Written by Gail Terry Grimes in response to media stories that seemed to lump all hospitals together.

Not-for-Profit Healthcare Puts People—Not Profits—First

In news about American healthcare, one big part of the story tends to get overlooked: the basic difference between for-profit and not-for-profit providers of care. All non-government hospitals and other providers fall into one or the other category, and the divide between the two is huge, yet few people, especially few reporters, seem to notice.

The for-profit, or investor-owned, hospitals operate like any other business. A return on investment for stockholders is their first priority. That's to be expected if a company sells widgets, but when the product is the saving of human lives, there is more at stake than stock values. I don't mean to suggest that for-profit hospitals cannot do good, only that their other, less altruistic obligations must sometimes get in the way, and that communities, not to mention individual patients, may suffer as a result.

By contrast, not-for-profit hospitals are required, by law and by conviction, to put people, not profits, first. This means:

- **Any excess revenue goes back into services, not into private hands.** Of course every hospital has to cover costs and save for a rainy day, but if revenue exceeds expenses, the money is used for equipment, facilities, and services—that is, to save lives, reduce suffering and keep people well, not make investors rich.

- **Voluntary governance protects against wrongdoing.** Every not-for-profit hospital is governed by a board of volunteers from the community. Not long ago one of the big for-profit chains was accused of inflating revenue by misusing federal funds. Could volunteers conspire to defraud society in such a way? Perhaps, but because volunteers have nothing personally to gain and their reputations to lose, the chances are next to nil. Voluntary governance protects the community.

- **No one is ever turned away or underserved.** Although the law requires every U/S. hospital to provide emergency care to anyone who needs it, for-profit hospitals tend to send uninsured and underinsured patients away as quickly as possible to minimize the cost of their care.

Accountability to stockholders gives the for-profits a disincentive to treat anyone whose care takes more money than it brings in. Children are unpopular as patients, for example, because they typically require more attention than adults. Some for-profit hospitals solve the problem by simply closing the pediatrics department. No kids, no shortfall.

Most alarming is the record of "preventable adverse events" among patients of all ages in for-profit hospitals. According to the *Journal of General Internal Medicine*, the number of such events is two to four times higher among for-profit hospitals than it is in a not-for-profit setting.

The history of the not-for-profit hospital is one of the great American stories. Pioneers settled down, witnessed suffering among their families and neighbors, and came together—often as a handful of physicians, nurses, religious missionaries or philanthropists—to find solutions. They had no other motive than to help. Names like Hitchcock, Lahey, Alta Bates, Mayo, Baylor, Scripps and many others stem from this long tradition.

A lot of the old names have now disappeared as rising costs and declining revenues have forced hospitals to merge and, sometimes, to accept a for-profit takeover. The big for-profit chains, such as Tenet Healthcare and the Hospital Corporation of America (HCA), are especially strong in the South and in Southern California. According to the *Health Affairs* journal, more than a third of hospitals in L.A. County are now investor owned; in Houston the toll is 55.2 percent. As of 2002, the U.S. had 749 investor-owned hospitals nation wide—13 percent of the country's 5,800 hospitals.

In Northern California, where I live, the vast majority of healthcare is still provided by not-for-profit institutions, many of which have been around almost since the Gold Rush. These institutions exist for no other purpose than to serve the *entire* community, children and all, regardless of cost. Most local residents seem to take their good fortune for granted, but they should heed what happened in downtown San Jose, where HCA bought the century-old San Jose Medical Center and soon shut it down to consolidate services, leaving the neighborhood's mostly low-income residents without emergency care nearby.

HCA has also bought Regional Medical Center of San Jose, Good Samaritan Hospital in San Jose, and Los Gatos Surgical Center. Tenet now owns San Ramon Regional Medical Center, Community Hospital of Los Gatos, Doctors Medical Centers in Pinole and San Pablo, and two hospitals in San Luis Obispo County.

So far, most of the rest of Northern California appears safe. San Francisco, Berkeley Oakland and Marin, Sonoma and Napa Counties continue to enjoy not-for-profit healthcare; there are no for-profit hospitals here—but, who knows what will happen as costs continue to rise and revenues fall. Insurance no longer even remotely covers the cost of care, legions of patients now have no insurance at all, and the nationwide shortage of nurses and other health professionals is pushing hospital salaries higher.

Meanwhile, new seismic laws are forcing most California hospitals to undertake costly reconstruction projects. The money must come from somewhere, yet the federal government is not stepping forward the way it did in the middle of the last century with the Hill-Burton Act, which paid for new hospital construction all around the country.

Which brings us to the third category of hospital: the public institutions. Like their not-for-profit cousins, they too are expected to put people first. They play an especially vital role in addressing issues of public health and care for the poor, notably in the inner cities, where this is typically their primary role. In many communities there exists a symbiotic relationship between public and not-for-profit hospitals. In good times, the public hospital takes the weight off not-for-profit shoulders by taking care of the lion's share of

uninsured patients—but when the economy weakens, leaving governments with less tax revenue to spend on public hospitals, the not-for-profits somehow manage to wield a greater share of the load.

In small communities, the public hospital, often run by an elected healthcare district board, may be the only game in town. It fills all the community's hospital needs—or at least it is expected to.

Public hospitals, including public university hospitals, do have a financial advantage over the not-for-profits, in that they are allowed to use state and local tax revenues to cover deficits. They may also pay for new construction through special bond issues. However, they too have a mission of service to all; they cannot simply close or chip away at low-return services the way for-profit hospitals do. No wonder, then, given the demands on available dollars, that many public hospitals are following the example of the not-for-profits in turning to the community itself for support—through philanthropy.

If this sounds like a pitch for contributions, so be it. Our community hospitals, both public and private, are our most valuable shared assets. In a disaster or a personal health crisis, we think first of the hospital, and we assume it will be there for us. This is one of our most deeply rooted expectations, yet donors collectively give far more to their alma maters and the arts. What can they be thinking? These are worthy causes to be sure, but a gift to a hospital is a matter of life or death. There is no comparison.

Even today, with so many California hospitals either shuttered or converted to the for-profit model, two thirds of all emergency care, and three fourths of all unfunded charity care, comes from the not-for-profit sector. Compared with investor-owned hospitals, the not-for-profit hospitals also spend 30 times more on research and medical education. We cannot afford to lose any more of them.

Analysts from the big for-profit chains are undoubtedly monitoring the financial ups and downs of all community hospitals for signs of weakness. They watch and they wait.

They also target public opinion. A few years ago officials at the for-profit Tenet chain made public a plan to freeze hospital rates and offer discounts to uninsured patients. That sounds like a noble gesture, but it was presented as part of a strategy to "regain trust of our investors and others." They said they have done "nothing illegal." They said, "Image and news flow is more of a concern…than the fundamentals…." In other words, the goal was not so much to serve as it was to influence. Such language would never, or should never, come from people with a true mission of caring—yet the media and the health-consuming public let it pass pretty much without comment.

Most people don't think about medical care until they need it. Given the financial challenges facing not-for-profit and community district hospitals, and the aggressive growth of the for-profit chains, this cannot be healthy for any of us.

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