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Conference Center Guide

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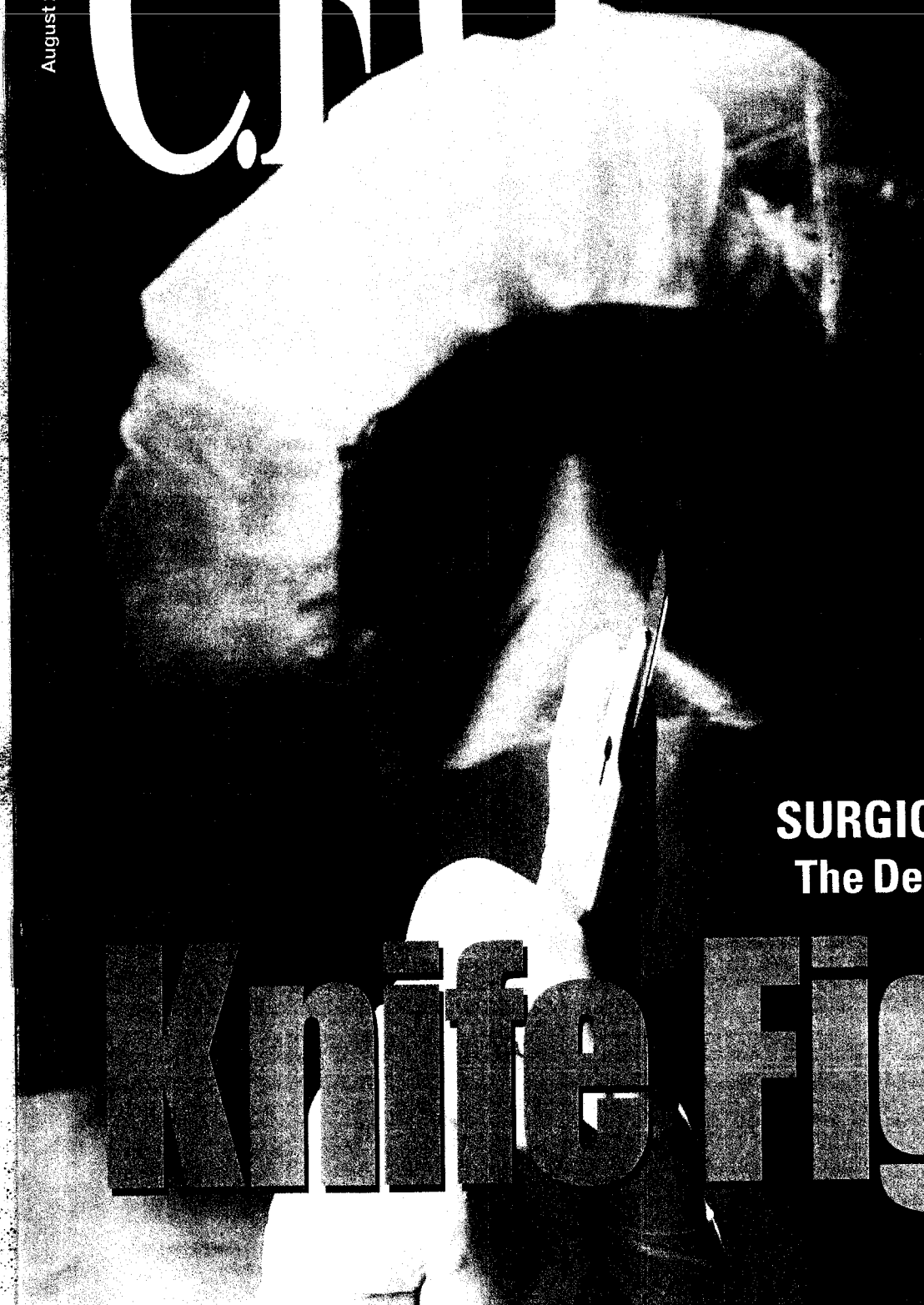
Fixing the State Fair



NEW ALBANY SURGICAL HOSPITAL: The Debate Gets Tough

Knife Fight

Roundtable

Hospital HUFF

An artist rendering of the New Albany Surgical Hospital

Does Central Ohio need a for-profit orthopedic hospital? Surgeon-investors say yes. Not-for-profit hospitals say no.

Hospital consolidation has been the norm in Central Ohio for years. Low patient counts, tough insurance rules and heavy debt loads have driven one facility after another into the arms of a stronger partner—or to the brink of failure. Doctors Hospital joined the OhioHealth system. St. Ann's became part of the Mount Carmel network. The Ohio State University Medical Center absorbed Harding Hospital and Park Medical Center. Columbus Community Hospital shut down entirely. The only constants, it seemed, were change and trouble.

By the end of 2001, though, the three large not-for-profit systems—OhioHealth, Mount Carmel and University—had reached a kind of competitive stability. All faced challenges, but none appeared in imminent danger.

But then, early in 2002, some 30 orthopedic surgeons sent shockwaves through the nonprofit system by announcing the region's first *new* hospital in many years—the **New Albany Surgical Hospital**. Led by hip and knee replacement superstars Tom Mallory and Adolph Lombardi, the doctors contracted with Surgical Alliance, a Tennessee corporation, to build and operate a 30-bed, for-profit orthopedic specialty facility.

Reaction from the not-for-profit hospitals was swift and fierce: not in *our* community. With strong editorial support from the *Dispatch*, the not-for-profits argued the New Albany Surgical Hospital will drain patients and revenue from the existing system, enriching investors at the expense of charity care. Physicians and administrators discussed revoking the practice privileges at OhioHealth's Grant and Riverside Methodist hospitals of surgeons who've invested in the new hospital. The debate quickly escalated into the hottest healthcare spat in years.

Seeking light as well as heat, *Columbus C.E.O.* invited three advocates from each side to a Roundtable discussion. Speaking in favor of the proposed hospital were surgeon-investors **Adolph Lombardi**, whose practice with Joint Implant Surgeons is dedicated to total hip and knee arthroplasty; **Dick Briggs**, whose practice at Mount Carmel East concentrates primarily on adult reconstructive surgery; and **Carl Berasi**, who has practiced general orthopedic surgery in Columbus for 18 years.

Opposing the new hospital were **Joe Calvaruso**, president and CEO of Mount Carmel Health System and chairman of the Franklin County Hospital Council; **Jack Chester**, a prominent Columbus attorney who's chairman of the board of OhioHealth; and **Mary Jo Welker**, a physician who chairs the Department of Family Medicine at the Ohio State University Medical Center and serves on a task force that's examining Ohio's nursing shortage.

Here's some of what they had to say.

LOMBARDI: What we've learned through the years is that focused care—giving patients a focused product that is based on excellence and based on specific needs—has been extremely successful. We're taking this to the next step. The New Albany Surgical Hospital is a specialized orthopedic hospital. We want a center of excellence that's focused on orthopedic care.

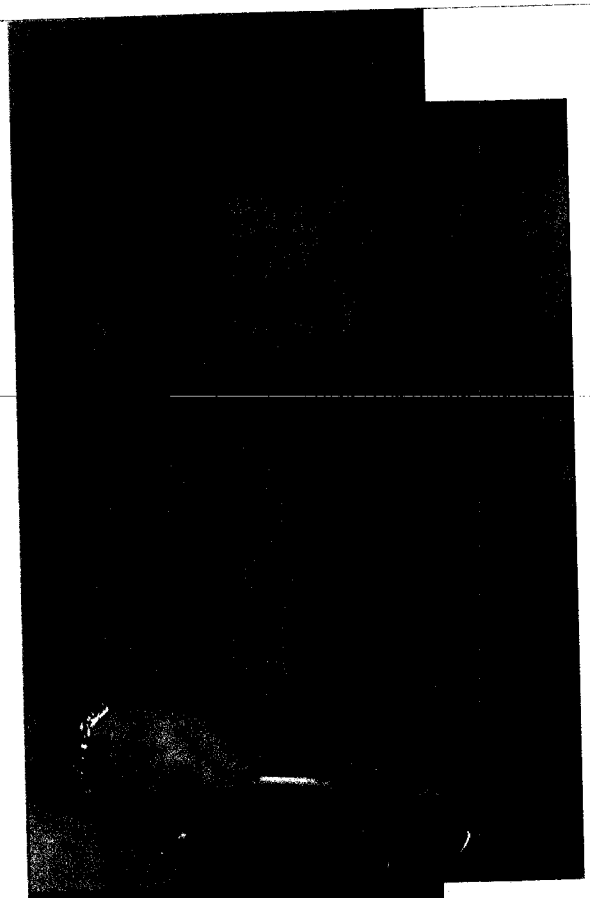
C.E.O.: Dr. Berasi, why not create within the existing hospital structure the kind of centers of excellence that Dr. Lombardi just talked about?

BERASI: We actually spent a considerable amount of time trying to convince the hospital systems to do exactly that, to partner with us on a specialty facility of this nature. We had discussions with both Mount Carmel and OhioHealth dating back probably over a year regarding this concept, and we still encourage them to participate.

CALVARUSO: It was actually back probably about three or four years. We feel the health system more than adequately meets the needs of the community right now. We don't feel there's a need for a facility in New Albany. I'm concerned that this type of limited service hospital could be detrimental to the system that has served Central Ohio so well for over a century.

LOMBARDI: Our patients want to know that the nurse on the floor deals just with orthopedic patients, that the nurse in the operating room is doing that, that the instruments are there. This is what we were striving for when we tried to set these centers of excellence up within our own healthcare systems. But what we don't have when we do that is the ultimate ability to control all the variables. You get it set up, you start to do it as we've done at Grant Medical Center. But then, little by little, control is weeded away and policies that are established from the hospital become the dictum of the day. You no longer have the respect of everybody working for you who feels that you are the boss and the way you want it done is the way it should be done.

WELKER: Let me tell you my concerns. The first relates to the fact that everything [at the New Albany Surgical Hospital] is going to be done in a specialized way. Histories and physicals, lab tests are not done by the primary care physician; they're done by somebody else. The primary care physician doesn't have ac-



ADOLPH LOMBARDI:
"Our patients want to know that the nurse on the floor deals just with orthopedic patients, that the nurse in the operating room is doing that, that the instruments are there. This is what we were striving for when we tried to set these centers of excellence up within our own healthcare systems. But what we don't have when we do that is the ultimate ability to control all the variables."

cess to those records and can't get them unless they go through a long process.

LOMBARDI: You're right; the histories and physicals are done by a group of internists who are dedicated to taking care of those patients at the time of the hospital stay. They see the patients preoperatively; they see the patients in the hospital; they follow the patients. Communication is provided to all of our referring physicians by our internal medicine team.

C.E.O.: Dick Briggs, you practice almost exclusively at Mount Carmel East. You mentioned that it had become, over the years, more difficult to get the services and accommodations that you needed.

BRIGGS: Our hospitals are good places. They're well run. I feel very comfortable there. However, there's not been a day in the last month that I have walked in that hospital that the census hasn't been 99 percent, 103 percent. We can't get patients on the [operating room] schedule. If we get them on the schedule, we have trouble getting the time. If we get them the time, we get bumped for an emergency from another service, like brain surgery or cardiovascular or thoracic. Beds are not easy to come by; operating rooms are not easy to come by; operating times are difficult to get.

WELKER: Part of the problem with the bed crunch is related to workforce shortage. Hospitals might be able to open more beds if there were more nurses to staff the beds.

BERASI: I have to disagree with Dr. Welker. There are more than 4,000 hospital beds in Central Ohio. We're putting in 30 hospital beds [in New Albany]. That represents 0.7 percent of the hospital beds in Central Ohio. We are an infinitesimally insignificant amount of hospital beds and nursing personnel. There's no way that we can possibly affect the nursing shortage in any way.

CALVARUSO: I disagree with that. We have the capacity for 15 ORs at [Mount Carmel] East, 10 of which are open, so we have the physical capacity. The limiting factor of having enough capacity so Dr. Briggs doesn't have a problem getting OR coverage is staffing, and this [new hospital] would exacerbate the situation.

C.E.O.: Will nursing be more attractive in the New Albany Surgical Hospital than it is in the existing not-for-profits?

LOMBARDI: Yes, because they'll be working with a set group of physicians. They'll learn their protocols; they'll know what the expectations are, and they'll be able to direct comments and questions to those physicians and get a response.

BERASI: I have to echo what Dr. Lombardi just said. When we, for a short period of time at Doctors Hospital North, brought in the Ortho Excel Program and devised an orthopedic institute with dedicated nursing personnel, their attitudes changed tremendously. The nurses worked tremendously hard. They were dedicated to that institute, and none of them wanted to leave.

C.E.O.: Will you pay your nurses better than the not-for-profit hospitals do?

BERASI: I'll have to leave that to the experts who run hospitals.

C.E.O.: Joe Calvaruso, you mentioned that you have 15 ORs and 10 are open. Are the other five not open because you can't staff them?

CALVARUSO: Yes.

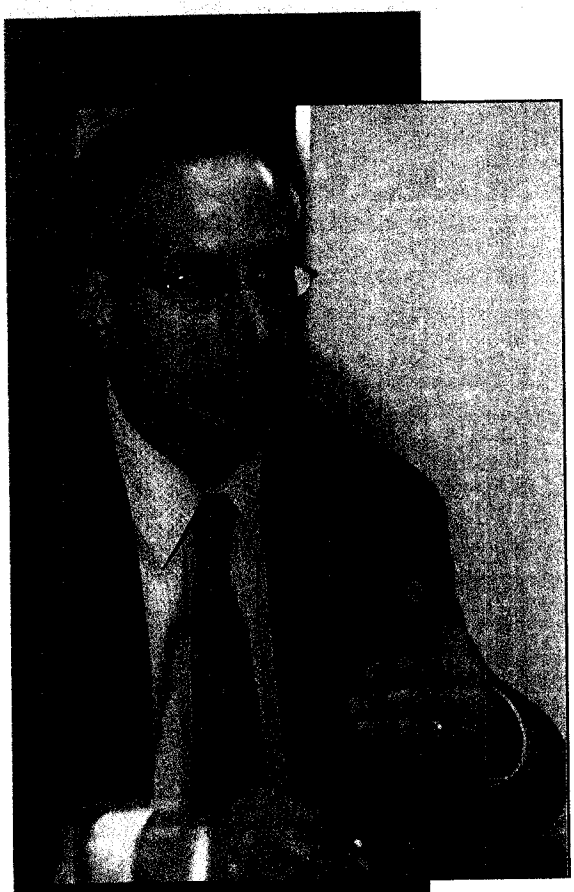
WELKER: I think Riverside may have some ORs that are closed as well for staffing issues.

BERASI: I would like to ask Jack if there's any way we can convince attorneys to become nurses.

BRIGGS: Medicine is like big business anywhere. There are bottlenecks that occur from time to time. The trick is to make sure the same bottleneck isn't jamming the works at all times. The bottleneck has to keep changing. At one time, there were too many nurses; now there are not enough. There were too many doctors and maybe now not enough; too many hospital beds and now not enough. These things always change.

This 30 beds in New Albany is going to be a drop in the bucket [compared] to what we're going to really be needing 10 years from now.

BERASI: Mount Carmel is undergoing an expansion. Riverside Hospital is putting in 100 beds for a cardiac facility. Ohio State Univer-



JOE CALVARUSO:
"The physicians [at for-profit hospitals] have the ability to direct or cherry-pick the medical cases they want, choosing the most profitable patients with the best insurance, the least amount of complications, the patients that are younger and will recover easily, patients that have lower lengths of stay—leaving the indigent and the higher-complication cases to the full-service community hospitals."

sity is expanding. Children's is putting in a heart hospital. Every single hospital in this town is expanding and putting in more hospital beds. Our 30 beds are an insignificant amount in comparison.

C.E.O.: Jack Chester, why is what they're attempting to do so different from the many for-profit outpatient facilities that have opened around Central Ohio in the last few years?

CHESTER: We think we have the finest hospital system in the country with the three hospital systems that we have in Columbus—Mount Carmel and Ohio State and OhioHealth. They have grown with the community over the years, and the outpatient services are simply an outgrowth of that.

It's important to this community that we have teaching facilities. Teaching is a vital factor in proper medical education and proper care. Teaching costs a lot of money, and the hospitals we have expend a lot of money for teaching. We [also] expend a lot of money for charity care, and I'm willing to wager the New Albany [Surgical] Hospital is not going to devote itself to much charity care.

BERASI: The physicians involved in this project have been involved in resident education for more than 60 years. We've already had discussions with numerous specialty colleges on establishing residency programs. We have a commitment letter from a major university to establish residency programs at the New Albany Surgical Hospital, as well as a research facility. We're seeking National Institutes of Health matching funds on a multi-million-dollar, multi-specialty research facility. Dr. Lombardi and Dr. Mallory have probably published and presented more articles and more orthopedic literature than all the rest of us combined. So I don't think we take a back seat to anybody on the research and education point.

CHESTER: The problem is they will siphon off the good cases. They will siphon off the cases where people can afford to pay their fees for specialized care—and believe me, specialized care will be expensive in a setting such as that. We have a large uninsured population in our community. We have a large population who cannot qualify for Medicaid. We have a large population who do use Medicaid. They can talk about taking care of Medicare and Medicaid patients all they want to, but I just don't believe that they will.

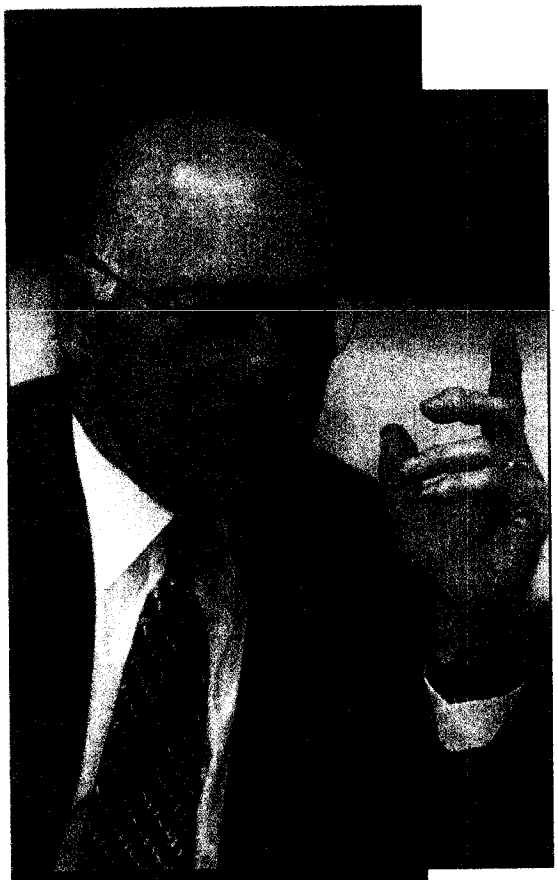
BERASI: Mr. Chester was incorrect in stating that Columbus has a large percentage of patients who are indigent and lack insurance coverage. Ohio actually has an uninsured rate of 10.8 percent, which is far below the national average, which I believe is in the 14 to 15 percent bracket. Let me state emphatically, without any hesitation, there will be no attempt [at New Albany Surgical Hospital] to select patients on the basis of their ability to pay or the severity of their cases.

We will have a charity policy that will be consistent with the recommendations by the American Medical Association and the Columbus Medical Association; one of my partners is president of that association, and he will ensure that that occurs. Just our small group of physicians—and there are five groups of physicians in this deal—provides $1.3 million of charity care a year. That is a greater percentage of our gross income than OhioHealth, Mount Carmel or, I believe, OhioHealth and Mount Carmel combined.

The assumption that for-profit hospitals provide less uncompensated care than not-for-profits is incorrect. The National Bureau of Economic Research found [the two types of hospitals] provided an equal amount of uncompensated care. We will do our share when it comes to charity care.

CALVARUSO: Dr. Berasi is correct about Ohio. Central Ohio, unfortunately, has the highest uninsured rate of any metropolitan area in Ohio because a lot of small employers don't offer insurance. It's about 16 percent, so it's higher than the state average and significantly higher than the national average.

The four systems in Columbus—the three adult systems and Children's—provided more than $200 million of charity care last year. It is not a small number. There is an inordinate amount of charity burden on the nonprofit, full-service hospital facilities.



DICK BRIGGS:
"We have no guarantee as investors that we are going to make money in this venture. We may lose it all. That's really not the reason we went in. Our primary goal was to create a better mousetrap, to create a better method of patient care specifically focused on the orthopedic patient, to see if we could do it more efficiently, more cost-effectively."

The physicians [at for-profit hospitals] have the ability to direct or cherry-pick the medical cases they want, choosing the most profitable patients with the best insurance, the least amount of complications, the patients that are younger and will recover easily, patients that have lower lengths of stay—leaving the indigent and the higher-complication cases to the full-service community hospitals. If physicians can direct the more profitable cases to the institution that they own part of and send the rest to the organizations that they don't own part of, that makes it hard for us to subsidize the unprofitable services that are vital to the community: burn units, intensive care units, charity care for the poor.

LOMBARDI: For the past several years, I have been told by the administrators of [Grant Medical Center] that I am not profitable to the institution, that I am a cost burden, that every day, we are costing the hospital system money. So these patients that I'm going to send to New Albany are going to, obviously, cost that hospital system money, as well.

CHESTER: I don't question the sincerity of these doctors when they say they're interested in rendering the best patient care, but at the same time they're also interested in making more money. This [New Albany Surgical Hospital] wouldn't open if the doctors didn't think they were going to make more money. They have been persuaded by an outfit out of Nashville they're going to make more money.

The existing hospitals will lose that money, will lose that business, and that's going to hurt the hospitals that we have in this community any way you cut it. Assuming that they're successful in their intention to make more money, then other specialties are apt to follow their example and leave the hospitals. This is going to destroy the ability of our hospitals to take care of the more generalized services that hospitals have to render, in addition to the charity care.

I think OhioHealth gave out something like $85 million this past year in charitable care, and I'm willing to bet dollars to donuts that that's not going to be the case with this [new] hospital even on a proportionate basis. Take the Cleveland Clinic. It opened a specialty hospital in Naples, [Fla.], and they made all sorts of promises about contributing to charity, but it didn't last very long, and they've admitted they didn't keep their promises.

WELKER: I have a real problem with investors—Nashville, Los Angeles, New York, I don't care where they come from—that take profit dollars out of this community.

C.E.O.: Jack referred a minute ago to an outfit out of Nashville. That's the Surgical Alliance. Sitting as an observer today is its CEO, Eddie Alexander. What's the relationship between the doctor-investor group and Surgical Alliance?

BERASI: As Mr. Calvaruso pointed out, we probably started discussions on a specialty hospital three to four years ago. We held those discussions with Mount Carmel, OhioHealth, and more recently with Ohio State University. We literally begged them to be our partners in this type of deal. Because they will not be our partners, we're forced to seek outside expertise.

It's interesting that we bring up "for-profit" as if it's a dirty word. I need to point out that both [Mount Carmel and OhioHealth] have for-profit physician offices; they have for-profit urgent care centers; they have for-profit diagnostic centers; they have for-profit ambulatory surgery centers. OhioHealth owns Prime Medical, which is a real estate company. They have two fitness centers, which are for-profit facilities. According to the Ohio Hospital Association, hospitals in this state have bought country clubs and vending machine companies. There are a lot of for-profit little corporations underneath that not-for-profit umbrella. For-profit is *not* a dirty word.

CALVARUSO: The big difference is, the profits in those subsidiaries flow through to support the nonprofit mission. They don't go to investors.

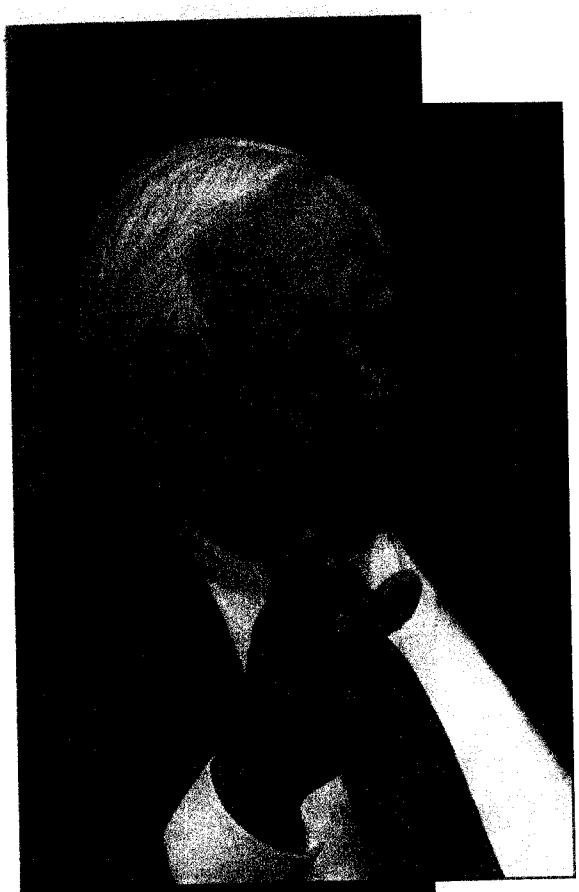
LOMBARDI: I wanted to address another issue Mr. Chester brought up. We're not leaving the current hospital systems at all; we're supplementing and creating more space for us to do our surgery.

CHESTER: No. All you'll do is take the good business with you ...

LOMBARDI: No, we won't.

CHESTER: ... and leave us with the bad business and the complex business.

LOMBARDI: There's enough



JACK CHESTER:
"You can quote all the figures you want to, doctor. You're obviously very good at drumming up statistics from someplace, but anybody can drum up figures and make them say what they want to say. ... I don't think there's any question that when you drain the money from the existing hospitals into for-profit hospitals, you're going to damage the existing hospitals substantially."

cases in my practice that we can support both systems.

CHESTER: Not as well as if all the cases are in [one] system.

C.E.O.: If you do surgery in the not-for-profit hospitals and in the new hospital in which you are an owner, how will you decide which patients go to which place?

LOMBARDI: I'll do what is best for the patient. It's always going to be patient-driven.

CHESTER: You just got through saying you're going to give the best patient care that there is.

LOMBARDI: Right.

CHESTER: Why wouldn't all your patients go to where the best patient care is?

LOMBARDI: There may be certain things, as you point out, that I cannot do at this facility.

BERASI: We face this decision every day. I practice presently at Doctors Hospital, which is now a surgery center. I also practice at Mount Carmel St. Ann's. When I have patients that have certain medical conditions that require a full-service hospital, we take those patients to St. Ann's without any qualms. When I have patients that have a low medical risk, they can be done at Doctors Hospital.

C.E.O.: Did the physician group consider creating the new hospital as a not-for-profit?

BERASI: Actually, [a not-for-profit would be] a much worse financial deal for the community. A for-profit hospital pays corporate taxes, property taxes. We'll pay personal taxes. That's a significant amount of income that's paid into that community.

CHESTER: As if New Albany needs it.

BERASI: Where we're building this hospital in New Albany is, I believe, about one-and-a-half miles from the Licking County border. Licking County has one-third the physicians per capita that Franklin County has. So if you're looking for an area with need and you're looking for an area for growth, you aren't going to stick it in downtown Columbus—although we entertained that option with OhioHealth and tried to encourage them to do that right at Doctors North. They preferred to close the facility.

CHESTER: I'm sure you remember, doctor, that OhioHealth did its very best to persuade you and your group to stay at Doctors Hospital. They would have made any change in the facilities that you wanted made, and it would have made an ideal orthopedic hospital for you.

BERASI: Actually, Jack, that's incorrect. We were willing to stay there. We had increased our volume there by more than double at one point, and we generated tremendous efficiencies. We had patient satisfaction scores that were the highest in all of the OhioHealth system. Then we were told that facility was closing. It had nothing to do with us.

CHESTER: That's not my understanding.

BERASI: I was at the meeting, Jack.

CHESTER: My understanding is that you were offered every opportunity to have inpatient beds continue at Doctors Hospital North.

BERASI: That's absolutely untrue. We were told those inpatient beds were closing because they were losing money—that we could move to Grant or move out.

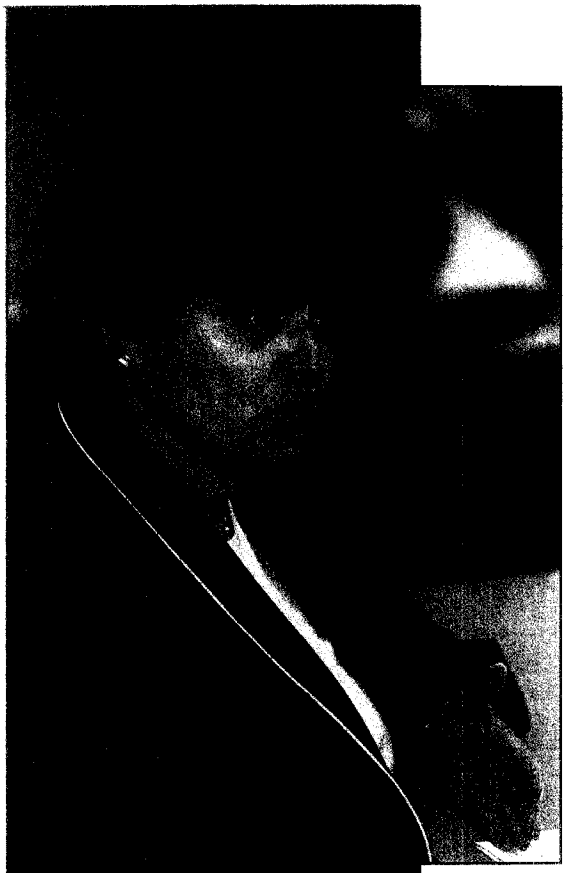
CALVARUSO: The location of your proposed hospital is approximately 10 minutes from two adult, acute-care, full-service community hospitals—Mount Carmel East and Mount Carmel St. Ann's—so I don't think there's a tremendous need.

C.E.O.: Dick Briggs, when you sign your tax return five years from now, do you expect that you will be making more money because of the creation of this new hospital?

BRIGGS: Wouldn't it be nice if I would say yes? But we have no guarantee as investors that we are going to make money in this venture. We may lose it all. That's really not the reason we went in. Our primary goal was to create a better mousetrap, to create a better method of patient care specifically focused on the orthopedic patient, to see if we could do it more efficiently, more cost-effectively.

CHESTER: I don't question that all of you are sincere in your desire to give better patient care. But, doctor, when those patients walk into your door, they'll all be referred to this [new] hospital, won't they?

BRIGGS: They will not. I'll still lean very heavily on my primary hospital. A lot of my patients have primary doctors that [practice at] Mount Carmel East. I'm not going to take



MARY JO WELKER:
"If you look at the cost of healthcare in Columbus versus the cost of healthcare in Florida, California, even the other cities in Ohio, we believe the cost is much higher [elsewhere]. Columbus, because we are a unique community, has kept our healthcare costs and reimbursement levels relatively low. That's a good thing."

those patients away from their primary doctors. If they have a primary doctor that takes care of them and sees them in the hospital, they're going right back to Mount Carmel East. It's of no significance to me, really, except for the opportunity for a better experience if, indeed, we can produce that.

CHESTER: Better experience for what?

BRIGGS: Better experience of getting well. Easy in, easy out, easy place to park, shorter lines, not exposed to the general milieu of a general hospital, which is sometimes very busy, sometimes very noisy. Sometimes when you throw sick patients in with well patients—and ours are generally well—there's a mismatch there.

C.E.O.: All three of you on the new hospital side have indicated your intention to continue to practice in the not-for-profit facilities, as well as at the new facility. That, of course, raises the issue of whether you will be *able* to continue. Mary Jo Welker, do you know of any discussions at OSU that might lead to the suspension or revocation of practice privileges for physicians who participate in this for-profit enterprise?

WELKER: No. Ohio State's just recruited a new chair of orthopedics. I think our vision is to grow the department of orthopedics. I don't know of any discussions.

C.E.O.: Joe Calvaruso, what about the Mount Carmel system?

CALVARUSO: Our board has not broached this topic at all. Our approach is to take a positive solution, at least at this point. We are expanding capacity of the Mount Carmel East operating rooms by 50 percent, of the Mount Carmel St. Ann's ORs by a similar number. We believe what physicians like Dr. Briggs and others tell us—that if we can expand capacity, they will continue to use Mount Carmel.

C.E.O.: If the new hospital is constructed and begins operating, it would not be your intent as CEO of Mount Carmel to lock Dick Briggs out?

CALVARUSO: At this point we have not broached that topic.

C.E.O.: Jack Chester, the speculation recently has been that OhioHealth would revoke practice privileges for physicians who participate in this investment group.

CHESTER: I've been told that there are resolutions being circulated in the medical staff that if adopted would do just that. But there's been absolutely nothing that's come before the OhioHealth Board of Directors.

C.E.O.: Can the medical staff on its own revoke privileges?

CHESTER: No.

C.E.O.: So it would have to go to the board?

CHESTER: Yes.

C.E.O.: In the event that such a resolution is signed by a majority of the medical staff and does come before the board, what would be your disposition toward it?

CHESTER: I don't answer "if" questions. It has to wait until it comes before the board.

BRIGGS: I would like to think that staff privileges would be dependent upon the training and qualifications of the physician—and not a punitive action.

CHESTER: If any of the hospitals did adopt such action, doctor, I don't think the action would be considered punitive. I practice with a law firm, and when we have a partner who leaves our law firm and goes into competition with us, we don't tender the use of our facilities to that lawyer.

C.E.O.: Dr. Lombardi, you practice a considerable amount at Grant, correct?

LOMBARDI: A hundred percent.

C.E.O.: If your privilege is revoked by OhioHealth, which owns Grant, would you consider that to be a restraint of your right to practice medicine?

LOMBARDI: I think it would be. I have shown I'm not inadequate in my ability to take care of patients, which I think should be the basis for my privileges.

C.E.O.: Would you contemplate some kind of litigation?

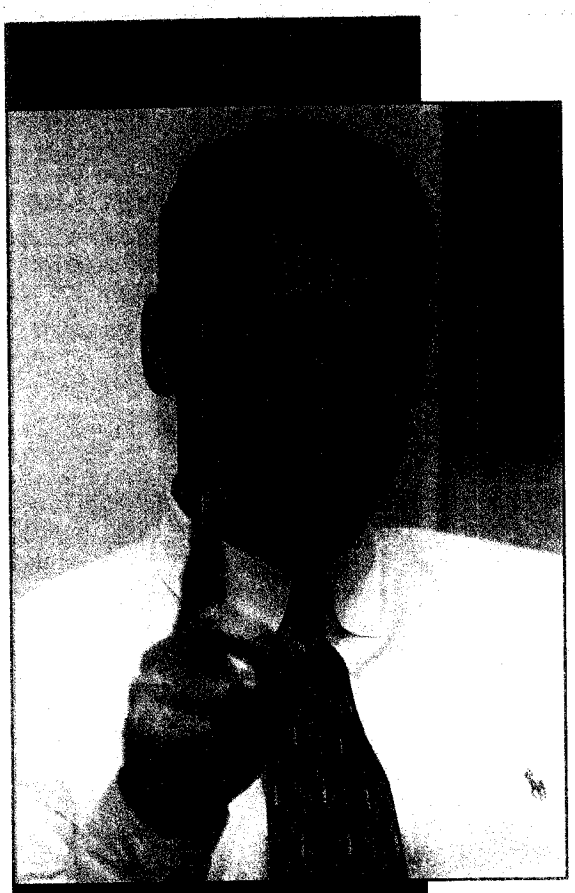
LOMBARDI: I don't know what other recourse I would have.

CHESTER: The recourse is to practice in his own hospital.

C.E.O.: But he's already said that he will have more patients than could be accommodated strictly in the new hospital, correct?

LOMBARDI: Absolutely.

C.E.O.: And I would assume that would apply also to Dr. Mallory and some of the other physicians who have a high-volume practice.



CARL BERASI: "Mount Carmel is undergoing an expansion. Riverside Hospital is putting in 100 beds for a cardiac facility. Ohio State University is expanding. Children's is putting in a heart hospital. Every single hospital in this town is expanding and putting in more hospital beds. Our 30 beds are an insignificant amount in comparison."

LOMBARDI: There are many physicians who have joined us at New Albany who have high-volume practices, and I don't believe that what we're planning right now will accommodate all of those physicians.

CHESTER: You've said that 30 inpatient beds may not be enough. Are you planning on expanding this hospital?

BRIGGS: I have no plans for that, nor have I heard of any. However, I think it would be shortsighted if there was not some feasibility of expansion as needed, and I wasn't just referring to this hospital but for all of our hospitals.

WELKER: Does that mean that for the New Albany community you're going to open up an urgent care center and have emergency care for the community that needs it?

BERASI: We will have emergency care. That's a requirement of a hospital, that you have to have an emergency room.

CALVARUSO: What happens if a patient undergoing a procedure has a heart attack in your facility?

BERASI: If he has a heart attack while he's undergoing a procedure, there will be an internal medicine specialist or a cardiologist immediately present that will take care of him right there. Actually, I'd be much better off than operating at your ambulatory surgery centers, or my ambulatory surgery center down at Victorian Village, or even in some community hospitals.

CALVARUSO: We don't do total hip procedures in our ambulatory surgery facility; we do those in our full-service hospitals.

BERASI: I practiced at Mount Carmel St. Ann's for 10 years without any cardiac coverage or cardiac cath lab being present there, and we were doing total joints all the time. In fact, we had an extremely low mortality rate. We'll have a surgical intensive care unit [at New Albany]; we'll have an internist; we'll have a cardiologist. If they need heart bypass surgery, obviously, we would transfer them to some facility that's capable of doing it, much like St. Ann's does with [its] patients.

WELKER: When you only have 30 beds, how many of those beds are committed to surgical intensive care or medical intensive care?

BERASI: We have the capability of providing surgical intensive care beds.

C.E.O.: Does that mean you will provide them?

BERASI: I don't know if I can answer that question at this time accurately.

C.E.O.: Will there be a temptation to any of the physicians practicing in this new hospital, who also will be investors, to do procedures that are either marginal or perhaps even unnecessary, just to keep the flow of patients and revenue coming?

LOMBARDI: Each and every one of us has practiced for a number of years under the Hippocratic Oath, and we do what is right by the patient. Why are we going to change once we have a hospital system that we are investors in?

BRIGGS: We're not selling surgery; what we are doing is educating the patient so that they can understand the issues enough to make an informed and intelligent decision. I can't see how in the world we're going to compromise our practice and our ethics by doing unnecessary surgery.

C.E.O.: Jack Chester, let us say that this hospital opens and is financially successful. Perhaps other specialty hospitals in other disciplines open and are profitable. Could you see 10 years from now Columbus winding up with one hospital that is primarily a charity care hospital and has to receive enormous levels of public support?

CHESTER: Columbus is the only major city in Ohio that doesn't have a tax-supported hospital, and it's due to the three hospital systems that we have in Columbus. If this [New Albany] hospital is a success, I believe other specialties will follow. There's already been attempts to establish a heart for-profit hospital in Central Ohio; those efforts will be renewed. I think ophthalmology may well follow suit and a number of others.

The drain on our existing hospital systems is going to be devastating, and I think it's going to result in detrimental health care in Franklin County—detrimental patient care, detrimental research, detrimental teaching. Everything that we and the medical profession

hold dear and important will be damaged by this move.

BERASI: That actually hasn't proven to be the case in states that have the highest uninsurance rates and the highest percentage of for-profit hospitals. People have brought up the state of Florida because it has 34 percent for-profit hospitals and it has a 20 percent uninsurance rate. The Urban Institute performed a five-year study in Florida. They stated, and I quote, "Hospitals have so far enjoyed relative financial security, and the poor have been served well."

CALVARUSO: In Florida, 44 percent of the hospitals are investor-owned; only 6 percent of the charity care occurs at those facilities.

BERASI: That doesn't compare apples to apples; it compares apples to oranges. The hospitals in Florida are supported by a public hospital system. The [public hospitals] treat the majority of the indigent patients in Florida. So neither the not-for-profits nor the for-profits have a huge percentage of indigent patients.

CHESTER: When we get the specialty hospitals, our hospital system will be unable to take care of those charity care patients that we take care of now; the community will have to do something about taking care of the indigent and the uninsured.

C.E.O.: Joe Calvaruso mentioned that in Central Ohio there may be as high as a 16-percent uninsured population. If that statistic is accurate, will your new hospital be prepared to dedicate 16 percent of its revenue to uninsured care?

BERASI: I don't think the present hospitals do that. We're willing to do our fair share, but if you look at the OhioHealth website, it reports revenues of more than $2 billion and charity care just under $30 million, which is 1.5 percent. I looked at the [Mount Carmel/Trinity Health] annual report, and [that system] contributed $39 million in traditional charity care on revenues of $4.1 billion; that's a little less than 1 percent. I don't think we want to get tricked into saying we're giving 16 [percent] when it looks like our competitors may be doing 1 to 1.5 percent.

CHESTER: You can quote all the figures you want to, doctor. You're obviously very good at drumming up statistics from someplace, but anybody can drum up figures and make them say what they want to say. The existing hospitals are struggling now to keep their bottom lines in the black. I don't think there's any question that when you drain the money from the existing hospitals into for-profit hospitals, you're going to damage the existing hospitals substantially.

WELKER: If you look at the cost of healthcare in Columbus versus the cost of healthcare in Florida, California, even the other cities in Ohio, we believe the cost is much higher [elsewhere]. Columbus, because we are a unique community, has kept our healthcare costs and reimbursement levels relatively low. That's a good thing. I don't know that we want to be like Cleveland and have a lot of those costs go up tremendously.

CALVARUSO: In Cleveland, in Cincinnati, in Dayton they all have tax support. We take care of our own in Columbus. All systems have said, "We exist for the community; we will provide care regardless of ability to pay." But when the lucrative patients are directed away from us to organizations that physicians own, we don't have the wherewithal then to do that without tax support. ◊

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