Sources: Adv Today, Mar/Apr 94 / Review, June 2,16, 94 / Spectrum Oct 94, p 51.

AHS Joins the Trend toward

Hospital Mergers

Part One of Two

The hospitals are getting together, and forming larger systems.

"Oh," you say, "that is nothing new. We know our hospitals did that years ago,—although, here and there, with disastrous results in financial corruption and mismanagement."

—No, I am not referring to Adventist Health Systems. This is something distinctively new; something quite different.

Seventh-day Adventist denominationally owned hospitals are forming mergers and joint ventures with non-Adventist hospitals throughout the nation!

This article will introduce you to this growing trend. But do not imagine we have covered the subject. It is going on right now as you read this. Every month the problem deepens, as more and more unions take place.

In earlier decades, the hospitals of America generally operated independently of one another. But, ever since Reagan took office in 1980, the hospitals have been struggling to survive. In the 1980s, the method used was strict economy, plus buyouts into several larger hospital systems. In the 1990s, and especially from 1994 onward, the pressure has been to partially merge the various medical institutions in each local area, and tie each local area into bundles. This would be done by uniting certain departments of the local Catholic hospital, Methodist hospital, Jewish hospital, and Adventist hospital in a single office under one roof.

It is predicted that whatever hospital is not willing to join, will gradually be squeezed out—by the lower cost-operating methods of the linked hospitals in that same area.

You might ask, How did we get ourselves into this fix? Why does the Lord let His people do this?

First, the Lord never asked us to enter into compacts and legal agreements with the world. To whatever degree we do so, it is our own choice.

Second, from about 1915 to 1920, the leaders of our hospitals and medical school decided to seek accreditation from the American Medical Association. In doing so, we agreed to only practice medicine according to its standards and methods.

As a result, today we are look-alikes. Some say that all one of our hospitals has to offer is an Adventist prayer at the bedside—and many times nowadays, the prayer is missing (since over 90 percent of the staff is generally non-Adventist). As for the treatments given, they are just like those of the world. Since our hospitals have nothing much different to offer, they are being pressured to unite even more closely with the world in order to survive the economic problems of the coming decades.

IT IS NOT "HEALTH-CARE"

Headlines scream, *"The Health-Care Industry in Jeopardy,"* meaning the hospitals are having a hard time financially. News reports are sent out about the latest *"Health-care bill before Congress;"* that is, another government-paid medical (physician and hospital) insurance program is being considered. The *Adventist Review* has articles on how the *"health-care crisis"* will affect the *"Adventist Health-care system."*

—But it is NOT "health-care"! none of it!

Health care is preventative medicine. It is taking care of your body so you do not become sick. It is adequate rest, exercise, proper diet, the use of sunlight and water, fresh air, and continued trust in divine power (MH 127). Significantly, these preventative measures, to withstand sickness, are also the best remedies—the true remedies—to alleviate it.

"Health care" is living right and visiting a health food store far more often than you visit a drugstore or a physician.

But as usual, the world is changing the labels. They did this earlier with the rainbow, which for thousands of years had pointed the people of God to the necessity of obedience to the divine law;—by changing it into a symbol of New Age demons and a flag for the gays.

Now the term "health care" has been subverted also. That which, twenty years ago, was called "hospital care" or "medical care" is now called "health care." With the new terminology for medical care, people are being led to believe that "health" is derived from drugs, surgeries, and radiation.

With three exceptions, you will find only the proper terms used in this and other articles by this author. Those three are cited quotations in which "health-care" is incorrectly used, corporate titles such as "Adventist Health Systems" (which should be "Adventist Hospital Systems") and special terms such as "health-care contracts."

In large metropolitan areas, the emphasis is quickly moving from single hospitals to financially- and management-integrated hospital systems. This is being done through carefully worked out alliances between the hospitals and the physician groups. It is declared that those who refuse to join will be crowded out of the patient market. The medical professionals call them "health-care contracts." It is said that, in large regions, only the big multi-hospital/physican groups will be the ones remaining in business, for they alone will be able to competitively bid for hospital contracts. Enactment of federal-imposed "national health-care plans" will only add to the financial crisis in the hospitals—and will only accelerate the mergers.

Here are the words of one of the top managers of the most prosperous of the Adventist health systems:

> "The health-care market already is radically restructuring itself from within—without regard to government legislation—in anticipation of a health-care plan."—*Mardian Blair, president of Adventist Health System/Sunbelt, in Adventist Review, June 2, 1994.*

The result is "networks." Each network (consisting of several integrated hospitals—Catholic, Jewish, Adventist, atheist, or whatever) competes with other nearby networks for the incoming patient load.

> "The market is consolidating. Networks are developing—that is, hospitals are combining into groups to compete for business. In Orlando, for instance, three groups are forming—two not-for-profit and one investor-owned. Businesses representing large numbers or blocks of patients will contract for a given period of time for health-care services. If any hospital is not a part of the network, it is shut out from caring for those patients. Obviously, any hospital can quickly become financially nonviable if it is excluded from access to a large block of business.
>
> "This is happening all across the nation. Hospitals are joining forces to compete in the marketplace. And if a given hospital is not in a group, it will likely be frozen out of business."—*Ibid.*

In a large alliance of medical providers, control over one's own hospital operations may be limited to efficiency measures. To what degree will the local Adventist hospital in that network have to give in to the demands of the others? Blair says it will depend on the size of that local hospital. If it is a flagship hospital (that is, one of our largest ones), such as Florida Hospital, it already dominates its local area, and it is in a position to dictate terms to the others. It can tell the other hospitals in the network how their hospitals are to be run, instead of being told by the others.

What does this mean? It means that in some localities we will no longer directly control our own hospitals! Later in this article, we will quote Blair as explaining that, most of the time, our hospitals will have minority status in each rapidly forming network.

> "In most places they [our Adventist hospitals] would network with other not-for-profit hospitals, which may be Catholic, Lutheran, or Baptist. But there might be relationships with investor-owned groups.—*Ibid.*

It was about the year 1966 that Medicare was enacted to provide free medical care for certain categories of the public. The funds provided for patient care were fairly generous. The physician and hospital could decide what each patient received, and how long he would be hospitalized—and the government paid the bills.

But in 1983, all this changed. The federal government imposed the *diagnostic related groups* (DRG) program. Under this arrangement, it paid a lump sum for the care of each type of illness, regardless of how much money the physician and hospital put into the care of that patient.

This immediately changed the financial picture for hospitals throughout the nation. Under the DRG plan, the hospital got the same flat rate reimbursement—regardless of how long the patient was there. So, the number of patient days fell off dramatically. Hospitals would devise ways to get the patients discharged as quickly as possible. Instead of three or five days, a patient would be out in one or two.

In addition, a significant number of potential in-patients were switched to outpatient settings. "Patient census" decreased dramatically, and many smaller rural hospitals folded. AHS/Sunbelt, for example, had closed down or sold nine of its hospitals by last year (1994).

Keep in mind that the 1983 crunch came right on the heels of the massive debt-pileup by Adventist Health Systems. It was mistakenly thought that living heavily in debt was the way to operate our hospitals, all of which were almost totally debt free before the various AHS corporations were started in the mid-1970s.

In our *Medical Tractbook*, you will find instance after instance of appeals we wrote to our people in the early- and mid-1980s, urging them to demand our leaders to stop the go-in-debt craze which was in vogue in our hospital systems at that time. Before it slowed down, AHS had a $2 billion debt load!—And it was right about that time that the federally mandated DRGs began, which drastically curtailed the income of every hospital in the nation, including our own.

Mardian Blair, of Sunbelt System (AHS/Sunbelt) maintains that, if medical-care contracts become mandated by the federal government, Sunbelt would have to step quickly or it would go broke. It would have to network with the other hospitals in the local regions it served, and it would have to be able to provide that care at the lowest possible cost.

> "*[Question by Myron Widmer:]* If you don't get enough health-care contracts, Adventist hospitals could be out of business overnight?"
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> "*[Answer by Mardian Blair:]* Yes, We would be forced into liquidating our assets. It's very, very important to have quality, a low price, and to be part of a competitive network. The assumption by those buying managed care is that if someone's in business and accredited by the Joint Commission, they

have quality. That's not exactly true, because there are ranges of quality within that. But that's the concept, and thus the issue comes down to price. We must have a low price, compared to other health-care providers, to stay in business."—*Ibid.*

In addition to networking with other hospitals, institutional costs must be kept down, and this will especially include salaries.

"Since the DRG program started, we have tightened up our operations, leaned them down, and reduced inefficiencies. Labor is our largest cost. This puts enormous pressure on any organization to trim personnel costs."—*Ibid.*

But now, let us return to this matter of Adventist hospitals "networking" with non-Adventist ones. In the process, part of our control over what we do is lost—unless, in that particular area, the Adventist hospital is the largest. Thus we find that if, say the local Methodist hospital was the largest, it would have something to say about how the Adventist hospital in its network metropolis was run.

"Being part of an integrated organization could present special challenges in maintaining the unique mission of Adventist hospitals. The primary challenge seems clear: unless an Adventist hospital holds a position with some leverage in the market, maintaining governance and control could be seriously jeopardized, if not impossible."—*James W. Boyle, president and CEO of Shawneee Mission Medical Center, Shawnee Mission, Kansas, quoted in Adventist Today, March/April 1994.*

Boyle goes on to say this:

"To choose not to participate in an integrated delivery system could bring serious consequences. Facing competition from large, integrated systems, an independent hospital could be poorly positioned to survive."—*Ibid.*

That statement brings two facts to mind:

(1) If we had stayed with our unique natural remedies program, administered through sanitariums located outside cities, we could today be the special medical and health (yes, "health") provider to the world. We would not only be able to heal the sick, but be in a position to teach the world how to withstand illness—through obedience to the laws of God. Can you not see how such a program was, indeed, the "right arm of the message"? It was the entry wedge to the Third Angel's Message—because it taught obedience to natural law through the enabling grace of Christ, whereas the Third Angel's Message (Revelation 14:12) teaches obedience to moral law through that same overcoming, enpowering grace!

(2) But instead we chose to be medicinal acute-care providers, and that has placed us in close company with all the medical interests in the world. Experts, such as Blair, predict that, if we fail to link up with the other hospitals (for that is what "networking" is all about),—our hospitals will go bankrupt.—And then, who will pay the hospital debts? Yes, you guessed it. Especially ponder the ramifications of the second paragraph, below:

"In an environment with use rates already driven down by managed care, the [Adventist] hospital would likely experience declining market share because of limited physician and payer relationships. Ultimately such a hospital might not survive.

"In the event of failure, several issues surface that are relevant to the Adventist Church, including loss of jobs for Adventist workers and, particularly, liability for debt."—*Ibid.*

Such issues would, indeed, be relevant to the denomination—especially when it was confronted with paying off the massive debt piled onto those hospitals by AHS leaders over the years.

Mardian Blair explains, in more detail, what networking is all about:

"A network is a grouping of health-care facilities—hospitals, physicians, offices, clinics, and other health-care providers—that unite to attract blocks of patients or managed-care businesses.

"Most Adventist hospitals can't get the contracts because they're just not large enough to cover whole cities or geographic areas. Networks allow us to participate in providing full health services across a given area."—*Mardian Blair, Adventist Review, June 16, 1994.*

Networking, according to Blair, is not a possibility; it is a certainty for our hospitals. Soon we will be linked with Catholic, Protestant, and other hospitals across the nation. Very likely the situation may eventually repeat itself throughout the Western world.

"*[Q:]* So Adventist hospitals and other medical facilities will have to join these groups?

"*[A:]* Yes. But we have some settings where we don't have to.

"*[Q:]* In a few large cities where we already have a dominant share of the market?

"*[A:]* Yes.

"*[Q:]* Who would accept us into a network? Would Catholic, Methodist, or other for-profit health-care groups?

"*[A:]* There doesn't appear to be any type of hospital that couldn't theoretically join with another. It is just how we work it out."—*Ibid.*

Well, that leaves us breathless. Soon all, or nearly all, of our denominational hospitals in the U.S. will be working with—either managing or managed by—Catholic, Protestant, or other hospitals!

It is clear that, unless in a given region our hospital dominates the field,—it will be the other hospital or hospitals which will control us. Blair discusses this—and then adds the fact that, in most localities, we are NOT the dominant hospital! Therefore, eventually we could nearly always be dominated—partially managed by—non-Adventist hospital administrators.

"*[Q:]* Is our distinct mission at risk in doing that [joining networks]?

"*[A:]* Many networks require no change in internal operations or philosophy or policies—nothing. It's a convenience and poses no real hazards. You can opt in or out. But they could evolve into haz-

ards.

"Then there are networks in which a single powerful provider wants to dominate, or is the dominant provider directly or indirectly. That's where risks arise.

"*[Q:]* But couldn't we be that dominant party?

"*[A:]* Yes, some Adventist hospitals may be the dominant party—like Florida Hospital. But generally we are not dominant."—*Ibid.*

Florida Hospital is cited as an example of a dominant hospital in its area. But we must keep in mind that there are few Adventist hospitals like it. Florida Hospital is the largest in our donomination, and serves a half-million people with five hospitals and a sixth which is closely affiliated. It is gigantic.

As an example of the dangers inherent in linking up with other hospitals in a community, Blair cites Smyrna Hospital, in Atlanta:

"Let's talk about a real situation. Smyrna Hospital, a 100-bed hospital in Atlanta, could possibly be excluded from the market unless we join a network. What do we do? Operate until we go out of business? Affiliate? Or sell?

"Let's say we affiliate. We could have an affiliation that does not impact the hospital's policies and values. Or we could have one in which we give up some control to someone else. In the latter case, who runs the hospital? If they run it, we've in essence sold it or given it away. It won't be an Adventist hospital, no matter what we say."—*Ibid.*

Blair then goes on to say that, in such a case, AHS could sell less than half ownership in the hospital, so AHS could continue to manage it. Perhaps the Catholics might own the other 49 percent.

"We would sell less than half ownership. Then through a lease or management contract we could have the absolute right to run it according to Adventist principles . .

"*[Q:]* Which means, in the network type of environment, that we could own a hospital and it not be an Adventist hospital?

"*[A:]* Yes."—*Ibid.*

Yet, according to Blair, we would be forced to do this, if we wanted to keep operating a hospital in that city.

"*[Q:]* And would we run it just because we have to have that geographical location to attract and fulfill managed-care contracts?

"*[A:]* Essentially, yes.

"*[Q:]* Do you see the day coming soon when all Adventist hospitals will be in some kind of network?

"*[A:]* I do, most of them.

"*[Q:]* No freestanding hospitals anymore?

"*[A:]* Maybe some rural hospitals; but the metropolitan hospitals will be in networks.

"*[Q:]* Is that true across the United States?

"*[A:]* Yes. Managed care has accelerated rapidly."—*Ibid.*

If we had done what we were told to do, all our health-restoring facilities would for decades only be out in the country. Ellen White repeatedly gave us that instruction. Through the Spirit of Prophecy, God also warned us that, by living in the cities and having our institutions in those cities, we would eventually become locked in. We are arriving at that time.

In the course of the interview, it was noted by Blair that "up to 90 percent" of the workers in Adventist hospitals are "non-Adventist physicians and employees." That fact, of course, only adds to the problem.

We are told that, adhering as we do to our present medical practices, policies, and outlook, networking is inevitable.

The question then comes to mind: To what extent are our hospitals forging ahead with such networking operations? Here are some insights along this line:

Los Angeles, California: Terrific market forces are at work in the greater Los Angeles area. It is filled with physician groups and major managed-care companies. They are directing the inflow of patients toward their own hospitals, clinics, and medical practices.

One Adventist hospital in the area has already lost an important physician group to a major physician organization.

Our hospitals there are trying to work out networking plans.

Portland, Oregon: Legacy Health Systems, Kaiser Permanente, Sisters of Providence and a few independent medical groups are vying for control.

Portland Adventist Hospital is not in a network yet; because of a joint ownership it has in Managed Health Northwest, it has a working agreement with Legacy, But Legacy is pressuring it to unite with it in a fully integrated operation.

Orlando, Florida: Earlier in this article, it was mentioned that three groups are forming in Orlando—two not-for-profit and one investor-owned.

Chicago, Illinois: In this immense metropolitan area several powerful medical networks are developing. Three of them are: (1) Evangelical Health System, which has joint venture networks with Lutheran, University of Chicago, University of Illinois, and other hospitals. (2) Rush-Presbyterian-St. Luke's merge with Pru-Care, which has resulted in a major health maintenance organization (HMO). (3) Northwest Alliance Network, which includes a number of hospitals.

The Hinsdale Health System will inevitably unite with one of these alliances or with a different developing one. Otherwise it will lose its physicians and not receive enough patients to keep it in business. That network will be controlled by the Catholics, the Protestants, or the world. Which one will it be?

Kansas City, Missouri/Kansas: In this city, if 1.5 million, nearly two thirds (a million) are already enrolled in managed care! Four immense networks receive added strength each month: (1) Health Midwest/Blue Cross has

Continued on the next tract

AHS Joins the Trend toward Hospital Mergers

Part Two of Two

Continued from the preceding tract in this series

merged with 11 hospitals in Greater Kansas City, and has a partnership with Blue Cross of Kansas City. (2) Columbia/Humana Health Plan. The local Humana hospital has affiliated with a major national hospital corporation: Columbia. Together, they are trying to take over non-affiliated hospitals in the region. (3) Kaiser Permanente is growing in power. (4) St. Luke's Health System. St. Luke's Hospital, in Kansas City, is a large teaching hospital, which trains many nurses.

Which one should ours unite with? St. Luke's is building a network with four hospitals, and has invited our own hospital (Shawnee Mission Hospital) to join the group. Already, Shawnee Mission Hospital and St. Luke's are linked together with eight other hospitals in the ownership of a managed-care company, with over 300,000 members. In addition, Shawnee Mission and St. Luke's, along with two other hospitals, own a newly formed HMO.

How are we doing elsewhere?

Californa: In California, two Adventist health systems (AHS/Loma Linda University Medical Center and AHS/West) have entered into a joint venture with three non-Adventist systems. The resulting new super-sized medical corporation has been named the "California Health Network" (CHN).

California Health Network was set up in the summer of 1994, and has a combined total of 1.2 million managed-care patients and over $3 billion in assets.

At the present time, it is competing with three other medical-care organizations for second place among medical conglomerates in that state. The largest is Kaiser Permanente, with over 4 million patients.

What are the members of California Health Network?

(1) Loma Linda University Medical Center, which is our Loma Linda hospital.

(2) Adventist Health Systems/West, which includes our Adventist hospitals in California. These two Adventist entities alone, are handing over the following assets to the new organization: 3,609 beds, 4,409 medical staff, and $1.6 billion in assets.

(3) California Healthcare System of San Francisco, which has 2,580 beds, 3,600 medical staff, and $932 million in assets.

(4) Sutter Health, which is based in Sacramento. It has 2,559 beds, 3,000 physicians, and $1 billion in assets.

To start with, the new giant Adventist/non-Adventist conglomerate will only negotiate contracts between insurance carriers and companies to provide medical care, and will try to cut costs by standardizing billing and administrative procedures. At least that is the theory of it. Note that administrative procedures will be standardized. Centralized management may be the next step.

The purpose of standardized administration is to get all the hospitals doing everything the same way, in order to cut costs to the bone. The look-alikes will end up looking even more alike than ever.

Who will be the dominant members of this new organization, the Adventists or the non-Adventists? We earlier quoted a statement by an AHS administrator, that the most powerful partners will ultimately control the network.

In the above statistics, the Adventists bring to Cali-

WHAT IS THE CURRENT TOTAL AHS DEBT?

We are asked whether AHS has as much debt as it did. Data is difficult to come by. Although, theoretically, every member and church owns AHS, yet their financial records are not easily obtained.

At its high point, in the early 1980s, the debt load was $2 billion. That is an immense sum of money! If you were counting dollar bills, at an average speed of ten every 15 seconds, it would require 2,800 years for you (going 24 hours a day) to count out a billion of them. A billion dollars is a lot of money, and handing it over could gobble up the assets of a lot of Adventist church properties.

We still do not know the current debt of AHS throughout the U.S. But Mardian Blair did disclose a little about his own Sunbelt System, which as you may know, has always been the most prosperous of the various AHS entities.

> "For every dollar of book assets, 63 percent is debt and 37 percent is equity. Debt was about 80 cents on the dollar 10 years ago."—*Adventist Review, June 16, 1994.*

That statistic tells us neither the total Sunbelt debt nor anything about the total AHS debt. But it does reveal that for every dollar of assets (buildings and equipment) owned by Sunbelt, our most prosperous health system, there still remains two dollars of debt.

fornia Health Network: 3,609 beds, 4,409 medical staff (primarily physicians), and $1.6 in assets. *The non-Adventists bring to California Health Network:* 5,139 beds, 6,500 physicians or affiliated physicians, and $1.63 billion in assets. Does that place us in minority status in California Health Network?

To date, this is the largest network, in which Adventist medical-care groups are affiliated with non-Adventist medical-care groups.

What about still other areas? Are certain trends developing in the selection of partners in these unions? The enclosed news clip tells the story of what is taking place in the Denver, Colorado area.

> "The agreement would be structured as a joint venture, and would bring together Denver's No. 2 and No. 3 not-for-profit hospital systems under common management."—*Denver Post, May 16, 1995.*

Did you catch that? "common management." And what hospitals are thus tied together into a bundle? It is our Rocky Mountain Healthcare (an Adventist AHS), joined together under "common management" with Provenant Health Partners, which is a Roman Catholic organization, which owns two large Catholic hospitals in the Denver area.

The article informs us that Rocky Mountain Healthcare is run by the "Seventh-day Adventist Church." Who owns Provenant? We are told that also: The Roman Catholic Church!! "Sisters of Charity Health Care Systems of Cincinnati, a Catholic order, runs Provenant."

The article explains that all, or nearly all, the medical-care institutions, in Denver, are becoming anxious to unite with one of the major medical-care providers.

And, of all the possible partners, who is it that the Adventists unite with? You guessed it; the Catholics. As we noted earlier in the Kansas City area, out of four different partners to choose from, our Shawnee Mission Hospital has selected St. Luke's Health System to unite with.

Some have said that eventually our hospitals will be taken over by the Catholics. Soon you can drop the "eventually."

Ironically, this networking issue is based on a need for our denominational hospitals to cut costs. AHS leaders are willing to even hand their hospitals over to the Catholics, if they can accomplish this coveted objective.

Why then did AHS coerce the General Conference leaders, in 1987, to up the salaries of all AHS and hospital leaders to astonomical heights? By agreement, salaries shot up from $75,000 to $150,000 a year for those men! We now know that AHS and hospital salaries are currently (1995) about $130,000 to $150,000 a year. See our book, *Collision Course: the David Dennis Disclosures,* for more on this.

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