Selling Teaching Hospitals To Investor-Owned Hospital Chains: Three Case Studies

Sales to for-profit chains may strengthen financial viability without harming social missions.

by David Blumenthal and Joel S. Weissman

A n increasing number of nonprofit health care facilities have been acquired by or converted to investor-owned organizations, which now own an estimated 15 percent of all U.S. general hospitals. Although this is not a new phenomenon, questions continue to arise about the consequences for health care facilities, patients, and communities.

Critics of investor ownership of health care facilities believe that for-profits are less likely than nonprofits are to provide charitable or unprofitable but valuable services, such as community outreach to indigent communities and uncompensated care to poor, uninsured patients. This belief reflects the view that for-profits place greater emphasis than nonprofits do on maximizing return on investment. Critics also question whether communities have been fairly compensated for the assets of nonprofit facilities.

Two decades of research has failed to provide definitive empirical evidence on the differences between for-profit and nonprofit health care facilities and on the social consequences of changes in ownership. In the past the subjects of such studies have mostly been community hospitals, with modest, if any, academic commitments. However, recent sales of several major teaching hospitals to investor-owned hospital chains provide new opportunities to explore questions about whether investor ownership alters the behavior of health care facilities. On average, major teaching hospitals provide more indigent care than other nonprofit hospitals do. In addition, teaching hospitals produce public goods in the form of teaching and research that are subsidized from clinical revenues. Theory would predict that for-profit hospital chains will reduce subsidies of charitable and academic activities at academic health centers (AHCs) to maximize return on investment.

This raises two obvious questions. First, in light of such predictions, why did these organizations sell their facilities? Second, what are the actual consequences of such changes in ownership for AHCs’ charitable and academic activities? We address these questions using data gathered from case studies of three teaching hospitals that have been acquired by investor-owned hospital chains.

Methods

Choice of cases. We studied cases that involved the sale of all or part of AHC hospitals to investor-owned organizations, excluding arrangements that involved the lease or
management of an AHC facility by a for-profit chain. We hypothesized that investor ownership of an AHC hospital would be more likely to affect social mission than would leasing or management arrangements, in which AHCs retain ultimate control.

To be included in our sample, teaching hospitals had to be the primary teaching affiliate of a medical school and to have been converted to new management at least six months prior to our study. These criteria assured that the study institutions would be involved in at least two of the major missions of AHCs—teaching and research—and that sufficient time would have elapsed to draw some conclusions, however preliminary, about the effects of the change in ownership on these activities. Only three AHC hospital sales or conversions met these criteria: the 1984 sale of St. Joseph’s Hospital, the primary teaching facility of Creighton University in Omaha, Nebraska, to AMI Corporation; the 1994 sale of Tulane University Hospital in New Orleans, to Columbia/HCA; and the 1997 sale of George Washington University Hospital in Washington, D.C., to Universal Health Services.

Our sample cases varied in year of sale, geographic location, and buyer. Although this raises comparability questions, the variation also enabled us to explore whether the timing of the sales, market factors, and characteristics of the acquiring organizations may have affected the social missions of the institutions. Summary statistics on the operations and finance of our sample hospitals are presented in Exhibit 1; summary statistics on the markets in which our case sites were located are contained in Exhibit 2.

### EXHIBIT 1
**Selected Data On Study Hospitals, Fiscal Years 1994–1998**

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<thead>
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<tbody>
<tr>
<td>Operations and finance</td>
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<td>6.0</td>
<td>4.7</td>
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<tr>
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<td>0.6%</td>
<td>-2.7%</td>
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<tr>
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<td>27.6%</td>
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<tr>
<td>Direct GME payments (millions)</td>
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<td>$4.6</td>
<td>$3.7</td>
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<tr>
<td>Indirect medical education payments (millions)</td>
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<td>$11.3</td>
<td>$10.2</td>
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<tr>
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<td>38</td>
<td>38</td>
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<tr>
<td>Indigent care</td>
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<td></td>
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<tr>
<td>Medicare DSH payments (millions)</td>
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<td>$1.7</td>
<td>$2.0</td>
<td>$2.3</td>
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<tr>
<td>Medicaid acute inpatient days</td>
<td>10.2%</td>
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<td>11.7%</td>
<td>18.1%</td>
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<table>
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<tr>
<th>St. Joseph's Hospital</th>
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<tr>
<td>Operations and finance</td>
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</tr>
<tr>
<td>Adjusted admissions</td>
<td>14,389</td>
<td>14,680</td>
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<td>13,334</td>
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<td>$146</td>
<td>$151</td>
<td>$144</td>
<td>$149</td>
<td>$150</td>
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<tr>
<td>Acute beds in service</td>
<td>364</td>
<td>364</td>
<td>334</td>
<td>222</td>
<td></td>
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<tr>
<td>Expense per case-mix-adjusted admission (thousands)</td>
<td>$5.6</td>
<td>$5.3</td>
<td>$5.3</td>
<td>$5.4</td>
<td>$5.1</td>
</tr>
<tr>
<td>FTEs per 100 case-mix-adjusted admissions</td>
<td>4.2</td>
<td>3.9</td>
<td>4.2</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Operating profit margin</td>
<td>3.0%</td>
<td>12.2%</td>
<td>10.9%</td>
<td>18.5%</td>
<td>20.8%</td>
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<tr>
<td>Medicare acute inpatient days</td>
<td>44.6%</td>
<td>46.2%</td>
<td>43.7%</td>
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<tr>
<td>GME</td>
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<tr>
<td>Direct GME payments (millions)</td>
<td>$3.7</td>
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<td>$4.9</td>
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<td>$8.3</td>
<td>$10.1</td>
<td>$10.4</td>
<td>$7.0</td>
<td>$9.9</td>
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<tr>
<td>Interns and residents per bed</td>
<td>0.37</td>
<td>0.39</td>
<td>0.61</td>
<td>0.41</td>
<td>0.6</td>
</tr>
<tr>
<td>Number of teaching programs</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Indigent care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare DSH payments (millions)</td>
<td>$3.8</td>
<td>$3.0</td>
<td>$4.0</td>
<td>$2.9</td>
<td>$4.5</td>
</tr>
<tr>
<td>Medicaid acute inpatient days</td>
<td>23.4%</td>
<td>15.9%</td>
<td>18.5%</td>
<td>16.9%</td>
<td>16.2%</td>
</tr>
</tbody>
</table>
### EXHIBIT 1
Selected Data On Study Hospitals, Fiscal Years 1994–1998 (cont.)

#### Tulane University Hospital

|------------------------|------|------|------|------|------|
| Adjusted admissions    | 15,375 | 15,539 | 13,324 | 15,534 | –
| Net patient revenues (millions) | $211 | $338 | $207 | $192 | –
| Acute beds in service | 215 | 195 | 232 | 217 | –
| Expense per case-mix-adjusted admission (thousands) | $7.4 | $7.2 | $8.3 | $7.1 | –
| FTEs per 100 case-mix-adjusted admissions | 7.1 | 4.1 | 8.0 | 6.1 | –
| Operating profit margin | 20.2% | 43.5% | 8.8% | 6.8% | –
| Medicare acute inpatient days | 38.5% | 40.3% | 34.5% | 30.6% | –

| GME | Direct GME payments (millions) | – | $2.4 | $3.4 | $2.6 | –
| Indirect medical education payments (millions) | – | $6.6 | $6.8 | $7.6 | –
| Interns and residents per bed | 0.40 | 0.56 | 0.48 | 0.53 | –
| Number of teaching programs | 35 <sup>c</sup> | 36 <sup>c</sup> | 37 <sup>c</sup> | –<sup>b</sup> | 41 <sup>c</sup>

#### Indigent care

| Medicare DSH payments (millions) | $6.5 | $5.7 | $5.9 | $8.7 | –
| Medicaid acute inpatient days | 29.8% | 26.2% | 34.8% | 33.5% | –

#### All major teaching hospitals

| GME | Direct GME payments (millions) | $3.8 | $3.9 | $3.9 | $4.0 | –
| Indirect medical education payments (millions) | $9.2 | $10.2 | $10.0 | $11.8 | –
| Interns and residents per bed | 0.49 | 0.57 | 0.49 | 0.58 | –

#### Indigent care

| Medicare DSH payments (millions) | $3.8 | $4.4 | $4.6 | $5.0 | –
| Medicaid acute inpatient days | 22.1% | 22.4% | 22.3% | 25.4% | –

**Sources:** All data items are drawn from Medicare cost reports, as provided by HCIA Inc., unless otherwise noted.

**Notes:** GW is George Washington. FTEs are full-time equivalents. DSH is disproportionate-share hospital.

<sup>a</sup> Data are not available for this year.

<sup>b</sup> These data are from the American Medical Association (AMA) Graduate Medical Education Directories, various years, 1992–1999. For years in which the hospital was not listed, we counted programs at the School of Medicine.

<sup>c</sup> Number of programs at medical school.

<sup>d</sup> Benchmark data on GME and indigent care missions were obtained by taking the average values for all major teaching hospitals in each year. Analysis by staff at the Commonwealth Fund Task Force on Academic Health Centers.

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### Case-study methods

Case studies were conducted between March 1997 and February 1998. To maximize validity we used multiple sources of evidence, key informants, and structured interview protocols. Each study included a one-and-a-half-day site visit by one or both of the authors. Before and after the visits we reviewed published and unpublished materials on the hospital and its AHC, including previous case studies, annual reports, and news coverage of the sale. We also gathered data from the American Medical Association (AMA) Graduate Medical Education Directory, Medicare cost reports, and the National Institutes of Health (NIH) Web pages, although some information from the

### EXHIBIT 2
Characteristics Of Three Local Health Markets, 1995

<table>
<thead>
<tr>
<th>Market</th>
<th>HMO penetration</th>
<th>Acute beds per 1,000</th>
<th>Occupancy rates</th>
<th>UHC market stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Orleans</td>
<td>9.2%</td>
<td>5.4</td>
<td>59.3%</td>
<td>2</td>
</tr>
<tr>
<td>Omaha</td>
<td>15.9</td>
<td>5.8</td>
<td>62.6</td>
<td>2</td>
</tr>
<tr>
<td>Washington, D.C. &lt;sup&gt;a&lt;/sup&gt;</td>
<td>21.3</td>
<td>3.4</td>
<td>76.1</td>
<td>3</td>
</tr>
</tbody>
</table>

**Source:** University HealthSystem Consortium (UHC).

**Note:** The UHC market stage measures the competitiveness of local markets, with Stage 4 being the most competitive.

<sup>a</sup> The market area includes northern Virginia and part of Maryland.
early years of the Creighton sale was not available. During and after the visits we interviewed senior managers (deans, vice-chancellors, university presidents, chief financial officers, board members, and faculty group-practice executives), faculty, and community observers, such as local public health and Medicaid officers. In each case, we interviewed at least three department chairs, focusing on departments likely to be involved in research, teaching, and indigent care. All interviewees were assured confidentiality. We conducted forty interviews across the three sites.

Although we requested copies of contractual arrangements between AHCs and for-profit chains, none of the sites provided these, citing confidentiality concerns. In one case, at George Washington University Hospital, we were able to review a draft agreement that had been submitted to and approved by local health planning authorities. However, by questioning multiple respondents at each site about the contracts, we believe that we gained an accurate understanding of their major provisions, especially as these pertained to the social missions of these institutions. Managers of for-profit teaching hospitals also were unwilling to share proprietary documents detailing their hospitals’ financial status. However, many did provide qualitative assessments of financial status and returns, which we verified by cross-checking with other university respondents who were privy to this information and by using Medicare cost reports (Exhibit 1).

We requested figures on uncompensated care from all three hospitals. All estimated their levels informally, but only one, George Washington University Hospital, released official data. Using Medicare cost reports, we constructed proxies for the commitments of study hospitals to indigent populations, including trends in Medicare disproportionate-share hospital (DSH) payments and Medicaid admissions as a percentage of all admissions.

**History Of The Sales**

- **St. Joseph’s Hospital/Tenet.** In 1983 the board of the Creighton Omaha Regional Health Care Consortium, the parent body of St. Joseph’s Hospital (SJH) and its related St. Joseph’s Center for Mental Health (SJCMH), conducted a strategic review of the organization’s prospects. A 431-bed teaching hospital of Creighton University, SJH had incurred substantial debts when rebuilding its facility in 1977, had small operating margins, and had only $7 million in reserves. The review found that the hospital, even at existing 90 percent occupancy rates, was not financially viable, and a partner was sought. Efforts to reach agreements with local nonprofit institutions and with a national chain of Catholic hospitals failed for various reasons, including these parties’ alleged unwillingness to commit themselves contractually to maintaining SJH’s indigent care commitments.

In 1984 the consortium sold both facilities in their entirety to AMI for $100 million, of which approximately $60 million was used to retire debt and the balance deposited in a charitable foundation called the Health Futures Foundation (HFF). The HFF board consists of the president of Creighton University and four community members.

In 1990 new management acquired AMI in a leveraged buyout and challenged a number of provisions of the original contract, including the guarantees of support for graduate medical education (GME) and levels of capital funding. That same year Creighton filed suit against AMI, seeking to purchase the hospital and mental health center back from the company. The suit was settled in February 1995, when AMI itself was acquired by the Tenet Corporation. At the instruction of the court that mediated the settlement, CU purchased a 26 percent interest in a limited liability corporation that became the owner of SJH and SJCMH. Tenet owned the balance. For Tenet, like AMI before it, this was the first time it had acquired a major teaching hospital.

Contract provisions require the hospital to maintain its existing complement of residents, its level of investment in indigent care, and its commitment to the pastoral activities of the hospital, which is affiliated with the Catholic Church. The board of the corpora-
tion has four members, of whom one is from Creighton and three are from Tenet.

■ Tulane University Hospital/Columbia/HCA. In 1992 Tulane University, owner of the 300-bed Tulane University Hospital (TUH), became concerned that managed care was threatening the financial viability of the facility. Although profitable, TUH had only 4 percent of the hospital market and was highly dependent on politically vulnerable Medicaid DSH payments. A formal review concluded that the university should seek a partner to reduce its financial exposure.

Like SJH, the university first sought a local, nonprofit partner. An effort to affiliate with the Ochsner Clinic failed, allegedly because Ochsner was unwilling to give Tulane the control it wanted over academic functions, including appointments of department chairs. When negotiations broke off with Ochsner, Columbia/HCA approached Tulane. In March 1995 Tulane sold 80 percent of TUH to Columbia/HCA for $100 million, of which $25 million was deposited in the university endowment, $50 million went to working capital for the university, and $25 million was made available to Tulane’s health science schools. Columbia/HCA also agreed to lend the hospital $75 million to create centers of excellence in areas to be determined jointly by medical faculty and hospital management. The TUH purchase was Columbia/HCA’s first involving a major teaching institution.

The sale of the hospital created a limited liability corporation owned 80 percent by Columbia/HCA and 20 percent by Tulane. Of the ten members on the corporation’s board, five are from Tulane and five from Columbia/HCA, with the chair named by Tulane. Three of five representatives from each group must approve major decisions affecting academic programs, such as funding GME, addition or transfer of medical services, or amendments to medical staff bylaws. The contract also stipulates that the hospital will provide Tulane University Medical Center $22 million annually to support academic activities, including GME, and will provide approximately $2 million each year to the university for various purchased services.

■ George Washington University Hospital/Universal Health Services. In 1994 the George Washington University (GW) concluded that it did not have the financial or managerial resources to support its 501-bed George Washington University Hospital (GWUH) in the Washington, D.C., market. Although the hospital was marginally profitable, its facilities needed to be completely renovated or replaced, at an estimated cost of at least $90 million. Equally important was the challenge of creating a competitive integrated health care system. In the words of a GW official involved in arranging the sale: “We didn’t think we could do this on our own.”

GW at first sought federal funding for renovation. When that failed, the university issued in 1995 a request for proposals for partnership. A number of for-profit and nonprofit organizations responded. Negotiations with Medlantic, a local nonprofit hospital group, failed because, according to GW officials, Medlantic intended to close GWUH and was unwilling to give the medical school control over appointment of academic department chairs at an alternative clinical facility. GW then began negotiations with for-profit companies. In July 1997 the university sold 80 percent of GWUH to Universal Health Services (UHS) in return for UHS’s investment of $80 million to renovate or rebuild the GWUH physical plant. This was also UHS’s first purchase of a major teaching hospital.

Explicitly modeled on the Tulane-Columbia/HCA contract, the arrangement created a limited liability corporation of which UHS owns 80 percent and GW 20 percent. The board of the corporation has six members, three from each side, with the chair alternating between UHS and GWUH representatives. GW board members must agree to any changes that materially affect the teaching program, including decisions to open or close major clinical activities. UHS is required to pay the university $17 million annually to cover direct and indirect GME costs. The arrangement also requires GWUH to maintain existing levels of indigent care for five years, a
condition imposed by local health planning authorities in Washington, D.C., who had to approve the contract.

**Reasons For Sale And Purchase**

In all three cases, AHC officials sold their hospitals because they felt they desperately needed wealthy partners to maintain the economic viability of their clinical facilities or protect themselves from potentially catastrophic losses. In the case of TUH and GWUH, the advent of managed care sharply increased these financial anxieties. University presidents and their administrators, rather than AHC leaders, were prime movers in two instances and were heavily influenced by the desire to protect the university from financial risks posed by the business of health care.

The universities chose to partner with for-profit chains only after discussions with nonprofits had failed, and the reasons for those failures are revealing. For the most part, the nonprofits were local competitors in overbedded markets and saw no advantage in upgrading rival institutions. They sought to close the AHC hospitals completely and/or demanded greater control than for-profits did over their clinical activities (including appointments of department chairs), which AHCs were not willing to cede.

Universities found that they could negotiate better prices and retain more academic control with investor-owned partners than they could with local nonprofits. The reasons reflected business considerations that made these institutions more attractive to for-profit chains. First, in Omaha and Washington the for-profits owned no clinical facilities, so the purchase of AHC hospitals enabled them to establish a new clinical presence. In New Orleans, Columbia/HCA owned many small community hospitals and saw the Tulane purchase as a way to provide tertiary referral services to them at favorable prices. Second, all three transactions were the chains’ first purchase of an AHC hospital. All welcomed the opportunity to demonstrate that they could partner with AHCs, thus making it easier to purchase other AHC facilities in the future if attractive prospects arose. Third, several chains saw the acquisition of AHC hospitals as a “branding” opportunity that would enhance their prestige and make it easier to market themselves to patients and providers in the future.

**Effects On Social Missions**

- **Teaching.** Faculty and university representatives at all three institutions cited no measurable adverse effects of the hospital sales on their undergraduate or GME activities. The data on GME, including Medicare payments, ratio of interns and residents to beds, and the overall number of teaching programs sponsored by the hospital, appear to support this claim (Exhibit 1). Creighton experienced some difficulty because the original acquisition agreement did not include provisions for inflation of GME costs, but this was remedied in a new agreement in 1995, and the residency program grew steadily from just under 100 house staff in 1982 to more than 160 in 1996. The for-profit owner never actually withheld support for Creighton’s teaching programs. In no case have for-profit partners tried to affect the content of medical education. Nor, according to AHC officials, have their relationships with for-profits reduced their ability to innovate educationally within their primary hospital or to establish new training relationships with other institutions.

Some positive effects were noted. At Tulane, Columbia/HCA has invested in developing a family practice department, including a new residency program. At GW, the partnership with UHS assured the survival of the hospital and ended a period of uncertainty that had destroyed faculty morale and eroded the quality of educational experiences in some residencies. However, all three contracts have provisions to reduce hospital support for GME if public payments for GME decline. Under provisions of the Balanced Budget Act (BBA) of 1997, Medicare will reduce GME payments by a total of $7.1 billion over the next five years. Hospital managers (employees of for-profit chains) at all three institutions left the strong impression that they feel no
obligation to fund GME beyond what their contracts require and, indeed, would have trouble justifying such investments.

■ Research. Ranking between 73d and 108th nationally in receipt of 1997 NIH funds, none of the universities involved in these partnerships are research-intensive by national standards. Their rankings have remained relatively constant during the past decade. Despite relatively small research efforts, faculty at all three institutions cited several benefits for their research missions, largely because of funds generated from the hospital sales. At Creighton, the HFF, whose corpus totaled $85 million when we visited, has provided seed funds that led to extramurally funded programs in osteoporosis and detection of the genetic basis of disease. At Tulane, department chairs were planning to use funds from the centers-of-excellence program and from proceeds of the sale to attract investigators in hematology/oncology and genetics.

Some academic leaders expressed frustration that their for-profit partners, especially senior leaders in central offices, did not understand the research mission or appreciate the contribution that research could make to the clinical missions of the organizations and the reputation and competitiveness of the hospital. Hospital managers at GWUH stated that they had no intention of funding any research but did not object to it as long as it did not adversely affect the hospital’s bottom line.

■ Indigent care. University and hospital officials at all three sites said that the hospitals had continued to fund indigent care at the same level as before the hospitals were sold. Creighton has remained the largest provider of indigent care in the Omaha market, spending 7–8 percent of its gross revenues on free care and bad debt. TUH officials noted that the terms of their agreement with Columbia/HCA required them to maintain charity care at historical levels; as a result, about 5 percent of their admissions were uninsured, the same as before the sale. GWUH had not completed a full year under UHS management when we visited, but GW department chairs had noticed no reduction in the volume of free care provided. A D.C. ordinance requires that hospitals converting to investor ownership maintain their levels of uncompensated care for at least five years. Furthermore, as one GW department chair commented, UHS is “not going to come in six blocks from the White House and...stop doing indigent care.”

GWUH expenditures on uncompensated care for fiscal years 1996, 1997, and 1998 totaled 6.3 percent, 5.6 percent, and 5.6 percent of operating expenses, respectively, which compares favorably with the experience of private AHCs nationally. Although Medicare DSH payments and Medicaid caseloads have varied year to year at study sites, no consistent downward or upward trends were apparent over the period (Exhibit 1). Virtually all independent community observers, including Medicaid and public health officials and representatives of medical societies, believed that AHC hospitals had maintained existing commitments to underserved populations.

Discussion

Despite differences in timing, geography, and for-profit partners, these three sales of AHC hospitals to investor-owned chains demonstrated marked similarities that shed light on the reasons for the transactions and their potential consequences for the social missions of teaching hospitals.

■ Reasons for sale. The sale of these particular AHC hospitals to investor-owned chains had a compelling short-term logic that overrode long-term questions about the impact of a change in ownership on charitable and academic missions. University administrators or, in the case of SJH, hospital trustees, concluded that health care had become a business in which they had neither the managerial capacity nor the capital to compete. Their solution was to divest all or part of their hospital assets, with consequent loss of control over their primary teaching facility. In exchange, however, they received a capital infusion that could be used to support academic purposes and relief from the burden of managing a complex business. The AHCs sold their hospitals to for-profit partners primarily because they
offered the best terms.

The decisions to sell these institutions to investor-owned partners remain open to criticism. The initial assessments of financial viability might have been incorrect. All three are profitable or are expected to be so shortly. At the time of our visit, SJH was the second-most-profitable hospital in the Tenet chain. With better academic leadership, the sale of hospital assets to investor-owned companies may have been unnecessary.

However, this criticism merely reemphasizes the fundamental point that some AHCs and affiliated universities—especially those with modest capital and managerial resources—may be ill-suited to running health care businesses in competitive environments. It is entirely reasonable for such institutions to seek partners with the required money and expertise. In the process, for-profit chains will at times offer the best arrangements.

Effects on mission. We detected no measurable adverse effects of change in ownership on the social missions of the three AHC hospitals. At Creighton and Tulane, proceeds of sales were contributing to research capabilities. At GW, the partnership with UHS had stanchéd a faculty hemorrhage that was eroding quality of instruction in several residencies. Indigent care seems unchanged.

These conclusions seem at variance with conventional wisdom, which predicts that profit-maximizing entities will not subsidize public goods, such as teaching and research, or engage in other activities, such as indigent care, that do not yield an immediate return for investors. How can our findings be explained?

First, for-profit purchasers seem to have concluded that supporting AHCs’ social missions is part of the acquisition cost of these institutions and is justified by the likely return on their investment, in both monetary and public relations terms. In particular, all three chains were purchasing their first AHC hospital and were intent on demonstrating that they were desirable prospective purchasers for other AHC facilities. This raises the question of whether investor-owners may be less generous in future transactions of this type. Academic officials were absolutely clear that investor-owned organizations maintained their commitments to social missions because of contractual terms. A typical comment by a university official was: “What should a medical center expect from a for-profit? Whatever’s in the contract.”

Second, supporting some missions of AHCs may, in fact, be less burdensome to investor-owned chains than it may first appear. Teaching hospitals receive extensive governmental support for GME. To some extent, therefore, investor-owned chains can continue to support GME without an adverse effect on their bottom lines. As for research, the direct and indirect costs are borne primarily by the university, not by the for-profit hospital owners.

Third, all three institutions were doing well or expecting to do well financially. If this changes, however, for-profit chains may try to negotiate reductions in support for mission-related activities. Having faced this situation with AMI and resolved it, Creighton officials strongly advised that contracts governing the sale of teaching hospitals contain ironclad buy-back provisions. Of course, under financial stress, nonprofit facilities may also seek to reduce their commitments to mission-related activities.

Taken together, these observations raise the question of whether ownership is a powerful predictor of the willingness of health care organizations to support the production of public goods. We certainly found that potential nonprofit partners for AHCs proposed terms and conditions that would have placed more restrictions on teaching, research, and even indigent care than the investor-owned chains to which the AHCs ultimately sold their institutions. This resulted in the preservation not only of the social missions of these institutions, but also the clinical facilities themselves, with their associated jobs and other community benefits. Thus, local market considerations and business issues may be more influential than ownership in affecting the social missions of AHC facilities and associated community benefits.

Study limitations. Several limitations
of our study should be noted. First, because we did not have access to formal contracts governing the partnerships, we may have missed provisions with implications for academic and charitable missions. Second, we visited the sites of only three conversions, which may not be representative of future takeovers. Third, we did not interview faculty or administrators who had left these institutions. They would likely have held different views about the sale, especially if it was viewed as leading to their departure. However, impressions from interviews of disgruntled former employees are difficult to interpret, since one potentially positive outcome of changes in management is to encourage underperformers to leave. Finally, our research did not address a number of issues that are important to judging the consequences of changes in the ownership of health care facilities. These include whether the chains paid a fair price for the assets they acquired, whether the change in ownership affected the facilities’ commitments to other charitable activities (such as community outreach and health education), and whether the cost or quality of care were greatly affected by the transactions.12

Within these limits, however, our study suggests that sales of teaching hospitals to investor-owned chains reflect the influence of powerful economic forces on AHCs that lack the resources to respond effectively through other means. The formation of partnerships with investor-owned chains helped these institutions to survive and sustain their social missions in the short term. The business relationships underlying these new partnerships do not assure the health of those missions in the long term, but the same can increasingly be said of nonprofit AHCs’ ability to sustain their social missions under competitive market conditions. Regardless of who owns their teaching hospitals, vulnerable AHCs will face challenges in sustaining their social missions in a competitive health care economy.

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NOTES
12. Gray, “Conversions of HMOs and Hospitals.”