WHY JEWISH HOSPITALS ARE DISAPPEARING

DAVID A. GEE
President Emeritus, The Jewish Hospital, St. Louis, Missouri
AND
ALAN WEINSTEIN
President, Premier Hospitals Alliance, Westchester, Illinois

Only half of the Jewish hospitals that were in existence 30 years ago are still operating today. Jewish hospitals no longer play their historical role as a haven for Jews, and they face greater challenges than other community and religiously affiliated hospitals—larger size, heavier financial burdens, secondary teaching status, high CEO turnover, and overmanaging boards of directors.

Only half of the 44 Jewish-sponsored hospitals that were operating in the United States 30 years ago still exist today. And, of the remaining 22 Jewish hospitals, several are on the verge of merger with non-Jewish facilities (Tables 1 and 2).

Why have so many Jewish hospitals closed or merged with other facilities over the last three decades? The reason is two-fold: first, the role assumed by Jewish hospitals historically is no longer the role that those institutions play today, and second, the challenges faced by Jewish-sponsored hospitals are greater than those of other community and religiously affiliated institutions.

HISTORICAL ROLE: A HAVEN FOR JEWS

Jews began coming to this country in colonial times when Sephardic Jews from Portugal and Spain settled in New York and New England. German Jews arrived in large numbers between 1815 and the mid-nineteenth century, creating the mercantile empires that became the financial backbone of American Jewish communities.

Although New York City was the chief port of entry for German Jewish immigrants, backpacking peddlers soon spread across the country and formed the core of small but numerous Jewish communities throughout America's heartland. Not surprisingly, the first Jewish hospital in the United States was organized in 1850 in Cincinnati, followed 2 years later by the Mt. Sinai Hospital in New York City.

By the end of the 19th century, anti-Jewish campaigns in Eastern Europe and especially in the Jewish Pale of the Ukraine, Byelorussia, Silesia, and Lithuania brought thousands of Jewish immigrants to this country. To meet the needs of the Eastern European immigrants for family and social services, job placement, income support, and medical care, established German-Jewish communities created a Jewish social service network for the new arrivals. Many services were designed to enable observant Jews to maintain halacha, the body of law governing many aspects of Jewish life, such as eating kosher food.

Anti-Semitism, particularly its impact on the training of Jewish physicians, was another contributing factor in the development of Jewish hospitals. Until World War I, Vienna and Berlin were the medical education centers of the world; many Jewish physicians received their training there. However, Jewish students who wished to train in this country were often turned away by local hospitals. As a result, the charters of many Jewish hospitals specifically refer to the training of Jewish physicians, even when they specify that patients will be cared for on a nonsectarian basis.

By the start of World War I, there were 19 Jewish hospitals in the United States.

Table 1.
JEWISH HOSPITALS IN OPERATION IN 1991

HOSPITAL	CITY	FOUNDED
Jewish	Cincinnati	1850
Mt. Sinai	New York	1852
Touro Infirmary	New Orleans	1852
Sinai	Baltimore	1868
Albert Einstein[a]	Philadelphia	1865
Montefiore	New York	1884
Maimonides[b]	New York	1886
Beth Israel	New York	1889
Beth Israel	Boston	1896
Jewish	St. Louis	1900
Beth Israel	Newark	1902
Jewish	Louisville	1903
Mt. Sinai	Cleveland	1905
Burnert	Paterson, NJ	1908
Mt. Sinai	Chicago	1918
Cedars-Sinai[c]	Los Angeles	1920
Brookdale[d]	New York	1921
Miriam	Providence	1925
Beth Israel	Passaic, NJ	1926
Menorah	Kansas City	1931
Long Island	New York	1949
Mt. Sinai	Miami	1949
Sinai	Detroit	1953

[a]Albert Einstein is the merger of the Jewish Hospital of Philadelphia (1865), Mount Sinai Hospital of Philadelphia (1900), and the Northern Liberties Hospital.
[b]Originally known as Beth David Hospital. The name was changed in 1910.
[c]Created by the merger (1963) of Mt. Sinai (1920) and Cedars of Lebanon Hospital (1930).
[d]Originally named Beth El.

Table 2.
JEWISH HOSPITALS WITH RECENTLY CHANGED STATUS

HOSPITAL	CITY	FOUNDED	CHANGE
Michael Reese	Chicago	1879	Sold to Humana, 1991
Mt. Zion	San Francisco	1887	Merged UCSF, 1991
Jewish	Brooklyn	1901	To City of NY
Mt. Sinai	Milwaukee	1902	Merged
Jewish Memorial	New York	1905	Closed
Montefiore	Pittsburgh	1908	Sold to U. Pittsburgh, 1990
Mt. Sinai	Hartford	1923	Merged St. Francis, 1990
General Rose	Denver	1949	Merger discussions
Mount Sinai	Minneapolis	1951	Merged, then sold

Another eight opened between 1918 and the end of World War II. Five more were organized after that war. In addition, another 12 institutions were identified as having been organized under some type of Jewish auspices.

CHARACTERISTICS OF JEWISH-SPONSORED HOSPITALS

Little Exclusively Jewish

Today, very little remains that is exclusively Jewish about a Jewish hospital. Catholic hospitals now routinely serve kosher food; a *brit milah*, or ritual circumcision, is performed in all hospitals. Although latent anti-Semitism persists in the United States, it is not a deciding factor in many patients' selection of physician or hospital.

Larger Size

What *is* characteristic of Jewish hospitals today is that on the whole they are larger, serve greater numbers of the disadvantaged, and are suffering more financially than both the typical community and religiously affiliated hospital, according to research conducted by Premier Hospitals Alliance. Premier, a cooperative of 49 major teaching and research hospitals of which about one-third are Jewish-sponsored, conducted the research in 1990 at the request of the Council of Jewish Federations.

In 1989, the average Jewish hospital had 470 beds, compared with an average size of 100 beds for a community hospital and 200 beds for a religiously affiliated hospital. However, the average size of Jewish hospitals has been falling over the past 5 years, from 580 in 1985 to 470 in 1990, whereas the average sizes of both the community and the religiously affiliated hospital have held virtually constant.

The Financial Burden

Premier's research on Jewish hospitals also shows that Jewish hospitals are significantly worse off financially than U.S. hospitals as a whole. Profit margins for the typical U.S. hospital in 1989 were 2.6%, compared to less than 0.05% for Jewish hospitals.

Regardless of religious sponsorship, location of hospitals in the inner city is an invitation to suffer negative economic consequences. Jewish hospitals tend to be situated in central cities where the Jewish population was concentrated when they were first built. The upward mobility of Jewish populations has left Jewish hospitals behind in neighborhoods that are no longer Jewish.

Hospitals, which have complex physical structures and capital-intensive plants, are not easily moved. Yet, some have attempted to follow relocating Jewish communities. In Baltimore, for example, the Sinai Hospital occupied an aged and obsolete structure across the street from the Johns Hopkins Medical School in a decayed and unattractive section of Baltimore. A new Sinai Hospital, this one handsome and modern, was built in 1960 in a more suburban part of the city. Yet, it was only a few years before the Jewish community relocated again, leaving behind a largely indigent black population. Having given up the benefit of proximity to Hopkins, Sinai failed in the long run to gain from its new location.

Sinai Hospital in Detroit made a similar decision by moving to the center of the Jewish population in 1953; the Jewish community then moved north to the suburbs, leaving the hospital behind. A more practical, long-range approach might have been to locate the Jewish hospital near the Wayne State Medical Center Campus where it could have enhanced its academic position.

Partly because of location, but also because of liberal social philosophy, Jewish hospitals also have a disproportionate share of indigent patients. Among Jewish hospitals, according to Premier's research, 17.8% of all patients were Medicaid recipients in 1988, compared with 8% among hospitals nationwide and 8.2%

among religiously affiliated hospitals. That represents a disparity of more than 100%.

"Second-Class" Teaching Status

During the post-World War II years as anti-Semitism declined, training opportunities for Jewish physicians began to increase as they were accepted and evenly sought out by other medical schools and teaching hospitals. Today, in a nation where only about 2% of the population is Jewish, 18% of all physicians are Jewish. Many enjoy the reputation of being the best-trained doctors.

Most Jewish hospitals continue to reflect their original mission of serving as a training ground for Jewish physicians by providing some form of medical education program or being affiliated with a medical school. Most, however, are not the primary teaching hospital of the medical school with which they are affiliated. Notable exceptions include Mount Sinai Hospital and Montefiore Medical Center, both in New York, as well as Beth Israel Hospital in Boston, which is well positioned because of the way in which Harvard Medical School affiliates with hospitals.

Sinai Hospital in Baltimore, however, is subordinated in terms of faculty to Johns Hopkins; Mt. Sinai in Cleveland and Jewish Hospital in St. Louis have similar relationships with Case-Western Reserve University Hospital and Barnes Hospital, respectively. This secondary teaching status of many Jewish hospitals could pose a greater problem in the future, particularly if federal regulations limit medical education funds to one primary teaching hospital.

Of more immediate importance is how differing missions and economic pressures make existing relationships fragile between teaching hospital and medical school. Michael Reese Hospital in Chicago and Montefiore Hospital in Pittsburgh both succumbed to those and other pressures last year and subsequently were sold and acquired in a merger, respectively. Another respected institution, Mount Zion in San Francisco, merged with the University of California at San Francisco.

High CEO Turnover/Overmanaging Boards

Although the annual turnover rate among hospital chief executive officers (CEOs) has dropped from 33% to 24% over the last 4 years, the fact that almost a quarter of CEOs lose their jobs each year suggests management instability in the hospital field. Financial exigencies, an inability to deal with a rapidly changing environment, and clashes with medical staffs and boards of directors are all contributing factors to this high turnover rate.

Yet, hospitals under Jewish auspices have experienced even higher CEO turnover rates. Between 1984 and 1986, for example, there was a 50% turnover rate among Jewish hospital CEOs. Of the 22 hospitals now under Jewish auspices, only four CEOs have held their current positions for longer than 10 years. Four of the current CEOs have been in office since 1986, and four others date back only to 1989.

When a large and prestigious Jewish hospital was recently sold, one of the reasons cited for its fiscal difficulty was the high turnover rate among its CEO and CFO positions. No one in a senior executive position had been at the hospital long enough to grasp the significance of the factors that were impairing the hospital's financial health.

Although never documented, Jewish hospitals also have a reputation for being overmanaged by their boards of directors. According to the bylaws of several Jewish hospitals, the board chairperson, not the hospital president, is the CEO. In some Jewish institutions, the board is closely involved in the day-to-day operating functions of the hospital.

Boards representing tightly knit communities, such as Jewish communities where board members often are direct descendants of the hospital's founders, tend to take a proprietary interest in the institutions they have created. Jewish hospital boards generally include professionals, small

business people and community leaders and tend to be much more involved than boards comprising corporate executives. In contrast, hospital boards with Fortune 500 company or major local business representatives typically expect management to do its job and do not interfere with operating functions.

Every Jewish hospital has anecdotes about board interference in the management process. One hospital cited 22 board committee and other similar events each week on average for the year. In another Eastern Jewish hospital, board members have allied themselves with specific chiefs of clinical services, thereby establishing multiple constituency groups of which many work at cross-purposes.

Premier Hospitals Alliance is currently conducting a study to gain greater insight into how the values and attitudes of a hospital's governing board affect its decision making.

Jewish Priorities

The absence of overt anti-Semitism, the lack of Jewish identity among Jewish hospitals, and the relocation of Jewish communities away from Jewish hospitals have diminished the perceived value of the Jewish hospital as a Jewish institution. Today, the needs of Israel, Jewish education, resettlement of Russian Jews, and programs for the rapidly aging Jewish population clearly have taken priority over Jewish hospitals.

Furthermore, although Jewish hospitals historically were an integral part of the social framework of the community, today they are large and complex and have outgrown their sponsors both in dollars and influence. For example, in 1950 the federation and Jewish Hospital in St. Louis both had annual operating budgets of $1 million. Forty years later, the federation was operating on $10 million while the hospital had grown to a $200 million budget. The community perception is the federation is the social safety net, and the hospital is "big business."

Nevertheless, Jewish communities traditionally have strong emotional ties to their local Jewish hospital. Even though Jewish physicians may now practice in Catholic or Protestant institutions and admit Jewish patients to those hospitals, many still feel that a Jewish hospital represents a haven in the event of the resurgence of anti-Semitism. Jewish communities in Minneapolis, Milwaukee, and Hartford have mourned the loss or restructuring of their Jewish hospitals.

Many Jewish communities also believe that their hospital is the chief bulwark against anti-Semitism because it is the practical representation of how the Jewish community serves the community at large. Mount Sinai Hospital Medical Center of Chicago, which today serves a predominantly African-American and Hispanic population, is an excellent case in point.

It seems likely that at least a few more Jewish hospitals will close because they have outlived their original mission and because their present-day burdens are simply too great to maintain. Yet, it also seems probable that, of the remaining Jewish hospitals in this country, many will continue to be highly regarded, not because they are inherently Jewish but because they are responsive to community needs, promote excellence in a complex field, and are models of quality both in terms of the health care services they provide and the way in which they are managed.