Is the Prescription Worth the Medicine?

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In recent years, Columbus' major hospital systems - Ohio Health, Mt. Carmel, OSU Medical, and Children's Hospital - have experienced an explosion in facility construction. Considering real and anticipated expenditures over the past three and next three years, the hospital systems will have collectively spent $2.6 billion on new in-patient towers and out-patient campuses.[1] This amount does not include the hundreds of millions of dollars spent on routine capital upgrades and other ongoing investments. According to the Deloitte accounting firm, the Columbus region's per capita hospital construction spending is the highest in the nation.[2]

During this time, two of Columbus' health care systems achieved profit margins more than double the national median for non-profit hospitals. Ohio Health experienced a 9.3% operating margin on $2.5 billion in revenue -- five points higher than the national average -- and OSU Medical had an operating margin of 8.3%.[3]

Concurrently, the region's employment in the health care industry grew by over 38% during the past 10 years to approximately 120,000 workers or 13.5% of our region's workforce.[4]

By their own estimates, the economic impact in 2011 of our local hospitals was a staggering $11 billion.[5]

Clearly, our regional health care system has become big business. It is a significant economic engine creating jobs, investment, and national recognition while attracting highly skilled and compensated professionals and drawing new patients to our region. Indeed, our business, civic and elected leaders tout the region's health care industry as an indicator of our economic success and future. And why not? It seems the only construction cranes in Columbus over the past several years have been at hospitals.

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[1] "Hospitals Buck National Trend," Business First, November 16, 2012.

[2] Id.

[3] "Hospitals Flying High, But Good Times May Not Last," Columbus Dispatch, November 23, 2013.

[4] William LaFayette, Ph.D., "Healthcare Employment in Ohio," Hannah News Service, February 8, 2013.

[5] "Local Hospitals' Economic Impact Put at $11 Billion," Columbus Dispatch, August 29, 2011.

However, can this growth model of hospital facility expansion be sustained? Most experts say no. On average 57% of all hospital revenues are from the federal government,[6] which is changing reimbursement formulas, dealing with budget deficits and trying to move the health care paradigm with the implementation of Obamacare.

Have the construction investment decisions been wise ones, the right ones? Our hospitals are increasing the number of hospital beds when federal government policy is going in the opposite direction - keeping people out of hospitals. Hospitals are building massive out-patients facilities in close proximity to their competitors' existing hospitals causing stress on balance sheets. There are only so many patients to be served. From the broader perspective a central question arises: has the *value* of our health care truly increased?

And, what about the long-term impact on economic development - our region's ability to attract new companies while enabling local companies to expand and create new jobs? Is the massive expansion of our hospital system the right economic development policy; does it produce the best bang for the buck? What impact does this have on the cost of doing business, and how do such costs compare to other regions that Columbus competes against for relocating companies?

These are the questions I will explore tonight with a focus on the last one - the economic development ramifications, because in part the hospitals are touting their expansion strategy's justification in those terms, and also because federal and other subsequent changes in health care are coming - and in some cases have already arrived - that will significantly affect hospitals' operations.

Let's start by reviewing the modern-day roots of Central Ohio's hospital system.

In April 1956, Edgar Wolfe, Sr. hosted a meeting of business leaders to seek financial commitments to build a modern-day hospital system in Columbus. This was not first time he convened a business group for the advancement of a civic agenda. After World War II, he did the same to successfully lay the financial ground work for massive infrastructure construction in Columbus for post-war growth. During the 1956 meeting, he noted Columbus' progress since then, and the business group's role - then called the Metropolitan Columbus Committee - in its success by stating: "Two simple words tell the story: Vision and Leadership."[7]

During the meeting, Mr. Wolfe stated that the current hospital facilities were "inadequate, outmoded, and in all too many points unsafe to meet population growth. Previous efforts by hospital supporters to raise the necessary funds were woefully inadequate."[8] So, he took the lead

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[6] "Annual Survey 2011," American Hospital Association.

[7] "Origins Of The Columbus, Ohio Hospital System," transcript of a speech made by Mr. Edgar T. Wolfe, Sr., April, 1956.

[8] Id.

to achieve his vision for a modern-day hospital system by obtaining state-law changes to permit the creation of a County Hospital Commission that issued bonds purchased by companies represented in the room. Two new hospitals were built - Riverside and Grant - and existing hospitals were expanded and upgraded.

Furthermore, the new funding mechanisms championed by Mr. Wolfe enabled private operation of hospitals to continue rather than build a county or municipal-operated hospital, which he strongly opposed. The deal was for the existing and new hospitals to share in the cost of charitable cases rather than have a public hospital do so. This model, which has served our community well, still holds true today with four major hospitals providing $195 million in free care to the uninsured in 2011.[9]

Edgar Wolfe's private-sector leadership in health care and his "measures of control" continued through his son, John Walton, better known as JW. He established the Central Ohio Health Coalition to keep hospital proliferation in check and by preventing unnecessary and expensive hospital construction by what JW then-described as "egotistical hospital CEO's building their kingdoms."[10]

In the void left after JW's death and the subsequent demise of the Health Coalition, a national expansion in health care enabled our local hospitals to build and grow into what now is described as a nuclear arms race in construction without state and local checks and balances. Experts acknowledge that our hospitals are competing without collaborating with each other. There is no coincidence that hospitals are building major outpatient facilities next to competitor's buildings, siphoning patients and resources. Ohio Health built a large outpatient facility in Westerville that competes with St. Ann's Hospital; Mt. Carmel purchased land in Dublin to build an outpatient facility that will compete directly with Dublin Methodist hospital; both Mt Carmel and Ohio Health are building major facilities in close proximity to each other in Grove City; and, most recently, OSU announced plans to convert the James Cancer research building into a dedicated facility for brain and spine specialties that will compete with Ohio Health's new $321 million neurological hospital now under construction at nearby Riverside Methodist Hospital.

What's going on here? Is this a thought-out approach to the region's health care? Does it make long-term financial sense? It appears that we are seeing up front and personal the competition for patient share -- especially in higher-profit specialty areas due to insurance coverage and higher reimbursements. Competition benefits the consumer as long as the insurance companies continue paying for the specialty health services (which many doubt), and the hospitals can continue to fill beds (which is discouraged in Obamacare). But if that scenario doesn't continue, what happens with the debt load, operational expenses, and fixed overhead, and who pays for them? Ohio Health CFO Michael Louge acknowledged the problem in stating "In the future,

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[9] Statement by Central Ohio Hospital Council, February 8, 2103.

[10] Jackie Fullerton, CEO,Central Ohio Health Coalition, 1997.

there's not enough money in the system to pay for these services given the known and unknown changes coming in health care."[11]

Dr. Ted Wymyslo , director of the Ohio Department of Health, was recently quoted as saying "I hope we're not building any more specific towers at hospitals for specific diseases to fill with patients that businesses are going to have to pay for."[12] Ah yes, the business community - the primary target of economic development strategies and primarily creator of jobs. We'll get to this later.

And as importantly for our community, who's asking the tough questions? Who's demanding answers and accountability? Who's looking out for the long-term economic interests of our region? Where's the vision and leadership that Edgar Wolfe fostered over 50 years ago?
To better answer these questions, let's examine the reasons behind the tremendous expansion in hospital construction.

Beds

An obvious result of new and existing hospital facility construction is a 15% increase in the number of hospital beds.[13] This sounds good until you realize that health care is headed in the opposite direction. Under Obamacare, hospitals are incentivized to keep people out of hospitals. They'll be penalized if a patient is re-admitted to the hospital within 30 days. Concurrently, businesses are placing more emphasis on wellness programs as a means to lower (or at least stabilize) insurance costs and thus keep employees (and their families) out of the hospitals. So why is the number of beds increasing? OSU for example is adding 300 critical care and cancer beds even though they acknowledge that federal reimbursements are expected to shrink.[14]

The increase in beds is primarily in specialty areas such as heart, cancer, and neurology. Such beds provide a higher-profit margin because patient expense is likely covered by commercial insurance. In turn, hospitals target patients who can afford the treatments. While there may not be a glut in *general* hospital beds, some would argue that there is a looming glut of *specialty* beds expected with the potential dramatic changes in health care.

A hospital CEO who works outside Columbus yet is very familiar with our market, believes that health care is headed back to the days of the preeminent primary care physician, with hospitals serving the very sick except for maternity wards. His prediction is that specialty hospital beds and doctors will shrink significantly given the changes in government reimbursements and insurance payouts and the concurrent smaller pool of patients who can afford such services.

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[11] "Hospitals Flying High But Good Times May Not Last," Business First, November 23, 2012.

[12] "Health Department Chief Questions Hospital Building Boom," Business First, December 12, 2012.

[13] " Hospitals Buck National Trend," Business First, November 16, 2012.

[14] "For Hospitals, Heavy Lifting Comes Net for Implementing Health Care Reform," Business First, June 28, 2012.

From his perspective, Columbus' hospitals - with their significant debt and ever-expanding specialty beds - face a fiscally challenging future.[15]

Market Share - "who's going to fill the beds"

If a hospital increases its number of beds, then it must find patients to fill those beds. Ohio Health CEO David Blom stated that the pressure to fill beds at hospitals is high now.[16] Thomas Campanella, director of Baldwin Wallace University's MBA health care program, added that this pressure, combined with long-term shrinking reimbursements due to federal budget deficits, are "making market share even more vital."[17]

Hospitals are fighting for increased market share using two primary tools: advertising and doctor referrals. Our region's four hospital systems spent a combined $10 million in advertising in 2010, up 18% from the previous year.[18] You can't help but notice the billboards, TV ads and other media touting the national rankings of our local hospitals. Last year OSU launched its first statewide advertising campaign to bring in more patients from outside the region. And its longer term plan is to increase the number of national and international patients.

The second tool used to gain market share is through doctor referrals. Thus we are witnessing an ever-increasing number of doctors becoming employees of hospitals and doctors' groups affiliating with hospitals. Jamie Cleverly, a local hospital consultant, stated that patient preference will remain a significant driver of hospital choice, and that "preference mostly starts at the physician level."[19]

Gaining market share through physician affiliation also has the potential downside of physician poaching. While some argue that the practice of recruiting doctors from one hospital to another has been going on for years, the stakes have increased to the point that Ohio Health filed a law suit against seven cardiologists who moved from Ohio Health to OSU. Not coincidentally, the former CEO of Mt. Carmel is now employed by Ohio Health to recruit doctors, and the former head of Berger Hospital in Circleville now works on regional hospital and doctors relationships for Ohio Health. The intense competition for patients results in a prolonged lack of meaningful collaboration among hospitals. In discussing physician poaching, David Blom stated that the result is an "escalation of health care costs that the business community ultimately pays."[20] (Yet another mention of the business community bearing the price and its impact on economic development.)

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[15] Interview with Mark Shuter, President & CEO, Adena Health Systems, March 10, 2012.

[16] "Hospitals At Odds On Physician Poaching," Columbus Dispatch, June 17, 2012.

[17] "Market Share May Be Key For Hospitals In Reform Era." Business First, April 15, 2011.

[18] "Hospitals Use Ads To Widen Reach," Columbus Dispatch, June 4, 2012.

[19] "Market Share May Be Key For Hospitals' Reform Era," Business First, April 15, 2011.

[20] "Hospitals At Odds On Physician Poaching," Columbus Dispatch, June 12, 2012.

As hospitals fight to increase market share, a corollary question arises: just how big and expansive is the patient market? Certainly it is not endless. While the Columbus hospitals extend their reach into other counties, other hospitals from adjourning metropolitan regions are doing the same and thus competing for the same patients.

Quality and Price

For the $2.6 billion spent for new and expanded facilities, what do the hospitals have to show in terms of providing and improving health care, which is their mission? When it comes to quality and price, the answer is "not much." According to national data, our local hospital systems are not delivering value.

In terms of *quality*, Columbus ranked in the bottom third - 207th out of 306 communities surveyed - according to a national study by the Commonwealth Fund, a private foundation that studies health-care policy reform.[21] Cities were ranked in categories of access, prevention and treatment, potentially avoidable hospital use, and cost. For cities in Ohio, Columbus ranked next to last, barely ahead of Youngstown.

In terms of *price*, the Center for Regional Competitiveness produces an annual national health care pricing index for participating regions, which includes Columbus. The index is based on five health care items in addition to office visits, and prescription and non-prescription drug prices. In the 1990's Columbus was below the national average in pricing by 2 to 10 points; however, in the first decade of this century we were above the national average by 2 to seven points, and as recently as 2010 Columbus had the highest cost index of any region in Ohio. In the preliminary 2012 data, our price index decreased but remains above the national average.[22]

Let me be clear: I am not targeting hospital CEO's as the culprits in this scenario. Our local hospital executives are excellent administrators with a passion for their business, employees and patients. We are fortunate to have them as heads of our local hospital systems.

Furthermore, it is a valid argument that hospitals need continuous capital upgrades and retrofits to deal with increasing technologies and consumer demands. Obtaining new equipment, building private rooms, and attracting top-notch doctors require significant capital expenditures. The analogy is similar to a factory that must constantly evolve its machines and workforce to stay competitive.

Yet, I do believe that our region's hospitals are trapped in a cycle of expansion for expansion's sake. In this exceptionally competitive environment, hospitals feel they cannot risk falling behind their competitors, so duplicate facilities are built and redundant services are offered. The

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[21] "Rising To The Challenge: Results From A Scorecard On Local Health Care Performance," Commonwealth Fund, 2012.

[22] Information contained on website (creconline.org) of Center for Regional Competitiveness.

community has also enabled this cycle, becoming more focused on creating health care jobs without considering long-term ramifications and trends. Unfortunately, there is no external check and balance structure to study the issue, challenge the assumptions, and consider what's best for the region's long-term economic interest. The process of "Vision and Leadership" that Edgar Wolfe cited is not evident in the current model.

Economic development

So, back to the key question: what impact does health care costs, quality and access have on economic development? For purposes of this essay, I define economic development in the traditional sense: the attraction of new companies/jobs, the retention and expansion of existing companies/jobs, and the creation of new companies.

Let's examine the question from two perspectives: micro - an individual company that is considering locating to Central Ohio or an already existing company in our region that is considering expanding here; and macro - the collective economic development strategy of a region to attract new companies, expand existing companies, and encourage start-up companies.

Micro

The cost of doing business is usually the number one factor in a company's decision to expand in or relocate to a specific region. The cost calculation is comprised of multiple factors: workforce - does the region have a readily accessible and qualified workforce to meet the companies needs and/or does the company have to incur additional training expenses; taxes; and, proximity to markets are some examples. In addition to cost, other factors in a company's decision have emerged that are important to a company's ability to move existing employees and recruit new employees from outside the region. Examples include: quality and choices of local schools in multiple neighborhoods, culture; worship centers for diverse religions; quality of life; affordability of a community; proximity to and quality of institutions of higher education; and, non-stop airport destinations. Also included in this group are accessibility and quality of health care.

Health care cost is the #1 concern of businesses according to a Columbus Chamber of Commerce polI.[23] In the past however, the *value* of health care was not a factor in a company's relocation and/or expansion decision, due to the difficulty of obtaining data for the analyses and in turn comparing it with competing regions. A site selector told me that taxes are less an issue and expense compared to health care costs. Yet, tax information is readily available and the comparative data from regions can be factored into the decision-making process. While health care was seen as uniformly expensive everywhere, the site selector couldn't access the data and therefore couldn't perform a similar analysis. Information from hospitals and insurance providers was considered proprietary and thus wasn't shared. It also was difficult to determine value because of the data's complexity. According to economic development professionals, health care costs are important to a company's expenses and operations; however, they were not

[23] "Columbus Chamber Survey..... Tops Election Issues for Business," Business First, October 13, 2012

a determinate in selecting regions to relocate or expand operations, simply because the data wasn't available.

That is now changing due to business demands for the information, technology that can disseminate and analyze the information, and federal health care reporting requirements. Thomas Campanella of Baldwin Wallace University stated that major Columbus employers have not previously pushed for the data, but "because of higher health-care costs and integrated networks, that's going to have to happen."[24] In other words, business are going to be playing - and have started playing - a more significant role in securing and analyzing the data. Other cities/regions already are aggressively compiling the information.

If a site selector and/or a company can determine the value of a region's health care costs, then they now have new and valuable information in the decision-making matrix of selecting a location for expansion. And, if a region can compile and provide such information, then it has a competitive advantage in economic development over regions that cannot provide such information.

In Cincinnati for example, the business community - led by large employers Procter and Gamble and General Electric - is building a health information infrastructure that compiles and analyzes value and cost. As an economic development tool, the information is shared with local companies that may be considering relocating. The data is also shared with site selectors and out-of-town companies considering a move to Cincinnati.

How is such data a competitive advantage for Cincinnati over Columbus? Let's say that a site selector and/or company have narrowed their choice for a relocation/expansion between Columbus and Cincinnati. In comparing the cost of doing business in the two cities, Cincinnati will have actual data to share about the expense and value of its health care that can be used in analysis to help in decision making. Columbus does not currently have such data to offer. Instead, we tout the high national rankings of our hospitals, which are often subjective and conjectural. A site selector told me that he's been to over 50 children's hospitals around the county, and all claim to be rated in the top 10 in the country. The point is that to site selectors and corporate decision-makers the multitude of national rankings is not of intrinsic value, while real data is.

From the micro prospective of economic development, health care value is an emerging component of a company's decision-making process to expand or relocate its operations. Regions that can produce such data have a competitive advantage.

Macro

As businesses drive efforts to obtain the data for their company's use, economic development organizations are in turn using the data as a business attraction and expansion tool. This is the

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[24] "Market Share May Be Key For Hospitals In Reform Era," Business First, April 15, 2011.

macro side of the economic development equation, which I define as a region's collective strategy towards attracting, retaining and expanding the health care industry and its jobs.

Over the past twenty years or more, every region in the nation has produced an economic development strategy. Traditional economic development strategies focus on identifying and deploying a region's existing or potential assets toward attracting new companies into the region, helping existing companies expand, and creating a favorable business environment where entrepreneurs thrive. Outside - and often highly paid - "experts" are usually brought in to assess the region, articulate the economic opportunities, and develop a sustainable plan for growth and prosperity.

While Columbus has had many economic development studies and strategies over the past 30 years *[if you performed a SWOT analysis of Columbus, the region's strength would be our ability to undertake studies while the weakness would be our inability to implement and/or sustain them],* a serious effort was initiated approximately seven years ago by the Columbus Partnership when it hired Dr. Michael Porter of Harvard. Dr. Porter is best known for his economic clusters theory: bringing together companies of similar or complementary industries in a proximate setting that will produces greater collective economic value - and in turn attracts additional companies and creates more jobs. After interviewing Columbus Partnership members and undertaking research during his million-dollar study, Dr. Porter recommended our region focus on six clusters: logistics and distribution; logistics-sensitive manufacturing; automotive; advanced business services; financial services packaging and process; and, hospitality and tourism. Health care and biosciences were not included, which surprised many. Dr. Porter felt that Columbus didn't have the catalysts - and never would - to create a bio-science hub to compete with the likes of Houston, Boston, New York, etc. In his opinion it was a cluster that would never exist nor develop. There was strong push-back from the Columbus Partnership members: they saw our excellent (based on national ratings) and growing hospitals, the medical research at Ohio State, and more importantly the new collaboration between OSU medical and Battelle. While skeptical, Dr. Porter eventually included health care (which he labeled "personalized medicine") as a long-term opportunity and acknowledged that the then-embryonic relationship between OSU and Battelle had the potential to produce such economic gain. For many reasons, Dr. Porter's strategy was never fully implemented or sustained, although the momentum it created eventually led to the significant economic development initiative centered through Columbus 2020 and the Columbus Partnership.

Since the issuance of Dr. Porter's report, our region's hospital construction boom has continued unabated, unchecked and not connected to the broader strategy he articulated. A recent article entitled "The End of the Road for Eds and Meds" by Aaron Rand[25] cites the multitude of regions with economic development strategies predicated on higher education and medical institutions, thus termed "eds and meds". He emphasized that many Midwestern cities have in effect economically "defaulted" and have regretfully tied their future to the eds and meds strategy,

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[25] New Geography.com, September 12, 2013.

because the industries already are growing and currently have large employment. Rand argues that the growth of the medical industry is not sustainable given the looming and long-term federal funding cutbacks (again, on average 57% of a hospital's revenues is federal funds) and the limited market growth. His conclusion is that the education and medical industries are at the end of their growth cycle.

Complementing the article is a report from Richard Florida, author of the book entitled The Creative Class, showing that the education and medical industries "contribute little, if anything, to levels of regional economic development."[26] He also states that education and healthcare do not appear to add significantly to regional labor productivity and wealth. "Eds and meds may constitute a large part of the urban workforce and provide a substantial job base.... but they are not by themselves a source of economic development."[27] Florida's research partner, Charlotta Mellander, concluded that eds and meds were not associated with regional wage increases, levels of high-tech industry or levels of innovation associated with economic output.[28]

The point of Florida's report is that healthcare and education occupations have minimal impact on regional labor productivity or wealth. Over investment in them can hold back a region's growth. The analogy is similar to putting too much of your portfolio in one or two well performing stocks that may be at the end of their growth cycle due to external changes. Your risk increases and your economic performance lags.

The context of Mr. Florida's analysis to Central Ohio's was provided by local economist, Dr. Bill Lafayette. He states that if college and hospital employees produce lower worker productivity, and if our region's economic focus is on these industries, then our regional wage level will be negatively affected as well as employment growth, which is the opposite of Columbus2020's twin goals of increasing the number of net-new jobs and raising the region's per capital income.[29]

In the economic development world, health care jobs are considered secondary or local, meaning they don't sell products outside the region or bring in additional wealth that enable true economic growth. These jobs exist to serve the local economy, similar to retail jobs. In effect, individual incomes and profits transfer dollars already here. "Export" jobs on the other hand provide added value because they bring in outside dollars. A region desires jobs that service a national and international market.

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[26] "Why Eds and Meds Alone Can't Revitalize Cities," Atlantic Cities, September 18, 2012.

[27] Id.

[28] "Inside the Black Box of Regional Development: Human Capital, The Creative Class, and Tolerance," Journal of Economic Geography, 2008.

[29] William LaFayette, Ph.D., correspondence, November 5, 2012.

So what is our region's current economic development strategy regarding the health care industry? Kenny McDonald, CEO of Columbus2020, the regional economic development organization, stated that his group supports the health care industry, will react aggressively when a health care company is considering re-locating to Columbus as well as help existing health care companies expand and industry-related start-up companies succeed. The industry is recognized and appreciated as a major employer in the region.

However, the health care industry is not the primarily focal point of Columbus2020's proactive economic development attraction strategy. It does serve as an important marketing tool to attract companies to the region because of the perceived quality, quantity, and accessibility of our health care system.

Contrary to Aaron Rand's observation about midwestern cities, Columbus is not "betting the ranch" on health care, nor is the industry a strategic focal point to attract jobs. Health care is not the dominating industry, nor the only industry growing in our region. That's an advantage compared to other region's that are dependent on such an industry and economic development strategy. Once again, Columbus' more balanced economic make-up serves us well. And, our regional economic development strategy purposefully and correctly reflects it.

Let's return to the other economic questions and concerns raised earlier? Who's to argue that new jobs and construction aren't a good thing? The question is whether Columbus' hospital systems currently are well positioned for the dramatic changes - known and unknown; short-term and long-term - in health care.

The intense and seemingly blinding competition among hospitals, the resulting construction boom with its concurrent debt, fixed assets, and duplicitous service, and the lack of true collaboration and community engagement have raised concerns among experts and professionals in the field.

Our local hospital systems must work more collaboratively on issues of significance. There have been some successes in working together: joint laundry facilities, bulk purchasing, and health awareness campaigns. Other areas are lacking, however. A prime example is the data collections that businesses and others seek in determining value. For example: through a federal grant our hospitals are attempting to collect and share data, yet each system has recently purchased different computer platforms which inhibit the sharing of data.

While a few large employers are working collectively to collect and analyze data to determine local health care value, their approach is from each individual company's economic perspective. The business community as a whole is not fully engaged in the value proposition, nor the broader public policy of health care and its economic perspectives that affect the region as well as their companies.

As previously stated, I believe that hospitals are caught in a vicious competitive cycle. They would benefit from business and civic leaders' support by asking the broader questions, providing a check and balance to hospitals' construction decisions, demanding further collaboration, and challenging them to improve value.

In this time of tremendous change and uncertainly about the future of health care, collectively we must ensure our hospitals' continued success but within context of our region's long-term best interests. As Edgar Wolfe stated, it's simply a matter of vision and leadership.