

Chapter 2

HOSPITALS AND NURSING HOME CHAINS

The industrialization of episodic medicine was not the original intent of the market idealists of the early 1970s who favored health maintenance organizations. Many of them regard chain hospitals and emergicenters as the antithesis of what they had in mind. They wanted corporate involvement to change the nature of health care; it seems likely, in the foreseeable future, to reproduce the defects of the traditional system on a grander scale.

—Paul Starr

Professor of Sociology, Princeton University

In a way, we're kind of like a utility.

—Thomas Frist, Jr.

Chairman, Hospital Corporation of America

The above comments cited in Starr (1982) and Lindorff (1992) provide a useful backdrop to this chapter. The first reveals the concerns of Paul Starr, a professor of Sociology at Princeton, more than 20 years ago after his comprehensive study of health care in the United States. The second reflects the perceptions and beliefs of a corporate insider, the CEO of Hospital Corporation of America (HCA), now the largest investor-owned hospital chain, during its formative years. We will return to these two different views of the health care world at the end of this chapter to see whether they can be reconciled.

Investor-owned chains of hospitals and nursing homes cannot be pigeonholed as such—they often extend into other areas of the health care system, such as surgicenters, urgent care clinics and even ownership of insurance companies. The purpose of this chapter is three-fold: (1) to provide a brief historical overview of trends involving for-profit investor-owned hospital and nursing home chains; (2) to present five case examples of large chains of general, rehabilitation, and psychiatric hospitals, and nursing homes; and (3) to briefly discuss

three ongoing policy issues resulting from the impact of these corporate chains on U.S. health care.

HISTORICAL OVERVIEW AND TRENDS

Ironically, public programs (e.g., Medicare and Medicaid in the 1960s) and their later reimbursement policies have been the major stimuli of what has become an enormous corporate empire of diverse, intertwined investor-owned chains of hospitals and other health care facilities and service providers. In earlier years, most hospitals and nursing homes were small, individually owned and operated companies. These companies became the launching pads for investor-owned corporations to enter into the delivery of medical care, as they bought them and organized them into chains. As these corporate enterprises grew, they typically diversified into related phases of health care, each new acquisition adding to their overall market share. Here are two examples of corporate integration, which had developed during the early 1980s:

- In 1984, the 8 largest investor-owned corporations together owned and operated 426 acute care hospitals, 102 psychiatric hospitals, 272 long-term care units, 62 dialysis centers, 89 ambulatory care centers, and a variety of other ambulatory and home health services (Gray, 1986)
- By 1980, National Medical Care (NMC) owned 120 dialysis centers; in addition, one of its subsidiaries made dialysis supplies and equipment and another performed laboratory tests for dialysis patients while NMC was also diversifying into psychiatric care and respiratory therapy (Starr, 1982, p. 443)

Today, investor-owned hospital chains have often set up their own financing mechanisms as an alternative to negotiating with third-party insurers. Early examples were the insurance plans established by Humana and HCA in the mid-1980s. In one of these plans Humana Care Plus offered free choice of physicians, but penalized subscribers for using hospitals that were not owned by Humana (Kirchner, 1985). Other strategies used by investor-owned hospital chains to increase their market share within an area are the development of urgent-care clinics, freestanding "emergicenters," and other "patient feeder" systems (Lindorff, 1992, p. 26).

Claiming cost containment and greater efficiencies through market discipline in a free health care market, investor-owned chains of hospitals invariably cut costs, especially by cutting nursing staff and

other clinical personnel (Woolhandler & Himmelstein, 1997). Quality of care is thereby compromised as cost savings achieved through these “efficiencies” are passed along as profits and dividends to shareholders rather than being used for institutional investment and improvement in patient care services. The chains seek out profitable markets and avoid “poor-pay” patients, whose care then falls to public and not-for-profit hospitals. Unprofitable services are often shut down regardless of community need (Coye, 1997; (Martinez, 2002; (White, 2002). Most chain hospitals are 100 to 200 beds in size, typically without residency training programs. Their administrative and general service costs are invariably higher than their not-for-profit counterparts. These higher costs are usually claimed to be due to higher interest expenses and financial services after acquisitions and mergers, but they also tend to add to the bottom line through complex billing procedures to payers (Himmelstein, Woolhandler, Hellander, 2001; Kuttner, 1996). Perhaps most important, ownership, policy and decision making are usually transferred from the community to distant corporate headquarters elsewhere in the country. This obviously interferes with the ability of public and not-for-profit facilities to develop coordinated health care systems that are responsive to the needs of the local community and surrounding region (Starkweather, 1981; (Starr, 1982).

Mergers and consolidation became common during the 1990s as hospitals struggled to survive in a time of declining patient census and reduced reimbursement by payers. Some not-for-profit hospitals were forced to close; many converted to for-profit status, often being acquired by investor-owned chains.

As a result of these changes over the last 30 or more years, there has been an enormous shift in relationships and influence between physicians, hospitals, HMOs and insurers.

Table 2.1 provides an historical overview of these changes. (Bodenheimer & Grumbach, 2002). In past years, hospitals were dependent on the loyalty of physicians for admission of patients and maintaining their daily census and revenue. More recently, hospitals have had to negotiate contracts with HMOs for sources of patients, while physicians in the community may have contracts with multiple HMOs, thus dividing their loyalty to any given hospital (Freudenheim & Abelson, 2003). Within this increasingly competitive marketplace, managed care has made it more difficult for many physicians to provide charity care. The higher the HMO penetration in a region, the lower the amount of charity care, and some for-profit HMOs even forbid physicians from seeing non-paying patients. (Himmelstein, Woolhandler & Hellander, 2001, p. 77).

TABLE 2.1. Historical Overview of U.S. Health Care**1945–1970: Provider-insurer pact**

Independent hospitals and small private practices
 Many private insurers
 Providers tended to dominate the insurers, especially in Blue Cross and Blue Shield
 Purchasers (individuals, businesses, and, after 1965, government) had relatively little power
 Reimbursements for providers were generous

The 1970s: Tensions develop

Purchasers (especially government) become concerned about costs of health care
 Under pressure from purchasers, insurers begin to question generous reimbursements of providers

The 1980s: Revolt of the purchasers

Purchasers (business joining government) become very concerned with rising health care costs
 Attempts are made to reduce health cost inflation through Medicare DRGs, fee schedules, capitated HMOs, and selective contracting

The 1990s: Breakup of the provider-insurer pact

Spurred by the purchasers, selective contracting spreads widely as a mechanism to reduce costs
 Price competition is introduced
 Large integrated health networks are formed
 Large physician groups emerge
 Insurance companies dominate many managed care markets
 For-profit institutions increase in importance
 Insurers gain increasing power over providers, creating conflict and ending the provider-insurer pact

Source: Bodenheimer, T. S., & Grumbach, K. (2002). *Understanding health policy: A clinical approach*. New York: Lange Medical Books/McGraw-Hill. Reprinted with permission.

CASE EXAMPLES OF INVESTOR-OWNED CHAINS*Acute Care Hospitals*

The two investor-owned hospital chains that I am about to describe are representative of the industry. They are both the largest chains in the country and have demonstrated their success in the open marketplace in economic terms. But they have strayed far from the stan-

dards and values of traditional not-for-profit community hospitals, which maintain local ownership and governance.

HCA

Today's largest investor-owned hospital chain, HCA took root in Nashville, Tennessee in the mid-1960s. Thomas Frist, a cardiologist there, having established his own new 50-bed acute care facility, sought funding from local investors to expand his hospital. Unable to raise local funding, he decided to team up with his surgeon son, Thomas Frist, Jr., and Jack Massey, the developer of the Kentucky Fried Chicken chain, to start a chain of hospitals. Their idea was to model after Holiday Inn, creating opportunities to buy supplies in bulk, and to raise money from Wall Street investors as a national corporation. Their timing could not have been better. The Medicare and Medicaid programs, established in 1965, brought new access to care for many millions of Americans and a reimbursement stream for expanded hospital services. By 1987, HCA had become the nation's largest for-profit hospital chain, owning almost 200 acute-care facilities in 28 states as well as 45 in 8 foreign countries (Lindorff, 1992, pp. 39–41). By 1995, HCA was the 53rd largest corporation in the U.S., with a market value approximating Boeing, Chrysler, and Time Warner (Derber, 1998).

In 1994, HCA was acquired by Columbia Healthcare Corporation, a large Texas-based chain founded in 1987 by Richard Scott, previously a successful surgical supply wholesaler. The resulting corporate giant, Columbia/HCA, soon entered upon hard times. Its prodigious growth was fueled by aggressive, even predatory, business practices that created widespread public backlash and attracted the scrutiny of regulators. Its attempt to purchase Blue Cross and Blue Shield (BCBS) of Ohio, for example, was met by public outcry and a lawsuit by the state's Attorney General to block the proposed acquisition, which would have provided over \$15 million in severance payments to the three top BCBS executives as "consulting fees and noncompete agreements" (Kuttner, 1996). In 1996, federal agents first raided Columbia/HCA all over the country, soon including laboratory and home care services as well as hospitals, and extensive investigations of alleged fraud were begun. Scott was soon forced out, Thomas Frist, Jr. took the reins, and the company (renamed simply HCA) started damage control against widespread allegations of fraud. In December of 2002, HCA announced a settlement with the Justice Department of more than \$880 million, raising its total amount

of civil fines and criminal penalties in recent years to \$1.7 billion (Associated Press, 2002). These fraudulent practices included falsification of patient records, billing for services that were not ordered by treating physicians and/or not provided, devious accounting procedures intended to increase reimbursements, and kickbacks to physicians for patient referrals to their hospitals (Sparrow, 2000).

In its pursuit of profits from hospital services as a chain business, its philosophy was expressed in these terms by Richard Scott soon after becoming president and CEO of Columbia/HCA:

Do we have an obligation to provide health care for everybody? Where do we draw the line? Is any fast-food restaurant obligated to feed everyone who shows up? (Ginsberg, 1996)

Scott disparaged his not-for-profit competitors as “social parasites,” (referring to their tax-exempt status) and rejected the arguments of critics that his hospitals should take more responsibility for care of the poor and the needs of the community.

Here are examples of typical practices of HCA and/or Columbia over the years, at various stages in their evolution:

- aggressive acquisition practices, typically involving secret negotiations, avoiding competitive bids, intensive lobbying efforts, and payoffs to helpful participants
- buying up underperforming hospitals, cutting staff and services, and then either making them profitable or closing them down
- taking over a Florida hospital and closing its emergency room, leaving the residents of the community with a 45-minute drive during rush hour traffic to the nearest emergency room
- gross overcharging for services (e.g., a Columbia-owned hospital in Georgia charged \$14,584 for an average hospital stay for a stroke patient compared with \$6,735 in a similar public hospital)
- after HCA’s purchase of Good Samaritan Health System in San Jose, California, nurses’ contracts were unilaterally terminated, many nurses were fired, quality of care deteriorated under a chronic staffing shortage, and charity care was cut by 89% (Ginsberg, 1996; Kuttner, 1996; Stein, 2002)

Tenet Healthcare Corporation (Tenet)

Tenet Healthcare Corporation is the second largest investor-owned hospital chain in the U.S. With headquarters in Santa Barbara, Cali-

ifornia, the company by 2002 owned 114 acute-care hospitals in 16 states. Through many of the same practices as HCA, its national marketing plan focuses on highly reimbursed services in cardiology, orthopedics, and neurology. Its hospitals are located in large communities across Southern California, Texas, Louisiana, and South Florida, where a growing population of aging baby boomers need these services (White, 2002).

Tenet, until 1995 known as National Medical Enterprises (NME), has been the target of recurrent federal investigations for many years. Recently, the U.S. Justice Department sued the company for up to \$323 million in damages, alleging that the company falsified patient diagnoses on Medicare claims from 1992 through 1998 to inflate its revenue (White, 2003). The company is now under investigation for exorbitant Medicare claims involving "outlier payments," which are designed to reimburse hospitals for extra care given to the sickest patients. Tenet was found by a state agency to have the highest average charges of any private hospital system in California, with charges 60% to 90% higher than statewide averages for 7 common diagnoses (Rapaport, 2002). Tenet hospitals in California were also found to charge an average of 10 times the cost of drugs, with one hospital charging 18 times their cost (Abelson, 2002).

In 1995, after contending with ongoing investigations, settlements and fines for fraudulent practices, NME sought to remove the cloud of scandal by changing its name to Tenet Healthcare, chosen because it was thought to represent integrity and "shared values" (Gentile, 2003). In 2004, Tenet is in the process of selling more than one-quarter of its hospitals after recurrent government investigations. (Rundle, 2004).

Rehabilitation Hospitals

HealthSouth is the largest investor-owned chain of for-profit rehabilitation hospitals in the country. It is now besieged by federal investigations for longstanding accounting and tax fraud. HealthSouth, with about 1,800 facilities in all 50 states and abroad, bills itself in its marketing materials as committed to providing high-quality, cost-effective care. Yet its claims are belied by a persistent story of predatory greed since its founding. Health South is a classic example of the dichotomy in ethics of corporate business and health care services.

Founded in 1984 by Richard Scrushy in Birmingham, Alabama, the company went public two years later. Scrushy, a former physical therapist, was the driving force in building a large chain of health

care and rehabilitation facilities, including inpatient, outpatient, surgical, diagnostic, occupational, and other medical centers (Freudenheim & Abelson, 2003). HealthSouth became the largest employer in Birmingham (3,500 employees), and Scrushy became well known as a flamboyant executive. He was one of the University of Alabama's main donors, and his contributions helped to finance a school for health-related professions that bears his name (Romero, 2003). Stock in the company climbed to over \$30 a share in 1998, but then plummeted to less than \$4 a share when its fraudulent practices became public (Freudenheim, 2003). HealthSouth and Scrushy were accused of adding at least \$1.4 billion to earnings between 1999 and 2003 and inflating assets by \$800 million in an effort to boost its attractiveness to investors. The Securities and Exchange Commission (SEC) believes that reported earnings for 1999 to 2001 were 100 times the correct amount (Norris, 2003). Scrushy has been charged with insider trading for selling about \$100 million in HealthSouth shares in the weeks before the company disclosed concerns about a change in Medicare reimbursement rates that was certain to reduce earnings. The company is also being sued by the Justice Department for billing Medicare for "one-on-one therapy by licensed physical therapists when the patients were actually treated in groups, often by unlicensed HealthSouth employees" (Freudenheim, 2003).

While the government continues its investigations, HealthSouth has had to scramble to arrange financing to avoid bankruptcy. It is being closely monitored by suppliers and insurers, and some believe that it will rival WorldCom and Enron for its brazen fraud (Atlas, 2003). After five months of widening investigations by the Justice Department, 14 former HealthSouth executives agreed to plead guilty to fraud (Weil & Mollencamp, 2003). The case is also expected to carry over into investigations of auditors and investment bankers who have advised the company over the years (Romero & Freudenheim, 2003).

Psychiatric Hospitals

Investor-owned for-profit psychiatric hospitals have been a growth industry since the 1970s. Between 1978 and 1983, they were increasing by more than 30% per year. (Gray, 1986, p. 476) Their record for quality of care and service has been disturbing, however, as reflected in these two examples during the 1990s (Sparrow, 2000, pp. 25–26):

- As one of the country's largest investor-owned psychiatric chains, National Medical Enterprises (NME, now Tenet, as already dis-

cussed) agreed to a settlement with the federal government of \$362 million, then the largest settlement between the government and any health care provider (Myerson, 1994). NME had already paid out over \$230 million to settle suits by 16 private insurers and more than 130 patients. The allegations included holding patients against their will, and paying kickbacks and bribes to community and church workers for patient referrals (Freudenheim, 1993).

- After cutbacks in mental health coverage by private insurers in the 1980s, psychiatric hospitals became more dependent on Medicare and Medicaid revenues. In Massachusetts, these two programs accounted for 72% of psychiatric admissions in 1997, up from 40% in 1990. Over those seven years, locked wards had increased markedly, with psychiatric admissions to these beds increasing by more than 50%. An exposé by reporters of the *Boston Sunday Globe* found a number of patients, after voluntary admissions, being admitted to locked wards not for medical reasons, but as one staff member admitted “because the census is down” (Kong & O’Neill, 1997).

Nursing Homes

Although nursing homes have been for-profit for many years, until 1970 most of them were small, individually owned facilities tied to their communities. By 1970 that was changing, since many of these facilities could no longer meet new building and safety standards, and were either closed or acquired by investor-owned chains. By 1984, the three largest chains (Beverly Enterprises, Hillhaven (a subsidiary of NME), and ARA Living Centers) together operated about 1,500 nursing homes across the country, controlling six times as many beds as not-for-profit nursing homes. These investor-owned nursing homes thrived on Medicare and Medicaid reimbursement policies, which covered operating costs as well as some profit factor. As we saw for other investor-owned hospital chains, administrative and other costs immediately went up as the proportions of spending on patient care services went down (Gray, 1986, pp. 32–33, 505, 524). Today about 70% of nursing home beds are in investor-owned facilities.

Although some investor-owned nursing home chains were the darlings of Wall Street during the early and mid-1990s, the industry has fallen on hard times as a result of federal cutbacks in reimbursements, especially from Medicaid. The majority of nursing home

patients are on Medicaid, and the 17,000 nursing homes in the U.S. are now experiencing a \$3.7 billion shortfall each year in meeting costs of care for these patients. Medicare reimbursement has been more liberal, and actually subsidizes some of this shortfall, but only 10-15% of nursing home patients are on Medicare. As a result, as states face deficits and have to make cuts in Medicaid spending, the financial health of the industry today has become precarious (Sherid, 2002).

About 1.6 million Americans live in nursing homes. This population has a high degree of disability and chronic illness, and presents a particular challenge to around-the-clock care. Many are unable to walk without assistance, one-half are incontinent, one-quarter have joint contractures, and many have dementia (Harrington & Carrillo, 2001).

Quality of care in U.S. nursing homes has varied widely for many years. Federal legislation that was passed in 1987 set standards for nursing home care and mandated periodic surveys. However, in 1997 only 29% of nursing homes surveyed could meet federal standards. One-quarter of nursing homes in the country had deficiencies that had either caused actual harm to patients or put them at risk for death or serious injury (Harrington & Carrillo, 2001). Persistent problems included low staffing levels with underpaid and inadequately trained staff, not enough nurses, and high staff turnover rates (Harrington, 1996).

Compared with not-for-profit nursing homes, for-profit nursing homes have been shown to have lower staffing levels and worse quality of care. (Harrington, Woolhandler, Mullen, Carillo & Himmelstein, 2001) Investor-owned nursing home chains avoid unionized staff, and often treat their staff badly. According to records of the National Labor Relations Board, the largest for-profit nursing home chain, Beverly Enterprises, accumulated 1,000 violations of workers' rights in 1987 (Lindorff, 1992, p. 271). In addition, fraud has been a pervasive problem throughout much of the for-profit nursing home industry. As Louis Freeh, director of the F.B.I. testified before Congress in 1995:

Nursing home and hospice operators exploit the elderly and Alzheimer's patients by fraudulently billing for services, incontinence supplies and medications; tragically choosing patients who have difficulty understanding or remembering what was and what was not done, much less complaining to their insurer or alerting law enforcement. (Freeh, 1995).

CONTENTIOUS POLICY ISSUES

Three policy issues stand out for their continuing controversy and importance to the health care system.

Is the corporate business ethic consistent with quality of care?

Although investor-owned chains tout their commitment to quality of care, increased efficiency and value, there is growing evidence that their emphasis on cost-cutting and bottom-line profits ends up compromising the quality of care provided. Since the late 1980s, the evidence consistently shows that corporate shareholder interests trump values of service and quality of care.

- a 1989 study found death rates 6% lower at private, not-for-profit hospitals than at for-profit hospitals (Hartz et al., 1989)
- a large 1999 study found death rates 7% lower at not-for-profit nonteaching hospitals and 25% lower at major teaching hospitals (almost all not-for-profit) than at for-profit nonteaching hospitals (Taylor, Whellan, & Sloan, 1999)
- other studies in the late 1990s showed higher rates of postoperative complications (Kovner & Gergen, 1998) and preventable adverse events (Thomas, et al., 1998) at for-profit hospitals than at private, not-for-profit hospitals
- investor-owned HMOs score worse on all 14 quality of care measures than not-for-profit HMOs (Himmelstein, Woolhandler, Hellander & Wolfe, 1999)
- a 2002 systematic review and meta-analysis of all studies comparing mortality rates at for-profit private hospitals with rates at their not-for-profit counterparts found consistently higher mortality rates at for-profit hospitals; this study represented more than 26,000 hospitals and 38 million patients (Devereaux, Choi, Lacketti, Weaver & Schunemann et al., 2002); it is estimated that this difference would result in 14,312 additional deaths each year if all U.S. hospitals were converted to for-profit status (Woolhandler, 2002)
- a 2001 study found quality of care deficiencies more than 40% higher in investor-owned nursing homes compared with either not-for-profit or public facilities (Harrington, Woolhandler, Mullen, Carillo, & Himmelstein, 2001)

A major underlying reason for consistently worse quality of care in investor-owned for-profit facilities is their aggressive cost-cutting of

staff, especially nurses, as they seek to achieve at least 10-15% profits for their stockholders (Devereaux et al., 2002; Woolhandler & Himmelstein, 1997).

Should Not-for-Profit, Charitable Hospitals be Sold to Investor-Owned Chains?

This might seem at first glance a naïve and irrelevant question, since many not-for-profits have already been sold to for-profit chains. The question, however, is a complex one, and there are both ethical and legal reasons to question these conversions. As Robert Kuttner points out, the not-for-profit hospital often has had land deeded to it under a charter to provide charity care, while the worth of the hospital represents many years of philanthropy, exempted taxes, other public investments, and the contributions of many in the community. A not-for-profit hospital struggling to compete and survive may see the funding and size of a chain buyer as attractive. The acquiring chain has a stable of analysts, accountants, attorneys, and consultants ready to put together a low-ball proposal, often in secret without competing bids, and with financial inducements to trustees or executives. The chain generally assures the hospital that its mission will be honored and preserved through a charitable foundation to be set up when the purchase is concluded. There are, however, many ways in which the chain can backtrack on such a commitment. One way is not to fund the foundation, which happened after Columbia/HCA bought HealthONE, a six-hospital system in Denver (Kuttner, 1996; Meyer, 1995).

State laws and regulatory policies with respect to hospital conversions to for-profit status vary widely from one state to another. Many states have little or no oversight of these transactions, while others take an active role in oversight and control through their state attorneys general. In Massachusetts, for example, the attorney general intervened in the purchase of two community hospitals by Columbia/HCA, retained an independent accounting firm to determine fair market value, obtained a commitment to keep both emergency rooms open for at least 3 years, and improved other community benefits, including the terms of the foundation (Office of the Attorney General, 1996). Other states have strengthened their oversight of these conversions. Nebraska, for example, enacted a law empowering its attorney general to block the conversion of a not-for-profit hospital on the basis of any of nine criteria, including conflicts of interest of board members, too low a purchase price, and “whether the purchaser has made a commitment to provide care to the disadvantaged, the

uninsured, and the underinsured, and to provide benefits to the affected community to promote improved health care" (Nebraska State Legislature, 1996).

Whose Interests Do Specialty Hospitals Serve?

A new battleground has opened up in recent years between specialty hospitals and acute care hospitals. As of 2003, there were about 100 operational specialty hospitals across the country with 20 to 30 more under construction. They are for-profit, investor-owned (often by local physicians), and usually have under 100 beds. They emphasize lucrative procedures, especially cardiac care and orthopedic surgery, and claim to be more efficient due to shorter turnaround times between surgeries, less bureaucracy, and the motivation of their physician investors (McGinley, 2003; Page, 2003). Full-service, acute care hospitals, however, see them as skimming away profitable parts of their operations, leaving them with poorly reimbursed essential services (e.g., emergency and trauma services, burn units) and less ability to make ends meet. They also point out that specialty hospitals take less responsibility for the care of lower income patients and generally care for patients with less severe illnesses than those in general hospitals, as was shown by a 2003 study by the General Accounting Office (Voelker, 2003; General Accounting Office, 2003). In view of concerns raised by critics of specialty hospitals, the 2003 Medicare reform law imposed an 18-month moratorium on reimbursing physicians who self-refer to a specialty hospital built after November, 2003, and also called for studies on the financial impact and referral patterns of specialty hospitals (Silverman, 2004).

In their backlash to the threat of specialty hospitals, acute care hospitals have several strategies at their disposal, including blocking specialty hospitals through the "certificate of need" process (still operational in one-half of the states) and termination of privileges for physicians working at a competing specialty hospital. Specialty hospitals are now gathering data on their outcomes of care, but there is little reason to believe that they will be less costly and their impact on acute care hospitals is likely to be detrimental.

CONCLUDING COMMENTS

Returning to the opposing views quoted at the beginning of this chapter, it is clear that Paul Starr's predictions were on target. The

defects of the health care system have indeed been magnified over the last 21 years by the corporatization of health care. Despite the claims by investor-owned chains of greater efficiency and value, their costs are higher, value has declined, and quality of care is worse than at their not-for-profit counterparts. The five investor-owned chains profiled here cannot be dismissed as anecdotal or unrepresentative of the industry since these are the largest chains of their types. The suggestion by Thomas Frist, Jr., chairman of HCA, that hospitals are “kind of like a utility” seems disingenuous since HCA and other investor-owned, for-profit chains go to great lengths to avoid public control. Having monitored corporatization of U.S. health care for years from his seat on the House Ways and Means Health Subcommittee, California Representative Pete Stark has this to say:

Making fat profits on hospitals at the expense of the poor and the sick may not be a prison offense in this country. What is a crime is the galloping privatization of the nation’s health resources and the rise of a competitive health care system that has less and less to do with health and access to care, and everything to do with money. (Lindorff, 1992, p. 22).

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