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ACQUISITION STRATEGIES OF MULTIHOSPITAL SYSTEMS

by Jeffrey A. Alexander, Bonnie L. Lewis, and Michael A. Morrisey

Prologue: The nation's community hospitals are undergoing a transformation in their corporate structure, their internal organization, and in the economic incentives under which they have traditionally operated. While these developments are underway, myths are rampant about the processes by which hospitals decide to recast their futures. Authors Jeffrey Alexander, Bonnie Lewis, and Michael Morrisey seek in this paper to report reality on the subject of how seven multihospital systems approach the strategic questions about their respective futures. The authors, all of whom hold doctorate degrees, were all employed by the AHA's Hospital Research and Educational Trust at the time this essay was written. The doctorates of Alexander (Stanford University) and Lewis (Purdue University), who resigned recently from the trust, are in sociology. Morrisey holds a Ph.D. in economics from the University of Washington. The research interests of all three authors have included multihospital systems. Alexander also has pursued research in hospital governance and Morrisey has targeted his interests on hospital-physician relationships and Medicare's prospective payment system. The findings of the authors were gleaned from interviews with multihospital system executives and data available to the AHA. One of the more interesting findings was that no system envisioned its future as solely or even mostly a provider of inpatient services. Rather, the corporate strategies culled for the marketing of health insurance as well as the provision of medical care. Insurance services were usually linked to participation in preferred provider or health maintenance organizations. Another interesting finding was the disinclination of all of the systems to pursue growth for growth's sake alone. Instead, all carefully analyzed market conditions facing the hospital and most acknowledged they often declined invitations to absorb hospitals because of unfavorable market conditions. This was true for religious and nonprofit secular systems as well as for investor-owned chains.
Medical care in America now appears to be in the early stages of a major transformation in its institutional structure, comparable to the rise of professional sovereignty at the opening of the twentieth century. Corporations have begun to integrate a hitherto decentralized hospital system, enter a variety of other health care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge health care conglomerates,” predicts Paul Starr in *The Social Transformation of American Medicine*.

An important component of the corporate transformation of health care is the multihospital system (MHS). These organizations, defined as two or more hospitals that are owned, leased, sponsored, or managed by a single corporate entity, now encompass 35 percent of the nation’s hospitals and 38 percent of all community hospital beds.

Despite the marked growth of multihospital systems in the past decade, Professor Starr's scenario of increasing consolidation in the hospital industry is speculative and reflects the widespread public view that systems have been and will continue on a path of unabated growth. Implicit here is the notion that all hospitals are equally desirable to systems as acquisition prospects and that horizontal growth for growth's sake is a desired goal. Also, implicit in his prediction, but as yet untested, is the assumption that recent changes in the operating environments of health care organizations (for example, prospective payment and the aging population) will not affect the acquisition practices of multihospital systems.

These and related assumptions, we argue, have also influenced the conduct of performance research on multihospital systems to date. In general, the empirical literature has found few differences in health care cost, quality, and access between system and nonsystem hospitals. As Dan Ermann and Jon Gabel report, there is some evidence of higher costs in system hospitals, although these findings pertain mostly to investor-owned system hospitals in the early stages after acquisition. Little or no evidence of differential care for the disadvantaged or differences in case-mix were reported between system and freestanding hospitals. Except for greater access to capital markets and somewhat more efficient use of personnel, research has demonstrated few advantages of systems over freestanding hospitals in economic efficiency, personnel recruitment, and quality of care.

The conclusions of the literature, however, are based on at least two questionable assumptions. First, system participation is implicitly assumed to be the result of some random selection process entered into by hospi-

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*The views expressed in this paper are solely those of the authors and do not necessarily reflect those of the Hospital Research and Educational Trust. We thank Jon Gabel, Dan Ermann, Stephen Shortell, and Sum Mitchell for their comments on an earlier draft. This paper was funded by a grant from the National Center for Health Services Research and Health care Technology Assessment.*
tals and/or established systems. Hospitals do not randomly enter into MHS but self-select into these arrangements as a result of a variety of organizational and market conditions. To the extent these conditions are not adequately considered, differences between system and freestanding hospitals will tend to be minimized.

Second, the research literature has given little consideration to differences among systems. Systems vary in their ownership, organization, and control of constituent members. For example, systems may own, lease, or contract manage hospitals, provide close policy direction, or allow considerable institutional autonomy. If factors such as these significantly affect hospital self-selection into systems, then failure to make the appropriate distinction among systems will again bias the estimated differences between system and independent hospitals.

This paper examines one element of the self-selection issue: the strategy and process by which multihospital systems acquire hospitals. The study compares and contrasts system acquisition strategies with respect to: (1) hospital market and management factors considered in the acquisition process; (2) the procedures followed from initial identification of a potential acquisition to final purchase; and (3) likely changes in acquisition strategies and system growth in the next five to ten years.

Data reported here were obtained from structured interviews with executives from seven multihospital systems and survey data available to the American Hospital Association. Those interviewed were chief executive officers of their system, or vice-presidents for planning and development. Interview topics included: characterization of system operation and competitive environments, description of the corporate strategy pertaining to hospital acquisition, nature of the acquisition decision-making process, and opinions regarding future changes in system growth and acquisition practices.

Systems were selected to maximize the range of ownership type, size, and rate of hospital acquisition since 1976. The final sample included four investor-owned systems, two religious nonprofit systems, and one secular nonprofit system. The emphasis on investor-owned systems reflects a decision to focus on those systems that have most actively acquired hospitals since 1976. As Exhibit 1 suggests, the 286 hospitals bought or leased by the investor-owned systems over this period are almost three times the number acquired by secular nonprofit systems and nearly twice the number acquired by religious systems.

Merger/Acquisition Model

The issues considered in a financial decision-making approach to hospital merger or acquisition fall into two categories: the market conditions in which the hospital operates and the management factors relating to how
Exhibit 1
Number Of General Acute Care Hospitals Acquired/Merged By Systems By Year

<table>
<thead>
<tr>
<th>Date</th>
<th>Investor owned</th>
<th>Religious not-for-profit</th>
<th>Secular not-for-profit</th>
<th>State and local government</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>unknown</td>
<td>41</td>
<td>21</td>
<td>20</td>
<td>3</td>
<td>85</td>
</tr>
<tr>
<td>Prior to 1976</td>
<td>180</td>
<td>421</td>
<td>165</td>
<td>41</td>
<td>807</td>
</tr>
<tr>
<td>1976</td>
<td>12</td>
<td>20</td>
<td>11</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>1977</td>
<td>12</td>
<td>9</td>
<td>10</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>1978</td>
<td>51</td>
<td>10</td>
<td>9</td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td>1979</td>
<td>31</td>
<td>28</td>
<td>7</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>1980</td>
<td>49</td>
<td>17</td>
<td>4</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>1981</td>
<td>78</td>
<td>37</td>
<td>14</td>
<td>0</td>
<td>129</td>
</tr>
<tr>
<td>1982</td>
<td>34</td>
<td>20</td>
<td>25</td>
<td>0</td>
<td>79</td>
</tr>
<tr>
<td>1983</td>
<td>19</td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>34</td>
</tr>
</tbody>
</table>

Source: The Hospital Research and Educational Trust
Note: Data do not include contract management.

Exhibit 2
Acquisition Algorithm

<table>
<thead>
<tr>
<th>Management Factors</th>
<th>Market Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>Favorable</td>
</tr>
<tr>
<td>Weak</td>
<td>Unfavorable</td>
</tr>
</tbody>
</table>

well the institution copes with its environment. (Exhibit 2) The market conditions help determine the potential income achieved from the hospital’s services. The management factors measure how well the hospital is currently achieving that potential.

In this framework the amount a system will pay to acquire a hospital depends upon its perception of the value of the hospital’s existing assets and the expenditures necessary to allow the hospital to achieve its market potential. From the hospital’s perspective, its willingness to sell depends upon its own sense of the market for its service, the costs of achieving market potential, and the value of alternative uses of its assets.

As the lower left quadrant of Exhibit 2 suggests, hospitals in favorable markets with weak management are good candidates for acquisition. A favorable market, for example, with a growing population, high income, and low regulation, suggests the potential for a large revenue flow. Weak
management, perhaps exemplified by lack of capital, excess staff, unhappy medical staff, and/or poor accounts receivable processing, suggests an opportunity for the system to take corrective action. In such a scenario the system could purchase the hospital, correct existing problems, and likely make at least a normal return on investment.

If, however, the market is weak but hospital management is very adept at efficiently serving the community’s needs, as in the upper right quadrant, those hospitals are poor candidates for joining a system because their problems cannot be corrected by any action the system could take.

Finally, conditions in the remaining two quadrants reflect the judgment, skill, values, and luck of the organizations involved. In either case, the suitor must evaluate the market potential and the management opportunities presented by the potential acquisition. Differences in acquisition strategies will be most apparent under these conditions. Given identical assessments of the market and management potential of a given acquisition candidate, a system that has acquisition objectives other than increased share value will be relatively more active in these scenarios than will investor-owned chains.

**General System Strategy**

The merger/acquisition decision framework is best understood in the context in which systems make such decisions. This section briefly summarizes how those interviewed characterized the corporate visions of what their systems should be. All seven of the multihospital systems interviewed had similar corporate strategies. They saw themselves becoming vertically and horizontally integrated health care services organizations. No organization envisioned itself solely as a provider of hospital services. Instead, the corporate strategy called for provision of both insurance and health care delivery. Insurance services were usually linked to participation in preferred provider or health maintenance organizations and were expected to be as regionally or nationally diffused as the system’s acute care services. Health care services were viewed on a continuum of ambulatory-primary care, acute inpatient care, and post-discharge recuperative or chronic care services.

None of the systems interviewed had yet achieved its corporate vision. The larger, investor-owned systems clearly were taking major steps to establish the nonhospital components of their strategies. One investor-owned system indicated that it anticipated allocating 10 percent of its operating expenditures to its insurance functions alone. Another said that only about half of its available acquisition dollars would be spent on hospitals. The nonprofit systems were at different stages of implementing their plans. One nonprofit system representative said 50 percent or less of the system’s available funds would go to hospitals, and that “increasingly...
more money is being devoted to health insurance programs, PPOs, and joint ventures with physicians.” Others, particularly some of the nonprofit systems, saw vertical integration as only a long-term goal. These statements are consistent with the work of Ermann and Gabel who found empirical evidence that systems were diversifying into other health-related activities but little documentation of expansion into non-health-care areas.⁶

A second component of each system’s corporate strategy was a consistent emphasis on acquiring or merging with hospitals located in expanding communities. No system was intent upon growth for growth’s sake. Rather, all carefully analyzed the market conditions facing the hospital, and most acknowledged they often declined invitations to absorb hospitals because of unfavorable market factors. This was as true for the religious and nonprofit secular systems as it was for investor-owned chains. Nonprofit systems, however, would on occasion look beyond market conditions if the provision of care in a particular community was deemed essential to the system’s mission.

While overall corporate strategies were remarkably similar, the marked differences in the professed missions of investor-owned and, particularly, religious systems lead to more complex acquisition criteria for the non-profits. A Catholic system representative spoke of a mission to preserve and maintain a Catholic health care delivery system through the development of strong Catholic multihospital systems. This mission led his system to consider mergers with other Catholic hospitals, sometimes in spite of unfavorable market factors, to maintain a Catholic health care presence in a community. Another religious system saw its mission as expanding the role of the church through health care services. Acquiring hospitals in communities where the church was not yet well established was a component of this system’s merger/acquisition strategy.

Executives from investor-owned and voluntary systems also differed in discussing the structure of linkages with other hospitals. Typically, investor-owned system representatives discussed acquisition or buying the assets of the hospital. Voluntary chains consistently spoke of merger. In a merger, little cash or other financial assets change hands. Rather, the parties agree to combine their organizations and pool their assets. The hospital may offer location in a favorable market, while the system offers resources for renovation and/or management expertise to enable the hospital to achieve its market potential. Investor-owned and nonprofit system executives acknowledged that nonprofit systems had less capital available to purchase hospitals outright. Thus, the nonprofits tended to be more innovative in structuring mergers which minimized the expenditure of capital—usually by giving the acquired hospital a significant voice in directing the new organization.

These differing approaches to organizational linkage and systems’ differing missions are reflected in the historical pattern of noncompetitive
system growth. As Exhibit 1 demonstrates, since 1976 the number of hospitals owned, leased, or sponsored by systems has increased by more than 60 percent. The majority of acquisitions have been made by investor-owned systems. While there has been substantial competition within system ownership categories to acquire particular hospitals, there has been relatively little effective competition between categories of systems. Exhibit 3 demonstrates this. The percentage of general acute care hospitals organized on a for-profit basis (that is, system and freestanding) has remained virtually unchanged since 1975. Thus, investor-owned systems have essentially acquired proprietary hospitals. The 1979-1981 trend and the decline in state and local government hospitals suggest that the historical pattern may be changing, and system executives do see a changing competitive environment for acquisitions.

<table>
<thead>
<tr>
<th>Year</th>
<th>Investor-owned</th>
<th>Nongovernment not-for-profit</th>
<th>State and local government</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>775 (13.2%)</td>
<td>3,339 (56.8%)</td>
<td>1,761 (30.0%)</td>
<td>5,875</td>
</tr>
<tr>
<td>1977</td>
<td>751 (12.8%)</td>
<td>3,350 (57.0%)</td>
<td>1,780 (30.3%)</td>
<td>5,881</td>
</tr>
<tr>
<td>1979</td>
<td>727 (12.4%)</td>
<td>3,330 (57.0%)</td>
<td>1,785 (30.6%)</td>
<td>5,842</td>
</tr>
<tr>
<td>1981</td>
<td>729 (12.3%)</td>
<td>3,340 (57.5%)</td>
<td>1,744 (30.0%)</td>
<td>5,813</td>
</tr>
<tr>
<td>1983</td>
<td>757 (13.1%)</td>
<td>3,347 (57.9%)</td>
<td>1,679 (29.0%)</td>
<td>5,783</td>
</tr>
</tbody>
</table>


The Merger/Acquisition Decision

Comments of system representatives are presented within the framework of the market and management factors. Market factors relate to the environment in which the hospital operates; management factors refer to the operation of the hospital in both the service and financial arenas. In each case we describe the investor-owned responses and then relate the differences or similarities found in the nonprofit systems.

**Market factors.** All of the system representatives interviewed identified a consistent set of relevant market factors considered in the acquisition process. Demographics and utilization trends were paramount. Discussion focused on growth, age structure, and income-insurance coverage of the service area/market population and their likely use of health services. The number of existing hospital beds per 1,000 population in the area was also a major concern. The investor-owned systems mentioned the importance of the community’s regulatory, legislative, and business climate in determining the viability of a market. Typical market data in the hospital acquisition process include: hospital patient origin studies; hospital Medicare, Medicaid, and indigent care loads and change;
hospital revenue from charge-based payers and change; community population and growth by age; per capita income and growth; unemployment rate and change; major employers in community; growth of HMOs and PPOs in community; other hospitals in the community; hospital bed-to-population ratio; days and admissions per capita and change; nursing home bed-to-population ratio; physicians, by specialty, in the community; physician-to-population ratio; incidence of illness date; business climate; and regulatory/legislative climate.

On a more generic level, investor-owned system executives generally identified four types of hospital-community settings that fit their respective corporate strategies. These systems are interested in declining urban hospitals, primary care community hospitals, major teaching hospitals, and locally competing hospitals.

The urban hospital acquisition strategy can be best described as purchasing the right to close a hospital in an area of rapidly falling occupancy and subsequently opening a new facility in a surrounding suburban market with favorable demographics. The rationale for such a strategy is almost certainly found in the state certificate-of-need (CON) legislation which limits the ability of providers to enter new markets. Indeed, preliminary work of McCarthy and Kass suggests that CON legislation has been effective in excluding investor-owned firms from hospital markets.7

The primary care community hospital is the archetypal acquisition target described above in our simple model. As one representative put it, “We are looking for the hospital which is or could be the hospital of choice in the community, is reasonably large, and has a good reputation for providing quality care.” Economic feasibility and the “fit” within the existing organization then become the central issues.

Investor-owned chains expressed an active interest in acquiring major teaching institutions, for three reasons. First, the tertiary care setting offers the ability to provide selected high-technology services, viewed by some in the industry as profitable. Second, the teaching facility offers an in-system referral center that allows the system to keep patients who otherwise would be transferred to other tertiary centers. System representatives felt this referral capability enabled their hospitals to demonstrate to insurers and employers as well as to physicians that they could provide a full range of hospital services. Third, the teaching hospitals would be positioned as system flagships, providing apparent evidence of high-quality care.

Finally, investor-owned system representatives expressed interest in the acquisition or sale of a hospital if a consolidation of two unprofitable facilities in a single community could result in one viable hospital. Executives argued that the cost savings resulting from economies of scale would allow the surviving entity (whether within the system or not) to be profitable. Such a consolidation also raises, at least in principle, the potential
for a local monopoly to increase the price of services.

In contrast, the nonprofit system executives were less precise in identifying the types of hospitals with which they sought to merge. This in part reflected their more diverse missions. One nonprofit system executive suggested his system operated much like the investor-owned chains. As he put it, “We seek hospitals with maximum potential for bottom-line effectiveness.” The religious systems stated that they attempted to expand or maintain the role of the church through the provision of health care. Market factors, however, are becoming increasingly important. As one religious system executive said, “We are now less willing to take on marginal hospitals in the hopes that they might come around to successful operating positions.”

Management factors. As they assess a hospital’s market potential, system suitors also carefully evaluate management factors. They determine the actions needed to make a hospital viable after a merger or acquisition. Management data requested of a hospital may include: audited financial statements; internal operating income statements and balance sheets; utilization by payer; full-time personnel and staffing ratios; ancillary service volumes; schedules of indigent care and contractual arrangements; Hill-Burton obligations; age of accounts receivable; Medicare cost reports; history of accumulated depreciation; bond prospectus; hospital charges; CON applications and long-range plans; size of existing facilities, floor plans, and site plans; medical staff roster, including age and number of admissions; corporate and medical staff bylaws; Joint Commission for the Accreditation of Hospitals survey report and fire marshall report; contracts and leases in place; personnel policy manual; and pension, retirement, and benefits plans.

Three general management issues surfaced in our discussions: adequacy of physical plant, medical staff relations, and administrative problems. Often the hospital’s physical facilities need rebuilding, renovation, or modern technology. In other cases the medical staff has been engaged in significant in-fighting, is nearing retirement, or sends the bulk of its admissions elsewhere. More commonly, the hospital has operational problems. One representative noted, for example, that in almost every acquisition the system must implement new accounting and management information systems. In some cases the hospital is over- or under-staffed, or is not able to effectively cope with emerging state or federal policy changes.

All of the systems expressed a desire to work with the acquired hospital’s existing management staff, but system representatives generally acknowledged this was not always possible. An investor-owned system representative indicated that in his experience the acquired hospital’s chief executive officer was replaced about 50 percent of the time; department directors, about 25 percent of the time; and other administrative staff in about 1 percent of the cases. A nonprofit system executive shared
this view, stating that his system would enter into a merger only if it received the right to replace the chief executive officer, the chief financial officer, and the director of nursing. He also said his system usually exercised this right. The reported practice of replacing the management but keeping most other staff positions is consistent with Wheeler and Zuckerman’s studies of contract managed hospitals. They found that the new organization made significant efforts to stabilize the workforce and improve personnel recruitment and retention policies.

On the basis of these seven interviews we conclude that the systems, whether investor-owned or private voluntary, look principally to market and management fundamentals in determining which hospitals are likely candidates for merger or acquisition. The different approaches systems take to merger or acquisition appear to stem from varying access to capital and different missions. The lack of capital and willingness to merge for noneconomic reasons result in asset-pooling, networks, and other innovative arrangements by the private nonprofit systems. To the extent that nonmarket factors enter into the decision, these arrangements, though innovative, are economically risky. It remains to be seen whether the market—and support from the parent organization—will allow such entities to survive in a price competitive health care market.

The Acquisition Process

In focusing on the process by which systems engage in hospital acquisition, four areas are discussed: (1) how initial contact with the potential acquisition is made; (2) the activities of the corporate staff responsible for acquisitions; (3) the process of negotiation between the system, the acquisition candidate, and key stakeholders; and (4) how monetary and/or asset exchange is effected between the system and the acquired hospital.

Initial contact. Despite the aggressive reputations of some of the larger systems, our data suggest that systems do not make unsolicited overtures to acquisition candidates. More often, a hospital interested in being acquired or a third party, such as board member, consultant, or physician familiar with the operations of the potential acquisition, will inform the system that the hospital is considering a sale. The initial overture in the acquisition process then appears to be informal and enacted by a loosely organized network of individuals, who unofficially broker the hospital to the system.

A second approach to identifying acquisitions occurs among those systems that are regionally oriented, that is, whose operational and development strategies focus on well-defined market or service areas (for example, community, state, or group of states). CEOs of these system hospitals are often responsible for identifying acquisitions. These individuals evaluate other hospitals in their market area as potential contrib-
utors to the regional development of the system. They are usually familiar with the operations and market conditions of a potential acquisition and have had considerable time to observe the institution in action. A detailed proposal will then be submitted to the central headquarters, outlining an argument for acquisition. Little differences in these initial contact procedures occurs across institutional sectors. The process is similar for both investor-owned and nonprofit systems.

**Analysis of potential acquisitions.** Once a hospital has been identified as a potential acquisition, an analysis of that hospital is conducted by the system. How this analysis is performed varies greatly from system to system. However, in all cases the objective of the analysis is the same: to determine whether the potential acquisition would assist the system in reaching the goals outlined by its corporate strategy. Virtually all executives interviewed contrasted this systematic approach to acquisition with indiscriminate growth for growth’s sake. In this context, analyses of potential acquisitions place relatively little weight on data-based algorithms that result in “acquire” or “no acquire” decisions. Rather, management and market indicators are regarded as baseline information for more general assessments of whether a potential acquisition is warranted by the strategic goals of the system.

Our interviews indicated that analyses by nonprofit systems are less formalized than those of larger, investor-owned systems. For example, one nonprofit system interviewed convenes a special ad hoc task force to study the potential acquisition and develop a feasibility study. This task force normally consists of corporate staff from the finance and planning areas, top administration, and sometimes representatives from member hospitals who have experienced similar situations or who are familiar with the type of market in which the potential acquisition operates. Other nonprofit systems appear to operate even more informally. One or two of the planning or administrative staff of the system will visit the hospital, talk with key members of the board and management, and then assess the feasibility of the acquisition in small high-level meetings.

Larger, investor-owned chains employ more formal, data-based mechanisms for analyzing potential acquisitions. These often include a network for channeling information from staff at the regional level to a marketing/acquisition staff at the system’s central headquarters. The latter may consist of highly trained demographers, market analysts, or other specialists who employ sophisticated data bases and analytic tools to conduct studies of any hospital in the country, sometimes in less than twenty-four hours.

This emphasis on rapid, sophisticated assessment of potential acquisitions stems, in part, from recent increased competition among systems for hospitals. Those interviewed suggested that although this competition is often fierce (for example, twenty systems bidding on the same hospital), it operates primarily on a hospital-specific basis rather than on...
a national level. A large investor-owned system, for example, may go head to head with a smaller religious system for one hospital and against another investor-owned system for another.

Because the acquisition process has been highly competitive, much of these analyses have been completed in advance of initial contact with a potential acquisition. Specific staff members are assigned responsibility for continually monitoring changes in the market conditions for a particular state or region of the country. Once a potential acquisition is identified, a base of information is already available on the hospital and its market. Obviously, this constant and detailed attention to market analysis is expensive, but it gives these organizations a significant advantage in analyzing potential acquisitions in a timely fashion.

Virtually all systems studied indicated that once a potential acquisition has been identified, the turnaround time from first negotiations to final closure can be as short as two weeks. Consequently, significant competitive advantages accrue to those systems able to analyze and begin negotiations promptly.

A second element of the analysis is an assessment of why the hospital wants to be acquired by the system. Most of the systems interviewed consider this step critical because information that is less amenable to quantitative data analysis can be uncovered. Several systems formalize this process by asking the potential acquisition to write a request for proposal outlining the reasons for wanting to sell to a system, including a specification of their expectations for acquisition such as a new building, modernization, and physician recruitment. It is important to emphasize that these reasons do not always relate to the financial or operational viability of the hospital. A religious order, for example, may put its hospital(s) on the market because it is reverting to its original educational mission. In this situation, proceeds from the hospital sale may be used to build or upgrade schools of the order.

In other systems this process is much more informal and consists of talking to key stakeholders in hospitals, such as management, members of the board, and members of the medical staff. These discussions are typically evaluated in light of the stakeholder’s position in the hospital. For example, because hospital management stands a chance of being removed by the system after acquisition, they may have quite a different opinion of the reasons for acquisition than members of the board. In addition, these initial contacts with the hospital allow the system to obtain information not necessarily available in its existing data bases.

Once the analysis of the hospital’s appropriateness for inclusion in the system has been conducted, a decision will be made about whether to pursue the acquisition. This decision, while incorporating many of the previously described indicators of market and management conditions, is by no means solely dependent on them. The decision to acquire or not
to acquire apparently reflects a combination of weighing “hard indicators” with a less certain assessment of future potential and how the hospital fits into the system’s strategic plan. Decision-making factors therefore include many gray areas not amenable to rigorous, quantitative analysis. To illustrate, several system executives cited instances where “all the facts on paper said ‘yes’ but when we sat down to decide whether or not to pursue an acquisition, the decision was ‘no.”’ Overriding the hard facts in these cases were such soft considerations as “lack of fit” and a “bad feeling” after visiting the hospital.

Finally, the emphasis on particular decision criteria will differ over time and as a function of the stage of implementation of the system’s strategic plan. A system in a period of consolidation may be less enthusiastic, for example, about acquiring a marginally profitable hospital than a system in a growth phase of development.

Negotiation. Once negotiations with a potential acquisition begin in earnest, a much different process ensues. During this period, the system will try to stress its unique characteristics in order to sell itself to the potential acquisition. Each system tries to emphasize its strengths and to simultaneously allay concerns of the hospital being acquired. One large investor-owned system, for example, characterized selling as a process of becoming part of a larger organization as opposed to simply selling off real estate. In discussing this organizational affiliation the system emphasizes advantages to the hospital in improved quality of patient care, access to financial and human capital, and ability to draw on the resources of a much larger organization. Another investor-owned system stressed as a selling point economies of scale related to management expertise: “We have a reimbursement staff of forty professionals here, which is only one half person per hospital. But because we have forty centered here we have expertise that no single-owned hospital has. Even hospitals with excellent reputations cannot come close to understanding reimbursement the way we do. But as a proportion of their revenue, they spend more on this activity than we do.”

These selling points are sometimes made tangible to a potential acquisition by inviting key members of the hospital board and medical staff to visit the system headquarters to view first hand the resources that will become available to them should they choose to be acquired.

The selling strategies of the smaller, nonprofit systems tend to be more specialized. One Catholic system interviewed indicated that its primary attraction lay in its religious orientation and mission statement. This system felt that its chances for expansion were best among other Catholic or religious-affiliated institutions with similar mission orientations. Another nonprofit system emphasized the strength of its management skills and the fact that it had been in business for over 100 years. Personnel recruitment was deemed a key selling point by this system, given its prior suc-
cess in attracting clinical and management staff to underserved areas.

Another central element in the negotiation process is involvement of key medical staff leaders or physicians. Several executives interviewed suggested that without the support of medical staff leaders, a potential acquisition was virtually doomed. In addition to assuring these physician leaders that appropriate facilities and services will be provided to them under the new management arrangements, some systems will go to great lengths to woo physician groups. One system, for example, offered to build a hunting lodge for the medical staff of a prospective seller. Often, however, involvement of medical staff leadership in the acquisition process is as problematic as it is important. “One of the most difficult groups to know how to effectively involve is physicians because in most of these situations there are overlapping medical staff appointments. As soon as you open up and involve (the physician leadership) you may as well put it on the bulletin board of the doctor’s locker room. You pay a price later, however, when you don’t talk to them. We haven’t figured out a way to really constructively, appropriately, and at the right time involve the physician leadership of the community because of the practice patterns, the loyalty, and the biases in the communication network.”

Once preliminary negotiations have been completed a more formalized process begins. Typically, the system will write a proposal to the potential acquisition specifying the conditions under which the acquisition is to occur. This proposal is reviewed by the board and management of the hospital and several counter proposals may be offered based on the response of the board and/or management staff. These negotiations continue until the system feels prepared to submit a formal bid to purchase or affiliate with the hospital.

While the specifics of negotiating vary greatly from system to system, a central component of this process is how the system determines a price for the hospital. Both nonprofit and investor-owned systems indicated that price was generally a function of three elements. The first is the value of the hospital’s physical plant, or what one system executive referred to as the “bricks and sticks.” Valuation of this element is conducted by a team of assessment specialists and/or consultants who visit a hospital and assign a price to its major physical holdings.

The second element of hospital valuation focuses on the business of the institution and its potential income stream. Indicators such as the prevailing charges of the hospital, its staffing levels, and revenue base are examined. The third element relates to the more intangible assets of the institution, such as the quality of the medical staff and the hospital’s reputation in the community. Despite being difficult to quantify, virtually all executives interviewed indicated that these elements were vital to determining the price of a hospital and its subsequent operational success.

It is important to emphasize that not all acquisitions involve a direct
money transfer. Frequently, nonprofit systems will reach an affiliation agreement with the potential acquisition. This amounts to a pooling of system and hospital assets without any direct transfer of cash. In these cases, the system will work to develop a document that outlines the roles and responsibilities of the two merging organizations rather than assessing the value of the potential acquisition. As one executive in a large nonprofit system explained: “Our basic approach is the development of a merger prospectus that clearly delineates the roles and responsibilities and mutual commitment of each organization. We present to relevant groups a prospectus with a subscription agreement, just as if they had gone to the stock market or financial market.”

**A View Of The Future**

Two factors are integrated into the scenario of the future for multi-hospital systems and of hospital acquisition practices: (1) potential barriers that systems will encounter in their growth, and (2) the global responses to what those interviewed saw as the future for the multi-hospital system industry.

**Limits to growth.** System executives were asked what they saw as limiting factors to the growth of multihospital systems. One system representative quickly said there were none. Other respondents felt there were limits, at least for growth of their own system or certain types of systems. Access to capital was at the top of everyone’s list—although the investor-owned systems saw this only as a long-term potential problem.

This observation is rather surprising in light of the findings of multihospital system research to date. It is, of course, no surprise that the cost of capital ultimately limits system growth potential. Rather, a newly emerging perspective is the capital access problems of nonprofit systems. Ermann and Gabel in reviewing the literature, found that one of the few established strengths of systems was their superior access to capital. However, they report no evidence that system ownership was a significant factor in obtaining funds for growth. Indeed the AHA’s Special Committee on Equity of Payment examined the issue of access to capital in 1983 and concluded that “it was not clear that investor-owned hospitals’ potential access to the stock equity market exceeds the economic advantage accruing to private not-for-profit and public hospitals to obtain private philanthropic gifts and/or government capital and operating subsidies.” Such government support, of course, includes access to the tax-exempt bond market.

The perceptions of those interviewed suggest that the operating environment for systems has changed. If so, one can more clearly predict that the investor-owned systems will continue to grow more rapidly than their nonprofit competitors. Other limits noted were largely organizational.
First, the nonprofit systems saw their continued inability to effect rapid, responsive decision making as an impediment to effective competition with investor-owned systems. On the other hand, regionally based systems saw fundamental geographic differences in political and economic climate limiting the ability of national systems to provide effective centralized management and policy control. The larger systems also saw anti-trust considerations as a potentially major limit to their growth. A simple lack of leadership vision and planning in some systems was also cited as a factor limiting growth. Finally, some systems indicated that they did not want to grow; their current size was seen as optimal for meeting their mission.

The shape of the future. Most executives predicted increased consolidation, both in the investor-owned and nonprofit sectors. The consensus was that "health care in this country is going to be more organized five years from now." Several different kinds of consolidation were anticipated: industry consolidation; mergers of systems, especially larger systems; consortia and alliances among nonprofit systems; and continued movement of independent hospitals into systems. One system predicts that twenty-five to fifty very large health services organizations will soon dominate the health care industry.

We see these organizations integrated with primary care, secondary care, and tertiary care at the core, plus the additional services of ambulatory, home, and long-term care, all covered under system insurance. The financing of health care will evolve from cost-based fee-for-service to fixed payment, capitated, or negotiated contracts. One respondent predicted that 80 percent of the population would participate in some form of prepaid health care plan. They suggest an integration of insurers and providers, with all large systems having either PPOs, HMOs, or contractual arrangements with independent insurers. These plans may be local, regional, or national.

Although one respondent said that DRGs are here for some time, most others felt that DRGs are a transitory form that will be replaced by a more sophisticated prospective pricing system. Since payment incentives would change—and in many cases systems would provide insurer services—systems will be motivated to provide services in the most cost-effective settings. Thus, the respondents would seek to provide a continuum of ambulatory, inpatient, follow-up, and long-term care services.

The core of these systems will continue to be primary and secondary hospitals selectively located to provide basic hospital care. At a more regional level, tertiary hospitals will provide the more complex inpatient services. As an insurer, or seller of hospital services to major insurers, systems perceived the ability to provide a complete range of services as essential. For similar reasons prehospital and ambulatory care services, such as urgent care centers and surgi-centers, were deemed necessary to
effectively compete for health benefits dollars.

Finally, to provide services to the growing aged population, home care, long-term care facilities, and skilled nursing facilities will be integrated increasingly into the network of health care services organizations. One executive remarked that at least 50 percent of home health care is driven by hospital discharges, which for his system represents thousands of potential clients.

The implications of this scenario for the acquisition of hospitals are profound. First, the scenario suggests that systems will be devoting more acquisition dollars to nonhospital activities: acquiring insurance firms, developing PPOs, establishing pre- and post-care capabilities, and forming joint ventures with multispecialty group practices. Second, it suggests that hospital acquisitions will focus more on market factors and on achieving a full range of hospital services. The acquisition of teaching hospitals, for example, is just beginning. One could expect primary hospitals to be acquired to complete grids of hospital sites determined by population density and patient convenience among other factors.

In this scenario it is important to note the changing nature of the hospital pool. Although fewer buyers are anticipated in a more restricted financial environment, more hospitals will be available for sale. One respondent pointed out that the “growing apprehension and anxiety on the part of trustees and on the part of private hospitals regarding the future is moving many hospitals to strategic planning and examination of alternatives.” If the scenario we develop is correct, many hospitals will see the pattern unfolding and will consider, a system affiliation. However, increased selectivity by systems suggests that many hospitals will not be attractive. Some will survive as freestanding hospitals, but others will be converted to other uses—perhaps long-term care facilities or ambulatory care centers.

While we noted the perception of greater access to capital by investor-owned systems, we are not predicting the demise of nonprofit systems. They will survive and perhaps thrive for at least three reasons. First, some hospitals are simply reluctant to affiliate with investor-owned chains. To the extent that they can continue to meet the needs of significant population segments they will grow and integrate as their corporate strategies suggest. It is important to keep in mind that one major rationale for the development of nonprofit enterprises was the fear that the for-profit form gives owners incentives to skimp on the quality of services in ways costly to remedy. While there is no evidence of inferior service quality, such perceptions drive markets. Second, nonprofit systems are becoming more and more capable of competing. Many now have for-profit subsidiaries to improve their revenue base. They also are beginning to develop extremely sophisticated market analysis capabilities. For example, one nonprofit system executive we interviewed described a capacity to conduct in-depth
analysis of future “social, technological, economic, environmental, and political attitude shifts in society,” and how these shifts will impact the health care industry. Finally, nonprofit systems are merging and developing other means to conserve on scarce capital. If these forms prove successful, the nonprofit system will have overcome its greatest impediment.

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