According to the local newspaper, groundbreaking for Mountainview Regional Medical Center in Las Cruces, New Mexico, was a gala affair, replete with mariachis, folklorico dancers, and hot Mexican food. The estimated 1,162 invitees were abuzz over the new hospital's cardiac care unit and state-of-the-art sleep center. By all accounts, Mountainview, to be built by the corporate giant Triad of Plano, Texas, would be a world-class operation, and one speaker after another celebrated the economic development that it would purportedly foster. They also affirmed the community's right to "choice" in health care.

Choice, in this case, meant that privately insured Las Cruces residents could go somewhere besides Memorial Medical Center (MMC), which for decades had been the only hospital in town, ministering to everyone, rich and poor, insured and uninsured. The issue of what the advent of "choice" might mean for the rest of the community— for those with scant insurance or no coverage at all, and for MMC itself, was ignored at the ceremony. "The question I get from a lot of people is 'What's going to happen to MMC?'" Mayor Ruben Smith is quoted as saying. "And I say, well, a second facility needs to be supported because it's what is needed, wanted, and the community is really responding to it."

But how would this shiny, new facility replete with boutique health services affect the community's ability to provide care for all its people? Those are the kinds of questions health planners ask, but no such analysis was being done. No one was asking whether Mountainview might destabilize the patient base for MMC and access to services for the community overall.

MMC's fate became clearer once Mountainview opened its doors. Within months, the older hospital announced that it would have to lay off 134 employees. Roughly a year later, MMC was placed on the auctioning block. In December, Tennessee-based Province Healthcare Company agreed to lease the 285-bed hospital for $150 million from the city of Las Cruces and Dona Ana County. Las Cruces, a city with a large number of uninsured, now must sustain two for-profit hospitals.

The Truth about Las Cruces

The truth about Las Cruces is that although it is growing rapidly and attracting more wealthy, insured residents, especially retirees, it is still mostly Hispanic and low-income, with an uninsured rate of about 35 percent. Theoretically, these people could "choose" Mountainview over MMC, but it is unlikely that they would, says MaryAnn Digman, MMC's former CEO. Mountainview is simply much less accessible. Just two miles apart, the hospitals inhabit different worlds. Mountainview, tucked away in an upscale neighborhood near the golf club, is not on any of the city's bus routes. But every bus in town stops at MMC, which is clearly visible from the interstate. The poor have been going there for years; they're comfortable there, and wouldn't think of going elsewhere.

Digman further notes that if somehow an uninsured patient or two did show up at Mountainview — even in the emergency room, where the law requires that everyone, regardless of ability to pay, must be "treated and sta-
profit hospitals. Their mission is to be there for people, the thoroughly insured and the less insured. They focus on community health needs. But companies like Triad focus on profits and shareholders. And if they suddenly own the only hospital in the area, that’s going to have a major impact on health care access for people there.”

You can already see the writing on the wall in Las Cruces. With more affluent patients flocking to Mountainview, M emorial’s patient mix today is increasingly drawn from the city’s lower-income neighborhoods, and these patients are often severely, chronically ill and expensive to treat. For example, diabetes is widespread among them. Then, too, there’s the matter of health care costs in general—which are rising—against a backdrop of what hospitals have long claimed are inadequate Medicare and Medicaid reimbursements.1

In December 2002, announcing their first round of layoffs, M emorial officials made no bones about what was going on. They noted that the “immediate adjustment in the facility’s workforce” was necessary because of an “onset of competition for insured patients” and an “increase in uncompensated care.” They also pointed out that these “significant trends...have been emerging since the opening of the city’s second hospital in August.”

Mountainview countered that it had not been in operation long enough to have caused the difficulties, but M emorial had some convincing numbers. For instance, the hospital had provided $38.2 million in uncompensated care in the previous year, but projected that it would spend $45 million on such services by the time the current year was over. With the hit M emorial was taking from the drop-off in insured patients, losses came to a whopping $2 million a month.

Mountainview never denied that it was drawing more of the region’s insured patients. Nor did it say much about what it was doing to address charity care needs in Las Cruces, asserting only that it was treating both insured and uninsured patients. It failed to supply any actual statistics and neglected to mention its practice of transferring the uninsured to Memorial and the implication that those patients are someone else’s responsibility.

Public Relations Maneuvers

One might have expected some kind of public outcry against Mountainview, especially as Memorial’s situation continued to deteriorate. After all, thousands of Las Crucesans who had once been served by a decent, solvent, community-oriented hospital increasingly found themselves ghettoized in an understaffed, debt-ridden facility whose future was uncertain. But Digman, who still lives in Las Cruces, reports that to this day, residents by and large see nothing wrong. The prevailing assumption seems to be that Memorial’s difficulties are just the result of bad management, and with regard to Mountainview, the buoyant, forward-looking spirit that was so much in evidence at the groundbreaking persists.

Digman credits Triad’s well-oiled public relations machine. “Never underestimate Triad’s skills,” she says. From the minute they roll into town, “they get out and talk to the developers, and convince them that their land will be worth more with one of these hospitals on it,” Digman says. “They convince the politicians that there’s a lot to be gained in property taxes. They talk up the economic development angle, how there will be more jobs, new jobs.”

But what of the public’s investment in the nonprofit Memorial, which for years has operated without paying...
taxes to the community? Isn’t it important to protect the viability of the health institution the community itself has so long nurtured and subsidized? Such arguments have not been made. Triad and Mountainview have won over many local doctors... They go to the physicians with high margins and high-volume business and they say, “O'nce your practice builds over here, you won’t need to work elsewhere so much, and you'll be able to limit your exposure to the uninsured.”

Triad and Mountainview have won over many local doctors... They go to the physicians with high margins and high-volume business and they say, “O'nce your practice builds over here, you won’t need to work elsewhere so much, and you'll be able to limit your exposure to the uninsured.” In fact, Digman recalls that when Memorial's chief of staff left for Mountainview, he told her and her board as much.

“He said, ‘This is not about the quality of Memorial Medical Center. It’s about your payer mix. If I work at Mountainview, even if I’m on call at their ER, I get fewer uninsured, and if I can limit my number of uninsured, then I’m going to make more money.’ He was that specific about it,” Digman says.

Among the few who have stepped forward to criticize Mountainview is the National Alliance for the Mentally Ill (NAMI), on behalf of the mentally ill of Las Cruces and their families. Their response is instructive because mental illness, perhaps more than any other health issue, points to the community’s shared fate on access to care. That’s because the disease can strike any family: it knows no income level. Treatment of severe mental illness can be very expensive. If you were insured to start with, you can easily wind up uninsured when coverage is exhausted.

Triad’s Game Plan

In the four years since it was spun off from Tennessee-based HCA, Triad has become the nation’s third largest health services provider. Its focus, explicitly laid out in its annual report, is small cities in the South, West, and Midwest. According to Attorney Melissa Lopes, who is part of the Community Catalyst team monitoring Triad transactions, it seeks markets that can support lucrative specialty services but that have remained somewhat insulated from non-hospital suppliers and the onslaught of managed care. Las Cruces was made to order.

Granted, Triad usually does not establish a brand-new hospital as it did in Las Cruces. Rather, it buys an existing hospital. Yet Lopes has noticed that after the sale is completed, a scenario curiously like the one in Las Cruces tends to develop. Triad ditches the hospital’s aging physical plant, which is often in an older, urban neighborhood, and constructs a lavish “replacement facility” in a more prosperous area, one to which lower-income residents do not have easy access. The Triad hospital, like Mountainview, is then set up to draw most of the well-to-do, insured patients, leaving a competitor to care for the more vulnerable, financially draining population.

“Joint Ventures” or “Conversions”: New Name - Same Game

The latest variation on Triad’s game follows.
plan, something it calls the “joint venture,” could help it both extend its dominion and reinforce its image as a magnanimous member of whatever community it targets. The corporation approaches capital-starved nonprofits and offers to link up with them, sharing its wealth.

With the sheer numbers of small hospitals across the country that have fallen on hard times, Triad CEO Denny Shelton estimates that his company will be entering into as many as four to six joint ventures annually. In the past year, Triad has broken ground in Denton, Texas, on the first replacement facility to result from such a transaction. It has also closed joint venture deals with McKenzie-Willamette Hospital in Springfield, Oregon; and Valley Hospital in Palmer, Alaska. Additionally, Triad has pursued joint ventures with hospital systems in Alabama and West Virginia. Both attempts have failed. Currently, Triad is in talks to partner with Good Hope Hospital, a nonprofit located in North Carolina. Triad openly states, however, that it will contribute funds sufficient to make itself the dominant partner in the relationship with these nonprofits. It specifies that it will take over the day-to-day operation of the hospitals as well. So in essence, it is buying them out and converting them to for-profit status, says Attorney Dawn Touzin, who directs Community Catalyst's Triad monitoring team.

“Triad started pushing to buy Good Hope, their people talked to all the surgeons, all the specialists. But they didn't talk to the internists or the pediatricians..., You know, pediatrics just doesn't interest them. It doesn't make money for the hospital.”

Déjà Vu All Over Again

The situation now unfolding in Harnett County, North Carolina, where Triad is ready to enter into the next of its joint ventures, bears watching. The parallel with Las Cruces is inescapable. Here, too, the population is overwhelmingly low-income, yet Triad appears to be ignoring that and catering to a smaller, more well-heeled crowd. It has its eye on Good Hope Hospital in Erwin, a manufacturing town ravaged by the loss of its biggest industry, textiles. The replacement facility it wishes to build would be in Lillington, a pocket of affluence in the county.

Good Hope, with the substantial infusion of resources it would receive from Triad, could endanger nonprofit Betsy Johnson Hospital, its sole competitor. Once more, a Triad hospital could be claiming the lion's share of insured patients and leaving its neighbor with a budget-busting load of charity care. “We could wind up in this county with no nonprofit hospital at all,” says T. C. Godwin, a local businessman and director of the community's New Century Bank. “All we'd have would be a huge out-of-state corporation whose driving motivation is to make money for its shareholders.”

Godwin observes that “when Triad was starting the push to buy Good Hope, their people talked to all the surgeons, all the specialists, but they didn't talk to the internists or the pediatricians, and one of our pediatricians told me, ‘You know, pediatrics just doesn't interest them. It doesn't make money for the hospital.’ ”

He further notes that mental health services would be especially vulnerable under Triad. Currently, Good Hope has Harnett County's only beds for psychiatric care, and such beds are hardly profitable.

Triad's Management Company: A Stunning Conflict of Interest

Triad is making use in Harnett County of a new addition to its arsenal: Quorum Health Resources, a hospital management firm that it purchased in 2001. Quorum, a fellow HCA spin-off, specializes in nonprofit hospitals. Not only does it manage Good Hope, but it also employs the hospital's CEO, Don Annis. It thus has an inside track in negotiating a deal.

The conflict of interest is stunning. The management of the hospital to be sold is a subsidiary of the company that would be buying it. Triad sits on both sides of the table. “Triad won't say how much they're going to pay for Good Hope, and there's a question in my
mind about whether the proper oversight is being done," Godwin says. “For example, why wasn't Good H ope put out on the market so other potential buyers could bid on it? Wouldn't that facilitate getting the best price?"

Godwin even wonders whether Q uorum has been carrying out its management responsibilities in good faith. “The year before last, Good H ope lost $40,000, and then last year, as Triad was getting ready to buy it, it lost $1.2 million. That sort of depresses the price, wouldn't you think? And if Quorum management is so great, and the hospital is still losing all this money, then why does Triad want to buy it in the first place?”

Quorum management allows Triad to stack the deck in other ways, too. “They've used a lot of scare tactics,” says Godwin. “They've been telling employees that if they're not able to lose jobs.” On one occasion, Triad also used the Quorum advantage to pack a public forum on the Good H ope transaction. Management simply gave people the day off to attend. In all, nearly 300 citizens showed up for the event, and since so many of them believed they would be unemployed if the deal failed to go through, they spoke up strongly in favor of it.

Despite these less-than-respectable moves, however, Triad does not come across as one to fight dirty. The public relations machine that D igman witnessed in Las C ruces is also working its wonders in H arnett County. In fact, the corporation may have gained even more support in H arnett County than in other parts of the country. The reason is that Quorum has given Triad a way to learn about the ins and outs of an entire community firsthand, since the managers live and work there.

Troubling Maneuvers

According to Adam Searing, project director of the N orth Carolina H ealth Access Coalition, one lesson Triad has learned is that in poor, rural H arnett County, the promise of economic development goes a long way. Many people there, like their counterparts in Las C ruces, have been persuaded that letting Triad into their community will not just save jobs but also create new ones, attract businesses to the area, and increase the tax base. Another forceful argument, directed at those who live in and around Lillington, has been that the travel time to a hospital in a neighboring town could mean the difference between life and death.

Galvanized by such hopes and fears, residents have joined with Triad in an ongoing letter-writing blitz to politicians throughout the state, including the governor and the attorney general. For those unable to compose something in their own words, Triad has supplied a form letter they can sign.

Local news coverage has been conspicuously one-sided. “It seems to be operating a very well-financed, coordinated media cam-paign, and the opposing view really isn’t getting out there," Searing says. Not only has the media largely skipped over issues like the possible health impacts of the conversion, but it has also completely overlooked the obvious conflict of interest at the heart of the Good H ope deal—which is, according to Searing, “just shocking. It makes absolutely no sense that it is not a major issue.”

Searing says Triad’s political maneuvers have been expert, too. The sense of vast popular support that the letter-writing blitz has created has been supplemented by “very intense lobbying,” he says. Current legislators and senior political figures, including former U.S. senator Robert M organ, are aligning themselves with the corporation.

Good News on the Legal Front

Advocates face an uphill battle in N orth Carolina. But Searing is hopeful about Triad in particular and hospital conversions in general. He believes that if other prominent people in the area were better informed about how their community's health care is at stake, they might join Godwin in raising concerns. That, in turn, could lead to more balanced coverage in the local press.

Searing also thinks some coverage in media with a statewide audience might be possible. Triad, after all, is an out-of-state corporation that has already established itself as an integral part of the health care system in N orth Carolina. Its subsidiary, Quorum, manages at least 10 hospitals there. If the Good H ope conversion comes to pass, and if it’s permitted to happen in a way that does not take legitimate community issues into account, a bad precedent could be set for the whole state.

There's been good news on the regulatory front, however. To build the Lillington replacement facility, Triad needs both a Certificate of N eed (C ON ) from the state's D epartment of H ealth and H uman Services (D H H S) and approval from the state's attorney general. Lopes notes that the company's move to turn Good H ope...
into a for-profit facility constitutes a conversion; the state’s Certificate of Need process is triggered by Triad’s desire to then move the facility from Erwin to Lillington.

This past September, the Certificate of Need application was denied. In its detailed review, DHHS found that Good Hope officials had failed, on nearly every item, to demonstrate that each facility feature or service they proposed for the new medical facility was the most effective and least costly.

Good Hope and Triad are appealing this decision, but even if they win, advocates will have gained a crucial advantage because the denial stalls the whole transaction. One of the biggest problems with for-profit hospital conversions is that AGs typically have just 60 days to examine the case before handing down a decision. With a clock that runs so fast, consumers barely have time to pull together information they want to be considered. As long as the Certificate of Need is still pending, however, the AG faces no pressure to rule on the deal, because it cannot be enacted anyway. There’s more time to study the particulars of a situation in depth.

Finally, Searing is confident that if the Triad deal ever does come before the North Carolina AG, he will conduct a thorough, unbiased review of all the relevant information. “He’s one of the most respected politicians in the state, and he’s seen as very fair,” he says.

Valuable Opportunities

Every state needs the kind of legal authority that North Carolina has given its regulators to examine such hospital conversions. Fortunately, more than 30 states have health care conversion laws, and some have Certificate of Need procedures on the books, authorizing them to investigate whether proposed new facilities and/or services are needed, what impact they will have on access to essential services, and how they will affect overall health care costs.

Such regulatory authority provides communities, and consumers with some of their most critical tools for protecting health care access. Anyone who doubts that need only consider the outcome of the joint venture negotiations with Triad in Springfield, Oregon.

Checking Out the Gift Horse

When advocates descended into the turmoil around small, nonprofit McKenzie-Willamette Hospital there, they knew that things weren’t going to be easy. McKenzie-Willamette had been financially strapped ever since its powerful rival, Sacred Heart, moved into its backyard several years ago. McKenzie recently, with the economic downturn, it faced the threat of insolvency. Hospital officials had sought assistance from one nonprofit health care organization after another—five in all—but none had been willing to invest the resources needed to make McKenzie-Willamette viable. Then, as if on cue, Triad entered with its offer of a joint venture. While some citizens may have harbored reservations about the deal, almost no one wanted to look a gift horse in the mouth.

“People just love that hospital,” says Mary Ann Holser, a retired professor of community health who lives in nearby Eugene and works with the Oregon Health Action Campaign (OHAC). “They built it themselves back in the 1950s, with money they got from holding breakfasts and collecting cans. And they felt betrayed when Sacred Heart was allowed to move into its territory and start taking away patients.” Indeed, McKenzie-Willamette is suing Sacred Heart. At issue is an allegedly exclusive contract Sacred Heart made with a large insurer.

Residents claim that McKenzie-Willamette has a greater commitment to patient care than Sacred Heart does, and Holser, who has used both hospitals herself, agrees. OHAC executive director Ellen Pinney says, “Sacred Heart is one of the hospitals that is always raised up to us as being lax about charity care, and incredibly hard-core about sending folks to collections if they’re uninsured and haven’t paid their bills.”

But loyalty to McKenzie-Willamette and fury at Sacred Heart, strong as they were, comprised only part of the emotional mix. According to Pinney, people also felt out of touch with the powers and processes that determine what happens with their health care. Like the poor of Las Cruces, they put most of their energy into caring for themselves and their families. “They figured the big decisions were being made elsewhere, and there was nothing the community could do one way or the other,” she says.

Equally striking was the element of fear. Springfield is a working-class town, and the loss of a hospital would mean the loss of jobs. Triad’s publicity machine not only tapped into this fear but also conjured a vision of prosperity that became especially compelling. Holser recalls that the company “brought in the suits with stories of hospitals they’ve built elsewhere, and how beautiful these places are and how well they do. Lovely surroundings, great doctors, high quality—they’re very good marketers.”

Cutting through the Tangle of Circumstances

All in all, it looked like advocates would have to content themselves with serious compromises, especially since they did not begin raising questions until Oregon’s attorney general was well into his official review. Instead, they walked away with an impressive portfolio of wins. The AG did approve the transaction, but imposed a series of
conditions, including full charity care for patients with household incomes up to 200 percent of poverty level, and partial charity care for patients with household incomes between 200 and 500 percent.

The ruling “elevates the bar for the whole state,” says Pinney. “Now any hospital looking to go for-profit will have to understand that there is a mandate for a commitment on their part. And we can go back to the table with all the other hospitals, whether they’re converting or not, and say, ‘Why should you guys be providing full charity care at only 150 percent of poverty level when these guys here are providing it at 200 percent?”

Though unexpected, the Oregon victory was no accident. Part of what made it possible was the community-minded AG, who was poised to listen to consumer concerns. But just as significant were the advocates who cut through the dense tangle of circumstances and directed attention to certain points that are key in every hospital conversion, regardless of local history, politics, or bad blood. Such key points include preserving access for the medically underserved, maintaining community oversight of hospital decisions, and ensuring that essential services are continued, regardless of whether they are profitable.

In addition to the generous charity care provisions, advocates’ insistence upon these bottom-line terms yielded the requirement that the hospital continue accepting Medicaid patients. Also, a community-based board of trustees was charged with advising the hospital’s governing board on any changes in essential medical services. Further, the AG provided for community involvement in decisions about where Triad might build a replacement facility for McKenzie-Willamette.

Needless to say, such involvement could make it much more difficult for Triad to fall back on its familiar strategy of siting its hospital in an area where it would attract mostly insured customers.

A Floor, Not a Ceiling

Oregon represents Triad’s first brush with solidly organized community involvement in a joint venture transaction. But advocates elsewhere who wish to shine a light on such deals should view the gains in that state as a floor rather than a ceiling. The truth is that much more can be done.

For example, the Oregon AG did not require that the assets from the Triad deal go into a separate and independent charitable foundation. He ruled that the existing foundation associated with the hospital would be adequate. The problem, of course, is that when Triad takes control of the hospital, it will also take control of the found-
dation, and its decisions about how to handle the foundation's money may be tainted by for-profit interests.

Further, a more thorough look at what the proposed transaction would actually mean for the community might have been commissioned. The letter of the law stipulates only that the AG must make sure both business partners are getting a fair shake, but when a city's hospital system is at risk, that's clearly not enough.

Attorney Carl Patten, also on Community Catalyst's Triad team, says, "One of the main things you need to do is get at the question of how the conversion would impact access to health care for residents, especially the medically underserved." Such an investigation, known as a "health impact study," would ideally be performed by an independent expert, he says, and it takes time—time that, in Oregon, was simply not available.4

Understanding "Assets" - A Highly Effective Approach

The reason a specific focus on health impacts is so critical has to do with the way in which the mission of a nonprofit hospital differs from that of a for-profit hospital, Touzin explains. "Basically, the mission of a for-profit is to make as much money as possible for its shareholders, and so it typically focuses on profitable services and downplays those that won't feed its bottom line, like having to deal with uninsured patients. The unpaid medical bill, for example, is much more likely to trigger aggressive collection activities at a for-profit. The mission of a nonprofit, on the other hand, is to serve people, and it traditionally accepts that not everything it does to serve the community can make money."

Thus, if a hospital is converting from nonprofit to for-profit, the nonprofit's less-than-lucrative obligations must be fully acknowledged and appropriately valued. That means a regulatory and community focus on preserving essential services, including access to free care for the uninsured, and it means making sure that the conversion doesn't suddenly blow local health costs sky high.

In other words, the institution's "assets" must be understood to include services to the community, and those assets must be protected. "When the community and regulators look at a deal," Touzin explains, "it's not enough to just look at the financial numbers. That doesn't begin to compensate a community. You've got to factor in overall institutional behavior including, most importantly, the unprofitable services the hospital is expected to provide because of the institution's longstanding nonprofit status."

Taking such an approach can be highly effective. For example, in a West Virginia bankruptcy court, advocates who, in consultation with Community Catalyst, raised the issue of health impacts saw the sale price of troubled Logan General Hospital increase by more than $15 million. Additionally, the presiding judge required the buyer to maintain charity care levels, keep the emergency room open, and establish a community health foundation.

For-profit encroachment into communities until now wholly served
by nonprofits has made it increasingly difficult to ensure that nonprofit community health obligations are fulfilled. Regulatory oversight is the only instrument for shaping institutional behavior in ways that go beyond mere profit-seeking activity. In addition, as communities seek to preserve the viability of their nonprofits, it’s up to the public sector to set new “rules of the game” that are fair to all institutions, including community-minded nonprofits, while ensuring that community health needs continue to be met.

Preserving the Humanitarian Mission
Notwithstanding such successes, the job of preserving the humanitarian mission of vulnerable nonprofit hospitals is far from over. According to Lopes, one crucial yet often neglected question is whether a particular institution might be able to survive without converting. Even the best foundation cannot compensate for the loss of services that nonprofit health care facilities provide.

“As we’ve come to depend more on more on the marketplace to control access to and quality and cost of medical care, it’s become difficult for many people to distinguish nonprofit hospitals from for-profits. They often behave in the same way,” observes Betsy Stoll, Director of Development and Policy at Community Catalyst. “But there are some very important differences. At least with nonprofits, there are specific things you can hang your hat on that dictate the way they should behave.” What that means is that when marketplace issues interfere with the community’s health care, citizens have recourse. They might appeal to mission-conscious hospital leadership or complain to state regulators. With a for-profit hospital, far fewer such checks are available.

It actually is possible to resist a hospital conversion. Kathy Goss, founder of Save Our Slidell Memorial Hospital (SOSMH) in Louisiana, has proven that. When Tenet Health Systems came to town, intent on buying tapped-out Slidell Memorial, the general feeling was that it was a done deal. But Goss noticed that the papers were publishing quite a few letters to the editor against the sale. Intrigued, she called all the letter writers whose numbers she could find, and those people became the core of her group. With support from Consumers Union, and some community organizing assistance from ACORN (the Association for Community Organizations for Reform), they were soon on their way.

“We started meeting, and I gave out a booklet on community forums5 that I got from Community Catalyst,” Goss remembers. “And one man, who is the president of a homeowners’ organization, took that booklet and ran with it. We held these forums, and we had the people who came sign in so we could generate a phone list and a mailing list. Then another guy, who is a webmaster, put together a website for us virtually overnight. We worked constantly to provide links to things that were important, and I took a lot of the research I had been doing and turned it into charts that people could look at on the site. We also, just in our own social circles, spread the word about SOSMH.” In the end, Goss and her cohorts were able to stop the conversion. This spring, in a public vote, Tenet’s bid to purchase the hospital was roundly defeated.

More recently, Triad itself has run into serious trouble in Alabama, where it had applied for a license to move Crestwood Medical Center out of Huntsville, an area with high rates of uninsured, into Madison, a city full of young professionals, such as engineers and computer experts, with enviable health insurance. Triad pulled out all the stops, hiring a former Democratic state senator-turned-lobbyist to push the deal, paying for a bus to carry supporters to the license hearing, and overwhelming hearing officers with 13,000 petitions in favor of the new hospital. But community members came together and handily defeated Triad’s well-oiled machine. The license was denied, and access was maintained for the medically underserved.

Triad has also faced a setback in Birmingham, where the board of the city’s Baptist Health System called off a deal. Local people wanted to retain control over their hospitals, and they were reluctant to relinquish Baptist’s faith-based principles.

A Call to Arms
To be sure, valiantly beating back Triad does not make sense in every situation. “If a conversion is denied, but then a hospital goes out of business and there’s reduced access to health care, that’s not a victory for us,” says Patten. “Our main goal is to maintain and increase access.”

Lopes and Stoll would be among the first to agree. And the fact that conversions really are unavoidable in some cases may be the biggest reason why the conditions set forth in the Oregon AG’s ruling are so important. They hold out the hope that communities and regulators can secure specific protections against the most harmful effects of the current trend toward for-profit conversion.

As these cautionary tales make clear, overtures from a corporation like Triad should trigger certain protective moves. Its focus on the bottom line and its obligation to its shareholders are bound to clash with a small community hospital’s mission. Its strategy, of siphoning off the best-insured patients while avoiding those who are sicker, lower-income, and often less-insured, actively undermines nonprofit hospitals that are
trying to fulfill a community health mission. The overemphasis on state-of-the-art technology, the discontinuance of essential but unprofitable services, and the relocation of facilities may leave a community without options, access, or oversight—or even without a hospital.

Nor is this a question of a single company or a single transaction. Other predator companies share the kind of “haves and have-nots” analysis that drives Triad’s approach. The public sector must respond in kind. Health care regulators must ground their oversight on the premise that the health system must meet the health needs of the whole community.

Just as the for-profit Triads have looked at our health systems and figured out how to make the numbers work for their shareholders, regulators must also engage in system-wide calculations. But they must undertake the “algebra” of health impact: services needed that generate little revenue; families working but unable to afford health insurance; and communities affected if their services are eliminated.

We are all at risk without this kind of public sector oversight. And it must be proactive intervention, driven by regulators committed to protecting community health systems. Nor is it enough to rely on state and local regulators. Community members themselves must get the facts, raise questions, and demand public sector action. Only if they are armed with information and empowered to speak can they ensure that their own best interests will be served.

Notes

1 The newly-enacted Medicare drug benefit law might change that somewhat, especially for rural hospitals.

2 Required State Agency Findings Regarding Certificate of Need Application from Good Hope Hospital, North Carolina Department of Health & Human Services; September 26, 2003; Project Analyst: Andrea C. Phillips; Chief: Lee B. Hoffman; Project ID No. M-6801-03; Good Hope Health System, L.L.C.; Replacement of Existing Hospital; Harnett County. The exact language of the Certificate of Need requirement is: “…the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and must demonstrate the effect of the reduction, elimination, or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.”

