the indigent population.

**Protecting Government Influence.** The Governing Committee has five Category A (government-appointed) and five Category B (Columbia) governors. Columbia has the management contract. Normally, the JOA party holding the management contract cannot be fired because this would require a vote from the Category B governors to fire themselves. However, this agreement includes a unique performance feature that allows the Category A governors to unilaterally fire the CEO if he/she performs below the approved operating budget by more than 5 percent for three years in a row. This means that if the CEO failed to meet the operating goals consistently, the governing committee could force a management change. This protects government influence while allowing the CEO the power to take difficult and even unpopular actions to achieve budget.

**Enhancing Medical Education.** Columbia will execute an Academic Affiliation Agreement with the University of Oklahoma, and the University has agreed to provide support to the University Hospitals. Columbia has agreed to separately pay \$23 million per year for these services, which include house staff medical directorships, emergency room coverage, and other academic support.

The JOA required significant state approvals and fairness assessments. The JOA required enabling legislation (over the course of three legislative sessions) allowing the state to enter into a joint venture with a private company, and it was scrutinized by an outside consulting company, Coopers & Lybrand, to assess the arrangement's overall fairness. Finally, at the request of Columbia/HCA, the Oklahoma State Supreme Court was also asked to review JOA and issue an official ruling on its constitutionality. A favorable ruling was issued on December 30, 1997, all legal barriers to the agreement were cleared on January 29, 1998, and the deal was signed on February 5<sup>th</sup>.

**What can we learn from this successful negotiation?** The basis of the agreement is trust. The Republican Governor and Democrat Speaker of the State House of Representatives both helped to bring parties back to the table when it appeared as if the deal would fall apart. The medical staffs knew each other due to the close proximity of the hospitals, which helped enormously. Administrators also knew each other, so a foundation of trust was already established. It was an example of flexibility in action; the deal started off as a straight lease and transitioned into a joint operating agreement as government sought and realized more influence.

All the parties' familiarity with Columbia from past experience (the company is the third largest private employer in the state) helped them focus on the firm's track record in the state and its high quality accreditation rating. This also helped decision-makers look beyond the negative publicity surrounding the Federal investigations of billing practices at other Columbia locations.

The public information plan included media relations activities by The University Hospitals, Columbia/HCA's Oklahoma Division, and the Governor's office. All three entities have been open and cooperative with the media in order to provide information to the general public. A communications plan was drafted during the transition period, which included weekly communications to employees, the legislature and the media; a "hotline" for employees to call with questions; information bulletins by the Human Resources department answering the most frequently asked questions by employees regarding their salaries and benefits; and employee "teams" to look for ways to establish efficiencies between the hospitals and define a new culture and set of values for the new organization.

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Since 1994, over 100 charities, with control of \$5 billion in assets, have been formed with the proceeds from hospital sales.

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The tough days lie ahead. Two very different organizations must be combined into a smoothly operating relationship. A transition team (comprised of leadership from the three hospitals and Columbia/HCA's Oklahoma Market office) has begun that difficult first step, building on their success at cooperating on transition steps prior to the signing of the lease.

Without the partnership, Oklahoma would have had to severely downsize both medical education and indigent health care due to rapidly rising costs. Instead, the JOA presents a chance to develop a leading hospital teaching center .

## **D. Service Shedding**

It makes no sense to try to privatize a hospital no one wants to run it and the community doesn't need. In such cases, service shedding may be in order. The facility or land may have greater value for alternative health-care related or even commercial purposes. Keep in mind that most governments have public bidding procedures and requirements for public hearings if a hospital is sold for other uses.

For example, the County of Los Angeles made a substantial profit on the sale of Long Beach General Hospital in 1989. The several acres of land were redeveloped as commercial park and the site is now used for furniture distribution. The programs once provided at the hospital, including a large chemical dependency treatment service, were purchased at less expense from community providers.

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***CaseStudy: Beach Cities Health District Considers Shedding South Bay Hospital***

*“Privatizing back in 1984 freed up over six-million dollars annually for health care and other indigent services that would not have been available if the District had continued to operate our the hospital itself. We used to put every dime into supporting the public hospital; now we have surplus funds to give people the help they need”.*

—Robert Riley, Executive Director, Beach Cities Health District

Beach Cities Health District in Redondo Beach, California, was a successful early pioneer in privatization of hospital services. It leased its previously government-operated 203-bed South Bay Hospital to Tenet (then AMI) for thirty years, back in 1984.

In 1994, AMI merged with Tenet Healthcare and Tenet recently gave notice that as of June 1988 it will no longer operate South Bay Hospital. Tenet’s analysis showed the small facility was unable to compete profitably against stiff competition from two larger local nonprofit hospitals: Little Company of Mary and Torrance Memorial (a nationally ranked acute care hospital). Torrance Memorial locked up most of the managed care contracts and the Little Company of Mary locked in many of the fine physician specialists. The best course for Tenet: get out and cut its losses.

However, Tenet is still honoring its lease payments of \$3 million per year under the 30-year lease set to expire in 2014. The District receives another \$1 million in tax revenue and \$2 million in interest payments on a \$35 million fund which has built up over the years—so the district has \$6 million per year in income from which it funds a comprehensive model social services program for local residents. Administrative costs are minimal. The lease language requires the lessor to continue basic services, such as emergency room and surgery.

District Executive Director Robert Riley readily admits they would not have been in this enviable position had it not privatized operations of the hospital thirteen years ago. “It would have taken every dime we had just to keep the doors open while maintaining our commitment to the poor.”

The district now has plenty of money to serve the poor. It funds a Community Free Clinic from the surplus it has accumulated by not operating a hospital and gives another \$400,000 to local schools for nursing programs. It funds an additional 40 prevention and fitness grants supporting local nonprofit agencies.

The question now is: what should the district do about the hospital now that Tenet is pulling out? The facility is debt free, but needs modernization. The district has hired a facilities consultant, investment banker and a strategic planning consultant to help it plan its next moves.

One option being seriously considered is to lease the hospital for non-acute services. This means that the new owner might convert the facility to another use or tear it down and redevelop the property for health-related purposes.

There will be public hearings. But unlike other communities that are concerned about losing their public hospital, this community may have more concern about losing the free clinic and preventive services. Funds currently used for these extra services would probably be stopped should the District decide to keep the hospital open and publicly operated.

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## **E. Community-Wide Public-Private Partnership**

In this model, the government simply purchases from local hospitals and clinics the bed days it needs. This model allows a jurisdiction to spread the burden of uncompensated indigent care proportionately among the medical community.

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### **Case Study: Orange County, California**

Orange County, California, does not own or operate any public hospitals. Through an annual fixed indigent-care allocation, Orange County buys the hospital bed days it needs from a total of 28 local contracting for-profit and non-profit hospitals. This program is called Medical Services for Indigents (MSI), and it has saved Orange County both time and money on its health care services.

The Healthcare Association of Southern California appoints a committee each year to negotiate with the county. All hospitals desiring to qualify for county payments sign a single “Master Medical Services Agreement.” The physicians’ payment arrangement is covered in the agreement. The single contract simplifies administration, and the county also reduces paperwork by contracting with a fiscal intermediary to process claims. The Master Agreement approach has several advantages:

- 1. The county protects itself through a fixed allocation of dollars to hospitals and to physicians in the Master Agreement. Funds remaining at the end of the year are paid to doctors and hospitals in proportion to past levels of service provided for indigents.*
- 2. Provider rate of reimbursement is based upon the year’s actual utilization.*
- 3. Every hospital with a 24-hour emergency room must treat anyone who shows up in critical condition, or they lose their license. Thus, there is little incentive not to sign the Master Agreement. Even though they “lose” money on paper, contracting turns what would otherwise be a 100 percent guaranteed loss into a partial win for the participating hospital.*

Orange County does not have a rate of payment for each day of inpatient service. The capped pool covers the inpatient and outpatient services. All indigent outpatients must obtain their outpatient pharmaceuticals and ancillary services from a contracting hospital.

The MSI program includes 28 contracting hospitals; 26,387 inpatient days; 12,503 emergency-room visits; 2,000 participating physicians; 182,983 visits; and 28,151 unduplicated clients. Orange County runs the entire program with a staff of seven employees.

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## **F. Comprehensive Outsourcing**

Many private firms outsource major functions. Some multi-million-dollar manufacturing firms operate with only a few dozen full-time employees. Even assembly-line and customer-service work has been outsourced. In some cases, the only functions kept in-house are strategic planning and market management.

Some public hospitals have adopted a similar approach by retaining the public hospital shell organization but contracting out a host of functions, including information systems, business offices, medical records, food service, housekeeping, and even clinical services, once thought beyond the boundary of outsourcing.

Commonly outsourced areas, such as housekeeping and food service, are being bundled together and managed under sweeping contracts across several departments or entire systems.

“Every managed-care agreement is paying our hospital less than last year,” says Daniel Neufelder, executive vice president and chief operating officer at 526-bed Memorial Hospital of South Bend (Indiana). Therefore, Neufelder is looking harder at outsourcing everything from business offices and medical records to sophisticated clinical services such as orthopedic surgery. “We’re looking at every service and trying to make a decision whether it’s an area we have a strategic competence in or should outsource,” says Neufelder<sup>47</sup>.

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***CaseStudy: Nassau County Medical Center, East Meadow, New York***

Nassau County Medical Center, a public hospital in East Meadow, New York, began to feel the cost pinch several years ago in some clinical departments, such as orthopedic surgery. Funded in part by local taxes and bound by civil service work rules, Nassau County Medical Center had trouble attracting and compensating orthopedic surgeons. Joseph R. Erazo, executive director at the 615-bed facility, noted: “For us to squeeze out a base salary of \$175,000 is a tough sell.”<sup>48</sup>

In response, Erazo, in consultation with the unionized physicians who staff the hospital, agreed in mid-1995 to contract out orthopedic services to the Musculoskeletal Institute, a local physician practice group. This sliced almost \$1 million in salaries and benefits from the county payroll and substituted in its place a contract that brings the hospital as much as \$1 million annually in additional billings.

Outsourcing, however, requires patient negotiations with affected workers. “You need to do this softly and gently without creating such a torrent of opposition that it becomes counterproductive,” Erazo said. The key is building an understanding that outsourcing is part of surviving, a message that takes time to be accepted.

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Despite its advantages, comprehensive outsourcing is unlikely to be the solution to the problems of public hospitals. Simply piecing together a new structure of service contracts cannot turn an organizational culture from a public-service orientation to one that is aggressively market driven. Even with extensive outsourcing, the hospital must still operate within a constraining and slow-moving governmental structure. Moreover, public hospitals lack a number of the strategic advantages enjoyed by for-profit hospital corporations, including a marketing orientation and culture, volume purchasing, and comprehensive, state-of-the-art information systems.

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<sup>47</sup> Scott Hensley, “Outsourcing Moves into New Territory: Hospitals Are Cutting Costs by Hiring Outsiders for a Wide Array of Tasks: If It’s Not Core Competency, It’s Fair Game”, *Modern Healthcare*, January, 13, 1997, p. 23.

<sup>48</sup> *Ibid*, p. 24.

### **Purchase Through Community Master Agreement: Pierce County, Washington**

On November 4, 1996, Pierce County contracted with five private provider groups to run 13 public health clinics. Previously, persons eligible for public health care in the county could get clinic services only at the health department. “The private partners we’ve contracted with will provide our clients with more cost-effective care, and, since they’re located closer to where people live and work, they’ll be more accessible as well,” says Dr. Frederico Cruz-Uribe, the director of the Tacoma-Pierce County Health Department.

The privatization is saving \$200,000 per year despite serving 10,000 more clients. This allows the department to direct its resources more intensively to preventative medicine and related programs.



## Part 5

# Communicating the Benefits of Change

**T**he best plans and best partnership structures often fail to be implemented because the public objects, or opposing employees and medical staff win the ear of a sympathetic press, which tends to oppose change it doesn't understand. These problems can often be avoided with simple measures such as communications and employee relations plans designed specifically for the partnership program.

The following case study highlights how one public healthcare district beat the odds by doing everything right on the public relations and employee relations fronts. The community was rewarded with a newly revitalized hospital that 9 months before privatization faced a serious possibility of closure.

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**Case Study: Sequoia Healthcare District and Catholic Healthcare West; Sequoia Hospital, Redwood City, CA.**

*“The key to making this kind of deal (privatization) work is to tell the public why you need to change. If you do that often enough, they will support you.”*

—Frank E. Gibson, District CEO

The Sequoia Healthcare District ran one of the nation's best cardiovascular units at Sequoia Hospital in Redwood City, a wealthy suburb located between San Francisco and the Silicon Valley. But payment cuts by managed care companies and increased competition from numerous hospitals within easy driving distance of Sequoia—including four hospitals operated by Catholic Healthcare West—caused three years of sharply accelerating losses. The 500-bed hospital lost \$26 million in 1996 alone.

In response, the district board held a series of highly visible public meetings inviting public comment. It became obvious at the forums that the community didn't want to see the hospital closed, especially the cardiovascular unit. But the public had no fondness for higher taxes either. A consensus formed around the idea of seeking a private partner, especially after the healthcare district board made it clear that further losses might result in the closure of the facility.

An open-ended RFP was issued, meaning bidders could propose a sale, lease, joint venture, or management agreement—whatever they judged would fix the financial problem while keeping the hospital open. Catholic Healthcare West won the bid with a proposed joint venture including \$30 million in cash up front.

**Box****Key Lessons from Sequoia:**

1. The RFP process was open-ended and allowed bidders to present a range of creative solutions.
2. The public relations was comprehensive and well-organized. It was a joint effort of all the leadership over a period of one year in public forums, service club luncheons, and cable access television.
3. It demonstrated that well-organized and well-financed nonprofit chains can stand up to larger investor-owned firms by stressing their record of community commitment.
4. A far-sighted and courageous hospital board took aggressive action to save its hospital before the market consolidated around them and choked it off.

Many assume is that nonprofit hospitals don't purchase hospitals because debt is their only source of capital.<sup>49</sup> However, CHW merged Sequoia's debt into a pool with the chain's other 35 hospitals, allowing it to produce the cash needed to cement the deal. But as important as the cash was CHW's understanding of the hospital's mission, along with its stellar reputation.<sup>50</sup>

To ensure the district's continued involvement in the hospital, CHW proposed the creation of a joint venture entity called Sequoia Health Services. It would be a 50/50 partnership, consisting of the five existing elected public board members from the district and five new board members from CHW. Sequoia Health Services then negotiated a 30-year management contract with CHW to operate the facility. The contract allows the management to be removed and services to be changed only with a super majority vote.

After the board approved the CHW structure, state law required them to put the decision to the voters in a public referendum. An astonishing 96 percent of the voters at the polls approved the new joint venture, an unprecedented show of support. This was a result of guarantees protecting indigents and quality of service, and a grass roots public education effort on the part of the administration and medical staff to sell the project. CHW agreed to continue the same level of indigent care as the district had provided before it assumed management control.

There was very little employee opposition and very few layoffs after CHW assumed management. In less than a year, CHW had the hospital running near the break-even level, which protected jobs that would have been lost had there been no privatization and the hospital had been a shut down. With four other hospitals nearby, CHW is exploring eliminating service duplication among the facilities, although they have guaranteed to continue the cardiovascular service at Sequoia.

Most of the savings came from efficiencies in administrative and back office operations, without a major reduction or consolidation of services. Outstanding bills are being collected, average days in accounts receivable have dropped from 130 down to 60, new vendor contracts have been installed to take advantage of CHW's volume purchasing discounts, and overhead costs are regionalized at CHW headquarters and shared by several network hospitals.

<sup>49</sup> Observation in a presentation by Steve Hollis, Cain Brothers Investment Bankers, to the Annual Meeting of the Association of California Healthcare Districts, May 29, 1997.

<sup>50</sup> Frank E. Gibson, Executive Director of Sequoia Healthcare District, interview with the author, June 1997.

Meanwhile, the District is continuing its mission of funding health programs separate from the hospital. With the \$30 million in cash from CHW, it is funding two public health grant cycles per year. The grants are for a wide variety of community services.

## A. Have the Communications Plan in Place First.

*“The sale of a public hospital takes place every day in the press.”*

—Josh Nemzoff, Hospital Financial Consultant.

All the transactions involved in the sale of a public hospital operate “in the sunshine,” making confidentiality a problem. All of the key meetings of the board are heavily attended by the public and the press. Board members who live and work in the community have to deal with substantial personal pressures.

The popular media typically starts out skeptical or even hostile to the privatization concept. Critics of the recent trend to privatize public hospitals, especially when the conversion is to investor-owned (profit making) status, have often condemned the change as threatening care to indigents, and abandoning the public hospital’s mission as the “medical haven of last resort for the underinsured and uninsurable.”<sup>51</sup> In a typical article in the *New England Journal of Medicine*, a physician predicts widespread treatment deprivation and scolds public officials for “withholding care from the most vulnerable.”<sup>52</sup>

Similarly, an op-ed article in the *New York Times* in January, 1997 deplores New York City’s plans to privatize several of the City’s public hospitals on grounds that: “Selling or leasing city hospitals to companies whose primary concern is the bottom line will make it more difficult for these (poor) people to receive adequate care.”<sup>53</sup>

Well before any RFP is released or deal announced, converting a public hospital can be one of the most contentious, difficult acts a public official can ever take. It requires that a comprehensive communications plan be in place to educate the public and media to new market realities.

The following should be included in the communications plan:

- *A list of the various stakeholders and their fears and interests.* Prepare targeted materials in a simple, straightforward presentation—question-and-answer formats work well. Focus groups consisting of representatives of various affected groups may help in preparing this material so that it addresses their needs.<sup>54</sup>
- *Use press kits to distribute a clear presentation of issues and benefits.* Use all available distribution mechanisms to get your messages out—including speakers bureaus, public print and electronic media.

<sup>51</sup> Jerome P. Kassirer, M.D., “Our Ailing Public Hospitals,” p. 1348.

<sup>52</sup> Ibid, p. 1349.

<sup>53</sup> Pamela S. Brier, “At Risk: Health Care for the Poor”, *New York Times*, January 18, 1997, Volume 146, p. 21.

<sup>54</sup> Have materials available in Spanish or other languages as necessary.

- *Use key stakeholders as communicators.* The medical staff and nurses are critically important in taking the message to their peers and other employees and in making community presentations. People want to know how the medical professionals feel about the proposed deal.
- *Notify the public at least 60 days before a conversion and hold public hearings.* Be certain that language translators are available and appropriate measures are taken to ensure accessibility to the disabled, especially the mobility and hearing impaired.
- *Make key documents public.* Information on valuation, indigent trust funds, payments to any displaced public employees and executives, and provisions of the RFP lease or sales agreement, should be made public.

The Sequoia case is a textbook example of a good public relations strategy. The district started the public forums early—before the RFP was released—and gave the public several opportunities to communicate what was important to them. The public’s core message: Keep the cardiovascular unit and other important services, but do not raise taxes. Addressing these concerns was the basis of the overwhelming popular support for the project.

## **B. Have a Strong Employee Relations and Adjustment Plan.**

Public-employee unions can kill a privatization. They have a legitimate interest in protecting employees who have devoted their careers to hospital services. Doctors and nurses and most other allied health professionals will always have jobs in the private sector, but in some cases, they may be at benefit levels lower than those they enjoyed as public employees. They deserve outplacement assistance in making the transition to alternative employment if such a move is necessary.

There are many techniques to ease the transition, such as giving employees with many years of service (for example, 10 years and over) who are rehired or retained within the new organization an opportunity to continue their public retirement benefits under the new employer. But regardless of the concessions made, employees must be told the truth: many public hospitals are on the road to extinction, and it is nobody’s fault. Private industry has gone through years of downsizing due to international competition and has faced and mastered similar challenges.

## **C. Include an Evaluation and Monitoring Component in Your Conversion Plans.**

Government is often not in direct control after privatization. This means that covenants negotiated into the transaction agreement should be checked for compliance by routine monitoring to ensure that indigents and the uninsured are finding their way into the system as planned. A government may desire to do an evaluation each year to check that providers are meeting their contractual indigent care obligations and take appropriate administrative or legal action if this is not the case.

Annual follow-up evaluations are also a way to get good news out to the public. As the case studies in this study show, taxpayers can be reminded that taxes are lower and indigent access has improved following privatization.

Evaluation need not be expensive or arduous and may be contracted out to experienced consultants according to established government guidelines. Evaluation criteria should tie back to the mission and goals established before privatization was initiated.

**Part 6**

# Conclusion: “No Margin; No Mission”

**P**ublic hospitals can no longer survive doing business as usual. The industry is consolidating away future opportunities for those who do not act soon. Finding a suitable private partner that will meet the mission of the hospital in a new competitive environment is often the hospital’s only hope.

Local government has a legitimate mission in protecting and promoting the general health of the community. But current market forces challenge the conventional wisdom that operating a public hospital is the best way to achieve that mission today.

By becoming an evaluator, observer, and a purchaser rather than a provider of services, government maintains its objectivity and meets its obligation to the public. It is instructive that one of the most cost effective models considered in the study, Orange County’s community-wide partnerships, started when government decided it needed no public hospital at all. It is a lesson worth learning.

## Part 7

# Appendix: Strategic Market Management Plan

This format is useful at the outset of privatization to fix the public hospital's current market position and as a foundation for goal setting.

## A. External Analysis

### 1. Customer analysis

"Customer" is the name of any consumer with the right to choose among health care providers, which is everyone in today's market, even the poor. This means that the strategic plan must answer:

- Who specifically uses the public hospital today? Describe each customer market segment by age, ethnicity, morbidity, zip code, transportation routes, financial status, and so forth.
- What are their unmet needs? For instance, is there is a large ethnic population that requires language and culturally relevant services? How is that need handled?
- Why do your customers come to the public hospital instead of a competitor?
- What is the core mission of the public health system?

### 2. Competitor analysis:

Who is competing for public-sector patients? HMOs? PPOs? Free clinics? Nonprofit hospitals?

- Look at each competitor in terms of performance, objectives, strategies, culture, cost structure, occupancy trends, strengths, and weaknesses.
- Identify the strategy of each competitor: low cost, focus, or differentiation.<sup>55</sup>
- With overall occupancies still shrinking throughout the region, how does the public hospital's "success" affect other hospitals in the community? What are the community and political consequences of forcing

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<sup>55</sup> See Michael E. Porter, *Competitive Advantage* (New York: Free Press, 1985), p. 12.

them out of business? What are the legal and moral implications of winning a “medical arms race” against charity hospitals?

### **3. Industry analysis:**

What are the key success factors in the marketplace today? What is working in terms of the following:

- Managed care firms. Names, locations, covered members. What do they want in selecting providers, e.g. regional coverage, cost containment, aftercare and follow-up, evidence of quality and program effectiveness.
- Size, structure, and barriers to competitive entry.
- Trends and growth in popular services. (What specialty clinics, teaching programs, and customer service programs are uniquely successful?)
- Cost control systems.
- Expected impact of technology, especially management information systems.
- New federal and state mandates.

## **B. Internal Analysis**

Looking *inside* your public hospital, determine if it can make the changes necessary to compete in the new market.

- Can the administrative organization be restructured, flattened, and made more efficient?
- What support and clinical services can be outsourced?
- How are the employees motivated? Can they adapt to competition? What is the attitude of unions toward productivity improvements?
- What is the culture of performance? Do employees get paid for productivity or for tenure? Has anyone ever been laid off? How hard is it to fire a worker who performs poorly?
- Does a management information system exist? Does it work? Does it maximize state and federal revenue?

## **C. Financial/Legal Resources and Constraints**

- What is the hospital’s fair market value?
- What are the legal and regulatory constraints to a sale? (Some states are passing tough laws restricting sales.)
- What are the existing finances and level of debt? Is the hospital budget currently in deficit? Has the county indigent care subsidy been increasing? How is Medicaid administered? Does the state block-grant these funds to counties for local discretion? Is Medicaid administered to encourage competition



among providers? How much control do you have in directing Medicaid patients to public hospitals? Is that control being challenged by competitors?<sup>56</sup>

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<sup>56</sup> Sandy Lutz, "Counties Would Get Medicaid Funds Under Texas' Managed Care Plan," *Modern Healthcare*, June 19, 1995. *Note:* Texas uses an Inter-Governmental Initiative (IGI) Board at each county level to make sure that for-profit, not-for-profit, and children's hospitals are included in the 17-person boards to encourage a competitive system

**Part 7**

# About the Author

**R**ichard L. Tradewell began public service in 1971 as a Management Trainee in the Chief Administrative Office of Los Angeles County. He advanced through several line and staff positions to the level of Principal Health Services Program Analyst, where he was involved with negotiating the phase-out of State hospital services and replacement with more cost-effective nonprofit community contracts. After leaving in 1979 for the private sector, Mr. Tradewell served in several senior level corporate management positions, including hospital administrator for Comprehensive Care Corporation and Director of Development for Travelers Health Network, a division of the Travelers Group. He received his MPA degree in Health Services Administration from U.S.C. in 1976 and Advanced Executive MBA from the Peter F. Drucker Graduate Management Center at Claremont Graduate University in 1983. He is currently working on his Ph.D. in Political Science at CGU, and serves concurrently as an Adjunct Scholar at the Reason Public Policy Institute, where he recently contributed to the Institute's 1997 publications: *Cutting Government Costs Through Competition and Privatization*, published in collaboration with the California Chamber of Commerce.

# Table of Contents

<b>INTRODUCTION .....</b>	<b>1</b>
<b>WHY COMMUNITIES ARE TURNING TO PRIVATIZATION TO MEET HEALTH-CARE NEEDS.....</b>	<b>4</b>
A. The Drag of Bureaucracy .....	4
B. The Poor Have a Choice of Providers: Hospitals Now Compete to Serve the Poor.....	5
C. Public-Hospital Beds Are No Longer Needed.....	<b>Error! Bookmark not defined.</b>
D. Managed-Care Plans, Competing For Medicaid Dollars and Members, are Bypassing Public Hospitals	7
E. Managed-Care Plans Prefer Private Providers That Can Contain Costs .....	8
F. If a Public Hospital Can Internally Restructure to Compete Aggressively, That “Success” Can Push Other “Safety-Net” Hospitals into Bankruptcy .....	8
G. Local Governments, Facing Limits on Their Ability to Raise New Taxes, Are Finding That Public Hospitals Are Taking More Than Their Share Of Limited Resources.....	8
H. Geography is Making Public Hospitals Obsolete.....	9
I. Picturing Consolidation Pressures .....	10
<b>THE PRIVATIZATION PROCESS.....</b>	<b>12</b>
A. Undertake Careful Evaluation of the Public Hospital’s Position in the Marketplace.....	12
B. Define the Goals of Affiliation .....	12
C. Assemble Your Team .....	14
D. Criteria for Selecting a Partner .....	15
E. Columbia/HCA: the Most Successful; the Most Targeted.....	16
F. Legal and Transaction Questions .....	17
<b>STRUCTURAL OPTIONS .....</b>	<b>20</b>
A. Sale .....	20
B. Lease .....	23
C. Joint Ventures .....	23
D. Service Shedding .....	26
E. Community-Wide Public-Private Partnership.....	27
F. Comprehensive Outsourcing .....	28
<b>COMMUNICATING THE BENEFITS OF CHANGE .....</b>	<b>31</b>
A. Have the Communications Plan in Place First.....	33
B. Have a Strong Employee Relations and Adjustment Plan. ....	34
C. Include an Evaluation Component in Your Conversion Plans. ....	34
<b>CONCLUSION: “NO MARGIN; NO MISSION” .....</b>	<b>36</b>
<b>APPENDIX: STRATEGIC MARKET MANAGEMENT PLAN .....</b>	<b>37</b>
A. External Analysis.....	37
B. Internal Analysis.....	38
C. Financial/Legal Resources and Constraints.....	38
<b>ABOUT THE AUTHOR.....</b>	<b>40</b>