The stand-alone osteopathic hospital was a necessity to the osteopathic medical profession in an era when it was isolated from allopathic medicine. As osteopathic medicine has become increasingly integrated with allopathic medicine, however, an independent osteopathic hospital is no longer a necessity. Moreover, a stand-alone institution seems to be economically out of place in today’s market. The Osteopathic Medical Center of Texas in Fort Worth is an example of a stand-alone hospital that was unable to capitalize on the benefits realized by integrated hospital systems. The author believes that this failure contributed to the institution’s demise. The market power of a hospital system can be used for more favorable contracting with vendors and providers, as well as facilitating negotiations with payers. System affiliation provides economic efficiency, security, and protection in the highly uncertain, complex, and competitive healthcare market.

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The last osteopathic hospital in Texas ceased all operations in the fall of 2004. The Osteopathic Medical Center of Texas (OMCT) in Fort Worth was one of 35 osteopathic hospitals in Texas as recently as 1988. The closing of the OMCT was due to management issues and transition factors affecting osteopathic medicine in general, such as changing physician referral behavior. Management problems included lack of participation in a hospital system, accounting and information system deficiencies, high levels of debt, and poor liquidity. The purpose of this article is to explore the issues faced by independent osteopathic hospitals in light of the transformation of osteopathic medicine and the trend of independent hospitals joining hospital systems.

Primary vs Specialty Care
The primary care orientation of osteopathic medicine corresponds with the vision and needs of managed care but does not accord well with a hospital market that is increasingly expected to provide tertiary care. Much of the success of the managed care model is dependent on cost-containment strategies—not the least of which is reducing hospital use. Consequently, hospitals are left with more critically ill inpatients requiring specialized care.

Cost Control
The issue of cost control is paramount in today’s healthcare marketplace. A comparative analysis of osteopathic and allopathic hospitals found significantly higher costs at osteopathic hospitals. The average cost per inpatient day at an osteopathic hospital in 1999 was $975 compared with $831 at an allopathic hospital. Outpatient visits were also found to be more costly at osteopathic vs allopathic hospitals. These higher costs were attributed to higher labor and supply costs, as well as sources of inefficient production, such as low volumes of care.

Many of the hospitals accredited by the American Osteopathic Association (AOA) that are financially viable in today’s marketplace have joined integrated hospital systems. They have subsumed their individual character to some degree to benefit from the economic efficiency and market power of hospital systems.
**Physician Referrals**
Historically, osteopathic hospitals relied extensively on referrals from osteopathic primary care physicians. The commitment of osteopathic physicians to osteopathic hospitals, however, has waned, owing to the general acceptance of osteopathic physicians by the allopathic medical community. Today, many osteopathic physicians complete their residency training in programs accredited by the Accreditation Council for Graduate Medical Education and then obtain hospital admitting privileges at allopathic facilities. Their referrals to hospitals are more likely to be based on perceptions of quality or convenience than on a sense of loyalty to osteopathic hospitals.

**Quality of Care**
Hospital quality is difficult to gauge, but there is a wealth of literature on the subject. One large study analyzed data for 16.9 million hospitalized Medicare beneficiaries from 1984 to 1993. The mortality rates for these patients were compared among hospital categories, including not-for-profit osteopathic teaching hospitals and allopathic teaching hospitals. While the study did find substantially more favorable odds ratios for some procedures at osteopathic hospitals, such as laminectomies and endarterectomies, these facilities had the highest risk-adjusted mortality rate for 10 common procedures. Osteopathic hospitals had a mortality odds ratio of 1.36 compared with the baseline of 1.0 for not-for-profit teaching hospitals and 1.3 for public hospitals. This study did not address concurrent disease states, severity of illness, or issues related to access to care in this population, however.

**What Happened at the OMCT?**
The OMCT was established in 1946 as a not-for-profit entity following the passage of the Hill-Burton Act of 1946. In 1970, what is now the University of North Texas Health Science Center at Fort Worth—Texas College of Osteopathic Medicine (TCOM) was established, and the OMCT became its major teaching hospital. The hospital also was also a site for AOA-sponsored graduate medical education.

**Public Payers**
The Osteopathic Medical Center of Texas was more reliant on public payers such as Medicare and Medicaid than many of its competitors. Public payers have commonly offered more constrained reimbursement than commercial health insurers. In 2001, the OMCT’s inpatient reimbursement from commercial insurers was estimated to be 10.5% of inpatient revenues compared with a statewide average of 33.5% (written communication, October 2003). In addition, liquidity was a concern. According to the balance sheets, the current ratio was a relatively healthy 2.2 in 2000 and 2001 but declined to 1.1 in 2002 and 0.9 in 2003.

In 2002, the OMCT experienced a loss of $21.7 million on total revenues of $112.8 million. Measures to reduce losses in 2003—such as attempts to renegotiate contracts, improve control of costs, and enhance revenues—were not enough to save the hospital. Financial results improved somewhat in 2003, but the center still showed a loss of $6.8 million on $121.8 million of revenue. Between October 2003 and late April 2004, the hospital reported further losses of $5.2 million on $73 million of revenue. The hospital then defaulted on a portion of $82 million in bonds when it failed to make debt service payments in August and September 2004. In addition, ratings for $7 million in uninsured bonds were downgraded.

**Deteriorating Physical Structures**
During this time of financial hardship, the general condition of the old hospital was deteriorating. The OMCT needed an estimated $16.5 million for expansion of the operating room, intensive care unit, and other units; $12.4 million for general renovation of the hospital; and $7.3 million to modernize the aging infrastructure (written communication, October 2003). New capital projects for the heavily indebted hospital could not be easily financed, however.

**Medical School–Hospital Relations**
Osteopathic hospitals have traditionally been ambivalent about close partnerships with colleges of osteopathic medicine because of concerns about fairness in policy development and issues of control or perceived control stemming from the classic “town and gown” conflict. The diminished size and scope of service of the OMCT Health Care System acquired two hospitals. This development infused capital into a hospital system, thus building more competition for the unaffiliated OMCT.

In addition, the OMCT’s venture into for-profit, nonhospital healthcare services may have become an added drag on its bottom line (written communication, October 2003).
negatively affected the hospital’s ability to support programmatic growth at TCOM. Rotations for medical school classes spread to other hospitals in Fort Worth, where the students were increasingly welcomed. Communications, although cordial, were subject to discord driven largely by the changing environment: as the demand for osteopathic hospitals was eroding, the demand for osteopathic education remained strong. At the start of the 21st century, the new administration at TCOM sought an open dialogue with the new executive leadership team at the OMCT, but it became obvious that both institutions had transformed over the years and only some mission-specific alignment was possible.

Hospital Closes Its Doors
By mid-2004, it was clear that the OMCT could not “reinvent” itself and that, without a massive infusion of capital, the hospital would not survive. The hospital closed on October 8, 2004, sending 1000 employees, 300 physicians, and 60 interns and residents scurrying to find employment with little more than 24 hours’ notice. MBIA Inc (Armonk, NY), a bond insurer, wrote off $49 million in debt. In February 2005, the main campus of the hospital was purchased through foreclosure for $6.5 million. The regents of the University of North Texas later acquired the property for expansion of its Health Science Center.

Economics of Hospital Networks
Economists commonly hold perfect competition as an axiomatic virtue. But in the challenging business of hospitals, market power is a cornerstone of survival. Hospitals must have the requisite market power to negotiate with insurers, suppliers, physicians, and others. Experts in industrial organization recognize that consolidation of the hospital industry with mergers and networks has generated efficiencies in some areas. Economies of scale and scope result in more efficient production. Independent hospitals may pay more for inputs, receive less compensation for services, and obtain fewer referrals because they lack the recognizable brand image that hospital systems provide. System affiliation provides security and protection in a highly uncertain, complex, and competitive environment.

The stand-alone osteopathic hospital is an anachronism in the 21st century. Historically, these institutions owed their existence to the isolation of osteopathic from allopathic medicine. However, this separation no longer exists, and osteopathic physician referral patterns are not limited to the osteopathic field. Many AOA-accredited hospitals have joined hospital systems and maintain their osteopathic identity within the context of these larger systems. While this transition may be associated with some degradation of autonomy, it is necessary for survival in a world where market pressures are fierce and osteopathic medicine has become well integrated with allopathic medicine.

Survival in today’s hospital marketplace requires affiliation with large systems. The market power of a hospital system can be used for more favorable contracting on the supply side and can facilitate negotiation with payers on the demand side. The OMCT failed to capitalize on systems integration. High levels of debt should have underscored risk and flagged greater attention, but perhaps fears of losing the osteopathic identity kept the administration from heeding those warnings.

References


All osteopathic physicians are university graduates holding medical degrees: in the US they study osteopathic medicine, which is fully integrated with medical schools, but elsewhere most osteopathic physicians are MDs with additional osteopathic qualifications. Ensure standards for public safety. More countries are now recognising and regulating osteopathic care. Andrew Taylor Still, founder of the osteopathic approach, was born in 1828 in the American state of Virginia, and took up medicine as an apprentice to his father, learning the rudimentary medical techniques of the day. In 1864, around the time he returned home from the Civil War, three of Still’s children died during a spinal meningitis epidemic, followed by a daughter from pneumonia.