Columbia/HCA: A Failure Of Leadership

Columbia/HCA’s agenda was to become a $50 billion company, not to reform the delivery of health care.

by Jeff Goldsmith

Within a confusing health care marketplace, sometimes illusions are more comforting than the realities they mimic. Capitalism itself is not a pretty sight. What Schumpeter called “creative destruction” sounds much better than it looks, when one grasps the realities of the ruined lives, fortunes, and franchises involved. Yet in evaluating the legacy of a company like Columbia/HCA, separating illusion from reality is particularly important.

The demise of Columbia/HCA had all the earmarks of a Sophoclean drama, in which an arrogant protagonist was punished for his hubris. The company certainly cut a wide swath in a conservative industry. This was a company whose marketing executives disrupted hospital association meetings with paint guns and whose senior management proclaimed the Three As—acquire, affiliate, or annihilate—as their corporate partnering philosophy. The Oakland Raiders’ motto “Just Win, Baby!” would probably have been the most accurate characterization of management’s message.

J.D. Kleinke’s thesis that Columbia/HCA was punished by a vengeful federal government for preemptively “reforming” the health care system reads much more like a failed Oliver Stone movie pitch than a story of miscarriage of justice by reactionary health policy. It is hard to argue with much of his critique of our health system’s unfinished business: excess capacity, antiquated payment methodologies, misaligned incentives.

However, to characterize what Columbia/HCA was attempting to do as “reform” not only reveals a fundamental lack of understanding of the company’s goals, values, and operating philosophy, but also insults those who advocate real reform. Columbia/HCA simply encouraged its managers to “push the envelope” of legally permissible business practices to grow the company’s earnings. The story is no more complicated or socially meaningful than that.

Management innovation was not Columbia/HCA’s strength. The company had an overextended and marginally capable management, notably thin and unstable at the critical regional level. There were a few authentic management innovations for which the company should be credited. Outsourcing its information technology to a commercial vendor was unique to Columbia/HCA, as was its strategy of using physician partnerships to facilitate facility closure and market consolidation. However, the company’s physician partnership strategies themselves, its conglomerate-style diversification, its dabbling in health insurance, as well as its forays overseas echoed failed strategies of an earlier generation of hospital management firms, many of which Columbia/HCA came to own. What distinguished it from its predecessor firms was not the uniqueness of its strategies but the frankness and rapacity with which it pursued them.

Kleinke’s characterization of Columbia/HCA’s strategies reads like a Classic Comics rendition of their story for Wall Street analysts, many of whom were too young to remember the earlier corporate failures. True
enough, Columbia/HCA was the first firm to buy and close facilities in overbedded markets. Its initial successes in El Paso and Miami provided the burst of revenue growth that fueled its acquisitions of Galen, HCA, and Health Trust. The problem was simply that the company was unable to execute the strategy anywhere else (Dallas, Houston, and Chicago bear study here). After the Health Trust acquisition in 1995, Columbia/HCA shelved the “buy and consolidate” strategy because it discouraged non-profit boards, which did not want their facilities closed, from selling to Columbia/HCA. The company’s senior management also had become arrogant enough to believe that they had enough capital and staying power to be able to close other people’s hospitals, so why close their own?

Indeed, in some overbedded communities such as Irving, Texas, Columbia/HCA was building new facilities to compete with hospitals that spurned its advances. In other markets the company was building new specialty hospitals to peel away profitable specialty physicians (orthopedic surgeons and obstetricians) from facilities that refused to sell to Columbia/HCA. All of these new facilities were in attractive suburban markets with significant residual indemnity health insurance. Meanwhile, existing Columbia/HCA facilities were being starved of capital in order to fund the company’s acquisition strategy. At the time of Columbia/HCA’s implosion, the company had ten completely new hospitals in the planning stages. To characterize them as market consolidators ignores the last three years of Columbia/HCA’s development strategy.

On its integration strategies, studying Columbia/HCA’s market performance is also important. In south Florida during the early 1990s, Columbia/HCA was claiming to analysts that it was achieving 5–10 percent annual growth in its hospital admissions. In my consulting experience, market-share gains of this magnitude are extremely unusual. I believe that these gains were the direct result of the incentive embodied in its physician partnerships to end physician splitting of admissions with non-Columbia/HCA hospitals. “Alliances for cost containment” the partnerships were not. They were a sophisticated form of a long-standing investor-owned hospital practice of offering financial inducements to physicians (medical directorships, subsidized office rent, and so on) in exchange for steering their business—a barely legal but ethically indefensible cousin of fee splitting.

Where Columbia/HCA’s franchises were not credible investments for physicians (or anyone else), such as in southwest Florida, the company’s next strategy was simply to purchase physician practices outright and set admissions targets for acquired physicians (which is accountably legal under physician self-referral laws). At the time of Columbia/HCA’s crash, the company owned roughly 2,700 medical practices. These acquisitions set off a chain reaction of purchases by nonprofit competitors anxious to avoid losing admissions. Reducing health costs played no meaningful role in these strategies; quite the reverse was true.

Kleinke seems reflexively critical of federal fraud and abuse regulation. These laws were enacted to protect consumers and taxpayers from unnecessary or inappropriate health care, not to thwart meaningful reform of the delivery system. The protections are pathetically inadequate, given the “state of the art” in physician “bonding” strategy. The more one learns about the magnitude of abuse in many markets, the more one supports tighter laws and better enforcement.

Columbia/HCA’s partnerships were not directed at aligning incentives for capitation. The company had almost no capitated revenue and was perfectly comfortable with discounted per diem payment. The firm’s *modus operandi* was to aggressively exploit the incen-
tive structure of existing reimbursement methodology. Few, if any, purchasers in Columbia/HCA’s markets (or anywhere else, for that matter) were interested in “one-stop shopping” for health services.

Although Columbia/HCA’s regional managers did have responsibility for such nonhospital services as home health care or ambulatory surgery, these services were operationally distinct from their hospital business. Scant effort was made to “integrate services across a continuum of care.” Where economic incentives to grow any of those businesses made sense, they were offered to physicians. To compare Columbia/HCA’s integration strategy with that of authentic, value-driven, integrated health providers such as Kaiser or Group Health of Puget Sound is insulting to these organizations, which actually are reshaping care processes under global health risk.

At the policy level, it is puzzling that Kleinke interprets the outcome of the Clinton health reform debate as a de facto public mandate for “market-based” reform by medical corporations. The lack of public enthusiasm for managed care, and corporate medicine generally, argues otherwise. It is more accurate to argue that the public opted for no reform at all. Guided by a hostile press, Americans have come to believe that corporate medicine, tax-exempt or tax-paying, is really about money, not about meeting their needs. “Reform” this is not.

However, the most troubling aspect of Kleinke’s critique is its almost exuberant moral relativism. He virtually concedes that the company bought physician referrals, padded its home care charges with corporate overhead and unjustifiable markups, and systematically inflated the intensity of its services to Medicare patients. But this is acceptable because the laws need changing, and anyway, “everybody does it.” He cites a recent press account of the Daughters of Charity as evidence of new business norms in health care that transcend the for-profit/nonprofit divide. These facile comparisons slander the Daugh-

ters and their sister organizations.

Not everybody does it, Mr. Kleinke. For someone who has worked extensively with investor-owned and not-for-profit systems, it is easy to distinguish truly value-driven organizations from mere opportunists. Values matter, in this or any other corporate field. Regardless of whether they pay taxes or not, health care enterprises are part of a community and society and cannot operate in a moral vacuum, awaiting enforcement actions to determine if their conduct was acceptable. Translating corporate values into acceptable business practice is the task of leadership. What Columbia/HCA’s story is ultimately about is the failure of leadership.

Columbia/HCA’s agenda had nothing to do with “reform.” It was simply about becoming a $50 billion company. Kleinke’s sophomoric essay does little to illuminate this company’s societal impact. It is an iconoclastic and poorly researched apology for a management that betrayed the trust of its shareholders, patients, and 260,000 workers. In Columbia/HCA’s case, the facts matter plenty. Kleinke owes it to himself and his readers to gather some. The issues he raises deserve serious study, and a couple of months spent in a couple of Columbia/HCA’s markets interviewing market participants and gathering data would be a useful place for him to start. What he will discover is that the reality is considerably messier and uglier than the myth of market reform thwarted, which he foists upon the readers of Health Affairs.