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THE HENRY J. KAISER FAMILY FOUNDATION

Summary of Findings:

Privatization of Public Hospitals

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Prepared for The Henry J. Kaiser Family Foundation by:

The Economic and Social Research Institute

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Summary of Findings

Public hospitals (other than those run by the federal government) account for almost one-quarter of the community hospitals in the United States, yet their numbers have been decreasing for more than a decade, through both conversions and closures.

The Henry J. Kaiser Family Foundation commissioned the Economic and Social Research Institute (ESRI) to conduct a study to better understand the causes and effects of the conversions of public hospitals to private ownership or management. ESRI explored conversions that occur via lease, sale, management contract, merger, consolidation, and the establishment of an independent hospital authority.

Recent studies of hospital conversions have focused primarily on hospitals that have converted to *for*-profit status, examining the impact on a community when a former not-for-profit hospital (whether public or private) becomes part of an investor-owned hospital organization. Very few studies, however, have explored the effect on communities and hospital operations of the privatization of public hospital care, broadly defined to encompass conversions from public to private (often non-profit) status. This study fills that void in the literature.

A particular goal of this study was to understand how the conversion to private status affects hospitals' public missions. Conversions of these public hospitals to non-public status naturally raise questions about their continued commitment to the mission of serving needy populations. Do the conversions adversely affect access for vulnerable populations served by the formerly public hospital? A related issue is the prominent role many public hospitals play in graduate medical education. Do these programs, whose residents provide much of public hospitals' free care, shrink under private ownership or management?

In researching public hospital conversions, ESRI analyzed national data for trends in public hospital conversions, reviewed 25 to 30 instances of conversion (ten of which are profiled in the Appendix of the full report), and chose five cases for intensive study through telephone interviews and site visits. These five were Boston Medical Center in Boston, Massachusetts; Brackenridge Hospital in Austin, Texas; University Hospital at the University of Colorado's Health Sciences Center in Denver, Colorado; Sutter Medical Center of Santa Rosa in Santa Rosa, California; and Oakwood Healthcare System, in suburban Detroit, Michigan.

This Summary presents background, findings, and data from ESRI's full report, *Privatization of Public Hospitals*. Section I provides background about public hospital conversions, including the role of public hospitals, reasons for conversion, the mechanisms of conversion and new ownership entities, and analysis of national and regional public hospital data. Section II provides a discussion of the five case studies of public hospital conversions and the key findings from the case studies. Attachment A is a table of public hospital conversions and closures by region and state.

Section I. Overview of Public Hospital Conversions

In recent years, public hospitals around the country have affiliated with or been acquired by private hospitals or hospital systems at an unprecedented rate. This trend toward conversion of public hospitals to private ownership or management typically reflects public hospitals' desires to ensure short- and long-term financial stability and enhance negotiating power in an era of decreased public subsidies and increased competition for funding and patients.

Traditional Role of Public Hospitals

Concern about this trend emanates from two vital roles traditionally filled by public hospitals:

- First, they often are considered the "providers of last resort," ensuring access to medical services for those who cannot go elsewhere. Primarily, this constitutes removing financial barriers to care for the uninsured and under-insured by serving eligible patients without expectation of payment. In addition, however, public hospitals also provide unique services for under-served populations (such as, translators for non-English speaking patients) that address non-financial barriers to care for patients such as newly-arrived immigrants.

- Second, urban public hospitals have traditionally filled the role of major teaching institutions. Not only are they affiliated with local medical schools for the training of medical students and residents, but they often sponsor their own independent residency programs. These residents provide most of the free care that is available from public hospitals. In this role, urban public hospitals are often providers of highly specialized care, and the only route for non-paying patients to the most sophisticated diagnostic and treatment services and equipment. The policy question this issue raises is: can these "public goods" that public hospitals provide survive the hospitals' conversions to private ownership or management?

Why Do Public Hospitals Convert?

The motives for the conversions ESRI examined were mostly related to the hospitals' financial viability. Hospital use has been declining nationally since the early 1980's, in part due to the substitution of case-based (diagnosis-related group) reimbursement for cost-based reimbursement and the growth of managed care plans that generate much of their savings from reducing hospital days used by their enrollees. As all hospitals, both public and private, compete for fewer patient-care revenues, public hospitals are often left with the financial burden of charity care. Private hospitals, having lost their ability (under the former, cost-based reimbursement) to shift the cost of charity care to insurers who reimburse them for other patients, respond by cutting their charity care load, increasing the burden on public hospitals. At the same time, Medicaid (and especially Medicaid managed care plans) has begun to look more attractive to private hospitals searching for revenue. Private hospitals have often successfully attracted Medicaid patients who used to receive services at the public hospital. This one-two punch both deprives the public hospital of one of its major sources of revenue (Medicaid patients) and leaves it with increasing numbers of patients who have no source of payment.

Mechanisms for Conversion and New Ownership/Operating Entities

The term "conversion" is often used to describe a wide range of reorganization activity by public hospitals. For example, leases, asset sales, closures, mergers, consolidations, affiliations, and joint-ventures are all characterized as conversions in the relevant literature.

Table 1: Mechanisms for Public Hospital Conversions

Mechanism for Conversion	Definition
Lease	A contract granting the use or occupation of property during a specified time period in exchange for rent. In the Brackenridge and Sutter Medical Center conversions, all of the assets of the former public hospital were leased. At Boston Medical Center, only the building was leased.
Merger	A union of two or more corporations. Typically, it implies the absorption of one corporation into the other. In Detroit, the PCHA hospitals merged into the Oakwood system.
Sale	The transfer of some or all of the assets of a corporation (partial or full asset sale) in exchange for a specified amount of money or its equivalent. Typically, the government no longer will be involved in the ownership or management of the former public hospital.
Management Contract	Management by an existing health system or management company. The degree of ongoing involvement by the local government varies, as does the length of the management contract.
Consolidation	The union or combination of two or more entities into one system. Boston Medical Center is the result of the consolidation of Boston City Hospital and Boston University Medical Center Hospital.
Closure	A situation where a public hospital ceases operations temporarily or permanently. Typically, all of the assets of the former public hospital will be sold to another entity and the hospital will no longer be referred to under its previous name.
Joint-Venture	A partnership, often to share risk or expertise.
Public/Private Partnership	The transfer to or combination with an existing private health system. There still may be a high level of ongoing involvement by and accountability to the local government.
Affiliation	A close association between two or more organizations. The entities maintain separate ownership and governance.

Source: National Association of Public Hospitals and Health Systems, *The Safety Net in Transition: Monograph II, Reforming the Legal Structure and Governance of Safety Net Health Systems*, June 1996.

In addition, the entity that assumes either ownership or management of a former public hospital can take many forms. The resulting organization can be purely private, such as a non-profit or for-profit corporation; quasi-public, such as a hospital authority, public benefit corporation, or hospital taxing district; or a public-private partnership, which can result from affiliations and joint-ventures. The following tables describe the diversity of reorganization activity that is occurring around the country and the range of organizations now operating former public hospitals. The degree of continued involvement by the government entity that previously owned or operated the public hospital varies and is determined by state law or the contract between the parties.

Table 2: Types of Entities that Own and Operate Former Public Hospitals

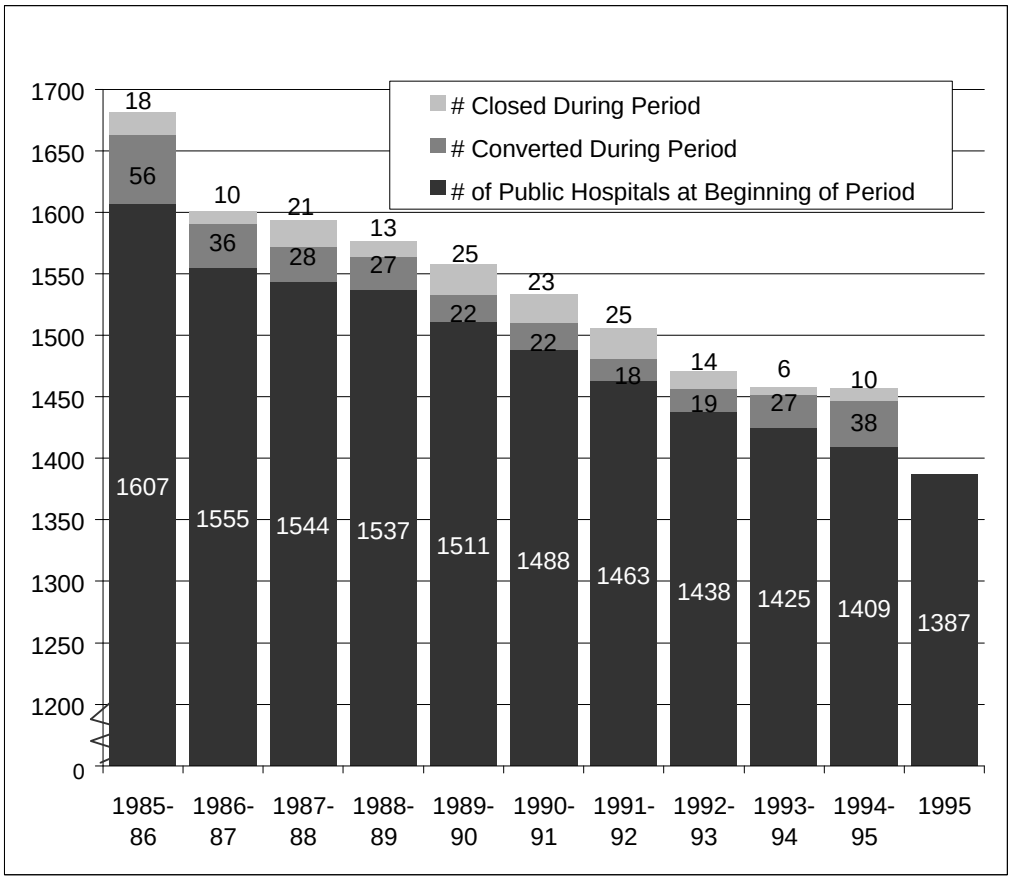
Type of Entity	Definition
Private:	
Non-Profit	A tax-exempt corporation, created under a state's non-profit corporation law to serve a charitable purpose. Any profits from its operation are reinvested in the corporation. Boston Medical Center, Sutter Medical Center, Seton Healthcare, and Oakwood Healthcare System are all private, non-profit organizations.
For-Profit	A corporation that is not tax-exempt, the profits of which are distributed in a systematic manner to the corporation's owners.
Quasi-Public:	
Hospital Authority	A public body or agency of a governmental unit created by a state statute to administer a portion of the powers of the government delegated to it. University Hospital in Colorado is now owned and operated by a hospital authority.
Public Benefit Corporation	A public corporate entity that provides a specific public benefit to state residents. Often established under a state's public benefit corporation law. The profits from this corporation inure to the state or the people of the state.
Hospital Taxing District	A quasi-municipal but independent corporation covering a defined geographic area that is established under state legislation. A hospital taxing district has taxing authority and operates a district hospital.
Public/Private Partnership:	Include affiliations, consolidations and joint-ventures. Each entity maintains its own board and ownership status.

Source: National Association of Public Hospitals and Health Systems, The Safety Net in Transition: Monograph II, Reforming the Legal Structure and Governance of Safety Net Health Systems, June 1996.

National and Regional Trends

Public, non-federal hospitals account for almost one-quarter of community hospitals in the United States. As shown in Figure 1, the number of public hospitals has been decreasing at least since the mid-1980s. In fact, from 1985 to 1995, the number of public hospitals declined by nearly 14 percent. During this period, 293 public hospitals converted to private ownership or management, and 165 closed; an additional 20 formerly public hospitals closed after converting to non-public status.[1] A small number of public hospitals that converted to non-public status converted back to public status in subsequent years.[2] This trend in public hospital conversions can be summarized as follows: for every 100 public hospitals, one is closing and two are converting to private ownership or management annually.

Figure 1: Number of Public Hospitals, Conversions, and Closures, United States, 1985-1995



Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

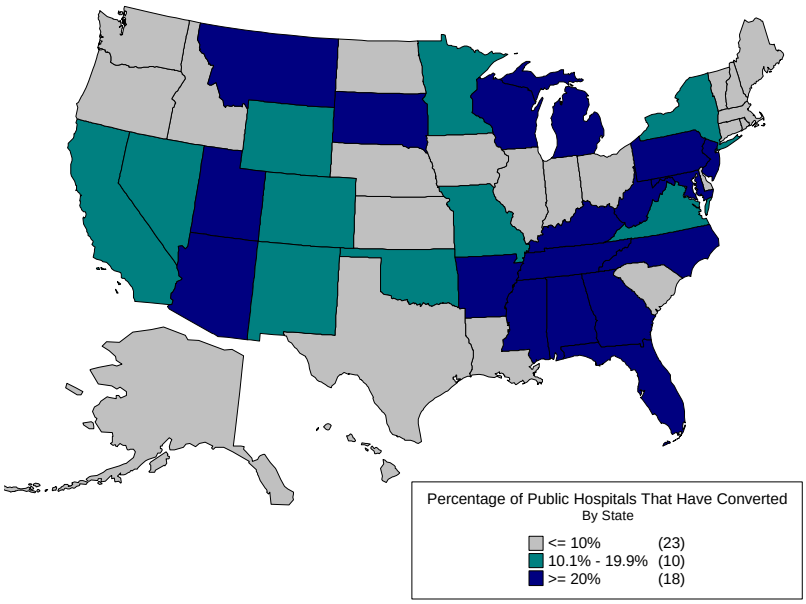
*Note: The Y-axis starts at 1200 rather than zero, which makes the closures and conversions appear to be larger relative to the number of public hospitals than they actually are. The graph does, however, accurately portray the trends.

The number of conversions of hospitals from public to non-public status is not evenly distributed across the United States. In fact, 12 states accounted for approximately two-thirds of the conversions from 1985-95. In a number of these states, between 25 and 40 percent of all public hospitals converted to non-public status. As Figure 2 and Attachment A illustrate, a disproportionate number of the states with high numbers of conversions are located in the South.

ESRI explored whether public hospitals that close or convert to some private status differ in some systematic ways from hospitals that do not undergo such changes. After examining variables such as the level of competition in a market or hospital inefficiency relative to competitors, ESRI did not find important and significant relationships between the various explanatory variables and hospital conversion or closure. In other words, the effort to identify characteristics that distinguish between closing or converting public hospitals and other hospitals in their market area did not yield significant insights. There is nothing obviously different about these hospitals that seems to explain in a systematic way why they changed from public to non-public status, echoing the results of the qualitative analysis, which found that converting hospitals are often quite different from one another, as are the markets in which they operate.

Figure 2: Proportion of Public Hospitals Converting to Non-public Status, by State, 1985-1995

Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*



Section II. Case Studies of Public Hospital Conversions

ESRI's analysis is based on a detailed review of five public hospital conversions (including one academic medical center). A brief description of each is outlined below.

Boston Medical Center. In 1996, Boston City Hospital (BCH), a public teaching hospital, Boston Specialty and Rehabilitation Hospital (BSRH), a public long-term care hospital, and Boston University Medical Center Hospital (BUMCH), a private, non-profit teaching hospital, consolidated their operations to form Boston Medical Center (BMC), a private, non-profit entity. As part of the consolidation agreement between the city of Boston and BUMCH, BSRH closed 90 days after the affiliation and its services were consolidated into the former BCH facility at BMC.

Brackenridge Hospital and Children's Hospital. Brackenridge Hospital and Children's Hospital were owned and operated by the city of Austin, Texas. On October 1, 1995, the city of Austin leased all of the assets of both hospitals to Seton Healthcare Network, a local, non-profit hospital system operated by the Daughters of Charity National Health System. Under the 30-year renewable lease, Seton effectively took over financial and operational responsibility for both institutions.

University Hospital. In 1991, the Colorado legislature passed a law enabling University Hospital, part of the University of Colorado's Health Sciences Center, to become a "quasi-public" organization under an authority structure. Under the University Hospital Authority, the institution retains several of the benefits of a public institution, but may operate free of many of the constraints on personnel management, debt issuance, and purchasing normally imposed by the state.

Sutter Medical Center of Santa Rosa. Sutter Medical Center of Santa Rosa, California is the result of a 1996 agreement between Sonoma County, located north of San Francisco, and Sutter Health, a non-profit organization that operates 26 hospitals in Northern California. Sutter leases the former county hospital and operates it under contract to the county.

Oakwood Healthcare System. Oakwood Healthcare System, in Dearborn, Michigan, is a product of the 1991 merger of Oakwood Hospital, a non-profit community hospital, and the five public hospitals that made up the People's Community Hospital Authority (PCHA), which served more than 20 communities in the suburban Detroit area.

Key Findings from the Case Studies

Motivations for Conversion

- The hospitals converted to private ownership or management to recover from or avert financial difficulties, due largely to increased competition for patients and revenue and changes in reimbursement caused by the growth of managed care. These market forces and the changes they wrought on public hospitals were often no different from what the community's private hospitals had already experienced earlier.
- The public sector placed constraints on these hospitals that handicapped both governance and management vis-à-vis private hospital competitors. These constraints included an inability to raise capital, complicated or inefficient purchasing and compensation systems, and requirements to develop competitive strategies in public because of open meeting laws.
- The governmental entities typically were not willing to continue to operate a hospital outside of the market; that is, to totally subsidize a hospital exclusively for the poor. Therefore, in most cases, the solution for failing public hospitals was to find a way to make them competitive so they could survive to serve both low-income patients and others. This meant that unique market characteristics played an important role in these conversions, since the desired outcome of the conversion was a hospital that would be successful in its local market.

Process of Conversion

- These conversions were essentially political processes, and those hospitals that approached them as such had greater initial success. Essential political strategies were to "embrace perceived opposition" and "appease affected parties."
- Private organizations that were successful in negotiating agreements to purchase, lease or manage public hospitals were credible partners with a good track record in serving communities, including vulnerable populations, and organizational characteristics that made them acceptable stewards of the hospital's mission in the eyes of the community.

Effect on Hospital Operations

- The manner in which the hospital handled inevitable changes in staffing, compensation, work rules, and job content was key to the success of these conversions. Management that involved labor early in the conversion process and worked with them to ease the effects of change on the formerly public workforce had fewer problems. It was necessary for the new, private-sector managers of these facilities to balance good business practices with: 1) a less aggressive method of reducing labor costs than the approach often encountered in corporate "turn-around" efforts (for example, job redesign and attrition versus large lay-offs); and 2) commitments to maintain levels of charity care on which the community depended from the formerly public institution.

Effect on the Local Community

- Conversions that went relatively smoothly were led by individuals who recognized from the outset the need to assure the community that the hospital's public mission would be preserved, and who developed mechanisms to ensure that the new entity would maintain a commitment to the mission of providing care to the uninsured.
- In most instances, access to care for low-income patients has been preserved after conversion and teaching programs have not been cut. Most community respondents told us, however, that the access issue would require continued monitoring by the community.

The bottom line emerging from the study is that hospitals committed to the public good of effectively serving lower-income people must first survive. Remaining viable in today's highly competitive health care market requires some basic ingredients of good business management. This translates into flexibility in managing labor and purchasing costs; access to capital; and the ability to conduct business-like strategic planning.

Ironically, these basic business components, if they enable institutions with a public mission to attract a base of paying patients, will enable them also to continue serving vulnerable populations. Instead of a Hobson's choice between public status with no modern business practices and private status with no commitment to the indigent, our study uncovered a wider set of options. By adopting the essentials of modern business practices, public institutions that convert to private status (and even those that do not) hope to balance the goals of financial viability and serving a public mission. Indeed, our findings suggest that the former is a precondition to the latter in today's competitive health care environment.

The findings suggest that, with health care as well as other public services, communities across the country are struggling to build market-oriented strategies into the delivery of public services without abandoning their commitment to serve those who may be left behind by the market.

Endnotes

[1] Calculations here and at subsequent points in this narrative are based on an effort by ESRI to verify, clean, and organize data from the American Hospital Association *Annual Survey of Hospitals.*

[2] This is one reason why in Figure 1 subtracting the number of conversions and closures from the number of public hospitals in one year does not equal the number of public hospitals in the subsequent year. The discrepancy may also reflect the fact that some hospitals listed as closed in one year may be coded as being reopened in a subsequent year. An examination of the data suggests that some hospitals that have had public status at some point are incorrectly coded in other years. Where such errors were obvious, ESRI tried to adjust to correct the problem.

Attachment A

Number of Public Hospitals, Conversions, and Closures, by Region and State, 1985-1995

	Number of Public Hospitals*	Number Converted	Number Closed	Percent Converted	Percent Closed
Region 1 (New England)					
Connecticut	2	0	0	0%	0%
Maine	4	0	0	0%	0%
Massachusetts	13	1	4	8%	31%
Total for Region 1	**19**	**1**	**4**	**5%**	**21%**
Region 2 (Mid Atlantic)					
New Jersey	5	1	1	20%	20%
New York	32	4	4	13%	13%
Pennsylvania	9	4	3	44%	33%
Total for Region 2	**46**	**9**	**8**	**19%**	**17%**
Region 3 (South Atlantic)					
D.C.	1	0	0	0%	0%
Florida	57	20	8	35%	14%
Georgia	105	26	7	25%	7%
Maryland	1	1	0	100%	0%
North Carolina	52	11	1	21%	2%
South Carolina	31	1	1	3%	3%
Virginia	7	1	1	14%	14%
West Virginia	17	6	2	35%	12%
Total for Region 3	**271**	**66**	**20**	**24%**	**7%**
Region 4 (East North Central)					
Illinois	43	4	3	9%	7%
Indiana	52	3	1	6%	2%
Michigan	48	22	4	46%	8%
Ohio	28	2	2	7%	7%
Wisconsin	11	3	1	27%	9%
Total for Region 4	**182**	**34**	**11**	**19%**	**6%**
Region 5 (East South Central)					
Alabama	63	14	3	22%	5%
Kentucky	25	11	1	44%	4%
Mississippi	80	20	7	25%	9%
Tennessee	43	13	1	30%	2%
Total for Region 5	**211**	**58**	**12**	**27%**	**6%**
Region 6 (West North Central)					
Iowa	68	1	4	2%	6%
Kansas	89	6	7	7%	8%
Minnesota	76	9	9	12%	12%
Missouri	46	5	3	11%	7%
Nebraska	49	1	5	2%	10%
South Dakota	11	4	1	36%	9%
Total for Region 6	**339**	**26**	**29**	**8%**	**9%**
Region 7 (West South Central)					
Arkansas	43	16	6	37%	14%
Louisiana	75	5	8	7%	11%
Oklahoma	72	12	3	17%	4%
Texas	195	18	26	9%	13%
Total for Region 7	**385**	**51**	**43**	**13%**	**11%**

Attachment A, cont.

	Number of Public Hospitals*	Number Converted	Number Closed	Percent Converted	Percent Closed
Region 8 (Mountain)					
Arizona	10	4	2	40%	20%
Colorado	35	4	2	11%	6%
Idaho	30	0	2	0%	7%
Montana	20	10	1	50%	5%
Nevada	11	2	0	18%	0%
New Mexico	17	3	2	18%	12%
Utah	11	3	0	27%	0%
Wyoming	20	3	1	15%	5%
Total for Region 8	**154**	**29**	**10**	**19%**	**6%**
Region 9 (Pacific)					
Alaska	9	0	0	0 %	0%
California	111	16	11	14%	10%
Hawaii	8	0	0	0%	0%
Oregon	21	2	3	10%	14%
Washington	45	0	2	0%	4%
Total for Region 9	**194**	**18**	**16**	**9%**	**8%**
Region 0 (Associated Areas)					
American Samoa	1	0	0	0%	0%
Guam	1	0	0	0%	0%
Puerto Rico	24	1	11	4%	46%
Virgin Islands	2	0	0	0%	0%
Total for Region 0	**28**	**1**	**11**	**4%**	**39%**
Total	**1,829**	**293**	**164**	**16%**	**9%**

Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

*Number of hospitals that were coded as public at any time between 1985-1995. States with no public hospitals were excluded from the table.

*Note: The count of public hospitals includes all hospitals that at any time during the period 1985-1995 were designated as a public hospital in the American Hospital Association Annual Survey of Hospitals.

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