
NONPROFIT SECTOR RESEARCH FUND

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Why Nonprofits Matter in American Medicine: A Policy Brief

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Executive Summary

The value and performance of private nonprofit organizations as providers of medical care have come under question from various skeptics, including their for-profit competitors, some scholars who study the impact of ownership form in American medicine, and some policymakers in state and federal governments. In this brief we assess the criticisms, drawing on the most recent and comprehensive evidence. We conclude that none of the charges are sustainable in their conventional form, but that nonprofit medical care in the United States nonetheless faces some very real and important challenges. We focus on three central concerns.

First, for-profit competitors often claim that the American public no longer knows or cares whether health services are provided in for-profit or nonprofit settings. Research provides partial support to this charge. A third of the public has difficulty defining nonprofit ownership or identifying whether their own health plan or provider is a nonprofit. But Americans do think that ownership matters – 80-95 percent, depending on question wording, expect ownership to influence medical care. Americans' expectations are nuanced; they see different strengths in nonprofit and for-profit providers. But the former typically outweigh the latter, so that between half and two-thirds of the public sees the growth of for-profit medical care as bad for the healthcare system, the communities in which they live, and most medical services.

Second, some academics have claimed that there are few consistent differences between nonprofit and for-profit medical care in terms of the cost, quality and accessibility of care. This charge is also partially correct. Our examination of over 250 empirical studies, covering a dozen types of health services (hospitals, nursing homes, etc.) found that the effects of ownership differ across services. For certain services and measures of performance, no ownership-related differences are apparent. But there is not a single type of service for which there were not **some** differences between nonprofits and for-profits regarding cost, quality or accessibility. These distinctions have not been diminished by growing competition or system-affiliation in American medicine. On some other dimensions of performance there are ownership-related differences that hold for all or most services. For-profits more aggressively markup prices and maximize revenue, provide medical care in a less trustworthy manner, have rarely been involved in the pioneering development of

new services, but are faster to respond to increases or decreases in demand or profitability of particular treatments.

Policymakers worry that a substantial portion of the nonprofit sector has lost sight of its charitable mission and needs to be held more accountable for meeting community health needs. If community benefits are narrowly defined in terms of services for indigent patients, this charge has some validity. Depending on how such services are measured, between one-quarter and three-quarters of all hospitals do not provide free care of a value commensurate with their tax benefits. For other types of services, there is little provision of free care to indigents. But charity care, we argue, is far too narrow a definition of community benefit. Although there is more limited empirical research on other forms of community benefit, they appear to be consistently more common in nonprofit settings, to be provided most by nonprofits that rank lower in the treatment of indigent patients, and to vary with the needs of local communities.

Although we conclude that the common charges against nonprofit healthcare are overstated, there are real and important challenges facing the sector. These include (1) Americans' limited understanding of ownership and, thus, limited capacity to select providers on the basis of ownership form, (2) an inadequate level of community involvement and public accountability for many nonprofit healthcare providers, (3) poorly defined standards or expectations for forms of community benefit that go beyond treatment of indigent patients, and (4) our currently limited understanding of the ways in which the behavior of for-profit and nonprofit providers interacts in local communities, and thus of the most appropriate mix of ownership for each locality.

Why Nonprofits Matter in American Medicine: A Policy Brief

In 21st century America, the legitimacy and favorable tax treatment of nonprofit medical care have come under fire from both political and academic fronts. Some policymakers doubt that nonprofit providers reliably contribute community benefits commensurate with the value of their tax exemptions as charitable organizations. Senator Charles Grassley of Iowa, for example, justified a recent “investigation” of practices at ten nonprofit hospitals by stating “tax-exempt status is a privilege. Unfortunately, some charities abuse that privilege.”¹ Some academics question whether there are *any* real differences between nonprofit and for-profit medical care. In the words of one recent review: “Many scholars claim that the diversity of corporate form is essentially a fiction. ... While the particular arguments vary, the message is simple. The not-for-profit form does not matter for the public good or, in many cases, matter at all.”²

Skeptics of nonprofit medical care allege three central failings, linked to the growing commercialization of American medicine. Some critics assert that nonprofits’ have lost public legitimacy and that ownership has become irrelevant to most Americans, reporting that “the vast majority of consumers either did not know the difference between for-profit and nonprofit insurers, or did not care”³ and “the public seems to have little concern about who owns their hospitals.”⁴ Second, because empirical comparisons of nonprofit and for-profit performance are judged to have “mixed and inconsistent findings,” in much recent scholarship “for-profits and nonprofits are assumed to be similar health services organizations.”⁵ Third, there are questions about whether nonprofits are deserving of tax exemptions. Many policymakers have grown concerned that a substantial portion of the nonprofit sector has lost sight of its charitable mission and needs to be held more accountable for meeting community needs.

Because these charges have been repeated so frequently in both academic and policy discourse, it would be natural to assume that they must be accurate. In fact, each is deeply mistaken. But each also contains an element of truth, giving the charges a semblance of plausibility. Our goal in this policy brief is a simple one: to set the record straight, distinguishing accurate criticisms from false charges in the assessment of nonprofit healthcare. We consider each of the three charges in light of the best recent evidence. From this assessment we develop an alternative perspective on the realistic benefits and real challenges regarding nonprofit healthcare in the United States.

Do People Think Ownership Matters? Public Perceptions of Nonprofit Healthcare

The claim that the public is unconcerned about ownership in American medicine is demonstrably false. This is evident whether one asks about general or specific aspects of healthcare. An example of a more general assessment comes from public opinion surveys fielded in the late 1990s. These described changes in ownership in American medicine in the following terms: "In recent years, some health insurance plans, HMOs and hospitals have changed from not-for-profit status into for-profit institutions." Respondents were then asked whether this was "a good thing for healthcare in this country," "a bad thing for healthcare in this country," or "doesn't make much difference either way." Between 70 and 80 percent (varying across the four surveys) felt that for-profit expansion would make a difference (in ways that we will describe).⁶ A more recent survey, fielded in 2002, inquired about the impact of ownership on specific attributes of medical care. Respondents were asked whether nonprofit or for-profit providers were superior in ten aspects of medical care (five involving hospitals, five involving health plans). Fewer than three percent felt that ownership would not matter in at least one of the ten aspects of care.⁷

The key question is thus not *whether* Americans see ownership as consequential in medical care, but *how* they think ownership might matter. Survey data suggests that the public sees for-profit firms as better at some aspects of medical care, nonprofits at others. In a nutshell, for-profit firms are considered by a plurality of Americans to (a) provide better quality medical care, (b) be more responsive to consumers, and (c) be more efficient in the provision of health services. Nonprofits, on the other hand, are considered to (a) provide care at lower cost, (b) more generously treat indigent patients, (c) provide treatment in a more fair and humane manner, and (d) be more trustworthy.⁸ The most pronounced differences in public expectations are related to efficiency, cost to patients, treatment of indigent patients, and trustworthiness.

Several of these expectations merit comment. The combination of expecting for-profits to be more efficient but nonprofits to offer services at lower cost suggests that the public expects for-profits to have high "markups" on prices.⁹ The combination of expecting for-profits to provide higher quality but nonprofits to be more humane suggests that the public views quality of medical care in largely technological terms.¹⁰ And the distinctive expectations of nonprofit

trustworthiness reveal that, despite the growing availability of report cards and other measures of provider performance, Americans continue to value trustworthy sources of medical care.¹¹

Comparative Advantage to the Nonprofit Sector, but Varying Across Different Services:

Some scholars have concluded from this public opinion data that Americans must have no strong preferences about nonprofit versus for-profit healthcare, since each is seen as having certain advantages.¹² This inference is too simplistic, because it presumes that the public equally values domains in which nonprofits and for-profits have distinctive strengths. Evidence suggests otherwise. When explicitly asked whether the growth of for-profit ownership is a “good thing” or “bad thing” for healthcare in the United States, two to three times as many of those surveyed (varying across polls) saw the change as bad rather than good (see Exhibit 1, page 18).

Alternative measures of impact yield even larger portions of the public favoring nonprofit healthcare. When asked whether nonprofit or for-profit hospitals and health plans are “more helpful” for the communities in which they are located, three to four times as many respondents favored nonprofit over for-profit organizations.¹³ Returning to the 2002 survey that itemized expectations for ten different aspects of medical care, more than three times as many Americans felt that the count of nonprofit advantages outweighed the count of for-profit; supporters of nonprofits were also more likely to see them as being superior in many attributes of medical care (see Exhibit 2, page 19). Lest readers suspect that these negative assessments of for-profit firms resulted from biased wording or questionnaire design, the *Wall Street Journal* – a stalwart proponent of free enterprise and the profit motive in American society – recently concluded, based on its own survey fielded in 2003, that “most of the public do not view health care as a business which should be driven by the profit motive. ...There is little appetite for businesses to run home care, health insurance, nursing homes, hospitals, or medical research.”¹⁴

It’s important to recognize that a portion of the American public – roughly 15-20 percent, depending on the framing of the question – does see for-profit medical care in a more positive light. The extent of this embrace varies strikingly across different medical services. The *Wall Street Journal* survey introduced above found that a plurality of Americans thought that the production of pharmaceuticals by profit-making companies was acceptable, but less than half of these same respondents favored having hospital and nursing-home care provided under for-profit auspices.¹⁵

(The public was even *less* supportive of the profit motive for medical research, suggesting that they're happy to have for-profit firms manufacture drugs, but not so willing to see profits determine what types of drugs are developed.) The public sees the profit motive as leading to better quality in hospital settings and health plans, to have neutral effects in nursing homes, but to have more pernicious consequences for emergency medical services.¹⁶

The Real Challenge: Misunderstanding and Misperceptions of Ownership: Although it is clearly wrong to suggest that the American public thinks ownership is irrelevant in medical care, there is one sense in which the skeptics' critique is more on target. Americans' awareness and understanding of ownership is sketchy at best. When asked about their reaction to "for-profit healthcare" in a 1996 survey, a quarter of the respondents indicated that they were not familiar with the term.¹⁷ If asked to define how nonprofit and for-profit organizations differ, roughly a third of all Americans are unable to even hazard a guess.¹⁸ Another 20-30 percent have difficulty articulating what that difference is, even in the simplest terms.

It is perhaps no great surprise that some people have difficulty understanding a legal abstraction like ownership form. But limited comprehension can have real consequences. As a result of their limited grasp of ownership, Americans overestimate the extent to which medical services have come under for-profit control.¹⁹ People who don't understand ownership also are less likely to see nonprofits as providing medical care in a beneficial manner.²⁰ Widespread misunderstanding can thus undercut the legitimacy of the nonprofit sector. And it biases downward the public's valuation of nonprofit medical care, as expressed on surveys of opinion or in political discourse.

Equally important, some of the benefits of maintaining a mix of ownership in local markets involve consumers sensibly sorting themselves between nonprofit and for-profit settings. For example, if some patients are especially worried about unscrupulous administrators taking advantage of their frail state, they might prefer a nonprofit organization that is seen as more trustworthy. Indeed, half of Americans report that they take ownership into account when selecting a health plan.²¹ But only 65 percent of these consumers can accurately identify the ownership type of the plan in which they are enrolled (even fewer can correctly identify the ownership form of the hospital or nursing home at which they or their family received care). If consumers err in making choices based on ownership, the benefits of consumer sorting may be

adulterated or transformed into liabilities. To continue our example from above, if consumers think themselves to be in a trustworthy nonprofit facility, but are actually under for-profit care, they may not be as vigilant about possible mistreatment, thereby increasing their risks of adverse outcomes.

Does Ownership Matter? Variation in Nonprofit and For-Profit Healthcare

The legal formulations of nonprofit and for-profit organizations cause them to differ in terms of the incentives facing their administrators and staffs, the sources of capital that they can tap to fund growth, and the sources of influence in their governance.²² Whether and how these organizational features translate into distinctive medical care has been the focus of extensive research. To date, there have been more than 250 published empirical studies comparing medical care provided under nonprofit and for-profit auspices. These studies cover a wide range of services: hospital care, psychiatric services, nursing-home care, home healthcare, treatment of end-stage renal disease, hospice care, rehabilitative services, preventive examinations and various forms of ambulatory treatment. For some of these services for-profit care is dominant; for others nonprofits provide the majority of treatment (see Exhibit 3, page 20). The studies in question consider a variety of attributes of each service: cost, quality, accessibility for indigent clients, trustworthiness of the organizations' practices, pricing policies, and stability of service provision over time.

Both supporters and critics of nonprofit healthcare agree on a key feature of this empirical landscape: the measured differences between nonprofits and for-profits in terms of cost, quality and accessibility vary greatly across studies. Critics of nonprofit healthcare find this troubling. For them, varied findings suggest a sort of randomness, implying that ownership can't count for much if it does not predict a consistent difference between nonprofit and for-profit practices. But this interpretation misconceives how legal form can be expected to affect organizational performance. When an organization operates as a *not*-for-profit, its ownership form does not define precisely *what it is for*. There is good reason to see this indeterminism as an attractive feature in the context of healthcare. Many health-related services can promote the public good, but purchasers may be unwilling to pay for services for which they don't experience the benefits. These valuable aspects of care will be different among organizations that provide services that are

well-insured (e.g. treatment of end-stage renal disease or hospice care) compared with organizations that provide services for which tens of millions of patients lack adequate coverage (e.g. hospital care). They will be different for activities whose benefits go beyond individual patients (e.g. health promotion and disease prevention programs) compared with those that help only patients or their families (e.g. long-term care). They will be different in communities with high rates of poverty compared with those in which most residents are well off.

Arguably, it is precisely because these public good aspects of medical care are difficult to define in a consistent manner across services, among communities, and over time that nonprofits have a vital place in American medicine. The ways that nonprofits behave differently from for-profits will themselves vary, and this variability in the nature of ownership-related differences should be seen as a virtue rather than as a cause for concern. To better understand the diverse findings from the empirical literature, we consider here three types of variation: over different medical services, across studies, and among different communities. We address the first two sources of variation in the next section, the third in the section that follows.

Variation Over Services: Much of the apparent inconsistency in the effects of ownership on medical care emerges when scholars carelessly combine findings drawn from different types of health services or differing measures of performance. However, a series of recent articles have applied rigorous meta-analysis to aggregate only studies involving a single type of service organization and employing a single well-defined outcome. These studies find consistent ownership-related differences: higher mortality rates in for-profit hospitals and renal dialysis facilities,²³ higher prices in for-profit hospitals,²⁴ higher rates of adverse events in for-profit nursing homes,²⁵ and larger barriers to access for indigent patients in for-profit psychiatric facilities.²⁶

Many of these ownership-related differences vary a great deal across services. We illustrate with the empirical research comparing three categories of outcomes for nonprofit and for-profit hospitals and nursing homes: economic performance, quality of care, and accessibility for indigent patients. Exhibit 4 (see page 21) summarizes the results of the 151 studies that use sophisticated methods (either multivariate models or matched samples to account for the influence of factors other than ownership form). Because some studies reported multiple outcomes, we have a total of 199

distinct comparisons. These are presented in Exhibit 4 grouped by the types of outcome, the type of service (hospitals vs. nursing homes), whether the analyses indicate a statistically significant advantage to nonprofit or for-profit providers (or insignificant differences between the two), and the specific type of outcome measure that was compared.

The impact of the ownership form of hospitals and nursing homes appears to be strikingly different. Consider first costs and efficiency. There is overwhelming evidence that for-profit nursing homes have lower costs and greater efficiency: 20 studies support this conclusion; the only other study found no statistically significant difference. For the eight nursing home studies with the most sophisticated comparisons of technical efficiency, seven found for-profits to be significantly more efficient. Among hospitals, however, costs (i.e. expenses) and efficiency results are more mixed, but predominantly favor *nonprofit* facilities. Among the most sophisticated models of technical efficiency, for example, five found greater efficiency among nonprofits, three found no statistically significant differences, and three found for-profit hospitals to be more efficient. Although it's difficult to determine conclusively whether ownership matters one way or the other for hospital costs, it clearly matters quite differently for hospital services than in nursing homes.

The differences are equally striking in the other two domains of performance. Nonprofit nursing homes have marked patterns of higher quality care than their for-profit counterparts, but ownership differences involving hospitals are less dramatic. (One can see this most clearly by contrasting similar measures of quality. Among studies that examine the frequency of adverse treatment events, for example, nine of the twelve studies in nursing homes found these to be less common in nonprofit settings; only one favored for-profit homes. Among hospitals, in contrast, only five of ten studies found adverse events to be less frequent in nonprofit settings, and three gave for-profits the edge.) But the relationship of ownership to access (the ability to obtain care by patients who are indigent or especially costly to treat) is much *larger* among hospitals than nursing homes and in the opposite direction. Of the 39 studies that compared hospitals, 29 found care to be more accessible in nonprofit settings. Only one study found significantly greater access in for-profit hospitals. For the six studies that looked at access in nursing homes, however, only one favored nonprofits and four found greater access in for-profit facilities.

The pattern illustrated by our comparison of hospitals and nursing homes is a general one. Our examination of the research literature has not found a single type of service for which there were not *some* differences between nonprofits and for-profits regarding cost, quality or accessibility. However, the effects of ownership manifest themselves in different ways for each of these services. In terms of cost, quality and accessibility, ownership *always* appears to matter, but *never* in precisely the same manner from one service to the next.

However, there are four attributes of medical care that are related to ownership in a more consistent manner across types of healthcare services. First, for-profit organizations are more aggressive than their nonprofit counterparts in their markup of prices over costs and in other efforts to maximize revenue. This pattern has been documented among community general hospitals,²⁷ nursing homes,²⁸ psychiatric hospitals,²⁹ drug treatment centers,³⁰ rehabilitation facilities,³¹ and health plans.³² Second, nonprofit organizations appear to deliver health services in a more trustworthy manner: They are less likely to make misleading claims,³³ less likely to have complaints lodged against them by their patients,³⁴ and less likely to treat less-empowered patients in a manner different from other clientele.³⁵ Third, nonprofits typically serve as the incubator for entirely new services, using philanthropy and cross-subsidies to finance the development of services for which payment systems have not been regularized for which, therefore, there is only a very limited market.³⁶ Fourth, nonprofit healthcare providers appear to be slower to react to changing conditions, both in terms of increasing their capacity when demand for care is expanding³⁷ and in dropping services or withdrawing from markets that have declining profitability.³⁸

The first two of these consistent differences stand out as advantages for nonprofits. In a healthcare system beset by increasing costs and ill-informed consumers, organizations prone to further markup prices and take advantage of vulnerable patients can hardly be considered assets. Pioneering new services is probably a vital societal role, though some observers fear that this may encourage excessive medical spending. But the full implications of the dynamic differences between nonprofit and for-profit organizations are the most difficult to judge.

There are clearly circumstances in which it serves the public interest to have organizations that rapidly adapt to changing conditions – to respond to market opportunities created by changes in

coverage by third-party payers, rapid shifts in population, or emerging developments in health policy. For-profit healthcare providers, with stronger internal incentives to respond to financial opportunities and more readily mobilized sources of capital, seem to have the edge in these circumstances. But there are other circumstances in which rapid response to monetary incentives seems more a liability. When organizations constantly alter their service mix or market areas, they can disrupt vital relationships between patients and providers or undermine patients' sense of financial security. Recent experience with private health plans that contract to treat Medicare beneficiaries in the Medicare+Choice program illustrates such concerns.³⁹ Frequent plan withdrawals and turbulent benefits have left many elders with disrupted medical care, uncovered medical expenses and confusion about their benefits. The greater dynamism of for-profit plans under Medicare+Choice has been a mixed blessing for enrollees and program administrators.

Variation Across Studies: Consider again the studies summarized in Exhibit 4. Even for outcomes where there are clear patterns of ownership-related differences, one still sees some variation across studies. Much of this variation reflects methodological considerations. Studies of hospital mortality with smaller sample sizes (fewer than one million cases) typically lack the statistical power to detect ownership-related differences⁴⁰; comparisons of adverse events in nursing homes fail to detect ownership-related differences when they do not account for case-mix variation among homes.⁴¹ But some variation in findings cannot be attributed to problems of methods or measurement. For example, studies of adverse treatment events in hospitals, or costs for a hospital admission, include multiple high-quality studies that identify nonprofit hospitals as more effective, but also multiple studies of equal quality that find either no difference in performance or significant advantage for for-profit facilities. Are these conflicting results due to subtle methodological differences or might comparative performance really vary this much? We believe that the latter is true.

This second sort of variation across studies can be traced to the context in which healthcare is delivered. Some studies in each group compare organizations operating under relatively benign conditions, others in far harsher contexts. If the financial pressures and external constraints are sufficiently intense, even the most publicly spirited organization has limited capacity to engage in community benefit activities.⁴² This helps explain why studies that compare organizations before and after they convert from nonprofit to for-profit ownership generally find only small

differences in accessibility or quality of services.⁴³ The nonprofits prone to conversion were typically struggling financially, prior to changing ownership.

The Real Challenge: Understanding How Context Affects Ownership-Related Differences:

Evidence of these contextual effects have led some skeptics to dismiss nonprofit healthcare as an anachronism, no longer compatible with a healthcare system that is market-driven and dominated by large corporations providing services. This seems quite intuitive – if market pressures and corporate hierarchies constrain the behavior of healthcare providers, how much can ownership actually affect cost, quality or accessibility of medical care?

The answer, surprisingly, turns out to be “quite a bit.” Evidence suggests that the growing competition and affiliation with multi-unit systems have *not* diminished the magnitude of ownership-related differences in performance.⁴⁴ Quite the contrary, the gap between nonprofit and for-profit hospitals in the provision of uncompensated care appears to be growing as markets have become more competitive,⁴⁵ and ownership-related differences among system-affiliated providers are larger than among independent organizations in terms of accessibility of services, quality of care, and trustworthiness.⁴⁶ These findings do not demonstrate that ownership-related performance is independent of context, only that the major institutional transformations of American medicine over the last few decades have not vitiated the impact of nonprofit ownership.

Does Ownership Matter Enough? Accountability and Reliability in Nonprofit Healthcare

Performance differences between nonprofit and for-profit healthcare are substantial in size, significant in a statistical sense and relatively resilient to changing market conditions. But are these differences large enough, relative to the tax advantages afforded nonprofit enterprise? Are the benefits associated with nonprofit ownership provided with sufficient reliability that policymakers can feel confident that any given nonprofit agency is honoring its social obligations?

Variation in the Forms of Community Benefit: These questions prove challenging to answer. It is difficult to assess the full impact that healthcare organizations have on the communities in

which they are located. Some forms of community benefit can be more readily measured than others. Some forms of community benefit carry a more robust historical pedigree than do others. Caring for indigent patients falls into both these categories. One can readily count the number of uninsured patients or the dollars spent on uncompensated care (though whether the latter should include “bad debt” remains a matter of continuing controversy).⁴⁷ Caring for the indigent has long been a standard for assessing charitable activity – prior to 1969, it was the primary criterion used by the IRS to determine federal tax exemption for nonprofit healthcare providers.⁴⁸

Judged by this standard, the performance of nonprofit healthcare appears far from adequate. For nursing homes and health plans, nonprofit ownership is not consistently associated with *any* propensity to treat low-income patients.⁴⁹ Even in hospitals, the commitment to caring for low-income patients is not always of sufficient magnitude to in itself justify tax exemptions. If one does not include bad debt as a component of uncompensated care, as many as three-quarters of all nonprofit hospitals fail to provide uncompensated care of a value equivalent to their tax benefits.⁵⁰ Nonprofits’ commitment to uncompensated care appears stronger in some states, but even in these jurisdictions, 20-40 percent of all nonprofit hospitals fail to cover the value of their tax benefits.⁵¹ Even by the broadest measures of uncompensated care, between a quarter and a third of nonprofit community hospitals in the United States do not provide sufficient free care to offset the value of their favored tax treatment.

However, care for the uninsured is neither the only meaningful form of community benefit nor the sole form of charitable activity in healthcare settings. For example, a recent study comparing nonprofit and for-profit health plans found that although there were no significant ownership-related differences in the extent of free or subsidized services, nonprofit health plans were significantly more likely to support safety-net healthcare providers or contribute to other community health initiatives that benefit the poor (see Exhibit 5, page 22).⁵²

More generally, if one compares nonprofit and for-profit health plans in terms of the three primary criteria defined by legal precedent for tax exemption, nonprofit plans are not significantly more involved in *any* of the three areas compared with otherwise similar for-profit health plans (Exhibit 5). However, there are significant ownership-related differences in three (of five) other domains of activity that can benefit community health. There is a small but growing

body of research suggesting that nonprofits provide substantially more of these diverse forms of community benefit.⁵³ And one study found that those nonprofits that are least involved in free or subsidized treatment are precisely those that are most engaged in other forms of community benefit.⁵⁴

The Real Challenge: Clarifying Expectations for All Forms of Community Benefit: The forms of community benefit used to justify tax exemption do not include most of the ways in which healthcare providers can and do influence the health of communities.⁵⁵ Enlarging and clarifying the scope of activities that could justify tax exemption would provide a sounder basis for ensuring the accountability of nonprofit healthcare. However, it is difficult to tell when a nonprofit organization has a sufficient commitment to these other forms of community benefit. Precisely because their provision and consequences are often difficult to measure, it is also difficult to add up their combined effects in a meaningful manner. One could count the resources devoted to this activity (probably as meaningful as counting the amount of uncompensated medical care), but this approach accounts for spending, rather than effectiveness of initiatives. Until we have better measures of the scope and impact of community benefit activities, it is difficult to fully determine when nonprofits are behaving in a sufficiently charitable and accountable manner.

Variation Among Locales: Does This Undermine the Legitimacy of Nonprofit Healthcare?

A second challenge to accountability involves geographic variation in nonprofits' commitment to particular forms of community benefit. Since the mid-1980s, there has been evidence that nonprofit and for-profit performance tends to become more similar when the two ownership forms are co-located in the same community. It's been primarily in the past decade that this pattern has drawn researchers' attention. Studies suggest that when nonprofits and for-profits are in the same locales, the former provide only marginally more care for indigent patients.⁵⁶ These results have been interpreted as suggesting that nonprofits are not really committed to indigent care and that past studies that had reported higher levels of uncompensated care among nonprofits had simply misread locational differences that were correlated with ownership.⁵⁷

This interpretation overlooks one crucial consideration: for-profit firms deliberately build or purchase facilities in communities that have few uninsured or low-income residents.⁵⁸ Nonprofits

in such communities do tend to provide less uncompensated care than do nonprofits in other locales – because there are fewer indigent patients in their service areas.⁵⁹ Since other community needs are of greater relative importance in these locations, one should not *expect* nonprofits to devote substantial resources to care of the uninsured. Once one appropriately accounts for the differences in the communities in which nonprofit and for-profit hospitals locate, ownership-related differences in uncompensated care are substantial.⁶⁰

Although the co-location issue proved a bit of a red herring regarding uncompensated care, researchers have come to recognize that the presence of nonprofit providers influences the behavior of for-profit organizations (and vice versa) in a wide variety of ways. More specifically, the presence of for-profit hospitals in a locality seems to encourage nonprofit competitors to (a) respond more aggressively to revenue-enhancing opportunities,⁶¹ (b) add more profitable services,⁶² (c) discourage admissions of unprofitable patients,⁶³ and (d) reduce the resources devoted to treating those patients who they do admit.⁶⁴ Conversely, the presence of nonprofit competitors in a community is associated with increased quality of care in for-profit nursing homes,⁶⁵ lower mortality rates in for-profit renal dialysis facilities,⁶⁶ and increased trustworthiness of for-profit health plans.⁶⁷

The Real Challenge: How Much of Each Ownership Is Enough? The policy import of these cross-ownership influences seems clear, but only in part. On the one hand, the presence of nonprofit competitors appears to have a generally positive effect on the performance of for-profit healthcare providers. Nonprofit neighbors appear to rein in some of the less palatable practices associated with the profit motive, though the precise mechanism for this influence remains poorly understood. (It may involve patients sorting themselves between nonprofit and for-profit settings, providers adapting to local norms of professional practice, or employers and other large purchasers of medical care revising their expectations.) For-profit competitors have a more mixed effect on nonprofits. They can exert a positive influence by stimulating more efficiency and greater responsiveness to changing market conditions. At the same time, however, a for-profit influence appears to erode nonprofits' commitment to uncompensated care, a vital concern for at least some health services and many local communities.

Whatever the net effect of these cross-ownership influences, identifying the most appropriate mix of nonprofit and for-profit providers in each community depends in part on how sensitive each is to the presence of the other. There is only a smattering of evidence on these relationships. It appears that even a small for-profit presence (a share of ten percent or less in the local market) will induce greater efficiency from their nonprofit competitors.⁶⁸ But a larger presence of nonprofits appears to be required to induce their for-profit competitors to behave in a more trustworthy manner – market shares of at least 20-30 percent.⁶⁹

Concluding Thoughts: Maintaining a Vital Nonprofit Presence in Each Community

Although nonprofits' community benefits vary across services and localities, these organizations play a vital role in American healthcare. The ownership-related outcomes that can be sensibly counted add up to be quite consequential. Although not all nonprofit hospitals (even in communities with many low-income residents) provide extensive free care, were private nonprofit hospitals to treat uninsured patients at the same rate as for-profit hospitals, the burden on government hospitals treating uninsured patients would double. Although not all studies find inpatient mortality to be lower in nonprofits, on average the reduced risk in nonprofit settings is about on par with the quality benefits from teaching hospitals, which policymakers have generally viewed as vital to a high-quality healthcare system. And extending the price markups associated with for-profit ownership to other healthcare organizations would increase their spending by five to ten percent, hardly trivial when total annual medical costs in the United States are predicted to exceed three trillion dollars by the year 2013.

But in many respects, the most precious aspects of nonprofit healthcare are those that cannot be counted. As we learn that even effective programs for patient education leave many consumers ill-informed and vulnerable, nonprofits' comparative trustworthiness will seem an essential attribute of American medicine. As we come to better appreciate the importance of the social determinants of health, nonprofits' greater predisposition to pursue community-based health promotion programs will become increasingly central to health policy. As an aging population increases the prevalence of chronic illness, nonprofits' predisposition toward collaborative involvements with other community healthcare providers will become increasingly valuable.

Most Americans care about maintaining nonprofit healthcare; we believe that they are right to do so. In our assessment, however, capturing the realistic benefits of nonprofit ownership does not necessarily require an entirely nonprofit delivery system, as some advocates have argued.⁷⁰ In view of the very limited evidence about the effects of mixed ownership at the community level, it is difficult to specify what the minimum nonprofit share (or maximum for-profit share) might be, and this may vary by type of service. We believe that a vital and robust nonprofit presence (at least 30-40 percent for each service) is desirable in every community. That situation currently exists for few services outside of acute care hospitals. It is also desirable that policymakers and nonprofit leadership address in a concerted and constructive manner the challenges raised by Americans' current misunderstandings of ownership, by some nonprofits' too limited involvement with the communities in which they are located, and by lack of clarity regarding community benefit expectations beyond the care of the uninsured.

Exhibit 1
Public Perceptions:
Is the Growth of For-Profit Healthcare Good or Bad for American Medicine

<i>Date of the Survey</i>	<i>Percent Reporting That For-Profit Growth</i>		
	“Is A Good Thing”	“Doesn’t Matter That Much”	“Is A Bad Thing”
July 1996	19%	24%	54%
March 1997	20%	30%	42%
August 1997	21%	23%	45%
October 1997	15%	29%	47%

Source: Roper Center for Public Opinion Research; Kaiser Family Foundation.

EXHIBIT 2

Public Perceptions of Ownership for Hospitals and Health Plans, 2002

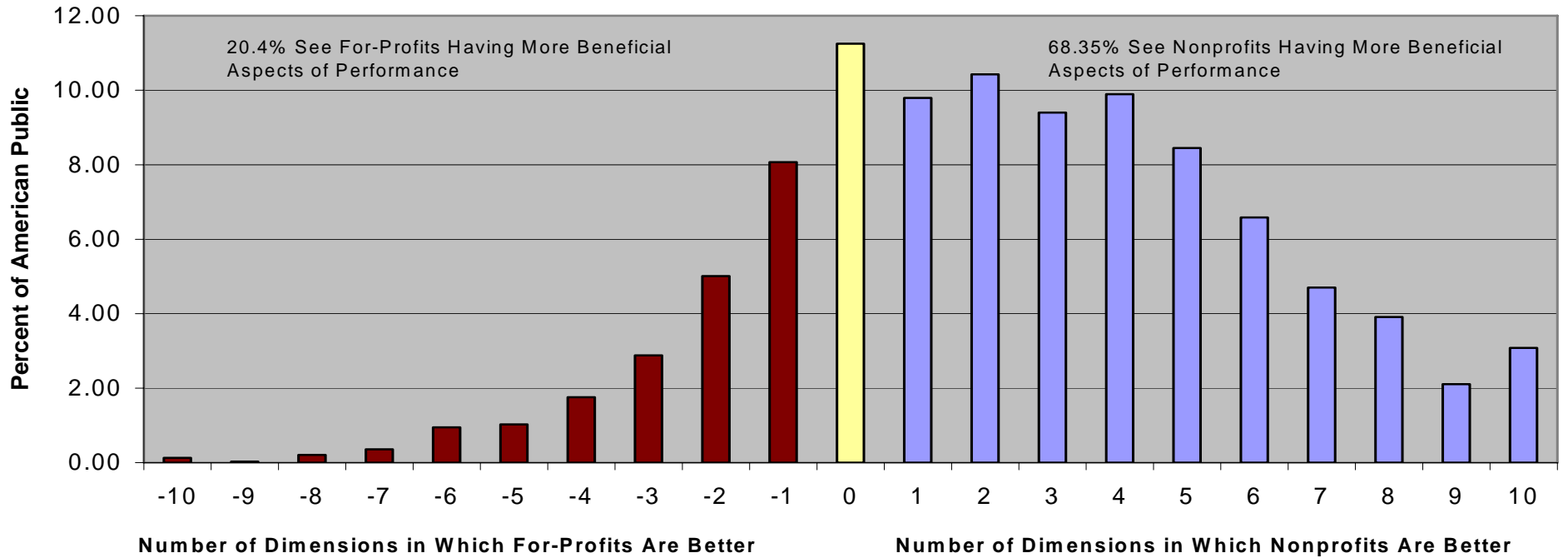


EXHIBIT 3

Proportion of Different Health Services Provided Under Nonprofit, For-Profit and Government Auspices (Late 1990s)

Type of Service	Proportion of Facilities/Agencies Operated Under:		
	Nonprofit Auspices	For-Profit Auspices	Government Auspices
Dialysis Centers	32%	68%	--
Rehabilitation Hospitals	35%	58%	7%
Home Health Agencies	33%	67%	--
Health Maintenance Organizations	26%	74%	--
Nursing Homes	28%	65%	7%
Psychiatric Hospitals	17%	46%	37%
Outpatient Mental Health Clinics	57%	18%	24%
Hospice Programs	65%	28%	7%
Acute Care Hospitals	59%	16%	25%
Residential Programs For Emotionally Disturbed Children	68%	8%	24%
Substance Abuse Treatment Facilities	61%	24%	15%

Source: Bradford Gray and Mark Schlesinger. "Health," In Lester Salamon, ed., *The State of the Nonprofit Sector*, Washington DC: Brookings Institution Press, 2002: 65-106.

EXHIBIT 4

Categorizing Empirical Findings Comparing Organizational Performance by Ownership: Acute Care Hospitals vs. Nursing Homes

Direction of Finding	Specific Measures (Number of Studies Using This Measure)		
	Economic Performance	Quality of Care	Accessibility for Unprofitable Patients
<i>Studies of Acute Care Hospitals</i>			
Nonprofit Advantage	Administrative overhead (3) ⁷¹ Cost per admission (10) ⁷² Measures of inefficiency (5) ⁷³ Revenues per admission (6) ⁷⁴	Post-discharge mortality (7) ⁷⁵ In-hospital mortality (1) ⁷⁶ Adverse outcomes (5) ⁷⁷ Process measures (4) ⁷⁸ Regulatory violations (1) ⁷⁹	Locating in low-income areas (5) ⁸⁰ Treating uninsured patients (12) ⁸¹ Restrict access of uninsured (4) ⁸² Providing unprofitable services (6) ⁸³ Treating Medicaid patients (2) ⁸⁴
No Difference	Cost per admission (7) ⁸⁵ Revenues per admission (2) ⁸⁶ Measures of inefficiency (3) ⁸⁷	Malpractice suits (1) ⁸⁸ In-hospital mortality (7) ⁸⁹ Post-discharge mortality (9) ⁹⁰ Adverse outcomes (2) ⁹¹ Process measures (1) ⁹² Hospital re-admissions (1) ⁹³	Treating uninsured patients (6) ⁹⁴ Treating Medicaid patients (3) ⁹⁵
For-Profit Advantage	Cost per admission (5) ⁹⁶ Measures of inefficiency (2) ⁹⁷	Adverse outcomes (3) ⁹⁸ Post-discharge mortality (1) ⁹⁹	Treating Medicaid patients (1) ¹⁰⁰
<i>Studies of Nursing Homes</i>			
Nonprofit Advantage	Administrative overhead (1) ¹⁰¹ Revenues per admission (4) ¹⁰²	Malpractice suits (2) ¹⁰³ Satisfaction with treatment (2) ¹⁰⁴ Process measures of quality (6) ¹⁰⁵ Regulatory violations(6) ¹⁰⁶ Adverse outcomes(9) ¹⁰⁷ Physical restraints (4) ¹⁰⁸	Services at reduced charge (1) ¹⁰⁹
No Difference	Administrative overhead (4) ¹¹⁰ Measures of inefficiency (1) ¹¹¹	Regulatory violations (2) ¹¹² Functional improvements (3) ¹¹³ Adverse outcomes (2) ¹¹⁴ Process measures of quality (2) ¹¹⁵ Physical restraints (2) ¹¹⁶	Medicaid admissions (1) ¹¹⁷
For-Profit Advantage	Average operating cost (7) ¹¹⁸ Measures of inefficiency (7) ¹¹⁹ Average total cost (6) ¹²⁰	Adverse outcomes(1) ¹²¹ Anti-psychotic use (1) ¹²²	Medicaid admissions (4) ¹²³

EXHIBIT 5 INDEX MEASURES OF COMMUNITY BENEFIT ACTIVITY
AMONG HEALTH PLANS, 1999**

	<u>Regression-Adjusted Means*</u>		
	<u>For Profit</u>	<u>Non Profit</u>	<u>P-value</u>
<u>DERIVED FROM BROADER MODELS OF COMMUNITY BENEFIT</u>			
Protect Vulnerable Consumers	0.430	0.455	0.684
Benefits for Family Members of Patients	0.288	0.334	0.467
Supporting Medical Research	0.447	0.666	0.008
Health Promotion/Disease Prevention in Community	0.366	0.461	0.023
Supporting Safety Net and Charity Programs in Community	0.380	0.509	0.015
<u>DERIVED FROM LEGAL PRECEDENTS</u>			
Free or Subsidized Services	0.326	0.407	0.125
Medical Education	0.296	0.367	0.288
Encourage Influence By Community Groups	0.326	0.346	0.656
<u>OVERALL COMMUNITY BENEFIT INDEX</u>	0.369	0.463	0.004

*Model controls for age of plan, Medicaid enrollment, size of plan, chain affiliation, plan type (IPA, Group/Staff, Network)

** Indices range from 0 (lowest possible involvement) to 1 (highest possible involvement).

Source: Mark Schlesinger, Shannon Mitchell, and Bradford Gray. "Measuring Community Benefits Provided By Nonprofit And For-Profit HMOs" *Inquiry* 2003; 40(2): 114-32

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