'My Hospital Was Doomed'

By Bruce C. Wilson

MILWAUKEE, Wis.—Health care is in big trouble, and everybody knows it. The problems seem innumerable, and the solutions seem to exist behind some big black curtain, if at all. I hoped to bring at least one set of solutions to my own community—which was found in a number of studies to have far greater health-care costs than most other cities. I was the chairman of the board of the Heart Hospital of Milwaukee, a "specialty hospital" of the kind that has been getting a fair amount of press in the past year or two. But my hospital was only open for one, single year. You should know why.

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The Heart Hospital of Milwaukee was one of a dozen heart hospitals built nationwide by MedCath, a North Carolina corporation in partnership with local cardiovascular physicians. Many experts think focused hospitals are the future of health care; our data certainly lead us to this conclusion. But most of the press coverage is negative, delivered by a well-organized, well-funded lobbying and public-relations machine representing the big, mostly not-for-profit, hospitals and the American Hospital Association (AHA). Hospitals like mine are attacked by these organizations for a variety of reasons—more on these later—and I could surgically dissect all of their arguments with data, as there is plenty of it. (Unfortunately, PR is often independent of facts.) But rather, let me tell you first what doctors love about practicing in the specialty hospital environment.

By focusing our main energies on heart care, and building a facility designed to do that efficiently, we had outstanding results and could perform some very complex operations because of the expertise of the staff and availability of excellent consultants. In health care, we have not traditionally been accustomed to having results carefully analyzed and subjected to rigorous quality improvement methods. But our results were carefully measured and benchmarked, part of a model that provided feedback to help the Heart Hospital produce superior clinical outcomes. The pride in achievement and ownership in one of these hospitals is precisely what makes them hum.

John Breaux

There is also tremendous efficiency in focusing on one area. The nurses had great expertise. Scheduling of procedures was much easier, and we could accomplish in a morning what would take one or two days to do in a general hospital. Turnaround in the operating rooms and catheterization labs was extremely efficient, occurring in just minutes. This, needless to say, saves a lot of money. It also translates into very high patient satisfaction. A full 98% of the patients cared for in MedCath heart hospitals across the nation said that they would return for further care and recommend us to others.

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There would seem to be an issue of conflict of interest in the specialty hospital model. That is, physicians would naturally be inclined to refer to a business entity in which they have ownership, just like every other business in our country. In addition, the AHA has argued that physicians are likely to care for the "easier" patients in their own hospitals, while sending the sicker ones to the general hospitals in the community. There have been several studies by government agencies looking at this issue, but the point is moot. Congress has recently enacted legislation that reimburses all hospitals based on how sick the patients are.

> ***The war against 'specialty' medical facilities.***

But while hospitals and legislators are saying that it is a conflict for doctors to own even a minimal stake in a hospital, nobody seems to be saying that it's a conflict for hospitals to own doctors. During the 1990s, many hospitals bought the practices of the family doctors and internists. As a result they now employ them directly, writing their paychecks. In fact, about 90% of the primary-care doctors in southeastern Wisconsin are owned by the hospitals here. Historically, the average loss to a hospital in owning doctors is about $100,000 per doctor, per year. But the reason so many hospitals own primary-care physicians is so they can direct referrals into their own hospitals. That is where the real money is made.

As has been true in virtually all of the cities where specialist hospitals have been built, the large hospitals in Milwaukee went to their "owned" physicians and told them whom they could and could not use as their heart specialists. They removed my partners from their emergency room on-call lists, and in some cases instructed the ER doctors to call other cardiologists, even if the patient was under the care of one of us. They came to us individually and asked if we had a financial interest in the Heart Hospital. If we said yes, we were told face-to-face that we would never again receive referrals from "their" doctors with whom we previously had very close relationships.

Pressure was exerted by the general hospitals on large insurance companies to exclude coverage for services provided at our hospital. The administrators of these hospitals have denied all of this. Nevertheless, it is true. If you are now or might ever be a patient, how does it feel to know that the administrator who manages a general hospital is choosing your specialist, and denying you access to programs that are using the latest data and systems of care to improve their patients' outcomes?

After having our referrals choked off by these tactics, we were significantly hindered by the Specialty Hospital Moratorium provisions of the 2003 Medicare Modernization Act. This amendment prohibits existing specialty hospitals from expanding or adding investment partners and prohibits new ones from being built. It was curious to us that Sen. John Breaux, who had welcomed a MedCath Heart Hospital into his home state with great enthusiasm just months earlier, would be the moratorium's chief sponsor. This anti-ownership measure was to last for 18 months, but was extended this past June until the end of 2005 so the issues could be studied further. There is great political pressure from the big hospitals right at this moment to make the moratorium permanent, and Congress recently extended the moratorium for nine more months. The big hospitals have claimed they need this moratorium to "level the playing field."

My hospital was doomed. Because of the heavy-handed tactics of the local hospitals and by the Specialty Hospital Moratorium, we never generated enough volume and revenue to stay afloat. It seemed like such a good idea to invest in the future of better health care for Americans, and one way to help was to contribute to a new model where efficient, data-driven health-care practices would set a new bar for excellence in cardiac care in our community. I was in it for the long haul. I understood that it would be years before I would see returns on my investment, if at all. That didn't matter, though. It was an honor for me to have had a chance to work along with other professionals to do it a better way, and to receive the appreciation and gratitude of our patients.

I was a partial owner who lost essentially all of my investment. I will recover, as will the others, but we find ourselves going back to huge systems that weren't designed for efficiency and don't really want our input. Patient care should be in the hands of caregivers. We don't relish working for systems that depend on negative PR and devious anticompetitive practices to generate what are often huge profits, even though many of them enjoy tax exemptions by being "not for profit."

This "not for profit" term is widely misunderstood. Hospitals with this designation make a covenant with their communities to care for indigent patients in exchange for a tax exempt status. In fact, many not for profit hospitals save far more on taxes than they spend on care for the poor or uninsured. When a patient without insurance is cared for by these hospitals, they are often billed at the full rate instead of the discounted rate afforded to those in insurance plans. I am told that the largest holder of foreclosed mortgages in a large city in Ohio is one of the big hospitals there. Dig down and look into where revenues in excess of expenses are distributed. Start with the salaries of the CEOs, and look at how fast those salaries have grown.

One last point: Many prominent medical centers, such as the Ohio State University Hospital, have decided that the specialty hospital model is superior, and have invested millions of dollars to build separate cardiac and other focused facilities. Johns Hopkins, Brigham and Women's Hospital and the Cleveland Clinic, among other institutions great and small, are in the process of creating the specialty heart hospital environment. This is about efficiency and quality, not avarice and profit.

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So, the lights went out in our specialty heart hospital. It is now being reconfigured and reopened as an ambulatory surgery center by the large hospital system that bought it. Nevertheless, it is because my colleagues and I were allowed to have a hand in how our services were delivered that we achieved such great results in an atmosphere never before encountered by our doctors, our nurses, and especially our patients. We are experts in our field—why should experts be denied ownership of their own companies? No other industry in America is so rigidly regulated; yet it is competition that brings innovation and better products and services. Don't we need innovation in health care?

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