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# Market Transformation: Will Not-for-Profit Providers Survive?

BY JANE HIEBERT-WHITE

**H**ospitals across the country are increasingly joining integrated delivery systems, and a number of those systems are organized on a for-profit basis. The percentage of acute care hospitals in for-profit healthcare systems rose from 42.5 in 1992 to 44.7 in 1994; meanwhile, the percentage of hospitals in Catholic systems declined from 27.2 in 1992 to 23.7 in 1994, according to the 1994 and 1995 Multi-Unit Providers Survey, sponsored by *Modern Healthcare*. In 1995 Columbia/HCA—the for-profit hospital system that most healthcare observers see as a catalyst for market change—showed phenomenal growth, acquiring 143 hospitals, thereby bringing its total to 338 and its annual revenue to \$4.6 billion.<sup>1</sup>

Data from the American Hospital Association show that the nature of hospital ownership has remained fairly stable over the past decade: Not-for-profit hospitals made up 58.4 percent of facilities in 1985 and 60.0 percent in 1993; investor-owned hospitals were 14.0 percent of the total in 1985 and 13.6 percent in 1993. Yet it is ownership of hospitals in systems—especially the newly emerging regional systems—that really bears watching, since U.S. healthcare is moving toward system integration.

As market trends pressure the owners of some not-for-profit hospitals to sell their facilities to—or form joint ventures with—for-profit systems like Columbia/HCA, this has renewed an old debate among policy and system leaders concerning the relative value of for-profit and not-for-profit healthcare delivery (see also Emily Friedman's article on pp. 28-34). Perhaps no one has put the issue more baldly than venture capitalist Paul Queally. He said, at a November meeting hosted by the Alpha Center in Washington, DC, "In 10 years, I think Catholic charities will be out of the healthcare business. They lack the management and capital to effectively compete today and in the future."

Queally, a Catholic who sits on the board of a Catholic hospital, elaborated in a conversation:



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"Some Catholic hospitals will make it, but I think they should redirect their mission elsewhere. . . . I hate to be crass, but I don't think a group of 70-year-old nuns have the energy to compete in this market." Queally is a general partner of Sprout Group, the venture capital affiliate of Donaldson, Lufkin & Jenrette.

William Cox, executive vice president, Catholic Health Association (CHA), responded by noting that "investment bankers like Paul Queally have a personal financial interest in seeing turnover [of health facilities from not-for-profit to for-profit]. There is tremendous personal financial reward involved, so their market analysis and observations must be examined critically." On the issue of management, Cox said:

Queally's denigration of Catholic hospitals' capacity to compete is completely gratuitous. Beyond his demeaning ad hominem attack on the management skills of sisters, he provides no evidence that Catholic hospitals are less well managed than Columbia/HCA's. As CHA examines each market, we find that, in general, Catholic hospitals and health systems are strong competitors. Our challenge is to compete successfully, but in a way that doesn't undermine our identity as Catholic organizations.

This column delves into some of the issues raised by the not-for-profit versus for-profit healthcare debate and looks at policy analysts' predictions for the future.

## FOR-PROFIT VERSUS NOT-FOR-PROFIT CARE

A recent national survey found that Americans' perceptions of for-profit and not-for-profit hospitals are mixed.<sup>2</sup> For instance, Americans generally believe that for-profit hospitals are more efficient (59 percent for-profit versus 35 percent not-for-profit) and provide a higher quality of care (57 percent for-profit versus 34 percent not-for-profit). Survey respondents also believe that for-profit



hospitals are somewhat more responsive to customers (54 percent) than are not-for-profit hospitals (42 percent).

But the survey also showed that not-for-profit hospitals are viewed as being "more helpful to the community" (65 percent not-for-profit versus 32 percent for-profit). And Americans have the impression that not-for-profit hospitals cost them less (73 percent) compared with for-profit hospitals (22 percent).

When asked what the trend toward for-profit healthcare meant for the country, a majority (54 percent) perceived it as a "bad thing." On the other hand, a plurality (46 percent) said they trusted for-profit and not-for-profit hospitals about equally to provide "high quality care at a reasonable price" (26 percent said they trusted not-for-profits more, and 25 percent said they trusted for-profits more).

This random-sample survey of 1,007 adults nationwide, conducted by Louis Harris and Associates for the Henry J. Kaiser Family Foundation, was released at a December 1995 media briefing. Kaiser Executive Vice President Mark Smith, MD, noted that "on one hand, people want the healthcare system to be more businesslike and efficient. Yet, given the philanthropic, charitable history, especially of healthcare delivery, people are concerned about the business ethic coming to dominate the healthcare system."

Although the survey's findings describe perceptions, not facts, they do indicate that not-for-profit providers need to improve their image if they expect Americans to support a continued not-for-profit healthcare delivery presence. CHA's Cox agreed that, even though "for-profits are not necessarily more efficient and it's about a draw with respect to quality, there is a perception problem for not-for-profits." Cox noted that this perception problem is especially serious in Congress and state legislatures, where regulations and laws concerning tax-exempt status are debated.

Regarding responsiveness to the consumer, Cox conceded that Catholic hospitals "have not done a good job of marketing ourselves to individuals. We haven't had to in the past." However, in an era where healthcare providers, industry leaders—even Medicare officials—are scrambling to understand and court the healthcare consumer, not-for-profit hospitals will need to reach out more to the individual.

### **THE COMPETITIVENESS QUESTION**

**Columbia/HCA** The expansion into many communities of for-profit hospital chains, especially

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Columbia/HCA, has forced not-for-profit providers to enhance their competitiveness. In a study of 15 U.S. communities for the Robert Wood Johnson Foundation, healthcare researcher Kathryn Duke of the University of California—San Francisco found that "all of the study communities consistently cited Columbia/HCA's actual, expected, or rumored entry into their community as a major influence on the actions of local hospitals."<sup>3</sup> Indeed, a Catholic hospital system based in Cleveland has gone so far as to enter a joint venture with Columbia/HCA. The 1995 agreement between the Sisters of Charity of St. Augustine and the for-profit system was a first for Catholic providers.

Cox predicted that, given the competitive situation in some communities, "there will be other Catholic hospitals that will sell out entirely to Columbia/HCA or another for-profit chain. . . . However, from our perspective, there's a big difference between completely selling to a for-profit hospital chain and entering into a 50/50 deal and calling the outcome 'Catholic.'" He continued:

As a rule, CHA is very doubtful that these kinds of [joint-venture] relationships [with for-profits] can, over the long run, truly sustain and further the ministry of Catholic healthcare. They can sustain hospitals, but not the mission of a Catholic institution. It's not that we believe the investor-owned institutions are in any way morally inferior. We just believe that a shareholder-driven healthcare organization is not the preferable structure for nurturing and sustaining the ministry of Catholic healthcare.

In defending Catholic hospitals' ability to remain competitive, Cox added that "Columbia/HCA has attempted to engineer a number of [joint ventures with Catholic facilities] over a long period of time and has succeeded only once." He acknowledged, however, that "we are going to see a determined effort on the part of Columbia/HCA" to use that success to leverage their way into additional 50/50 deals with Catholic healthcare facilities.

**Downsizing** Cox noted analysts' prediction that, between now and 2000, up to a third of hospitals in the United States will close because of the spread of managed care. "This will affect Catholic institutions as well," he said.

Some analysts suggest that not-for-profit providers are less able than for-profits to respond quickly to market pressure for downsizing, given the not-for-profits' organizational structure and



their hesitancy to close hospitals. Indeed, according to Duke, "one Orange County [CA] hospital CEO suggested that a philanthropic foundation could make a valuable contribution to local health care by reducing excess capacity through buying and then closing selected hospitals."

Cox countered that "Catholic hospitals tend to close in the same proportion as the rest of the universe and retain the same percentage presence," which argues for Catholic hospitals' ability to remain competitive with other hospitals in the market. In 1960 there were 1,000 Catholic hospitals; today there are 680. Cox added, "On the face of it, being slower to react to market conditions is not necessarily a bad thing for a community's healthcare systems. A community-based institution may take longer to act than a shareholder-driven institution, but that might well be in the long-term best interest of the community. Immediate efficiency gains should be only one measure of a healthcare organization's performance."

**Access to Capital** For-profit hospitals are generally able to borrow money from banks at a lower rate of interest. On the other hand, not-for-profit hospitals are exempted from paying taxes. Yet a number of Wall Street analysts perceive not-for-profits as struggling in the competitive marketplace, with capital-starved facilities forming mergers "out of desperation."

Other analysts, however, say that not-for-profit hospitals have no real problem with acquiring enough capital to compete with for-profits. Said Daniel Bourque, head of VHA Inc.'s Washington, DC, office, "Lots of hospitals are sitting on big pieces of cash, yet there is the attitude that they need more capital and deep pockets to compete with Columbia/HCA." Smith of the Kaiser Family Foundation also disagreed with the notion that not-for-profits cannot compete because of lack of access to capital: "Once a [not-for-profit] hospital network is large enough, raising capital isn't a problem. Hospitals are cash cows. What they bring to the market is money."

### THE ACCOUNTABILITY QUESTION

The question of accountability is especially contentious. Advocates of not-for-profit healthcare delivery argue that their organizations are accountable to the patient and the public—not to the shareholder. As Kaiser Foundation Health Plan head David Lawrence wrote in a pointed exchange with Leonard Schaeffer, CEO of Blue Cross of California: "The most important distinction between nonprofit and for-profit status is that the net income we (as a nonprofit) generate

does not go to shareholders—it is retained for the benefit of our members and the public in the form of facilities, technology, and lower premiums in the future."<sup>4</sup>

Lawrence added: "Health plans such as Schaeffer's seem to view their primary activities as developing and marketing insurance products, collecting premiums, and making the best economic arrangements they can with providers. . . . We [at Kaiser] are not subject to the pressures of short-term profit-and-loss statements. We are able to take a longer perspective in our decision making."

Schaeffer, in return, claimed Kaiser does not live up to its community benefit claims, and argued that "nonprofit health plans should enjoy tax subsidies only if their contributions to society equal or exceed the value of the subsidy."<sup>5</sup>

The question of not-for-profits' contribution to society will continue to be raised as for-profit providers make a stronger effort to demonstrate their own contributions. For instance, at the Kaiser Family Foundation press briefing, Stephen Wiggins, CEO of the fast-rising for-profit Oxford Health Plans, tried to persuade the press that his managed care plan provided community benefits at least equal to those of his not-for-profit rivals. As for-profit providers make more of a case for community benefit, not-for-profit providers will need to better justify their tax-exempt status.

In the end, however, it remains to be seen whether for-profit providers will really be willing to provide the "safety net" function often performed by not-for-profits. Health lawyer Peter Grant, of Davis Wright Tremaine, suggested at the Alpha Center meeting that "the publicly held for-profit system is not going to deliver care to 50 million uninsured." Robert Restuccia, executive director of the consumer organization Health Care for All, concurred: "The time for charity care is now. The question is, Are we getting charity care from our nonprofits? We need a lot more accountability." He added that the "challenge for [states'] attorneys general is to make nonprofits more accountable."

When asked about accountability, some Wall Street analysts suggested that the publicly held for-profits are actually more accountable than not-for-profit healthcare providers. "Public companies are [held] under an incredible microscope" by investors, said analyst Geoffrey Harris of Smith Barney, Inc., at the Kaiser briefing. "I would argue that public companies have more accountability than companies that are nonpublic (whether nonprofit or for-profit). A nonpublic

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## WHAT IS SPIRITUALITY?

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### WHEN GOD COMES COURTING

How does the holy approach this remarkable human being? When the mystery makes itself known to a person, the human is filled with wonder and experiences being grasped by love.

If the person attends to this, several changes take place. First, the divine takes its place clearly in human awareness, effecting a religious conversion. Next, the new awareness usually changes behavior. The person realizes, I don't want to do some of the cheap stuff I've been doing; and thus moral conversion begins. Third, the love strengthens the person to face the buried garbage of his or her life, including decisions or events that left scar tissue. Psychic conversion may begin, often with therapy. Finally, the person might come to know herself or himself—how he or she processes things, avoids things, skips things. The person learns to be attentive, to intelligently question, to reach reasonable conclusions, and to act responsibly. Love's agenda is relentless, its goal the total healing of the human.

But love does not just make demands.

It comes with gifts in hand. Three graceful abilities begin to show themselves in attitude, speech, and behavior. The religiously converted long for an intimacy with the holy: We call this longing "hope." There is a knowing born of love: We call it "faith." And there is action born of religious love: Its name is "charity."

And still love is not finished. In the mind a prudence grows, a wondrous common sense amid the millions of decisions that lace up our days. In the will, justice appears like a rudder of fairness as we relate to those on the job or in the neighborhood. In the psyche two capacities permeate our image making and emotional energy: fortitude to deal with what threatens, and temperance, which moderates our sensual appetites and our need for food and drink.

Driven by a new obsession with what has become the person's primary love, a transfiguration is under way. The project is nothing short of holiness, a wholeness the human did not dare to dream of. This is the fullness of spirituality. This is the destiny of each of us. □

## DEVELOPING LEADERS' SPIRITUALITY

In its 1994 study of outstanding leaders in Catholic healthcare, the Catholic Health Association's Center for Leadership Excellence identified a model of 18 critical competencies of leadership. Three competencies of spirituality are at the core of the model, having the most influence on leaders' behaviors: Finding Meaning, Faith in God, and Positive Affiliation.

Responding to the essential role of spirituality in outstanding leadership, the center has created a resource for developing these three competencies. To be released in June 1996, the resource—published as a guide for facilitators—includes descriptions of the behaviors and characteristics of these competencies, along with case study discussion and self-reflection exercises for increasing awareness of these behaviors and characteristics. The guide also includes helpful support materials:

- Tools for teaching such disciplines as centering prayer and discernment
- A glossary
- Reading lists
- An introduction to accelerated learning techniques applied to the development of the spirituality competencies

- Essays, including one by Sr. Carla Mae Streeter, OP

The resource is the work of a task force—Rev. Gerald Broccolo; Sr. Margarite Buchanan, RSM; Sr. Joanne Lappetito, RSM; Sr. Maureen Lowry, RSM; Sr. Sharon Richardt, DC; and center staff Regina M. Clifton, Carol Tilley, and Ed Giganti.



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## NOT-FOR-PROFITS

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company could probably cut quality easier than a public company," he said.

But CHA's Cox said that although for-profit companies are very accountable to shareholders, they are not as responsive to their communities as not-for-profits are. "A for-profit hospital will pull up stakes and move tomorrow if the shareholders demand it," Cox said. "Because of pressures from their communities, not-for-profits are rarely able to act so precipitously."

### IS THERE A DIFFERENCE?

As Catholic providers seek to renew their mission, forging a "new covenant" to preserve the spirit and ministry of Catholic healthcare in a competitive marketplace, it will be critical for them to keep in mind accountability to both the community and the individual patient. If not-for-profit Catholic providers cannot convince the public and the policymakers that they are caring for society's most vulnerable, and providing a community benefit beyond that rendered by for-profit facilities, then there will be good reason for the public to ask, What's the difference? □

### NOTES

1. Kathryn Duke, "Hospitals in a Changing Health Care System," *Health Affairs*, Summer 1996.
2. Henry J. Kaiser Family Foundation, "A Survey on American's Perceptions about For-Profit and Not-for-Profit Health Care," Menlo Park, CA, December 1995.
3. Duke.
4. David Lawrence, "Nonprofit Versus For-Profit Health Plans," *Health Affairs*, Spring 1996, pp. 237-238.