surgery patients to Clarian. Wishard operated a burn unit, whereas Clarian's local Methodist Hospital did not, so Clarian sent its burn patients to Wishard.

Wishard was recognized as an important part of the area's healthcare system. The other area hospitals and community knew that closing Wishard would have a devastating impact on area healthcare providers in that they would have to absorb the indigent care. Indigent patients would also have a much more difficult time finding care.

Mark Mueller, a patient whose perspective on Wishard had changed with his own fortunes and health problems, exemplified the struggle of indigent people to obtain care. He counted on Wishard for almost all of his healthcare—in fact, his life depended on it. He had been diagnosed with diabetes, and his kidneys had failed. He had been unemployed for six years and lived on disability. He had lost his insurance coverage, so Wishard was the only place he could go for care. "I wouldn't have any options," said Mueller, a widower. "I just don't see how the poor . . . well, a lot of them won't survive if Wishard goes down the tubes" (Penner 2003a).

An Interim Solution

Wishard had to do something to stem its losses. Frustrated, Wishard's board realized that most of the options it had considered were too long-term or impractical. However, it seriously discussed yet another option—increasing and enforcing copayments. While the overall purpose of Wishard was to care for the poor, the more poor patients it served, the greater the hospital's losses. In an effort to reduce the number of visits by poor patients, Wishard implemented a new copayment policy on October 1, 2003, that dramatically increased copayments for patients visiting physician clinics and using emergency department services. Although revisions of this policy in 2004 decreased the amount of up-front (time of service) copayment required of self-pay patients, copayments still ranged from $35 to $120, a significant amount for most indigent patients.

Collection of copayments also became vigorously enforced. In the past, the clinics and the emergency department often overlooked it, understanding that many of their patients had little or no money. Beginning in late 2003, each clinic, hospital, and emergency department was required to collect copayments from all nonemergency patients up front.

Some board members and physicians were concerned that this policy would discourage vulnerable patients from seeking care. They speculated that pregnant women might skip physician visits and wind up rushing to the emergency department at the time of delivery. They also feared that patients with diabetes and hypertension might self-treat and seek care only in emergencies, which could increase hospital stays and the overall cost of care.

Wishard continued to struggle to find its strategic direction. The only certainty was that the future would become only more difficult for all healthcare providers, especially those like Wishard that primarily served poor and vulnerable populations.

Sources: Penner (2003a, 2003b); Swiatek (2003).

Questions

1. What was Wishard's competitive situation?
2. Did Wishard have direct competitors? If so, in what areas did it compete?
3. What strategic leverage did Wishard have over the other area hospitals?
4. From a societal perspective, what problems occur by having a stand-alone public hospital with a primary mission of serving the indigent population?
5. What strategic steps would you recommend for Wishard?

6. St. John's Reengineering

St. John's Hospital, a medium-sized hospital located in Seattle, Washington, was established in 1894 with a primary mission of caring for the sick and downtrodden. The hospital had grown and developed as a solo facility until 2000, when it merged with a suburban hospital, St. Agnes. This merger caused many changes in the organizational structure of both hospitals. A corporate office was established and located approximately halfway between the facilities. The president of St. John's, Abhishek Ghosh, was promoted to the position of corporate president, and the president of St. Agnes became the senior vice president.

The early 2000s was a busy time for the corporate office. By 2002, it had 45 employees. The hospitals diversified their organization by purchasing a number of urgent care centers, physician office practices, and skilled nursing facilities. Ghosh was certain that integration would create stability and financial success. However, the urgent care centers and the skilled nursing facilities barely broke even, and the physician office practices lost almost half a million dollars per year. As the years progressed, it became increasingly critical for the hospitals to generate enough cash flow and profit to subsidize the other parts of the corporation.

Both hospitals did reasonably well in the early 2000s, but with reductions in Medicaid and Medicare reimbursements, their margins narrowed. By 2003, both hospitals were earning less than a 2 percent net profit margin, and the prospects for 2004 seemed worse. In 2003, patient revenues did not cover expenses for the first time. After seeing these figures, Ghosh called an emergency executive session. Those in attendance included the presidents of both