Assessing Outcomes:
Analyzing the Public Impacts of Conversions

The terms of conversion transactions receive the lion's share of public attention. In comparison, there is relatively little information available about how conversions affect communities in the long run. Now that so many conversions among health care institutions have been completed, attention should be directed toward assessing the public impacts of these transactions. The challenge for advocates and policymakers is to ensure that communities actually realize the benefits they are owed when valuable nonprofit institutions convert to for-profit status.

Conversion Foundations

Working to preserve charitable assets in health care conversions has resulted in the creation of hundreds of new foundations worth billions of dollars collectively. These foundations have the opportunity to channel this enormous wealth into grants that will serve the unmet health and educational needs of communities around the country.

It is not clear whether grantmaking foundations are adequate substitutes for nonprofits that actually provide services, however. In health care conversion foundations, a large percentage of grants do not serve health needs, even though these foundations are endowed with the charitable assets accrued by converted nonprofit health care institutions. A study by Consumers Union on nonprofit hospital conversions in Texas found that:

> While some foundations created from the disposition of the sale proceeds continue to support health projects in the community, as required by law, not all communities benefit in this way. One foundation uses its funds to support a number of non-health-related causes, while another large nonprofit absorbed the proceeds into its statewide system and removed them from the community[.][1]

The outcomes of conversion transactions should be scrutinized to determine how the resulting charitable foundations serve the public.[2]

Insiders from converting nonprofits often are interested in retaining control over conversion foundations, which are endowed with public money. These insiders may deny that the foundations are accountable to the public. Those who seek to protect the public's interest must ensure not only that the charitable assets of converting nonprofits are preserved, but also that these assets are reinvested in the community.

Community Benefit Obligations

In addition to a new foundation, a conversion will also bear another offspring – a new for-profit enterprise. In a number of hospital conversions, Consumers Union's and Community Catalyst's work with local coalitions has resulted in commitments from the new for-profit owners to continue to serve community health needs by providing needed services. Because services such as charity care and emergency room care tend to be less profitable, without public pressure and effective regulatory oversight, they might otherwise head straight for the chopping block after a conversion. The 1998 conversion of nonprofit Queen of Angels Hospital in Hollywood, California, illustrates this principle. Tenet Healthcare, the for-profit buyer, originally offered terms that put the community's access to health care services at risk.[3] A coalition of community groups and consumer advocates sprang into action and challenged the deal. Their efforts bore concrete results. Before approving the conversion, the Attorney General retained the full price originally agreed upon and negotiated much-improved charity care, emergency room, and obstetrical care commitments from Tenet.[4]

Community Benefits Analysis Pre-Conversion

In the health care context, some efforts have been made to assess the quantifiable public benefits provided by a nonprofit institution *before* it converts to for-profit status and as a prerequisite to conversion approval. California's hospital conversion legislation, for example, mandates that a nonprofit seeking approval to convert must prepare a health impact statement.[5] These reports are intended to evaluate how a potential conversion will affect the quality and quantity of services provided by a converting hospital. And, in particular, they identify the services that are at risk of being cut post-conversion. Nonprofits also provide valuable benefits

that are not quantifiable, such as making quality health care available to those less able to pay and not viewing health care primarily as a profit center. The intangible public benefits that nonprofits provide should be included in the assessment of a conversion's impact.

A health impact statement can be an effective means to educate the public about what is at stake. It can also serve as a tool for regulators to negotiate transaction terms that mitigate potential adverse impacts, and for the public to hold regulators accountable for addressing the true impacts of nonprofit conversions. A potential weakness, however, is that health impact statements contain data that is self-reported by the converting entity and is not audited. Nonetheless, requiring that the converting entity gather information about probable health impacts, and that the Attorney General consider such information before approving a conversion, are important first steps toward accountability.

Applying a "health impact statement" type of analysis to a broader array of conversions, and possibly to other forms of restructuring, would greatly increase our understanding of the public impacts of nonprofit reorganizations. And thorough study of post-conversion community benefit outcomes could provide the data and foundation to inform policymakers and persuade them of the wisdom of pre-conversion "community impact statement" legislation. An analysis of the intangible benefits that nonprofit institutions provide to the community would allow a more complete understanding of the public impacts of conversions.

Community Benefits Analysis Post-Conversion

The second step in measuring the impact of conversions on public benefits is to assess whether charitable services and values previously provided by a nonprofit remain available to the public after the conversion. For transactions that are already completed with charitable dollars set aside, this will require examination of the services provided by the post-conversion company, the activities of the conversion foundation, and changes in other less tangible factors.

In theory, when a nonprofit converts, the charitable assets that are transferred to a foundation (or to another nonprofit institution) should replace lost services, and in some cases, even extend benefits beyond what the original nonprofit provided. In addition, some community benefit obligations may be assumed by the new for-profit entity, particularly in hospital conversions. But examining the outcomes of completed conversions reveals that this theory may not be in sync with practical reality.

A study by Consumers Union of ten acute care hospital conversions in California from 1993 to 1998 found that, once hospitals converted to for-profit status, the amount of charity-care provided generally declined in the absence of tight charity-care guarantees. At some hospitals, the decline was quite substantial. For example, Good Samaritan Hospital in San Jose, California, experienced a decrease of 88% in charity care between its last year as a nonprofit and its first year as a for-profit.[6] This conversion took place before enactment of the California statute requiring public notice of hospital conversions, Attorney General oversight, and submission of a health impact statement by the converting entity.

Others interested in the health care conversion phenomenon, and in the increasing "corporatization" of health care generally, also have turned their attention to studying how these changes affect the affordability and quality of health care. A study published in the Journal of the American Medical Association found that for-profit HMOs were consistently "associated with reduced quality of care." After comparing data on 329 nonprofit and for-profit HMOs, the authors concluded that the "drive for profit is compromising the quality of care, the number of uninsured persons is increasing, those with insurance are increasingly dissatisfied, bureaucracy is proliferating, and costs are again rapidly escalating."[7]

And a study published in August 1999 in the New England Journal of Medicine reported that adjusted per capita Medicare cost "in for-profit areas was greater than in not-for-profit areas in each category of service examined: hospital services, physicians services, home health care, and services at other facilities."[8] This study found that hospital service areas that converted from nonprofit to for-profit

ownership from 1989 to 1995 had larger increases in total per capita costs than did areas in which all hospitals retained their nonprofit status.[9] According to the study's authors, when direct costs to communities are considered, "our data do not demonstrate any cost savings associated with for-profit ownership. Our findings are consistent with the possibility that for-profit hospital ownership itself contributes to higher per capita costs for the Medicare populations served by these hospitals."[10]

Still another study by the American Association of Retired Persons (AARP) focused on a different aspect of the public impacts of hospital conversions. AARP found that management instability was often a by-product of these transformations. "'When a hospital is in the throes of management instability, it isn't a community player the way a hospital that is more stable can be,'" remarked one of the authors.[11]

Another commentator lists the factors to be considered to ensure integrity and to protect the public interest in the conversion process. "It will be interesting to see if the wave of conversions continues under circumstances in which procedures are in place to bring public awareness to the matter, to ensure that a proper price is being paid, to make provisions for conflicts of interest, and to protect communities from the loss of community benefits."[12] Vigorous advocacy has been dedicated over the past several years to each of these four factors, emphasizing the first three: public education, fair valuations, and conflicts of interest. Now, with statutes on the books in many jurisdictions, resources should be dedicated to the fourth factor, assessing changes in community benefits post-conversion (including an assessment of changes in intangible benefits). Ultimately, our aim should be to make the protection of all public benefits part of the conversion approval process.

The Territory Ahead: Assessing the Public Benefits Provided by Nonprofits

The prevalence of conversions and other restructuring activity throughout the nonprofit sector underscores the need to understand better how nonprofit organizational change affects all types of public benefits, both tangible and intangible. Assessing outcomes will be neither a simple nor a straightforward task.

The public benefits provided by nonprofits include an astonishing array of direct services, including: meals for the homebound, shelter for the homeless, medical care for indigent patients, low-cost loans to college students, day care for low-income workers, Saturday and Sunday church services, scouting for boys and girls, care for abandoned pets, job readiness training, and advocacy for everything from preserving the right to bear arms to eliminating pollution in the environment. Measuring these diverse benefits will require new thinking and methodologies. Indeed, prominent nonprofit organizations such as Independent Sector, The Urban Institute, and United Way of America have undertaken groundbreaking research on how to best measure the contributions that nonprofit organizations make to society.

The magnitude of the job is daunting. Nonprofit conversions and reorganizations of all types are occurring at a dizzying pace. Nearly every day, stories emerge about planned conversions, mutualizations, mergers, joint ventures, or affiliations. But with so many conversions happening, an inadequate track record of outcomes has hampered meaningful analysis of the true public impact of these transactions.

Assessing public impacts is further impeded by substantial gaps in information.[13] Base data about the level, extent, and value of services provided by a converting nonprofit health care institution are often unavailable, for example. Some hospitals collect and report data regarding health services provided at cost, below cost, or at market rates. Some data combine patient bills that are not collectible with charity care provided without any expectation of payment. The former accounting merely reflects the cost of extending credit to customers, or the cost of "bad debts." Only the latter constitutes charitable services.[14]

Even in cases where quantification of benefits is possible, problems arise in evaluating the quality of services. In the health care arena generally, quality measurement continues to be a contentious issue.[15] Questions of quality can be especially nettlesome when replacement services are different than original services. For example, if a converting hospital's reproductive services are replaced by foundation grantmaking for health education programs, serious concerns emerge

about inappropriate, or at the very least inequitable, "apples to oranges" comparisons.

Much of the work on community benefits has been done by nonprofit institutions to facilitate their community benefits planning.[16] More could be gained from looking at these issues from the perspective of the public beneficiaries or consumers, drawing on the hard data now available from conversions that have already taken place. This data would allow for quantitative pre-and-post-conversion community benefits analyses that could both inform and drive public policy on the issue.

Given the formidable barriers to measuring and assessing outcomes accurately, some may question whether the effort ought to be a priority. Free-market advocates may argue, for instance, that increased competition will lead to lower costs and improved services.[17] Greater competition, they declare, will realize efficiency gains that make society better off despite changes in community benefits. But throughout modern history, nonprofits have provided services to those whom the competitive marketplace has failed. Free-market concepts like competition and efficiency do not attempt to address questions of equitable distribution of society's wealth. Larger societal benefits of fostering charitable enterprises and volunteerism, and providing opportunities for individuals to work collectively for a greater good must not be lost, let alone diminished in value. Further in-depth research is warranted to ensure that conversion transaction outcomes realize the goal of maintaining community benefits and values. The need—and opportunity—to pay close attention to public outcomes has never been greater.

[1] *Preserving the Charitable Trust: Nonprofit Hospital Conversions in Texas* (Consumers Union Southwest Regional Office, July 1998), Executive Summary, p. 3.

[2]For a report examining how six health care conversion foundations are carrying out their missions, see, *New Foundations in Health: Six Stories* (New York: Milbank Memorial Fund 1999).

[3] Mateo and Rossi, *White Knights or Trojan Horses?*, p. 27.

[4] Ibid., p. 41.

[5] Cal. Corp. Code § 5917(h) (West Supp. 1999). The California Attorney General has interpreted this provision to require preparation of a health impact statement.

[6] Mateo and Rossi, *White Knights or Trojan Horses?*, p. iv.

[7] David U. Himmelstein, Steffie Woolhandler, Ida Hellander, Sidney M. Wolfe, "Quality of Care in Investor-Owned vs. Not-For-Profit HMOs," *Journal of the American Medical Association* (July 14, 1999), p. 163.

[8] Elaine M. Silverman, Jonathan S. Skinner, and Elliott S, Fisher, "The Association Between For-Profit Hospital Ownership and Increased Medicare Spending," *New England Journal of Medicine* (August 5, 1999), p. 420.

[9] Ibid., p. 424.

[10] Ibid., p. 425.

[11] Deanna Bellandi, "Seniors Also Probe For-Profits' Impact," *Modern Healthcare* (August 9, 1999), p. 16.

[12] Gray, "Conversion of HMOs And Hospitals: What's At Stake?" p. 43.

[13] For a discussion of the evolution of the concept of community benefits in the health care field, as well as definitional and other measurement limitations, see Mark Schlesinger and Bradford Gray, "A Broader Vision For Managed Care, Part 1: Measuring the Benefit to Communities," *Health Affairs* (May/June 1998), pp. 152-168.

[14] See, for example, Gary J. Young, Kamal R. Desai, and Carol Van Duesen Lukas, "Does The Sale Of Nonprofit Hospitals Threaten Heath Care For The Poor?," *Health Affairs* (January/February 1997), p. 138.

[15] See, for example, David M. Eddy, "Performance Measurement: Problems And Solutions," *Health Affairs* (July/August 1998), pp. 7-25 and Elizabeth A. McGlynn, "Six Challenges in Measuring the Quality of Health Care," *Health Affairs* (May/June 1997), pp. 7-21.

[16] See Kevin Barnett, "The Future of Community Benefit Programming," (Berkeley: The Public Health Institute and The Western Consortium for Public Health, 1997).

[17] See, for example, Hasan, "Let's End the Nonprofit Charade," pp. 1055-1057.