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A Community Perspective on Hospital Ownership

When I first began working in the hospital field nearly forty years ago, I quickly learned about the tradition in the United States of classifying hospitals by ownership. Everyone took it for granted that the type of ownership made a difference, and it seemed clear to me that this was true.

Although all hospitals had certain characteristics in common (overnight care, services of nurses and physicians, patients, buildings, records, etc.), there appeared to be marked differences among groupings of hospitals that were owned by government (federal, state, and municipal), by individual and corporate proprietors, and by religious and other nonprofit associations. Hospitals were viewed primarily from a community perspective at that time, and almost everyone seemed to agree that nonprofit ownership was preferable. Proprietary hospitals were not given much consideration, primarily because they were almost all quite small, with limited community service programs. Government hospitals were viewed as reflecting the state of local politics and public administration, which was generally not highly respected at that time.

More recently, a number of developments have brought into question the conventional wisdom about hospital ownership. Highly visible, publicly traded investor-owned hospital chains, valued in billions of dollars, are proliferating rapidly. Nonprofit hospital corporations are floating hundreds of millions of dollars worth of investment-grade securities to buyers willing to risk their money for financial gain, most having no personal interest in the hospital's community service missions. Government district and authority hospitals, insulated to some degree from politics and from civil service and other governmental procedures and processes, have emerged.

I have found myself thinking a great deal about the nature of hospital ownership. Did it ever really make a difference? Should it make a difference? Should we change our way of thinking about ownership? Are major shifts in hospital ownership either likely or desirable in the near future? Should society apply different standards to hospitals, depending on their ownership? The invitation to comment on Dr. Rosett's and Fr. O'Rourke's papers has provided an opportunity to begin to think these questions through, from a community perspective, and to set forth some preliminary findings and conclusions.

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CHANGES IN HOSPITAL OWNERSHIP, 1928–1982[1]

Throughout the past half century, the majority of hospitals have been owned by nongovernment and government public service enterprises, as contrasted with private, investor-owned firms.

Even excluding from the analysis all federal and long-term care hospitals (where government ownership is dominant), the investor-owned group makes up a small and declining proportion of the total.

Among short-term community hospitals, the investor-owned hospitals accounted for two-fifths of the total in 1928, about a quarter in 1946, and about one-eighth during the past decade. During this same period, government hospitals increased from about one-eighth to three-tenths of the total. The nonprofit group went up from 44 to 58 percent. These proportions have changed very little during the past decade.

Beds. Measured in terms of beds, the nonprofit group has always predominated, rising from 58 percent of the total in 1928 to 70 percent during the past decade. The government and investor-owned groups have both declined during the past half century. Despite some increase in the share of beds owned by the investor-owned group in the past decade, they still amount to less than half the government share and only about one-eighth of the nonprofit share. The recent increase in the investor-owned group's share of the beds presumably reflects their strong emphasis on inpatient service relative to less costly ambulatory services. This contrasts with the somewhat broader (albeit limited) focus on community health care of the nonprofit and government hospitals, which provide a higher proportion of hospital ambulatory care.[2]

Historically, there have been significant differences in the balance among nonprofit, government, and investor-owned hospitals in different parts of the country, with the investor-owned group having a relatively larger share of the beds in the Far West and South. These geographic differences have been maintained throughout the twentieth century, with only a few notable exceptions.

Chains. Chains of hospitals owned by nonprofit and charitable organizations, particularly church-related, have existed for many years, as have chains operated by the government.[3] Investor-owned chains, in contrast, are a development of the past fifteen years, and have resulted primarily from payment policies incorporated into the Medicare legislation passed in the 1960s to help the elderly. An inevitable feature of any chain operation is that ownership and control are distant from the communities served—a problem that is quite familiar to those of us who were working on community hospital planning back in the 1950s and 1960s.

From a community perspective, the major shortcoming of chain hospitals—investor-owned and others—is the lack of involvement of the distant governing body and top management staff in community affairs, especially in efforts to raise the level of effectiveness and efficiency of the community's overall health service system. This problem can be overcome—and chains can be a positive force for community health care effectiveness—if the headquarters of the chain formulates appropriate community health policy, and decentralizes authority for implementation and accountability.[4]

Private medical practice. In the early days, many of the investor-owned hospitals were primarily annexes to the offices of private medical practitioners. Proprietary hospitals were among the first to enter the field of general medical and surgical care for the well-to-do.[5] Although most were quite small, they were an integral part of the fabric of the community's health services. A few were large and well known, including a number that were owned by the attending medical staff and the general public. The Virginia Mason Hospital in Seattle and the Cleveland Clinic Hospital are outstanding examples, both now transformed into nonprofit corporations. With a few notable exceptions, physicians have not been directly involved in the ownership and management of the new investor-owned chain hospitals.

Today, almost all investor-owned hospitals are operated to provide a return to investors by meeting the felt needs of private medical practitioners. From a community health perspective, private ownership by local medical practitioners seems preferable to ownership by stockholders who have no explicit commitment to health. Conflict of interest may be preferable to no interest in the community at all.

Contract management. To a much greater extent than the nonprofit and government chains, investor-owned chains have diversified into contract management of hospitals which they do not own. Over a quarter of the hospitals managed by investor-owned chains are not owned by the chains; these hospitals have their own governance structure, based in their com-

munities. Contract management is now the fastest-growing segment of investor-owned chain operations. These chains manage government-owned and nonprofit institutions, including major teaching hospitals, and even hospitals primarily for the poor, such as Cook County Hospital in Chicago.

Contract management by private corporations at the departmental level—primarily radiology, laundry, and food service—has been a feature of nonprofit and government-owned hospitals for many years. Such arrangements do not involve ownership of capital or control of policy by the contractors. Frequently, payment for the contract service is not related to net earnings, but rather is a flat negotiated sum, or a percentage of the gross.

Strictly speaking, contract management of entire hospitals by investor-owned chains is an extension of departmental contract management, rather than an extension of investor ownership. Since contract managers from investor-owned chains are not responsible for policy formulation, they are in a unique position to help focus and strengthen the community responsibilities of hospital governing bodies. This has been the experience at Cook County Hospital in Chicago.

Profits and community contributions. The profit margins of investor-owned hospitals may be compared with the net surplus/deficits of nonprofit hospitals. Government hospitals usually follow accounting principles which do not allow for any "net," although most governmental authority hospitals are able to identify and manage net gains and losses.

In general, the profits of investor-owned hospitals and the net margins of nonprofit hospitals have been increasing. Although there are exceptions, hospitals in the eighties are doing better and better financially. In an earlier period, many physician-owned hospitals operated avowedly at a loss, but more than made up that deficit in the medical and surgical fees collected. Similarly, many nonprofit hospitals believed that deficits were important resources for attracting philanthropic and government monies, and "buried" net operating surpluses in complex accounting classifications. Today, nongovernmental hospitals—both investor-owned and those operated by nonprofit corporations—strive for profits and net operating surpluses. In general, the investor-owned hospitals do better in this respect, primarily because of their imaginative approaches to capital financing, careful selection of profitable "lines of business" in selected markets, and shrewd pricing policies, more than by producing units of service more efficiently.

Ultimately, the surpluses of nonprofit hospitals must be reinvested in the institution's community health programs. The profits of investor-owned hospitals are frequently reinvested, but a share is often paid to the investors for their private use. At the same time, most investor-owned hospitals—except those located in one-hospital towns—limit uncompensated care to "bad debts" and carefully selected "contract" losses, and avoid lines of business that lose money. Many government and nonprofit hospitals give special attention to care for low-income groups and to community service activities that absorb surpluses; investor-owned hospitals are not expected to emulate this behavior. Perhaps investor-owned hospital corporations are leaders in corporate philanthropy, but evidence to that effect is not available.

Capital investment. Investor-owned hospitals have different sources of capital investment than nonprofit corporations and government hospitals, although the differences have narrowed in recent years. Philanthropy, government grants, and tax-exempt bonds have been important sources of hospital capital that are not generally available to investor-owned hospitals. Among the nonprofit group, however, hospital revenue has gradually become the ultimate source of capital, primarily because of the astounding confidence of the tax-exempt bond market. The bond market seems to believe that tax-exempt hospital bonds are underwritten by government. More often than not, there is no basis for this belief. The claims of bondholders do not necessarily take precedence over the obligation of nonprofit institutions to provide community services, even those that are revenue-draining.

HOSPITAL OWNERSHIP AND ETHICAL STANDARDS

By Fr. O'Rourke's standards, investor-owned hospitals are ipso facto unethical; he does not attempt to judge how their performance compares with that of other hospitals. Dr. Rosett asserts that investor-owned hospitals are "doing

good," and he is "hopeful" that they "will preserve the humanitarian . . . qualities we all value in the hospitals of our country"; but he does not articulate any of these humanitarian qualities or provide any concrete basis for hope. Is there some perspective between unqualified condemnation and groundless hope? I think so.

Realistic and useful answers to ethical questions involving hospitals require a balanced perspective with respect to the dual role of hospitals in serving patients and in serving the community. The issues involved in balancing service to patients and service to society are more important and more complex than the tough issues which well-motivated investor-owned hospital leaders must face when balancing the demands of customers and stockholders. In the absence of a community perspective—which necessarily involves consideration of the arrangements and relationships among all the institutions serving the same community—there will always be uncertainty about whether or not individual hospitals are "doing good."

Can one really condemn a hospital for violating ethical standards if it provides high-quality, cost-efficient units of service to its customers? Licensing laws and accreditation standards for hospitals and hospital departments suggest that such a hospital is doing as much good as can be expected. A hospital and its governing body can meet every legal and accreditation standard without giving any consideration to community concerns: whether the services it is providing are appropriate, necessary, or desirable; whether the services, individually or collectively, are contributing to the health status of the community or to the affordability, accessibility, and effectiveness of the community's health care resources.

From another perspective, however—that of existing formal codes of ethics—a hospital that is simply providing high-quality, cost-effective services to patients is not measuring up. In the "Guidelines on Ethical Conduct and Relationships for Health Care Institutions" adopted by the American Hospital Association and the American College of Hospital Administrators (see page 40), hospitals are defined as service organizations that should provide not only patient care, but a wide range of services for their communities.[6] They carry public responsibilities for the health of their communities, which places them under special obligations to adhere to ethical principles of conduct. Guideline number 1 prescribes that hospitals be interested in the overall health status of people, not simply in providing direct patient care services. Guideline number 2 prescribes that hospitals support the most effective use of resources, within recognized economic limits, to assure access to comprehensive, high-quality services. Guideline number 3 prescribes promotion and support of interinstitutional cooperation in planning and providing services. Except with respect to publicity (guideline number 9), the AHA/ACHA guidelines make no distinction among investor-owned, nonprofit, and government-owned hospitals with respect to acceptable ethical standards.

Clearly, there are two different standards for determining whether hospitals are "doing good": (1) Dr. Rosett's standard, which most hospitals (including most investor-owned hospitals) meet; and (2) the profession's higher standard, which few hospitals (including few investor-owned hospitals) meet. Ownership per se is not the critical variable; responsible governance and management commitment to community health are the key. In my experience, the governing bodies of most hospitals, irrespective of ownership, are oblivious to the existence of a formal written code of ethics for hospitals, although many intuitively accept the code's precepts. Most hospital trustees would be prepared to follow the guidelines, if they were visible and publicized as the accepted measure of excellence.

The failure to build basic standards of ethical behavior related to community service into standards for hospital accreditation, for professional recognition, for recognition as a teaching hospital, and into other indications of excellence and prestige is the basic missing ingredient in this nation's health system—and this can be remedied.

Three approaches are worth considering: (1) raise the standards of the Joint Commission on Accreditation of Hospitals to include explicit standards related to improving the community's health status and conserving scarce health service resources; (2) establish a well-publicized, higher level of JCAH accreditation, incorporating community service standards; or (3) create a new hospital accreditation body, limited to those hos-

pitals that meet the AHA/ACHA ethical standards as well as JCAH standards.

Those responsible for governance of most hospitals wish to strive for excellence, however society defines excellence. This applies to almost all hospitals, irrespective of ownership.[7] However, most investor-owned hospitals will have great difficulty in conforming to the AHA/ACHA ethical standards while meeting the other expectations of their stockholders. But it won't be easy for other hospitals, either.

The American Hospital Association defined the leadership responsibilities of hospitals in a policy statement adopted by the House of Delegates in 1981.[8] This official policy position reiterates, and spells out in detail, the ethical responsibilities of hospitals for community leadership in improving health status and conserving scarce community resources. The policy position makes no distinctions with respect to ownership.

Dr. Rosett's assertion that investor-owned hospitals are currently "doing good" points to a standard of "good" behavior that most hospitals can readily achieve. More and more community hospitals are attempting to follow the investor-owned approach. If most hospitals accept Dr. Rosett's standard of "doing good" (simply providing efficient, quality care to customers and hoping for the best), society, to protect access, equity, and community health, will eventually impose on hospitals a level of government regulation that will drive private investors from the field. For this reason, the continued existence of investor-owned hospitals requires that most community hospitals maintain high ethical standards and a community perspective.

Service that is acceptable to patients, physicians, quality-standard-setting bodies, and investors can hardly be condemned and drummed out of society. But recognition of prestige and excellence should be reserved for those hospitals that meet standards of ethical institutional behavior that are responsive to contemporary community and social imperatives. Historically, the responsibility for developing credibility and public recognition for higher standards of service has fallen upon professional societies and philanthropic foundations. Neither has yet faced this key challenge.

In the absence of new standards of excellence that go beyond quality care to reflect social imperatives, won't hospital trustees, medical staff, and management continue to reflect confusion about their hospital's mission? Won't they continue to stress institutional survival and financial health more than community health? Is it any wonder that most national policy makers searching for better health care results, with less drain on national resources, view hospitals as an important part of the problem, rather than a key to solutions? Investor-owned hospitals should not be held up as role models for other hospitals to emulate.

ARE INVESTOR-OWNED HOSPITALS DOING GOOD?

Investor-owned hospitals in one-hospital towns are probably doing as much good—maybe more—than other hospitals in one-hospital towns. In contrast, few, if any, investor-owned hospitals in multihospital towns are doing good in the sense of providing community leadership. Community Programs for Affordable Health Care, the multimillion-dollar Robert Wood Johnson Foundation grant program cosponsored by the American Hospital Association and the Blue Cross and Blue Shield Associations, has found no example of investor-owned hospital leadership in any of the communities mounting community cost-containment initiatives.[9] While it is also generally true that few nonprofit and government hospitals in multihospital towns are providing outstanding community leadership, some do serve as examples of high ethical standards and demonstrate concern for community health status. There should be more.

Whether investor-owned hospitals can provide the leadership that "doing good" calls for at this point in history and also "do well" for the stockholders is questionable. Excessive attention to profit margin is not the issue at this time; the real problem is the absence of explicit attention to community service by most investor-owned hospitals. Community service and profits may or may not be compatible; we do not have solid evidence to support either position. If, in fact, they are not compatible, the stockholders' interests will certainly prevail until society finds ways to reduce or eliminate stockholder influence.

HOSPITAL OWNERSHIP AND HOSPITAL MISSION

Hospital goals and missions have changed throughout the history of hospitals in this country, reflecting changes in society and in medical science. In the long historical march forward, the hospital has evolved over time through seven stages, from (1) an institution to help protect society from exposure to dangerous sick people, to (2) also an institution providing humane care to sick people, to (3) also a doctor's workshop, to (4) also a center for medical education and research, to (5) also a medical service center responsible for the quality of medical care provided by the medical staff, to (6) also a community health center concerned with the health status of the community, and now to (7) an institution with emerging responsibility for cost-effective and affordable and accessible health care for the community.[10]

Investor-owned hospitals were born during the beginnings of the doctor's workshop stage of hospital development, and their missions have been less influenced by community forces than the missions of hospitals under other forms of ownership. Moreover, most of the hospitals that were influenced by community and social concerns have changed their ownership and converted to nonprofit status. Because of their continuing commitment to the doctor's workshop approach, investor-owned hospitals put much more emphasis on inpatient care, even as the proportion of patients served by other hospitals on an inpatient basis declines. Investor-owned hospitals put much less emphasis on hospital-controlled ambulatory programs. They have been slower to focus on comprehensive health and medical care and new forms of medical organization, and have looked upon hospital care as a commodity to be marketed through private practicing physicians. Even though they have been extremely innovative in managing the support services of the hospital, they have lagged far behind in managing health and medical care on a population or community basis. Although some American investor-owned chains have developed innovative, comprehensive health care programs in developing nations, these same corporations have been extremely conservative in the United States.

Dr. Rosett expects that there will be major changes in the years ahead in the relationships among investor-owned hospitals, their medical staffs, the populations served, the financing mechanisms, and medical education. The evidence for his expectations is not obvious to me. By and large, investor-owned hospitals have done well by concentrating on a medical care model that is shrinking and becoming less relevant. The need for change is clearly indicated, but the *short-run* feasibility and profitability of new directions involving new relationships with both physicians and populations is much less clear. There is little evidence that stockholders have the patience that permits hospital managers to embark on risky *long-range* strategies.

Hospitals owned by government and nonprofit corporations tend to have deeper community roots that may permit them to weather the adversity and tension of changing goals and missions more easily than the investor-owned group, which has the difficult task of balancing stockholder and community interests in a period of changing expectations, shrinking resources, and a redefinition of the nature of the product.

WHAT OF THE FUTURE?

The probability that "doing good" will become more profitable for hospitals in the future than at present seems quite low. As the crunch of limited resources from government, industry, and consumers closes in on the hospital field, "doing good" will probably become ever less profitable. As a result, investor-owned hospitals are not likely to become a much more significant segment of the hospital field than at the present time. Their limited approach—limited by their history and by the continuous short-term pressure for profit margins—is also likely to limit their growth in the period ahead.

The real problem is not the existence of the investor-owned hospitals, but rather the effect of their behavior on nonprofit community hospitals. Influenced by the investor-owned hospitals' recent spectacular success at "doing well" financially, will community hospitals increasingly concentrate their efforts on "doing well," or will they also give more explicit attention to "doing good"?

Investor-owned hospitals have been with

us for a long time, and are not likely to disappear. The issue is the extent to which this nation's communities can develop a workable balance among those hospitals—irrespective of ownership—that subordinate financial objectives to community service goals and those that subordinate community service objectives to financial goals. Only when a sufficient number of hospitals are responding to social and economic imperatives and maintaining high ethical standards can we expect an environment conducive to the continuing vitality of even a limited number of investor-owned hospitals. Investor-owned hospitals with little or no commitment to community service and values are well advised to avoid any sharp business practices which might adversely affect the commitment, viability, and success of institutions with basic community service goals. If only in their own self-interest, stockholders of investor-owned hospitals should divert a share of their profits to the support of those organizations that are upholding the highest ethical standards of community health service. By doing so, they would be maintaining the best tradition of innovative investor-owned corporate philanthropy.

In the final analysis, however, the responsibility for maintaining the predominance of hospitals operated in the community interest rests with the medical and hospital professions and with community leadership, particularly those serving on hospital boards of directors. Communities can hope to find that leadership in the investor-owned hospitals, but should insist on it among the nonprofit and government-owned hospitals. Medical and hospital professionals have a responsibility to develop and publicize standards of community service to the same extent as standards of quality, so that community leadership can know the level of performance it is expected to achieve.

Notes

1. Rorem, C. Rufus, *The Public's Investment in Hospitals* (Chicago: University of Chicago Press, 1930); American Hospital Association, *Hospital Statistics*, 1973 and 1983 editions (Chicago: AHA).
2. In 1982, among the short-term community hospitals, the ratio of outpatient visits to admissions in investor-owned hospitals was only 4:1; this compared with 7:1 in nonprofit hospitals and 8:1 in government hospitals. American Hospital Association, *Hospital Statistics* (Chicago: AHA, 1983), Table 1, p. 6.
3. For a discussion of hospital chains prior to Medicare, see *Proceedings of the National Forum on Hospital and Health Affairs* (Durham, N.C.: Graduate Program in Hospital Administration, 1965), particularly chap. 10, "Implications for Hospital Planning," pp. 111–23.
4. Sigmond, Robert M., "The Issues Facing Multihospital Systems," in *Multi-Institutional Hospital Systems* (Chicago: Hospital Research and Educational Trust, 1979), pp. 185–97.
5. Rorem, chap. 4.
6. The AHA/ACHA "Guidelines on Ethical Conduct and Relationships for Health Care Institutions" are an echo of the American Medical Association's "Principles of Medical Ethics," which provide that "the responsibilities of the physician extend not only to the individual but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."
7. The argument that concern for social values is a part of the underlying philosophy of both nonprofit trustees and directors of profit-making institutions is well presented by Robert M. Cunningham in "Changing Philosophies in Medical Care and the Rise of the Investor-Owned Hospital." *New England Journal of Medicine* 307 (September 23, 1982):817–19.
8. American Hospital Association, *Imperatives of Hospital Leadership*, Catalogue no. 166700 (Chicago: AHA, 1982).
9. Gerber, Donna L., "Community Programs for Affordable Health Care," *Inquiry* 20 (Summer 1983):127–33.
10. Sigmond, Robert M., "Old and New Roles for the Community Hospital," the William B. Woods Memorial Lecture, presented to the Rochester Area Hospitals Corporation, 1981.