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SUPERSIZED MEDICINE

As hospitals merge into major systems, the benefits to patients are uncertain

BY EUGENE L. MEYER

Alenna Gonzales, 25, was 20 weeks pregnant with twins when she experienced internal bleeding. She entered the small hospital near her home in Queen Creek, Ariz., outside of Phoenix. But the hospital was not equipped to deal with her high-risk condition, so she was flown by helicopter some 30 miles to Banner Desert Medical Center in Mesa, where specialists were waiting with her full medical history in hand.

Gonzales was quickly wheeled into surgery, where her cervix, already 3 centimeters dilated, was stitched up, and she was put on bed rest at the hospital until she was deemed able to go home for the duration of her pregnancy. They kept “round-the-clock checks on me,” Gonzales says.

By being treated in a large multi-facility system, the expectant mother had easier access to more advanced care than she would have had a few years ago. She was able to move seamlessly from one hospital to another because both were part of the consolidated Banner Health system, which includes 23 hospitals in seven Western states, from Arizona to Alaska.

According to the American Hospital Association, more than half of U.S. hospitals now belong to multi-hospital systems, accounting for over 60 percent of all patient admissions. Many of these systems cross a number of states; others cover local regions.

The move toward consolidation began in the 1990s. Hospitals had started to receive smaller payouts from insurers, says John Hensing, executive vice president and chief medical officer of Banner Health, so they looked to consolidation to increase their negotiating leverage. More than 900 mergers and acquisitions would occur in the ensuing two decades. Those consolidations boosted hospitals' bottom lines, but prices continued to rise far more than inflation, notes Lee Sacks, chief medical officer and executive vice president of the Chicago area's Advocate Health Care. Two key factors contributed to this. First, there was a drive by competing systems to invest in expensive new technologies to bring in new patients. Second, healthcare providers participated in “fee-for-service” programs that rewarded

them financially for performing more tests and procedures. Studies have shown that this “more is better” approach did not result in improved patient care.

More recently, Hensing, Sacks, and others say, some mergers have led to improved medical outcomes for patients, and the 2010 Affordable Care Act may encourage better cost controls. At Advocate, the largest health system in Illinois with 12 Chicago-area hospitals and one downstate, coordinated care is being increasingly emphasized in partnership with BlueCross BlueShield of Illinois. “Our expectation is this will help us bend the cost curve,”

says Sacks. “The goal is to get increases in line with inflation.”

Despite some signs that patients may benefit from hospital mergers, significant concerns remain. Here are some of the changes—positive and negative—that consumers may experience over the next few years.

Improved record-keeping. In the case of Alenna Gonzales, Banner's use of system-wide electronic medical records, a \$200 million investment, paved the way for her 3 a.m., 45-minute surgery. There was no need for her to fill out new



GETTING CARE IN A NETWORK MEANT STEVEN RIVKIN'S INSURANCE WAS ACCEPTED.

forms. The doctors already knew what they had. “The advantage of the system is improved communication,” notes Curtis Cook, medical director of maternal and fetal medicine at Banner Desert. System-wide standardization of care—what he calls the checklist approach—also benefits patients. “It eliminates the number of human errors,” he says.

Starting this year, institutions that are “meaningful users” of electronic records can get higher Medicare and Medicaid payments, and beginning in 2015, those that aren't will get less. Many have a long way to go. Currently, fewer than half of U.S. hospitals are close to meeting the government's high standards, notes Protima Advani, director of strategic re-

search for the Advisory Board Co., a Washington, D.C.-based consulting and services firm.

Wider insurance coverage. Steven R. Rivkin, 74, a semi-retired lawyer in Bethesda, Md., was desperate to find a primary care physician after two doctors stopped taking his medical insurance. "I felt somewhat bereft," says Rivkin. Then he found a group of physicians associated with Johns Hopkins Medicine who accepted his plan. Hopkins, the highly ranked Baltimore-based medical system, now encompasses five hospitals around Baltimore and Washington, D.C., and a sixth in St. Petersburg, Fla. Hopkins also is affiliated with some 30 community physicians groups in Maryland.

When hospital consolidations lead to alliances with physicians' groups, more insurance plans are likely to be accepted. In the end, it's all about the reimbursement rates. The larger the group, the more negotiating clout it has. "That is clearly part of the appeal of being part of a larger system for independent docs—access to better rates and system scale," says Chas Roades, the Advisory Board's chief research officer.

Access to specialists. For at least some patients, the growth of hospital systems has provided lifesaving opportunities to be seen by the top doctors in their field. Cheryl Lynch, 56, of Mentor, Ohio, had gone to her local hospital in suburban Cleveland for a mammogram, which resulted in a breast cancer diagnosis. The biopsy did not go well; it took two hours. Dissatisfied, she sought more specialized care at the Cleveland Clinic. The sprawling 180-acre complex of 50 buildings—each with a special medical mission—is only part of a system serving northeastern Ohio (through nine community hospitals and 18 family health centers) and other locations (with satellite facilities in Florida, Nevada, and Canada).

Lynch saw a breast cancer specialist, and "before I knew it, I was having a double mastectomy," she says. "They are so good at coordinating things. They organize it all." That was in September 2009. Then, after her younger sister was found by doctors in Toledo, Ohio, to have ovarian cancer, Lynch once again sought specialized care, going for genetic counseling at the Cleveland Clinic's suburban reproductive health facility. Learning that she carried the same cancer gene, she opted for a hysterectomy, done at the Cleveland Clinic last summer. Early-stage ovarian cancer was discovered during the surgery, but after another procedure, Lynch is doing fine. The coordinated care she received "saved my life," she says.

Clash in values. Sometimes mergers can lead to clashes in missions and values, particularly with religious institutions. Of the nation's seven largest systems, five are under Catholic auspices, according to a 2009 survey by the industry journal *Becker's Hospital Review*. The largest of these, Denver-based Catholic Health Initiatives, has 72 hospitals in 19 states. The church's involvement is testament to its dedication to healing the sick, but Catholic hospitals in the United States are governed by the Ethical and Religious Directives for Catholic Health Care Services laid out by the U.S. Conference of Catholic Bishops. These guidelines

prohibit abortion, sterilization, in vitro fertilization, and some other reproductive health services. This can have important consequences for patients seeking these services where hospital choice is limited.

In November 2010, a woman 15 weeks pregnant, who had miscarried one of the twins she was carrying, arrived at the emergency room of the Sierra Vista Regional Health Center in Arizona. Sierra Vista, a non-Catholic institution located in the town of the same name, had recently joined the Catholic Carondelet Health Network. The hospital doctor who saw the woman determined that the other twin would also not survive. The hospital administration, however, citing the church directives, would not permit the staff to carry out the procedure needed to complete the miscarriage. So, the physician, Robert Holder, arranged for the woman to travel some 80 miles by ambulance to a Tucson hospital to have the procedure. The case caused a local uproar; after a year-long citizens protest, the hospital disaffiliated from the Catholic system this spring. (Carondelet declined a *U.S. News* request for an interview about the case.)

MergerWatch, a New York-based nonprofit organization focused on partnerships between secular and Catholic hospitals, has had some success in its efforts to maintain reproductive services at such institutions. Sometimes, this entails having the non-Catholic hospital establish separately incorporated facilities, occasionally even coexisting in the same building. Lois Uttley, the group's director, says the need for creative solutions is greater "because there is an increasing number of these mergers going on."

Reduced competition. There is another potential downside to hospital consolidations: An anticompetitive environment could develop. The result? "Consumers will pay more through the health insurance premiums they and their employers pay," says Paul Ginsburg, president of the Washington-based Center for Studying Health System Change.

Underscoring such concerns was the purchase in 2000 of Highland Park Hospital by Evanston Northwestern Healthcare Corp.; according to the Federal Trade Commission, it led "immediately and substantially" to a jump in hospital prices. The FTC later ordered the two groups to negotiate separately with insurers. In March of this year, a federal judge in Toledo, Ohio, granted the FTC's request for a preliminary injunction against the ProMedica system's acquisition of a seventh hospital in the greater Toledo area on antitrust grounds.

As these cases reveal, hospital consolidations can be a double-edged sword from a patient's perspective. They can result in better treatment—and in some cases already have. Yet, to the extent they reduce competition, they can also lead to higher prices and fewer choices. If the new healthcare law rewards hospitals for patient outcomes (and not for padding profits through high-volume procedures and investments in pricey technology of dubious value), then patients could benefit from the flood of mergers. But it will take several years for the results to fully be known. ●

Consolidations boosted hospitals' bottom lines, but prices kept rising beyond inflation

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