How Does a Hospital's Not-for-Profit or For-Profit Status Affect Its Commitment to Community?

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Abstract

Historically, private firms organized as not-for-profit corporations have dominated the delivery of hospital care in the United States. However, the number of investor-owned, for-profit hospital and delivery systems has recently been on the rise. Past research has suggested that not-for-profits are charitable organizations and provide a higher level of benefits to the communities they serve than for-profit hospitals. Though recent research suggests that there is no significant difference in the amount of charity care for-profits and not-for-profits provide, many are concerned that the increasing number of for-profit hospitals will endanger community benefits.

By examining two similar hospitals in the same community, one being a converted for-profit and the other a not-for-profit that was sold to a not-for-profit hospital company, I investigated the levels of community benefits before and after each hospital’s sale. I also compared the hospital’s community benefit levels against each other in order to determine ways in which a hospital’s status can affect its community benefits. As expected, there were no significant changes in community benefits from the not-for-profit hospital that remained not-for-profit. However, the for-profit increased its community benefits level after it bought the not-for-profit. Hospital status as well as other associated factors play a determining role in community benefits. Like previous research, I also found that it was difficult to conclude that the not-for-profit in this case study provides more community benefits than the for-profit.
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1. Introduction

Historically, private firms organized as not-for-profit corporations have dominated the delivery of hospital care in the United States. However, the number of investor-owned, for-profit hospital and delivery systems has recently been on the rise. Today, approximately 86% of American hospitals are not-for-profit and 14% are for-profit. In addition, 4% of not-for-profit hospitals were converted to for-profits between 1990 and 1996. Radical changes in the health care marketplace have contributed to the rising number of conversions. Demand for hospital services have declined as technological advances have allowed for more surgeries to be done on an outpatient basis. Hospitals also suffer from lower reimbursement rates from public and private payers. The growth of multi-hospital companies has also encouraged hospital conversions (Nicholson, et. al 2000).

Both not-for-profit and for-profit hospitals are in business to provide hospital services to the communities in which they are located. The primary difference between these two types of institutions is that for-profit hospitals have the obligation of providing financial returns to their stockholders and they also pay taxes. Not-for-profit hospitals are not obligated to stockholders and are exempted from most taxes, including property and some income taxes. While for-profit hospitals gain access to equity capital for improvements from issuing stock, not-for-profit hospitals are dependent on donations for capital although they do have some access to equity capital (Reinhardt 2000).

During the last fifteen years, there has been a debate over the community benefits that not-for-profit and for-profit hospitals provide. And this debate has been re-ignited over the past several years. Some past research has suggested that not-for-profits are
charitable organizations and thus provide a higher level of benefits to the communities they serve than for-profit hospitals. Studies in the early 1980s, such as the one done by the Institute of Medicine, suggested that for-profit hospitals are less charitable than not-for-profit ones (Gray 1986). However, recent research suggests that there is no significant difference in the amount of charity care that for-profits and not-for-profits provide as discussed further in the literature review.

Community benefits provided by hospitals include charity care to patients who cannot afford to pay for services, health-related outreach activities such as screenings and health fairs, losses on medical research and education, and taxes paid to local communities by for-profit facilities. Community benefits can be considered to be public goods in that they generate benefits for people other than the direct consumers of the benefits (Nicholson, et. al. 2000). For example, free immunization clinics benefit those immunized as well as the general public. The community benefits that hospitals provide are crucial to the citizens in hospitals’ service areas. As the number of uninsured persons continues to remain high and as the costs of health services exponentially increase, the supply of charitable hospital services will need to increase to counter these problems. For-profit hospitals in addition to not-for-profit hospitals have mission statements, which declare hospitals’ aim of providing quality health services for all. Thus, the provision of community benefits is a responsibility that medical facilities should be held accountable for. Barnett and Pittman argue that hospitals could also economically benefit from providing benefits (2001). For example, they state that hospitals can benefit from a positive local image, which could increase customer loyalty.
The concern over community benefits provision extends to both for-profit and not-for-profit institutions. As for-profit hospitals grow in number through conversions, it will be important to assure that they provide care and services comparable to those of not-for-profits. Policy makers have also been scrutinizing the community benefit levels of not-for-profits, especially since they are given tax-exemptions for their charitable status. Community benefits provision is an important issue and could have implications for tax policy and other health care-related policy. Although federal legislation has not been very detailed in community benefits requirements, many states have imposed stricter guidelines on not-for-profit hospitals. As the number of not-for-profit to for-profit conversions increases, it must be assured that there is adequate oversight. With cases of not-for-profit health systems acquiring and closing facilities and cutting back on community benefits, policy makers and advocates will also be keeping a closer eye on not-for-profit hospitals as well (Barnett and Pittman 2001).

Many previous studies on community benefits have been quantitative and have not implemented a qualitative perspective in the research on conversions and community benefits (Sloan 2001). According to Sloan, “qualitative studies can reveal differences in and changes in decision making processes that otherwise can only be inferred very directly from outcome changes. By peering inside the ‘black box’ of hospital decision making, our understanding of these changes enhances.” In order to determine if there are differences in levels of community benefits after a not-for-profit hospital converts, I conducted case studies of two not-for-profit hospitals in a metropolitan area of Northern California: one that converted to for-profit status and one that remained non-profit. I looked at community benefits levels before and after conversion. The not-for-profit was
previously a stand-alone hospital bought by a not-for-profit company. It serves as a control because one would not expect significant changes (particularly declines) in community benefit levels because the hospital and the company are likely to share similar philosophies and missions. I also compared the hospitals community benefit levels against each other. The measures of community benefits I focused on are: trends in the prices of services, unprofitable services offered, the amount of uncompensated care, educational and community outreach activities offered, community representation on the hospital board, employment levels, and the amount of money spent on Medicare and Medicaid downfalls. I took more of a qualitative approach through interviews with hospital administrative and medical staff, board members, employees, and labor union representatives to assess changes in levels of community benefits pre-conversion and post-conversion. I took these different stakeholders’ perspectives into account. In addition, I investigated the decision-making process of each hospital to convert or not to convert and asked about the community’s involvement. I felt that looking at the issue on a local level instead of focusing on a large sample is more beneficial in determining the real effects of a hospital’s conversion. The names of the hospitals in this study are not used. Every effort is made to preserve the anonymity of the hospitals and the interviewees. The not-for profit hospital is referred to as Hospital A and the converted for-profit hospital is referred to as Hospital B.
2. Literature Review

2.1 The Changing Marketplace of Hospitals in the United States

In the United States, private firms organized as not-for-profit corporations have traditionally provided hospital care. Physicians’ services have been rendered through partnerships, proprietorships, and for-profit corporations (Pauly 1996). Hospitals in the late 19th and early 20th centuries were mostly not-for-profit and had to be charitable because they mostly took care of the very ill poor. However, paying patients received care at home from physicians (Bovbjerg, Marsteller and Nichols 1998). Half of early 20th century hospitals were small for-profit organizations that were owned by physicians as adjuncts to their private practices and many of them failed during the Great Depression (Horwitz 1998). Although there were both not-for-profit and for-profit hospitals at the beginning of the 20th century, not-for-profit hospitals had better community support (Bovbjerg et. al 1998). For example, the federal Hill-Burton Act passed in 1945 loaned hospitals money for capital with the stipulation that they provide a certain level of uncompensated care (Horwitz 1998). Over the past ten years, there has been a wave of the entry of for-profit, investor-owned firms into the hospital sector which is simultaneous with the increasing development of integrated health delivery systems and multi-hospital firms (Pauly 1996). Today, most American hospitals are still primarily organized as not-for-profit, tax-exempt corporations (Horwitz 1998).

There have been many changes in the health care marketplace that have affected the provision of medical services in hospitals. During the late 1980s and early 1990s, the financial condition of many not-for-profit hospitals deteriorated. This was caused by the decline in the demand for traditional hospital services as medical technological advances
allowed more surgical procedures to be done outside of the hospital setting. More than half of surgical procedures performed in 1992 were done on an outpatient basis compared to 21% ten years prior. It also became more difficult for stand-alone, not-for-profit hospitals to negotiate favorable transactions with physicians, insurance companies and medical suppliers because of their lack of size and lower number of services provided (Phillips 1999). This led to the increase of ownership consolidation in the 1990s (Florence, Seiber and Thorpe 2000). Hospitals have also faced decreasing reimbursement rates from public and private payers, which do not adequately cover the cost of providing services. There is increased competition from provider networks. And the system of capitation under managed care has also complicated the provision of medical services (Phillips 1999).

2.2 Why Hospitals Convert

Changes such as these have contributed to the increase in the number of not-for-profit hospitals converting to for-profit status. Over the past twenty-five years, 7% of not-for-profit hospitals converted to for-profits. Whereas the number of conversions in the 1970s averaged 5 to 10 per year, in 1995 there were 44 conversions of hospitals from not-for-profit to for-profit status. Within the last ten years, larger hospitals have decided to convert. Hospitals with over 200 beds only accounted for 15% of conversions in the 1970s and early 1980s, but they accounted for nearly half between 1994 and 1995 (Cutler and Horwitz 1998). In the following subsections, I discuss reasons hospitals may decide to convert.
2.2.1 As a Defense Strategy

In order to counter unfavorable market conditions, many hospital owners use conversion as a defense strategy (Horwitz 1998). Instead of facing closure as a result of poor financial conditions, some hospitals decide to merge with a for-profit in order to sustain the hospital’s operations. On average, hospitals that converted experienced a major decline in financial performance in the years preceding conversion (Sloan 2001). A study of the financial characteristics of fifty not-for-profit hospitals acquired by for-profit chains between 1978 and 1983 found that the acquired not-for-profit hospitals tended to be small, with low profitability and relatively old and depreciated assets (Mark 1999).

As another defensive strategy, independent community hospitals have also consolidated into larger not-for-profit and for-profit corporate entities in order to manage risk and secure market viability (King and Avery 1999). Many for-profit hospitals are part of bigger corporations, which can appeal to stand-alone not-for-profit hospitals. It is also easier to compete for managed care contracts and revenues when a hospital is part of a larger system because of the stronger position and bargaining power (Sloan 2001). Past case studies have shown that there are efficiencies associated with conversions as well as consolidations such as increased access to capital, cost cutting and higher reimbursement rates from the public sector. Consequently, conversions and consolidations are attractive to not-for-profit hospitals in financial trouble (Horwitz 1998). For-profit hospitals have also been recognized for their management expertise (Desai and Young 1999).
2.2.2 For Increased Access to Capital

For-profit hospitals have more access to capital. Although not-for-profit hospitals have access to capital sources through benefits from tax-exempt donations and tax-exempt debt, debt capital can be very expensive due to administrative restrictions. Equity financing would be cheaper for not-for-profit hospitals. However, for-profit hospitals have more access to equity debt (Horwitz 1998). Equity debt is more accessible to for-profit hospitals because they can obtain it by issuing bonds or selling new stock certificates (Reinhardt 2000). On the other hand, not-for-profit hospitals obtain equity from donations, insured patients who pay higher costs for services, and through income saved by not having to pay property and income taxes (Reinhardt 2000). If a hospital is in serious need of capital sources, conversion can be a beneficial strategy.

2.2.3 To Avoid Responsibility to Community

Some not-for-profit hospitals may also convert to avoid responsibilities to their communities (Horwitz 1998). Many states such as Texas have passed community benefits legislation concerning not-for-profit hospitals. For example, five percent of operating revenues from not-for-profit hospitals in Texas must go towards benefiting the community. Although there is conflicting research on the differences of levels of community benefits between the two types of hospitals, this could be a deciding factor in conversion. However, a desire to change its mission is rarely a motivation for conversion (Sloan 2001). On the other hand, Cutler and Horwitz argued in 1998 that conversion can help a not-for-profit hospital better fulfill its health care mission by giving it access to more resources. Therefore, avoiding community responsibility as a factor in the decision to convert is a very disputable argument.
2.3 What Happens During a Conversion

Typically, when a not-for-profit hospital converts, it sells its assets to a for-profit entity, leaves the hospital business, and uses the proceeds from the transaction to create a not-for-profit, grant-making foundation (Horwitz 1998). According to federal tax law, not-for-profit assets cannot be used for profit-making purposes. Consequently, when not-for-profits convert to for-profit status, the proceeds must be directed towards another not-for-profit activity and cannot benefit private individuals or for-profit buyers. Therefore, foundations established with the proceeds from conversions must pursue community goals similar to those of the converting hospital’s character. Conversions of hospitals do not only occur in the form of acquisitions, but there are also mergers, consolidations, lease agreements, and various forms of joint ventures. Joint ventures involve continuous relationships between not-for-profit and for-profit hospitals (Cutler and Horwitz, 1998).

2.4 What are Community Benefits?

Hospitals and researchers vary in the measurements they use in calculating an institution’s level of community benefits. In its broadest sense, community benefits are services that a hospital provides to its community for which it bears the financial costs. Numerous studies have been done over the last two decades that investigated hospitals’ community benefit levels, but they have not been in agreement over the measurements that should be included. In a 2000 study done by Sean Nicholson, Mark Pauly, and Lawton Burns, the researchers use the economic concept of a public good to define community benefits. A public good is something that benefits all, whether all those who benefit pay or not. Community benefits are positive externalities to communities.
Community benefits differ from other services provided in that they are not sold at a profit (Nicholson et al. 2000).

2.4.1 Uncompensated Care

A measurement of community benefits commonly agreed upon and probably the most recognized one is the amount of charity care provided to those who are unable to pay. Sandra Pelfrey and Barbara Theisen sent each of a random sample of 813 hospitals surveys asking questions about their mission statements and community benefits. Of those that responded, 100% stated that medical care provided to indigent patients is included in their community benefits reporting (1996). In later studies, charity care evolved into uncompensated care. In 1999, the Legacy Health System, a not-for-profit, Oregon-based health system was considering being sold to a for-profit hospital management company and decided to determine the impact of the sale on community benefits by estimating the change in community benefit levels. One of the system’s concerns was charity care. However, uncompensated care was used in a separate category. Uncompensated care is classified as funds that hospitals attempted to recover but patients were delinquent on. However, there is no consensus over whether these bad debts or uncollectibles should be included in a hospital’s community benefits amount as Mark Pauly discussed in his 1996 study. Nonetheless, more recent studies include uncompensated care, which usually consists of both charity care and bad debts, when analyzing community benefits. This is done in order to standardize hospitals’ results due to the inconsistency in the reporting of bad debts as community benefits. For example, in 1999 Young and Desai use uncompensated care, in which they included charity care, as one of their primary indicators of community benefits when they did their study of not-
for-profit conversions. In 2000, Thorpe, Florence, and Seiber's study on hospital conversions and uncompensated care, which they consider to be the most comprehensive study on the topic up to date, uses both charity care and bad debt.

2.4.2 Conservative Measures of Community Benefits

In their study, Nicholson, et. al., divide the measures of community benefits into conservative and inclusive measures, which is how I will frame the next two subsections as I discuss similar measures used by other researchers. As mentioned previously, uncompensated care is mostly an indisputable element of community benefits. Nicholson, et. al. in addition to uncompensated care include losses on medical research, taxes generated by for-profit hospitals, and other unbilled services such as education classes and community activities. These aspects are included because they provide a public good according to the authors. Although Legacy's study did include numerous community benefits indicators, the study investigated how clinical programs and support services provided below cost and medical research would be affected by converting to for-profit status. Hospitals, most likely teaching hospitals, fund medical research, which is a positive externality for society. And the taxes that for-profit hospitals pay can be considered a community benefit because sales and property taxes usually go to the city, state, and counties that the hospitals are located in.

2.4.3 Inclusive Measures of Community Benefits

There are also other measures of community benefits that are considered in research, although they might not be necessarily tracked or reported by hospitals. Both the Nicholson, et. al. and Legacy studies consider Medicare and Medicaid downfalls as community benefits. Medicare and Medicaid downfalls account for the lower
reimbursement rates received for these types of patients than rates received from privately insured or self-paying patients. Hospitals that provide a disproportionate share of Medicare and Medicaid patients crowd out more profitable privately insured patients, which can lower revenue streams. Losses sustained by hospitals serving Medicaid and Medicare patients can be considered to be similar to the losses from uncompensated care (Claxton, Feder and Altman 1997).

Prices are also debatable community benefits. Hospitals, both not-for-profit and for-profit, normally provide price discounts to health plan members that the hospitals are contracted with. These discounts could benefit community members through lower premiums and out-of-pocket expense. Young and Desai also used net prices as a measurement of community benefits. Net patient revenue per adjusted discharge served as a proxy for hospitals’ pricing structure to compare prices pre-conversion and post-conversion. Lower prices do benefit the community; however, it is questionable whether a hospital foregoing its profits is a benefit to the community, especially when many may assert that hospital services are overpriced.

Medical education is also arguably a community benefit. In Pelfrey and Theisen’s study, 59% of the respondents stated that they included the unreimbursed costs of medical education programs as part of community benefits. However, Nicholson, et. al., argue that losses on medical education should not be included in community benefits if the hospital administration and/or ownership believes that there would be a sufficient number and quality of medical students without subsidies. On the other hand, if a hospital’s administration feels that subsidies are needed to attract physicians, then losses on medical research should be considered a community benefit. Because the decision
whether to include losses on medical education appears to be subjective and can vary from hospital to hospital, these expenditures can be a controversial community benefit. 

There are several other measures, which can be considered to be community benefits. Unprofitable and non-reimbursable services such as emergency care, neonatal care, burn care, and substance abuse treatment could be considered a community benefit as Young and Desai (1999) indicated, although they are not widely used, partially because they may be difficult to measure. Claxton argues that hospitals controlled by volunteers from the community will be more responsive to local health care needs (1997). Community representation on hospital boards has been investigated in studies and written about in issue papers done by the American Hospital Association. Including community members on a hospital’s board is an indicator of the hospital’s interest in serving the needs of the community (Young and Desai 1999). Hospitals are also usually a large provider of employment in the communities they serve. Thus, high employment levels can benefit the community.

2.5 Effects of Hospital Ownership Structure on Community Benefits Debate

There has been continuous debate between policy makers, hospital administrators, physicians, and researchers over the differences in levels of community benefits provided by not-for-profit hospitals and for-profit hospitals. With the reentry of for-profit, investor-owned hospitals in the mid 1990s and profit-oriented integrated care, many stakeholders in the health care community feel that this may result in fewer community benefits and could be harmful to citizens (Pauly 1996). Because of increasing anxieties about the levels of benefits provided by for-profit hospitals and the growth of for-profit hospitals though they are still a minority, not-for-profit conversions to for-profit status
have become a major public policy issue (Young and Desai 1999). Public policy makers and health care workers have also perceived that large for-profit corporations and multi-hospital systems are becoming a more dominant force in the provision of medical services. There is concern that these systems may endanger patient care, remove charitable assets from local control, provide less community benefits in the form of uncompensated care and other community benefits, and focus too much on the financial bottom line (Spetz, Mitchell and Seago 2000). Sloan speculates that community benefit levels might be lower in for-profit hospitals because they are less likely to treat unprofitable cases and more likely to invest less in public health programs and medical education and research. For-profits may compromise the quality of care for the sake of decreasing costs and maximizing profits (Sloan 2001).

Nonetheless, no conclusive evidence has shown that for-profit hospitals provide fewer community benefits than not-for-profit hospitals. In 1986, the Institute of Medicine found that the cost of care is the same for not-for-profits and for-profits (Gray). All other things equal, for-profit hospitals charger higher prices after the effects of taxes are removed. And for-profit hospitals provide less uncompensated care and lower levels of some other community benefits. However, there is a theory that not-for-profits have to provide more community benefits to attract donations and prices are higher in for-profit hospitals because they pay higher taxes and locate themselves in more affluent areas that support higher prices (Pauly, 1996). Bovbjerg, et. al. argue that part of the not-for-profit hospital’s mission is to provide community benefits, mostly in the form of uncompensated care, which is rooted in the historical not-for-profit’s hospital mission of providing health care to the sick poor. These authors state that for-profits have no
uncompensated care mission and provide it to maintain good relations with the public and medical staff. Bovbjerg, et. al. based the assertion of not-for-profits’ higher level of uncompensated care on national data from 1994 that found that not-for-profits’ spending on uncompensated care was 4.5% of costs while for-profits’ were 4% of costs. The same study indicated that not-for-profits provide 58.3% of all uncompensated care on a charge basis and for-profits provide only 7.8% (Bovbjerg, et. al. 1998).

There are also claims that not-for-profit hospitals are turning away from their community-focused missions. According to Pittman and Barnett (2001), not-for-profit hospitals are in an increasingly competitive environment, and in order to survive they have undertaken activities from creating for-profit subsidiaries to developing specialized services that target more affluent populations. Although not-for-profit hospitals face a lot of pressure to provide a lot of charity care, many are reluctant to portray an image as a provider of last resort for the uninsured. Not-for-profit hospitals are also accused of only providing community benefits to attract donations for equity capital and paying for the cost of benefits out of charges they receive from paying patients.

2.6 Other Differences Between Not-For-Profit and For-Profit Hospitals

Not-for-profit and for-profit hospitals are fundamentally different in that for-profit hospitals are accountable to shareholders that hold stock in the hospital and not-for-profit hospitals are classified as 501(c)(3)s under the Internal Revenue Service Code. This essentially means that not-for-profit hospitals are charitable organizations exempt from income taxes, and from both income and property taxes in some states. However, for-profit hospitals must bear the burdens of paying income and property taxes. Not-for-profit and for-profit hospitals also differ in their ability to raise capital. As previously
mentioned, not-for-profits’ capital comes from donations, which provides equity capital. However, the reward for these benefactors is not a financial return but “donor-pleasing” activities such as the provision of community benefits. For-profits raise capital through investments and investors expect financial returns (Pauly 1996). The argument has also been made that since for-profits have the ability to distribute surplus funds to investors, they have more of an incentive for efficiency than not-for-profits (Bovbjerg, et. al. 1998).

While for-profits are accountable to investors, not-for-profit hospital managers are accountable to non-owner Boards of Trustees. Gramm has identified four types of not-for-profit hospital accountability: political, commercial, community, and clinical (Horwitz 1998). Not-for-profits are political in that they have to maintain their tax-exempt status and they are commercial in that they are involved with commercial payers such as managed care companies. They are also accountable to the community and are accountable clinically because the hospitals have a role in addressing their community’s needs and providing access to patients (Horwitz 1998). Sloan theorizes that for-profits locate in more affluent neighborhoods, which can contribute to their lower levels of community benefits if they are less than not-for-profits’ (Sloan 2001).

2.7 Community Benefits Legislation

As a result of the concern over the increasing number of the uninsured and the fear that greater numbers of for-profit hospitals will provide less care to the uninsured and other community benefits, legislation has attempted to deal with the issue. Although not-for-profit hospitals converting to for-profit status raises anxiety about community benefits, not-for-profit hospitals have also been scrutinized for the level of community benefits that they provide. As previously stated, in order to be designated as a 501(c)(3)
by the Internal Revenue Service, a not-for-profit hospital must have a charitable purpose, community representation on its board, and it must give care to patients that cannot pay. However, federal law is nonspecific regarding community benefits obligations beyond those legal requirements. Not-for-profit hospitals are not required by the government to give any specific amount of charity care for their tax-exempt status. In response, some states have imposed more specific and stricter rules about community benefits on not-for-profit hospitals as a condition of retaining their exempt status. Many states that have adopted stricter community benefits guidelines have done so as a result of judicial challenges to hospitals’ tax-exempt status.

Two states, Utah and Texas, have had influential cases affect their community benefits legislation. In 1985, the Utah Supreme Court ruled unconstitutional the state’s tax-exemption statutes, which allowed the Utah County Tax Commission to tax Intermountain Health Care, a not-for-profit system of hospitals. The court felt that not-for-profit hospitals were becoming difficult to distinguish from their for-profit counterparts and decided that they should be reviewed more frequently to ensure that they deserve their tax-exempt status. The court came to the conclusion that the amount of community benefits provided by not-for-profit hospitals should equal or exceed the amount of the tax exemption (Nowicki 1999).

There was also a similar case in Texas in 1998 when the Texas Attorney General sued Methodist Hospital in Houston charging the hospital did not provide enough charity care. The case was eventually dismissed because the district judge ruled that the hospital had broken no current state law and that under then current law only local appraisal districts could determine hospitals’ tax-exempt status. As a result of the case, the Texas
attorney general formed a statewide task force to address the issue of uncompensated care. The governor also appointed the Texas Health Policy Task Force, which made recommendations to the legislature in 1993. This led to the drafting and enactment of Texas Senate Bill 472, which established the legal duty of not-for-profit hospitals to provide a certain amount of community benefits in return for their tax-exempt status. Community benefits include charity care and government-sponsored indigent care. Currently in Texas, a not-for-profit’s budgeted expenses for community benefits must equal 4% of net revenue, 100% of state and local tax exemptions, or an amount that is reasonable in relation to community needs (Nowicki, 1999). Hospitals must develop a needs assessment and a plan to address those needs. This is also required of not-for-profit hospitals in the state of California as directed by SB 697, The Hospital Community Benefit Plan Legislation. Hospitals must assess the needs of their community. Every three years, each private, not-for-profit must submit a community plan which includes the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Office of Statewide Health Planning and Development. These benefits include: medical care services, other benefits for vulnerable populations and the broader community, health research, education and training programs, and non-quantifiable benefits.

On the federal level, there has been very little legislation concerning the tax privileges of not-for-profits. The Taxpayer Bill of Rights II was passed in 1996, which gave the IRS the ability to revoke an organization’s tax-exempt status. Although the legislation does include not-for-profit hospitals, it is not specific to them. In the late 1980s and early 1990s, the Internal Revenue Service focused attention on exempt health
care organizations. In 1991, the coordinated examination program was initiated to do more thorough audits (Nowicki 1999).

2.7.1 The Appropriate Level of Community Benefits: Is there One?

Thus far, Texas is one of several states that have explicitly set requirements for the amounts of community benefits that not-for-profit hospitals must provide. Nicholson, et. al. claim that since not-for-profit hospitals do not need to generate a profit to satisfy investors, they should provide community benefits that are equal to the sum of those provided by for-profit hospitals and the profit these hospitals earn. In other words, when comparing a not-for-profit and for-profit hospital of similar size in the same market, the benchmark level of community benefits for the not-for-profit hospital should be equal to the sum of the for-profit hospital’s tax payments, cost of the community benefits, and after tax profit, adjusted for differences in the assets or equity at each hospital. However, this would mean that not-for-profit hospitals should spend more on community benefits than they would have paid in taxes. Though this may seem unfair, but perhaps this is what is meant by an organization’s charitable mission.

2.8 Conversion Legislation and Oversight

Concern over not-for-profits providing inadequate community benefits led to increased legislation, but so have the increasing number of conversions. States such as California, Indiana, Massachusetts, Minnesota, New York, and Pennsylvania have required not-for-profits to report their community benefits, which appears to have the intention of discouraging conversions (Milstead 1999). However, there are those who advocate conversions because they see insufficient benefits in not-for-profit hospitals. Conversions have affected community benefits legislation as well as encouraged more
specific legislation regarding the oversight of conversions when they do take place. It seems unlikely that there will be a general policy opposing conversions because there is recognition that conversions can ensure the survival of some not-for-profit hospitals (Gray 1997).

Currently, state attorneys general are responsible for conversions (Bovbjerg et. al. 1998). State attorneys general are usually the only officials with the authority to conduct comprehensive, advance reviews of conversions, although other government departments may oversee some aspects of conversions (Horwitz 1998). The authority of state attorneys general to regulate hospital conversions is mostly derived from charitable trust law. Three important doctrines under charitable trust law providing the bases for attorney general oversight are the Cy Pres doctrine requiring advance court approval of conversions, the director’s duty of care, and the Parens Patriae to protect the public interest. Under Cy Pres doctrine, the state attorney general is automatically a part of the hearing to approve the conversion of a hospital’s assets. The doctrine’s purpose is to ensure that charitable assets are held to the initial purposes for which they were given. Under director’s duty of care, the directors of a charitable organization fulfill their duty of care by maximizing the charitable purpose of the corporation for the benefit of the community. If a director breaches this duty, the attorney general has the authority to hold the director personally liable. And the Parens Patriae doctrine gives the state attorney the role as protector of the public’s interest in charitable assets such as not-for-profit hospitals (Marschke 1997).

Though state attorneys general have roughly the same authority under federal law, several states have enacted special legislation governing conversions because federal
guidelines are still non-specific and allow a great amount of state discretion. Because conversions put not-for-profit financial assets at stake, state regulators have drafted legislative responses to hospital conversions. States such as California, Nebraska, and Massachusetts have enacted legislation delineating a process for state oversight of hospital conversions (Marschke 1997). There have also been more conversions nationwide than there have been foundations created as a result of the sale of not-for-profit’s assets. New statutes that have been created typically do five things: clarify traditional authority over conversions by specifying responsible officials and their responsibilities, re-emphasize the obligation to preserve charitable assets by preventing private gain and rededicating assets to community use, set criteria to review proposed conversions, create legal procedures such as public hearings to allow community members access to the process, and create enactments that authorize new legal structures and continuing obligations like rules on foundations and requirements on resulting for-profit hospitals to provide uncompensated care (Bovbjerg et. al. 1998).

Conversion legislation and oversight is crucial to preserving a not-for-profit’s assets for public benefit and to preventing a hospital’s conversion leading to personal financial gain for executives. Oversight is also important so that charity care and other community benefits are ensured in the future even after conversion (Bovbjerg et. al. 1998).
3. Methodology

For this study, I utilized qualitative interviewing techniques discussed by Arksey and Knight. I interviewed a hospital administrator and board member from each hospital as well as labor union representatives and other employees from each hospital. The interviews were semi-structured in that I developed a main list of fixed questions. However, semi-structured interviews allowed room to follow up on ideas and adjust questions accordingly. These types of interviews also gave interviewees more freedom to answer the questions in terms of what they saw as important and relevant. I used diverse data sources in terms of people interviewed, the time span covered, and the sources. Questions asked inquired about information regarding the facility and how that information and data has changed over time. In addition to completing interviews, I also collected internal reports, memos, and documents to confirm comments made by interviewees. I also used newspaper articles to get the media’s perspective on the hospitals. Using diverse sources and looking at community benefit levels before and after the hospitals’ sales allowed me to examine changes over time.

3.1 Limitations

The purpose of this case study was to concentrate on the effects of a hospital’s sale and/or conversion on the community benefits that it provides. However, the scope of this paper is limited as discussed in the introduction. Some studies that have included larger samples of hospitals have been inconclusive on the effects on community benefits of a hospital’s not-for-profit or for-profit status. By doing this study, I sought to investigate how a hospital’s sale affects its surrounding community in addition to the
changes that occur inside of the hospital. As a result, the two hospitals presented in this research are in no ways representative of what occurs nationally.

Although I include information and background support from internal hospital documents, data and literature, and news articles, I also rely heavily on the perspectives of a relatively few number of interviewees. Those interviewed were members of the organization prior, during, and after the hospital sale. These interviewees were very knowledgeable about the levels of community benefits before and after the sale, giving informed opinions and perspectives. There was also an imbalance of information provided by interviewees, thus an imbalance of information presented in this paper. This could have partially been due to the positions of the two administrators interviewed. The not-for-profit hospital administrator is the Director of Community Services and the for-profit interviewee is the Chief Operations Officer. There were more brochures and pamphlets on different community activities located in the not-for-profit hospital. And I also found more information available on the not-for-profit's website. But this could also just be a reflection of the varying amounts of community benefits the hospitals do indeed provide.
4. Case Studies-Observations

Due to the health care marketplace that hospitals today face such as rising costs of medical care and prescription drugs, insufficient reimbursement rates from payers, and growing competition from multi-hospital corporations, many facilities have decided to join not-for-profit and for-profit health care companies. Advocates and policy makers are concerned about the community benefits provided by both types of institutions because of the large number of uninsured Americans and the positive impacts that hospitals can make on their surrounding communities. In this section of the paper, I will explore the conversion decision-making process of two facilities located in the same community. Both facilities were not-for-profits prior to their acquisitions by large health care corporations. However, Hospital B was sold to a for-profit company and Hospital A was sold to a not-for-profit company. I will go on to describe their pre-conversion and post-conversion community benefit levels as perceived by hospital administrators and affiliates who were a part of the organizations throughout the conversion process.

4.1 Backgrounds and Structures of Hospitals

Hospital A, a not-for-profit hospital was started approximately 50 years ago by community residents in order to provide a source of acute care hospital services. In the late 1940s, the residents agreed to form a hospital district and be assessed a property tax to support the hospital.

Hospital A is an integral component of the Healthcare District. The district has a publicly elected Board of Directors, which consists of five members. The District’s board serves on the board of Hospital A along with five appointees from the hospital’s parent company. The district has the responsibility of ensuring that the hospital fulfills
its commitment to the community. Although the tax revenues the district receives and distributes to the hospital are a very small portion of the hospital’s budget, the directors have the duty of ensuring that the funds are well spent (The Healthcare District website). The hospital administrator that was interviewed iterated the point that Hospital A is a community hospital started by community members who saw a need for health services for the residents of their community. According to the administrator, the hospital is truly a community hospital because many of the neighbors that help found the district and their families still live in the area and the residents care passionately about the hospital. The district is a source of financial and community support for the hospital. Hospital A’s commitment to the community is evident in its mission statement which is to “promote healing and wellness in partnership with physicians by providing compassionate, quality, cost-effective care to meet the identified needs of the communities we serve, with special concern for the poor and underserved” (Hospital A 2001 Strategic Plan). Another entity connected with Hospital A is the hospital’s foundation. The foundation is a separate charitable organization within the hospital that consists of a group of volunteers who work to raise money for capital improvements to the hospital, for patient care services, and for the development of health and wellness outreach programs. As stated in its mission, its role is to “support the hospital, helping it expand its caring and commitment to the community.” For example, in the past, the foundation has raised money to purchase computer equipment and other technology for the hospital (Hospital A Foundation’s Report to the Community).

Hospital A has grown from an approximately 100-bed hospital to its capacity of 450 beds, 600 physicians, and approximately 1100 employees. During the 2000 fiscal
year, Hospital A had 94,000 outpatient visits and 50,000 inpatient days. It provides a wide range of medical services. Hospital A is most renowned for its cardiovascular program, which draws patients from all over the country. Other programs include cancer care, diabetes treatment, sleep studies, pain control, weight management, physical therapy, mental health, and cardiopulmonary rehabilitation. Hospital A also provides labor and delivery, emergency, and spiritual care services. In addition, the hospital offers numerous health and wellness services (Hospital A website).

Whereas Hospital A has very extensive information regarding its history and background and the interviewees were very knowledgeable of its background, Hospital B, the for-profit hospital examined, did not have much information about its history on its web site or in hospital literature. Hospital B opened thirty-five years ago and is currently licensed for 200 beds. There is an employed staff of 1200 and more than 350 medical professionals. Though Hospital B does not state its mission on its website, the mission of the hospital is to provide total customer satisfaction according to the administrator interviewed. The busiest departments are the Emergency and Obstetrics Departments. The Emergency Department treats about 45,000 patients annually. Additional services include cardiology, oncology, orthopedics, pediatric rehabilitation, surgery, respiratory therapy, and women's services. Hospital B is currently in the decision-making process regarding full consolidation with its sister hospital. Obstetrics was transferred from the sister hospital to Hospital B and neurology has been transferred from Hospital B to the sister hospital.
4.2 The Decision to Sell

During the mid to early 1990s, Hospital A found it hard to remain a stand-alone hospital. According to an administrator, the primary factor in Hospital A’s decision to look for a purchaser was the difficulty in negotiating favorable contracts with health maintenance organizations. Because of its small size, Hospital A was not able to negotiate with managed care organizations to get reimbursement rates to adequately cover overhead costs. The costs of prescription drugs and supplies were exponentially increasing and the hospital was not large enough to compete to get lower prices from suppliers. The hospital lost approximately $2 million in 1994 and $8 million in 1995 (Pimentel 1996). By the end of fiscal year 1997, the hospital had lost a total of almost $30 million (Lazarus 1997). As a journalist wrote in the San Francisco Chronicle, “It could no longer compete with the consolidation craze. The big players were getting the price breaks on supplies and affiliations with health maintenance organizations” (Simon 1996). Hospital A’s leadership decided that it should become part of a large system in order to achieve economies of scale and ensure its survival as a community provider of health services.

In 1995, the hospital sent out requests to 125 organizations to purchase or manage the hospital. The two final choices for buyers were a large, religious not-for-profit company and a large for-profit company. Both corporations campaigned for the support of the hospital’s board and the community. The for-profit chain ran full-page ads in area newspapers stressing its commitment to quality care (Pimentel 1996). There were both pros and cons associated with the not-for-profit, faith-based company, and the for-profit chain. According to the interview with the administrator, Hospital A’s leadership viewed
the not-for-profit’s chain as mission-driven and community benefit-focused. The majority of board members felt more comfortable with the not-for-profit because the company promised to reinvest revenues from Hospital A’s operations into the district (Pimentel 1996). However, there were concerns over the religious health care company and women’s loss of reproductive rights, specifically the right to abortions. The community was unsure if it wanted the hospital to be taken over by a religious institution, especially one against choice. As a solution, Hospital A conducted forums for community members to discuss this issue and bioethicists were brought from the company to conduct focus groups. Hospital A partnered with Planned Parenthood so that patients could receive services and support that would not be available under the potential not-for-profit buyer. However, the hospital found that it only performed 7 elective abortions. As a result, the hospital felt that the number of the procedures performed at the hospital were not great enough to make a significant impact on the decision to sell.

The for-profit hospital company was also a very attractive purchaser to some community members, although it is investor-owned. Many were impressed with its proven track record of turning around financially ailing institutions. However, some saw its “cookie-cutter” approach to management and infrastructure styles to be a disadvantage. Because it was so large and experienced, the for-profit company had developed its own “best business” practices and forced these onto their new institutions. Aligning with the chain would mean having to deal with many sweeping changes. According to the administrator, it was believed that the for-profit company would bring in highly professional business types with financial marketing and expertise. This was
attractive to some of those in the community because of the huge losses that Hospital A incurred during the years prior to its sale.

However, because Hospital A is driven by community need as it had been since its inception, the community voted by an overwhelming 95% to merge with the not-for-profit over the for-profit chain in August of 1996. The district’s residents were given extensive opportunities to participate in the decision-making process. For eighteen months, there were town hall meetings to discuss concerns and every board meeting was open to the public. In the not-for-profit’s agreement to purchase Hospital A, the company donated $30 million to the Healthcare District in order to contribute to meeting the health needs of the community. The district uses these funds to give grants to local, not-for-profit organizations. The use of these funds by the district is overseen by the Office of the California Attorney General. Also, the terms of the agreement stated that Hospital A would remain a community hospital and would not be subject to religious dictates.

Although Hospital B faced the same financial conditions as Hospital B, its financial condition was not as severe. The decision to be purchased by another company was mostly a strategic decision for the parties involved. Before its sale to the for-profit chain in December of 1998, Hospital B was owned by a faith-based, not-for-profit chain based in Chicago. The not-for-profit owner had only one facility located in the area. Because of the conditions in the health care market, the number of the company’s hospitals began to decline and the company found it increasingly difficult to extend the mission of their organization outside of Chicago. At that time, the same for-profit chain which attempted to purchase Hospital A had two facilities in Chicago that it was
interested in transferring to the then current owners of Hospital B in exchange for expanding their market share in the county where it already owned three hospitals (Henneman 1998). The arrangement would be mutually beneficial to both parties. Being a faith-based, not-for-profit and having its values of compassion and caring for the poor, the organization wanted to ensure that the for-profit chain would continue to provide a high level of service and charity care. The hospital was also severely undercapitalized prior to the sale and the for-profit company had the funds to make improvements to the facility.

However, there was resistance from the community because the facility was being sold to a for-profit corporation. As a result of concerns that the for-profit company would offer less free care for uninsured patients, a local community group opposed the deal because the members felt it would hurt poor residents. These suspicions were based on past evidence. When the same company bought a previously not-for-profit hospital nearby, annual charity care fell from around $2 million to $170,000 (AP 1998). The group believed the deal would give the for-profit “too much power to affect the accessibility, affordability and quality of health care in the county” (Henneman 1998). As a result of anti-competitive concerns and the community uproar, the state Department of Justice initially halted the transfer. The state attorney general’s office ruled in the beginning of December of 1998 that the deal was anti-competitive because the chain would own more than half of the hospital beds in the city (AP 1998). Concessions had to be made by the for-profit in addition to the current owners’ conditions for the attorney general to approve the sale. The attorney general mandated that $4 million had to be donated to a nearby not-for-profit hospital to provide health care for the poor. The buyer
also had to agree to make $15 million in capital improvements to the hospital and provide $10 million in charity care over the five years following the sale (Wilson 1998). The company had also made a commitment to the current owner to continue to provide services for the poor and to provide similar levels of pastoral care to patients. The for-profit company agreed, for five years after the sale, to maintain the free clinic which provides pregnancy services for poor women. The interviewee did not note whether the clinic would remain operational after the five-year mark. The next subsections look at different components of community benefits and how they were changed by these hospitals’ decision to sell.

4.3 Uncompensated Care

As discussed in the literature review, uncompensated care is care a hospital provides free of charge without attempting to collect. Hospitals usually have a policy that outlines the process of the provision of charity care. Oftentimes, patients must fill out an application and meet certain income requirements. Administrators at both Hospitals A and B stated that their policies on uncompensated care did not change after being purchased. Hospital A’s administrator stressed that the hospital is committed to providing services for the entire community regardless of insurance status. Hospital B’s administrator stated that in his opinion, the policy was improved upon by making the guidelines more clear. Hospital B also assists patients in applying for public health insurance. Under the previous not-for-profit owner, the policy was inconsistent in that there were no set criteria. However, this is still how the system works at Hospital A. Charity care is given on a case-by-case basis; there is no written policy. Before a patient receives care, the administration determines whether the patient is a charity case.
depending on the situation, such as income, insurance status, the severity of the health condition, and whether the services could be provided elsewhere. If a physician is willing to give his or her services for free, he or she may request for the hospital’s assistance in caring for a charity care patient.

According to the interviewees, the amount of money spent on charity care has not been very affected by their sales. For the 2001 fiscal year, traditional charity care accounted for .2% ($265,000) of Hospital A’s expenses. Because of the demographics of the hospital service area where there are not a large number of low-income persons, the hospital does not incur a lot of charity care revenues. It is not due to a policy of precluding charity care. During the 2001 fiscal year, there were approximately 210 charity cases. The hospital has also had international charity care cases for patients seeking care from their world-renowned cardiologists (Administrator). On the other hand, Hospital B’s service area includes a greater proportion of low-income persons and the hospital has not had any problems fulfilling the $2 million charity care requirement as dictated by the state attorney general. For the first three years after the sale, the hospital surpassed that amount. Before the sale, the hospital provided only $1.4 million of charity care per year on average. Uncompensated care is currently around 5% of total gross revenues. Hospital B has to only fulfill the $2 million requirement for two more years (Administrator). It is not certain whether the amount will decrease as a result. In sum, Hospital A felt that its expenditures on charity were not affected by its sale and Hospital B’s conversion to for-profit status actually increased charity care, although this may be just a temporary trend.
4.4 Unprofitable Services/Pricing of Services

In some research literature, unprofitable services that hospitals provide and even their pricing structure can be considered to be benefits to the community. Hospitals may choose to offer services because of their need although they may be losing money by doing so. After its sale, Hospital A still continued to provide the costly and unprofitable oncology, diabetes, obstetrics and acute rehabilitation services. According to the administrators, no services were taken away or added after the sale. However, a board member stated that pediatrics was cut. The hospital negotiated with a nearby children’s hospital to serve their constituency. Due to the hospital’s dire financial situation, some special types of research programs were cut before Hospital A’s purchase. During this year’s strategic planning process, the hospital will contemplate whether to continue to provide all of the services previously mentioned or just focus on a few. The board member interviewed stated that acute rehabilitation is likely to be cut. It was made clear that these cuts are not related to the sell nor is the hospital being forced to do so by its parent company. It does not appear that Hospital A’s sale affected the provision of its services.

On the other hand, Hospital B has cut some services. However, the services cut were not focused on inpatient, acute care. Home health services were eliminated due to the establishment of stricter regulations, which would have been difficult to comply with. A financially unstable senior center was shut down. The administrator iterated that these were closed partially due to the fact that they were losing money. But the most pertinent reason was the hospital’s desire to concentrate on acute care after its sale. An outpatient surgery center has also been temporarily closed, but will be reopening this summer.
Nonetheless, none of the inpatient services has been cut. The services that were cut could have been due to the for-profit’s business strategy. During the interview, it did not appear that the primary reason for cutting the services had anything to do with intent to decrease community benefits.

As mentioned in the literature review, lower prices for services can benefit the community. Young and Desai use it as a measure of community benefits in their research. Many factors affect the prices of medical services such as inflation, costs of technology, rising costs of medical supplies and drugs, and reimbursement rates from managed care organizations. Although more quantitative techniques such as measuring the net patient revenue per adjusted discharge as a proxy for hospitals’ pricing structure have been utilized, I chose to look at insiders’ perceptions of the changes in pricing. Interviewees were knowledgeable enough to know the general trend in pricing, but did not offer any specifics.

Both the administrator and board member from Hospital A felt that the pricing of services has not been affected by the hospital’s new ownership. The increases in prices have been mostly due to inflation. However, some costs have decreased, such as the costs of providing drugs to patients and the costs of medical supplies. This is due to the greater negotiating power Hospital A now has as a result of being a part of a large system of hospitals.

On the other hand, Hospital B was prohibited from increasing prices above the rate of inflation for two years after the sale. This was beneficial to the community, which felt that prices would drastically increase after the hospital was taken over by a for-profit corporation. The administrator noted that this was a financially difficult time for the
hospital, and it incurred huge financial losses. While costs went up 14%, which was heavily due to raising the salaries of nurses, charges went up only 3%. Expenditures greatly outweighed revenues. However, after 2001, the hospital made adjustments to the prices that made their prices equal to the market. Hospital B’s prices were not necessarily greater than other hospitals’. In the cases of Hospitals A and B, any changes in prices appear to have more to deal with market and internal conditions than their for-profit or not-for-profit status.

4.5 Community Relations

Perhaps the most important aspect of a hospital’s community benefits is its relationship to the community. In this section, the number and types of educational and outreach activities of each facility are explored. The information regarding Hospital A’s community benefits comes from the 2001-2002 Community Benefit Plan submitted to the Office of Health Planning and Development and from the hospital’s brochures on programs and services. Hospital B’s information comes from the administrator and the hospital’s website.

4.5.1 Outreach and Educational Activities

As dictated by state legislation, S.B. 697, all private, not-for-profits are required to annually assess the needs of their community. A community plan, which includes the activities that the hospital has undertaken in order to address community needs, must be submitted to the Office of Statewide Health Planning and Development. Hospital A’s first needs assessment was conducted in 1995 by the county’s Hospital Consortium. The consortium sought to recognize a broader definition of community health that was not limited to traditional health measures, such as including indicators relating to the quality
of life and physical health of residents. The consortium grew to include other county
organizations and formed the county’s Healthy Community Collaborative with the goals
of producing a community needs assessment to use for the strategic planning of
community programs and to promote collaborative efforts in the community in order to
develop projects to improve community health.

The process of performing the assessment includes secondary data collection,
quantitative and qualitative primary research, and community feedback in the form of
community forums. The 1998 assessment was used for the development of the 2001-
2002 Community Benefit Plan. The assessment presents several key findings. The
number one self-reported problem facing families in the county is the cost of living.
There are concerns with access to and the equity of health care services. This is mostly
due to the inability to pay, inconvenient hours and lengthy waiting, and language and
cultural barriers. Other major community health problems are cancer, cardiovascular
disease, obesity in children, AIDS, and tuberculosis. Two vulnerable populations are
identified: youth and senior citizens. Many youth are involved in high-risk behaviors
such as substance abuse and there is concern over low-income seniors and the physical
activity levels of seniors. As a result of the findings, three top priorities were selected:
adolescent risk behavior, the underserved, and services to enhance senior health and
foster independence.

Hospital A’s ongoing programs, services, and activities reflect their commitment
to the community and these priorities. For example, the “Kids are Giants Too” program
is a collaboration with the Giants baseball team to provide tobacco prevention education
to elementary school children. El Corazón Vivo y Activo is a program aimed at
improving the cardiovascular health of the Latino community. The Active Aging Program seeks to increase the physical activity of seniors.

The majority of Hospital A’s community benefit programs are operated in the Health and Wellness Center. It is located in a 10,000 square foot building located off-campus and is open to all members of the community, not just to hospital patients. The Healthcare District and the hospital provide financial support to the center. About half of the services are free and reported as community benefits, and the other half of the programs require fees and are revenue producing. During the interview with the administrator, she explained that the center is run on a business model. Services that require fees help pay for the free services provided to citizens.

The center provides a variety of free services and programs. Among the most utilized is the Community Health Resource Library. Over 3500 people used this resource in fiscal year 2001. The library contains current medical literature, health videos, an online health reference library for medical research, and information on community health agencies, support groups and services. The center provides meeting space and program administrative support services for community based, health-related organizations such as the American Cancer Society and the Alzheimer’s Association. There are spiritual care services and educational programming such as a monthly Prostate Cancer Information Forum, Advanced Directives workshops, and adult asthma education classes. Support groups for bereavement, Hepatitis C, Osteoporosis, pain management, and Parkinson’s are open to the community. There are also a variety of senior services including information and referral services, health screenings, and Aging with Energy workshops as part of the Active Aging Program for seniors.
Hospital A has a Community Health Education and Support Programs booklet, which details all of its programs. Among these are maternal and family education programs, which include infant care, breastfeeding, and childbirth preparation classes, which carry a fee. The Health and Wellness Center also has nutrition and fitness programs, weight management, and stress management classes that require payment. There are also cardiovascular services, which include screenings and lecture series; diabetes programs consisting of diabetes management classes and support groups; and emergency preparedness courses such as CPR and First Aid. The center supports health clinics that provide free and fee-required screenings such as bone density, blood pressure, cholesterol and glucose screenings. The hospital advertises medical research studies that patients can be apart of, although the hospital may or may not financially support them. The center also sponsors other activities such as free tax preparation for seniors and low-income persons.

The services provided by the Health and Wellness Center and the hospital have been heavily utilized during the last fiscal year. The Active Aging Program, Diabetes Awareness Campaign, Community Health Lectures, and Health Wellness screenings provided information to 1800 community members. Health fairs were attended by close to 1,000 people. Prostrate screenings and support groups helped approximately 300 men and their families. The Hepatitis C Support Group served 240 people. And close to 4,000 people attended Maternal and Family Education Programs at the hospital. In the opinion, of the administrator interviewed, the hospital’ sale did not cause any decreases in the number of programs and services provided to the community. On the contrary, there was a push by the parent company to provide more free services because of the
number of fee-required services such as nutrition and weight-management services. However, Hospital A maintained that services such as these enable the hospital to provide the free services. A popular statement that the administrator mentioned was “no margin, no mission.” It is by generating revenues and securing a healthy margin that the hospital can expand its mission, according to the administrator. At the time of purchase, the buyer offered the Healthcare District $50 million. The District has been able to use the money to not only fund grants to community foundations, but to also help support the Health and Wellness Center (Healthcare District board member).

The administrator at Hospital B also iterated the services and activities that the hospital makes available to the community. Most of the community classes are maternity and family related. These classes are free for those who deliver at Hospital B and there is a fee for those who deliver elsewhere. Childbirth preparation classes are available. There are also infant care and breastfeeding programs. There is a “Boot Camp for New Dads” class that charges a small fee for all attendees. According to the administrator the hospital supports diabetes research and geriatric care. There was no further information found on community activities in the literature located in the hospital, nor on the website.

4.5.2 Community Representation on Hospital Board

As mentioned in the literature review, it has been argued that hospitals controlled by volunteers from the community will be more responsive to local health care needs and including community members on a hospital’s board is an indicator of the hospital’s interest in serving the needs of the community. Both the hospitals examined in this study have community members on their hospital boards. The Health Services Board, which is the board that governs Hospital A, is made up of the five district-elected officials from
the Healthcare District Board along with five appointees from the parent company. The five district members come from diverse occupations. There are two physicians, one banker, a dentist, and a retired hospital CEO. This board meets every other month and according to the administrators, the board is very involved in the hospital’s operations and is very visible. As the board member stated, the board members have a very strong voice in what occurs at the hospital and the staff is very responsive to them. Community members are also very involved in the Health Services Community Advisory Council. This council was started as a result of SB 697 and the hospital’s desire to improve the health of its communities and implement effective community benefit programs. It is made up of twenty-five diverse individuals from different segments of society. For example, there are community leaders in the fields of politics, labor, business, and religion that serve on the board. The members are appointed by the hospital president and Director of Community Health Services and serve a term of two years. The committee meets quarterly and the members help devise community benefit activities, participate in the community needs assessment and help the Director of Community Health Services prioritize community needs and budget how to spend limited funds. Although the hospital’s foundation is a separate entity whose fundraising efforts and gifts do not contribute to the hospital’s community benefits, it is made up of community members who work to improve the hospital.

Hospital B’s hospital board is made up of five community members. In addition, these same board members also serve on the board for Hospital B’s sister hospital. These board members also come from diverse occupations. A radio personality, a real estate developer, an insurance company owner, a former dean of a school of nursing, and a
retiree all serve on the board. Board members are picked through recommendations and are interviewed by senior staff. They also meet with senior hospital staff monthly, which requires a significant time investment. According to the administrator, members are very involved with the hospital’s operations and are kept knowledgeable of what is going on in the hospital. There are also several subcommittees such as the Attorney General Oversight Committee which meets monthly with the chief operations officer to ensure that the hospital is abiding by the guidelines set forth in the decree. This decree entails the obligations the hospital has to meet as a result of its sale.

4.6 Employment Levels

Hospitals also provide a benefit to their communities by providing a source of employment. In many areas, hospitals are one of the largest sources of employment. However, when a hospital changes ownership, its employment levels can be affected. But there also other economic factors that affect a hospital’s staffing levels.

As of fiscal year 2000, Hospital A employs 1,070 people. Before its sale, the hospital had to reduce its staff because of the hospital’s financial insolvency. During the mid 1990s, there were three layoffs. The hospital received criticism from the media in 1996, for laying off 12 employees and reducing the hours of 7, near the Christmas holidays (Simon 1996). Both the administrator and board member mentioned that there have been cutbacks since the sale, but these cuts were not due to the parent company. These reductions were made in response to the declining number of patients and revenues. In order to operate on a healthy margin, the hospital had to streamline operations. However, there were problems between the parent company and the California Nurses Association, which is a labor union that represents the issues of nurses.
In November of 1998, more than 300 nurses at the hospital walked off the job after talks stalled between the labor union and the company. There were disagreements about reduced staffing, health-care benefits, and a wage increase. The company had offered the nurses a contract that would only give them a 7% pay increase and would require them to make monthly contributions for health insurance coverage. There was finally an agreement to a 15% pay increase and health coverage that would not require any monthly payment (Lynem 1998).

The hospital’s dietary, environmental services, clerical, and other medical workers below the position of registered nurse are represented by the American Federation of State, County and Municipal Employees (AFSCME). These union workers also complained of reduced staffing levels and health benefits after the sale. According to the business agent who works with the hospital, employees felt that there were severe reductions in staffing and that the levels were inadequate. Many employees felt a sense of betrayal, abandonment, and loss as a result of the sale. The agent mentioned that before the sale, the hospital still tried to retain most of its staff although the hospital became overstaffed due to declining numbers of inpatients. The hospital did realize that it was important to keep community members employed. However, in the few years preceding the sale, the worsening financial conditions made layoffs inevitable.

Despite small cutbacks since the sale, the staffing levels have mostly remained constant according to a hospital board member. The AFSCME agent also iterated that there have not been reductions in the last two years. In 1996, before the sale, there were 1040 employees and in 2000, there were 1070.
Hospital B’s sale to its parent company has increased its staffing levels according to the administrator. The parent company, being one of the largest for-profit hospital companies in the country, has had the opportunity to make a lot of mistakes and come up with its own best administrative practices. The company compared Hospital B’s staffing levels with other comparable facilities in the company and found that there were many understaffed departments. In response to the findings, the hospital increased staffing levels in understaffed departments. Overall, the EEOB (equivalent employees per occupied bed) has increased since acquisition according to the administrator. The administrator also stated that the majority of the employees feel that the hospital is better run under the new parent company than under the old one. Overall, there has been a positive impact on employment levels from the administrator’s perspective.

However, a representative from the Service Employees International Union (SEIU), which represents the same laborers as AFSCME, painted a different picture of employment levels. The hospital has been resisting signing a contract with SEIU to represent the hospital’s workers. Although the administrator stated that the departments have been adequately staffed according to the parent company’s analysis, many of the hospital’s employees feel that the hospital has a shortage of workers. The workers are required to work mandatory overtime and they currently have to pay an average of $120 per month for health insurance coverage for their families. The SEIU agent maintained that the hospital may be wary of a contract because the union has a staffing committee to ensure adequate staffing. When there is disagreement between the union and the hospital, an outside arbitrator is brought in. The agent stated that the hospital’s
management currently sets the staffing and is reluctant to another party taking that power away.

The employment levels at both hospitals have declined relatively over time though the cause was not solely due to the hospitals’ sale. Providing jobs to community members is an important benefit. The number of jobs at both hospitals has declined after the sale. However, low staffing levels can pose dangers to patients as well. Rectifying the problem of understaffing will require both the employees and hospital management compromising and working together.

4.7 Patient Mix/Medicare and Medicaid Downfalls

Hospitals who treat a large number of publicly insured patients might also have this service considered as a community benefit. Usually, reimbursement rates from Medicare and Medicaid are lower than those from privately insured and self-paying patients as previously discussed. Hospitals normally have to cover the downfall. In Hospital A’s service area, the majority of the county’s residents are privately insured, however there are a large number of Medicare and Medicaid enrollees. During fiscal year 2001, unpaid costs of Medicaid were 3% of hospital expenses and unpaid costs of Medicare were 4.5% of expenses. Although expenditures were not available for Hospital B, the administrator did report the patient mix. Thirty-five percent of the patients the hospital cares for are covered by Medicare, 25% are Medicaid, 35% are private insured, and 5% self-pay. From these figures, it appears that the hospital does spend a considerable amount of funds on the unpaid costs of Medicare and Medicaid.
5. Discussion

Though formal research has not reached any formal conclusion about the effects of a hospital’s not-for-profit or for-profit status on its community benefits, general public opinion may assume that a not-for-profit hospital is likely to provide more because of its mission and character. This is evident in the community’s negative reaction to the for-profit corporation’s attempts to purchase both of the hospitals. In this paper, I set out to affirm or deny that assumption. From the interviews done in this study, I found that a hospital’s conversion from not-for-profit to for-profit status does not necessarily have adverse effects on its community benefits. Declines in community benefits were averted as a result of the strict requirements set forth by the state attorney general. However, the requirements that were described earlier in the paper were only enforceable for five years after the sale. It is unsure whether community benefits will continue to increase or decrease in the converted hospital. The hospital that remained not-for-profit, Hospital A, reported no drastic changes in community benefit levels after the sale. Though the hospitals are located in the same location and provide similar services, this is not a truly fair and equitable comparison. The for-profit hospital is required to donate a certain amount of funds to contribute to charity care, while the not-for-profit found that it did not receive a large amount of charity care cases because of its service area demographics. As a result, the not-for-profit may not be a fair benchmark of the amount of community benefits the for-profit should provide.

Both hospitals surprisingly stated that there were increases in community benefits after their sales. Hospital A stated that its sale did not affect its uncompensated care levels, however Hospital B’s expenses on community benefits increased from $1.4
million to $2 million per year as directed by the state attorney general as a condition of the sale. Both hospitals have chosen to eliminate unprofitable services, but representatives from both hospitals asserted that this was due to economic reasons and had no bearing on the hospital’s not-for-profit or for-profit status. Prices at the not-for-profit have increased only as a function of inflation and the prices at the for-profit were forced to also increase at the rate of inflation. Hospital A reported that there has been a push for the hospital by the parent company to provide additional free outreach activities and these have expanded since the sale. Hospital B’s administrator stated that because of the financial backing of the parent company, it is able to provide more outreach. On the other hand, Hospital B’s classes are mostly limited to labor and delivery classes. Both have had declines in employment levels and problems with labor unions before and after their sales. However, Hospital A stated that the labor cuts were due to financial reasons. There were no significant changes reported in patient mix and Medicare and Medicaid downfalls as a result of the sales. Unexpectedly, community benefits increased for the converted hospital. However, there is no guarantee that these levels will remain the same after the contract’s 5-year term of these conditions. As expected, there were not many significant changes at the not-for-profit.

Because of the qualitative nature of this analysis, it is difficult to ascertain which hospital contributes more community benefits. As far as the amount of dollars spent on charity and other uncompensated care, Hospital B spent 7.5 times more on charity care than Hospital A. This was partially due to the reasons mentioned earlier. Both of the hospitals cut some unprofitable services after the sale and are now looking to cut other high-cost, low revenue-generating services. So, this may be unrelated to a hospital’s not-
for-profit or for-profit status. It could just be “good business.” Hospital A greatly
outnumbers Hospital B in terms of outreach and educational activities. Hospital B mostly
offers maternal and parenting classes whereas Hospital A reaches out to all segments of
its community including seniors and adolescents. Both hospitals include community
members on their boards, which allows input and perspectives from the point of view of
the community. Both have also had problems with labor unions and have been accused
of understaffing after their sales. Regarding Medicare and Medicaid downsfalls, both
hospitals contribute significantly to the uncovered expenses of these patients.

Although Hospital B may spend more on charity care, Hospital A definitely has a
more diverse and expansive offering of community programs. However, some of these
programs are funded through other fee-required programs. Although it is interesting to
compare these indicators of community benefits, which have been used in the research on
the issue, I also feel that there is another way in which to define a hospital’s commitment
to the community. A hospital’s mission statement and visions and goals can give some
insight to the importance of community.

During the interviews, I observed the different ways in which the administrators
described the purpose of their hospital. This is also reflected in the hospitals’ mission
statements, which in turn has a lot to do with the nature of the parent company. For
example, I noticed that the not-for-profit’s hospital administrator always reiterated the
importance of community and the hospital’s duty to the community throughout the
interview. The hospital was actually founded by members in the community as
mentioned before. It still continues to partner with community organizations to improve
the health of community members. And the community has a strong sense of ownership
of the hospital. The community commitment is evident in the hospital’s mission statement which is to “promote healing and wellness and to provide compassionate, quality, cost-effective care to meet the identified needs of the communities served, with special concern for the poor and underserved” (Hospital 2001 Strategic Plan). It is understandable why the hospital would match up with a company whose mission, values, and vision closely aligns with the hospital’s although I am sure that this mission was somewhat modified after the sale to coincide with the company’s mission. For example, the parent company’s mission is to “deliver compassionate, high-quality, affordable health services and to provide services to the poor and to advocate on their behalf” (Company website). The company’s values include dignity, justice, collaboration, and excellence. These reasons could have a great a great deal to do with why the hospital has so much community programming and perhaps the hospital would provide more charity care if more cases were presented to the hospital.

Whereas I found the not-for-profit hospital to be community-oriented, the for-profit hospital appeared to be more business-oriented. For example, according to the administrator, the hospital’s newly changed mission statement is: “Our business is health care. Our mission is total customer satisfaction.” Nonetheless, both hospitals view themselves as businesses and strive towards quality health care and increasing patient satisfaction, which in turn helps improve the performance of the hospital. It appears that Hospital A portrays its mission and its motivating factor as providing for the community out of an altruistic mission, whereas Hospital B concentrates on operating a successful business where its customers are satisfied. It should not be assumed that the not-for-profit is not concerned with profit margins or customer satisfaction. Hospital B’s vision
is to be the hospital of choice, which will be achieved through total customer satisfaction. It seems as if the driving force is increasing customer satisfaction in order to increase revenues. However, this is not necessarily true. The parent company’s mission is to strive to deliver high quality, cost effective health care in the communities served. According to the mission, the company is committed to the care and improvement of human life (company website). Because the company is in “the business of health care” as the administrator stated, does not mean that it does not care about community.
6. Policy Implications and Recommendations

In this case study, I found the not-for-profit hospital to be somewhat more community-oriented than the for-profit hospital. However, this may not be the case for all not-for-profits and for-profits. It cannot be assumed that for-profits are not concerned about providing community benefits given their differences from not-for-profits. All hospitals are in business to provide health care services. Earlier, I discussed the concern about the growth of for-profits and their perceived lower level of community benefits and the public concern that not-for-profit hospitals were losing sight of their community-oriented missions. As seen through legislation that has already been passed dealing with this issue, many policymakers, health care workers, and other citizens have worked to ensure that the country’s most vulnerable citizens have access to hospital services in the form of medical services and other outreach programs. However, there are some recommendations that could be made to improve the current legislation.

Private, not-for-profit hospitals in California are subjected to SB 697, which requires them to complete community needs assessments every three years and report how the hospitals plans to address them. The legislation states that not-for-profits have a social obligation to provide community benefits in the public interest in exchange for their favorable tax treatment by the government. Legislators also recognize the changing health care environment where hospitals face increasing competition. The legislation’s goal is to ensure that these hospitals periodically review and reaffirm their community commitment in light of increasing market pressures. There are benefits as well as costs associated with this legislation. As seen in the hospital in the study, it takes time and financial resources to conduct research regarding community needs. These could be
resources that could be desperately used elsewhere. However, it can be argued that the benefits outweigh the costs. Hospitals are required to continuously be attentive to the needs of their communities. The legislation provides a mechanism and an incentive for hospitals to partner with other community organizations. This could benefit the hospital by improving the public’s perception of the hospital.

It has already been recommended to the legislature that the plan formats submitted to the state Office of Statewide Health Planning and Development (OSHPD) be standardized. There have also been suggestions that the OSHPD should emphasize certain priorities. Though setting certain requirements may ensure that hospitals are meeting certain fundamental community needs, this could inhibit hospitals from setting their own priorities and focusing on what they feel is most pertinent to their local communities. A statewide requirement setting priorities for hospitals defeats the purpose of requiring them to perform needs assessments and could overlook issues that are specific to only some communities.

This state could also follow the example of states such as Texas, which require that a certain portion of not-for-profit hospitals’ budgets be dedicated to providing community benefits. Although there have been no problems with hospital submitting plans and many hospitals that are not required to do so have submitted them voluntarily, adding a component that specifies expenditures to be spent on community benefits could ensure that hospitals are putting those plans into action. This part of the legislation would be relatively easy to enforce. The legislation could require that a certain percentage of revenues or a certain dollar amount be dedicated to the community and this is easily traceable. However, this recommendation may be disadvantageous to certain hospitals
that do not have a high number of charity cases such as the hospital in this study. Setting a quota may be unfair. Perhaps one way to remedy this could be to increase the tax cuts of hospitals that go over the legally required amount instead of penalizing hospitals that cannot meet certain quotas. Though state and federal governments and perhaps local government may lose tax revenues by giving hospitals even bigger tax breaks, this could incentivize hospitals to increase their commitment to the community.

Currently, there is no federal legislation that requires for-profit hospitals to provide a certain level of community benefits. State attorneys general have authority over and oversight of the conversion process as discussed in the literature review. Although federal laws are very general regarding conversions, some states have specific statutes that delineate specific criteria for hospital conversions such as including community members in the decision-making process. Conversion oversight might be more effective if a federal law is set to standardize the process. Federal legislation would be beneficial in that there would be consistent oversight of the preservation of charitable assets. The enforcement of this law could be delegated to the Department of Health and Human Services or the office of the Attorney General. This may draw criticism from for-profit hospital companies because acquiring hospitals could become even more of a bureaucratic process and could be more costly for companies seeking to acquire not-for-profit hospitals. The federal government does not necessarily have the authority to oversee conversions. The IRS may become involved in conversion transactions because cash is distributed during the process which must be taxed and the IRS also classifies hospitals as 501(c)(3)s (Horwitz 1998). For reasons discussed in the literature review, states have more authority to oversee conversions. It is also easier for states to have the
oversight responsibility because it would not be as difficult to closely monitor the conversions within the state instead of having a department which was responsible for conversions nationwide. Though state-level oversight is more logistically efficient, the federal government should still play a role in encouraging states to adopt specific conversion guidelines. There should be legislation in place to assure that there is no personal gain resulting from conversions and that community members are involved in the conversion decision-making process.

The question arises if for-profit hospitals should be required to provide certain community benefits such as uncompensated care. It is understandable if for-profit companies acquire not-for-profits they should be required to compensate the community in terms of donations to charity and being committed to certain levels of community benefits as a condition of their purchase. This was the case in the conversion in this study. Hospital B only had to provide $2 million of uncompensated care for five years after the sale and it is not certain that it will keep up this level. Congress should consider passing legislations that would give for-profit hospitals tax deductions for devoting a certain level of their revenues to community benefits. This gives for-profits an incentive to be focused on community. As discussed earlier, it is good business for hospitals to be favorably perceived by their community members. So for-profit hospitals could benefit in many ways.
7. Conclusion

As a result of the nature of the for-profit hospital in this study, it was not possible to ascertain if a hospital’s conversion affects its community benefits. It would be interesting to look at the measures within the next three years after the for-profit hospital is no longer bound to the state attorney general’s requirements. Though this paper reaches no definite conclusion on whether not-for-profits provide more community benefits than for-profits, it explores issues such as community involvement in the decision-making process that other empirical studies have not approached in depth. The hospitals discussed do not typify all American hospitals, but they serve as examples of what occurs at the community level when hospitals are bought and sold. As hospitals face increasing competitive pressures, rising prescription drug and medical supply costs, and decreasing reimbursement rates, community services could possibly be neglected. State legislation should be considered to ensure that both not-for-profit and for-profit hospitals are committed to assisting the community. This will be even more important as health insurance premiums exponentially increase and more people are unable to afford health insurance. Policymakers, health care workers, patients, and other citizens must work together to assure that hospitals remain a source of community support.
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