The Effect of Hospital Ownership Conversions on Nonacute Care Providers

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SINCE 1985, THE PROPORTION OF FOR-PROFIT community hospitals has hovered around 15 percent (AHA 1988, 2002). Although nonprofit hospital conversions to for-profit status have yet to significantly alter the overall distribution of investor ownership in the hospital sector, the consequences continue to cause considerable concern (Claxton et al. 1997; Cutler 2000). This is true primarily because investor ownership imposes new fiduciary responsibilities that may undermine a hospital's implicit social contract to meet the needs of the community it serves, regardless of profitability. Given this, many worry that for-profit health institutions will harm local communities, particularly the availability of services for uninsured and underinsured populations. Thus, much attention has focused on the impact of ownership change on a hospital's provision of uncompensated care and other unprofitable but socially valuable services.

Existing conversion studies do not provide definitive answers regarding the significance of conversions for local communities. Most studies report that nonprofit hospitals do not reduce their provision of uncompensated care following a change to for-profit status (Needleman, Lamphere, and Chollet 1999; Young and Desai 1999; Young, Desai, and Lukas 1997). Studies also find few changes in hospitals' provision of other essential community services, such as emergency departments (Chollet and Kirk 1999; Hadley, Gray, and Collins 2001) and teaching and research activities (Blumenthal and Weissman 2000; Feder and Hadley

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1987). These “no change” findings, however, may be due to small samples and selection bias. In the first nationwide study of its kind, Thorpe, Florence, and Seiber (2000) found that when nonprofit hospitals converted to for-profit status, they provided, on average, less uncompensated care following the change in ownership. And although it is a relatively less common phenomenon, a few studies have examined the significance of conversions among public hospitals—institutions that bear a relatively large burden of a community’s uncompensated care—and report that they provided less uncompensated care after their conversion (Desai, Lukas, and Young 2000; Needleman, Lamphere, and Chollet 1999; Thorpe, Florence, and Seiber 2000).

A slightly different perspective suggests that existing conversion outcome measures may incorrectly specify the potential effects of hospital ownership changes (Cutler and Horwitz 2000). Despite efforts to broaden the conceptual framework by which community benefits are defined (Schlesinger and Gray 1998; Schlesinger et al. 1998), much of the focus remains on hospitals’ outputs, whether specified as provision of care to the poor, delivery of unprofitable services, or services that attract a relatively high rate of uninsured and underinsured patients. A recent exception was Cutler and Horowitz’s examination (2000) of the interaction between hospitals. They found that nonprofit hospitals tended to mimic the behavior of their converting counterparts. We offer here a related and still broader lens to see how hospitals interact with nonacute care providers that serve vulnerable populations and, by extension, the potential for ownership changes to affect the health care safety net.

Health care today is delivered in an environment that is being massively restructured (Bazzoli et al. 2001; Robinson and Casalino 1996; Shortell, Gillies, and Devers 1995). During the past two decades, providers have been pulled in two directions. On the one hand, cost containment strategies have encouraged competition among health care providers by placing a premium on cost-efficient care (Thorpe 1997). On the other hand, health care organizations are also expected to achieve a certain level of cooperation (Robinson 2000; Sofaer and Myrtle 1991). Therefore, providers often need to both compete and collaborate to provide quality care and attract patients and health care dollars.

Hospitals are not unique in this sense. They may affiliate with providers of complementary services to offer a continuum of care and satisfy the sustained demand of purchasers and consumers for broad provider networks (Lesser, Ginsburg, and Devers 2003). Hospitals may

align with outpatient facilities that diagnose patients before their admission, which helps generate referrals for inpatient services (Snail and Robinson 1998). In the case of complex health problems, hospitals may also cooperate with organizations outside the health sector as traditionally defined (Sofaer and Myrtle 1991). These alliances may help hospitals manage particularly complex conditions such as AIDS, substance abuse, and long-term care. Hospitals may also work with or provide assistance to community-based providers in order to satisfy more mission-oriented goals (Kane and Wubbenhorst 2000).

In short, a hospital can be usefully conceived as a nexus of linkages that bind together in different ways the many contributors to delivering health care (Robinson 2000). These linkages enable a hospital to secure the resources deemed necessary for overall viability, including patient referrals, insurance contracts, and political legitimacy. When the ownership of a hospital changes, however, particularly resulting from a national for-profit health system acquisition, some of these arrangements may change as well. Health systems often bring with them new resources, which may make some local partnerships less valuable. Ownership change also may usher in new missions for a hospital, missions that may affect how a hospital understands and carries out its responsibility to serve the local community.

In light of the increasing complexity of local delivery systems, new insights into conversions may be found in a research model that sees the hospital as part of a local network of care and that focuses on how a change in ownership affects its role in the network, including its effects on other providers. In particular, changes that affect providers that serve the poor and other vulnerable populations may have secondary effects on a community's overall "benefits." According to this view, a change in ownership extends beyond a hospital's direct provision of service. In the next section we examine interorganizational theory as a model for exploring these and related effects. Next we present our methods and sample, followed by our findings and then a discussion of the major themes emerging from our research.

Framework

Interorganizational theory suggests that one way to conceptualize the relationship between two service-providing organizations is how the

		Compete	
		Yes	No
Collaborate	Yes	Collaborate/compete	Collaborate
	No	Compete	No relationship

FIG. 1. Categories of hospital-provider relationships.

relationship supplies one or more of the elements each organization needs to fulfill its mission (Levine and White 1974). In this sense, interorganizational relationships are regarded as interdependent. Organizations align with other organizations to obtain resources that neither is able to generate internally but that are essential to their overall health and survival (Sofaer and Myrtle 1991). In addition, in a service sector like health care, organizations frequently depend on one another to provide complementary elements of care for clients.

Building on interorganizational theory, we classify the relationship between a local hospital and other providers in one of four ways: collaborative, competitive, collaborative and competitive, or no relationship at all (see figure 1). We define a collaborative relationship as one in which the link between two agencies generates a resource gain, such as desirable patient referrals, in-kind assistance, or financial support. In

contrast, we define a competitive relationship as one in which the interface between two agencies revolves around their vying for resources or avoiding operational costs at the other's expense. This is a deliberate expansion of the classic economic construct of competition but one that has particular relevance in the health care sector. Given the scarcity of health care resources, providers are increasingly motivated to maximize resource gains and minimize losses, which can include minimizing services to uninsured populations. Indeed, much of health policy is aimed at compensating for providers' disincentives to serve particular populations (Felland et al. 2003). We include both of these maximizing and minimizing actions under the rubric of "competition" when one agency's gain may be another's loss, in either missed resources or higher costs.

A community hospital may compete with other health organizations that provide comparable services to comparable patient populations, such as other community hospitals. In contrast, a hospital may collaborate with a home health agency in order to facilitate discharge planning and market hospital services. In return, the hospital may offer the home health agency a steady stream of patient referrals. At the same time, hospitals are apt to both compete and collaborate with other organizations if there is some overlap in either services provided or patients served. A hospital that has diversified into various nonacute care services may find itself both competing and collaborating with community-based providers of these similar services. Finally, in any city, some health care organizations may have a tenuous relationship—or no relationship—with a given hospital because the organizations provide completely different services or serve entirely different patient populations. For example, an agency providing social services to disabled populations may have little or no contact with a hospital that does not have a spinal cord injury service.

Methodology

An examination of how hospital ownership change affects local nonacute care providers requires a detailed knowledge of how institutions and people in the community experience the change. It also requires an understanding of complex interorganizational relationships, as well as how contextual factors such as the local economy and political

climate mediate observed impacts. Our primary objective was to develop a more complete model for studying this issue and to create an analytical framework for future research. Under these conditions, a case study methodology is the most efficacious approach (Yin 1993) and one that is gaining increased recognition in health services research (Sofaer 1999; Yin 1999), particularly with respect to learning the significance of hospital restructuring (Bogue et al. 1995).

We studied cases that involved the sale of all or part of an urban non-profit hospital to a national investor-owned organization. We restricted our study sites to those that had converted between 1994 and 1998 (to ensure that sample respondents could accurately resurrect events from the past) and were moderately large (we predicted that larger hospitals could generate larger community "effects"). Within these restrictions, we used a sampling strategy to select sites that maximized variations in key criteria: teaching versus nonteaching, acquiring company (HCA, Tenet, Universal, etc.), and location (whether in states with laws regulating conversions). This is a standard approach designed to increase confidence that the patterns that emerge are common across sites and to provide insight into the conditions that explain the different conversion effects (Patton 1980). Our sample also depended on the hospitals' willingness to participate. It is hard to determine the level and type of bias that this willingness introduced, although given the variation observed in our final sample, we do not believe it systematically skewed our overall findings. Table 1 summarizes the characteristics of our study sites.

We created semistructured interview protocols to ensure data comparability across sites and over time. We used interorganizational theory to determine our preliminary code list, which we continually refined based on knowledge gained from the interviews (Miles and Huberman 1984). Our interviews with key informants focused on resource gains and losses following the conversion, including those attributed to the hospital as an institutional partner and service provider and to overall market trends. If a foundation had been formed from the conversion's assets, we also looked at its role. Although existing studies have examined the overall value and grant-making agendas of conversion foundations, considerably less is known about whether these resources benefit specific agencies and populations (Sloan, Taylor, and Conover 2000; Williams and Brelvi 2000). Our interest was the degree to which foundations provide additional or compensatory community resources from the perspective of nonacute

TABLE 1
Characteristics of Case Study Sites

Case	Converting Institution	Local Context	Previous Community Role
A	A 280-bed community hospital in a nine-hospital market converted in 1995.	Medium-size city near a major metropolitan area. No conversion laws.	Existing linkages with health department, primary care, and behavioral health.
B	A 340-bed community hospital in an eight-hospital market converted in 1994. Resold to local nonprofit system in 1999.	Small city serving a mainly affluent user base in a large metropolitan area. No conversion laws.	Minimal linkages with AIDS case management agency and senior services.
C	A 420-bed teaching hospital in an 11-hospital market converted in 1996. Resold to another national for-profit system in 1999.	Large city outside a major metropolitan area. Conversion laws.	Existing linkage with mental health, home health, substance abuse coalition, AIDS, and social services.
D	A 370-bed community hospital in an 11-hospital market converted in 1996. Resold to another national for-profit system in 1997.	Large city not near a metropolitan area. Conversion laws.	Existing linkages with primary care, home health, behavioral health, and senior services.
E	A 260-bed nonprofit teaching hospital in a seven-hospital market converted in 1998.	Large metropolitan city. No conversion laws.	Minimal linkages with primary care and behavioral health.

care providers. In addition to our key informant interviews, we reviewed published and unpublished materials regarding our study hospitals and collected relevant reports from our local respondents during our site visits.

TABLE 2
Key Community and Hospital Respondents

Community Agencies	Converted Hospital Staff
Primary care (20)	Senior administrators (28)
Behavioral health (8)	Department heads/vice presidents (42)
Home care/health and seniors (7)	Clinical staff (28)
Aging network provider and administrators (11)	Board members (15)
Social services for special populations (11)	
Conversion foundations (7)	
Advocacy/planning (8)	
Total Respondents = 72	Total Respondents = 113

We conducted case studies between March 1998 and December 2001, completing all the initial site visits within three years of the ownership change. Approximately two years later, we made follow-up visits to each site to evaluate longer-term conversion effects. Although the turnover of staff in some of our study hospitals disrupted the continuity of information that we were able to collect from the hospital’s perspective, we observed remarkable stability in most of our community sites. In total, we interviewed 113 respondents representing five converted hospitals and 72 respondents representing 45 community agencies (see table 2). We conducted our study of “community effects” resulting from an ownership change in conjunction with a stakeholder analysis of the conversion’s “in-hospital” effects. The variety of respondents that we interviewed in and out of the hospital reflects the different data needs and resources of these two projects. The findings reported in this article draw from both sets of interviews, although the dominant perspective is that of our community respondents. In the case of our community contacts, we typically interviewed the executive directors of the agencies involved.

Two members of the research team conducted each interview. We transcribed our interview notes into word files and then imported them into NUDIST, a qualitative software program that we used to manage all our interview data, including content coding and analysis. We customized NUDIST for this project with a detailed coding structure to track and analyze the data by site, provider type, and specific conversion effects. The first author content-coded all the interviews, and then the two

remaining authors independently examined this work to minimize bias (Miles and Huberman 1984).

Our study shares the strengths and limitations of all studies that use a multiple-case study approach and nonrandom site selection. Our site visits yielded relatively detailed and contextual information about the impact of hospital conversions, but we do not know whether the case study sites are representative of all hospital conversions. Nor do we know the extent to which the changes we observed in our study sites are mirrored in nonconverting hospitals. But our goal for this project and this article was not to generalize to hospitals as a group but, rather, to develop a framework for analysis and to generate usable theory. By including in our study sample converting hospitals that have quite different characteristics, we tried to describe more accurately the variation in conversion effects on community providers (Patton 1980). Although we hope that our findings characterize the ways in which ownership change affects a hospital's relationships with community-based providers, a case study methodology does not ensure this. Instead, it is up to future researchers to determine the degree to which the model captures both the full range of interorganizational effects and the generalizability of these effects.

Findings

The degree to which an ownership change affected a hospital's preexisting relationships with its nonacute care providers varied both across and within our individual case study sites. In some community-based organizations, the conversion caused little or no change. More often than not, however, respondents reported that the conversion affected the hospital's collaborative as well as its competitive behavior toward other providers and organizations. We organized our findings according to the broad categories (and subcategories) of the outcomes we observed following the ownership change. Our broad categories of findings are as follows:

- Less collaboration: fewer resources flow to the community.
- More collaboration: community gains resources.
- More competition: adverse shifts in patient demand for services.
- No change: interorganizational linkage remains the same.

Table 3 summarizes our five case studies, describing the relevant contextual information (the presence of laws regulating conversions, the

TABLE 3
Summary of Case Study Findings

Site Context	A	B	C	D	E
State laws regulating conversions	No	No	Yes	Yes	No
Hospital's preexisting linkages	Extensive	Minimal	Extensive	Extensive	Minimal
Community involvement in sale process	Minimal	None	Active	Active	None
Conversion foundation	No	Yes	Yes	Yes	No
Subcategories of Outcomes					
Hospital provides less financial and in-kind support.	✓			✓	
Hospital is less involved in community efforts.	✓	✓	✓	✓	✓
Converted hospital provides additional resources.			✓	✓	
Conversion foundation provides additional resources.		✓	✓	✓	
Patient referral patterns change.	✓		✓	✓	
Hospital adopts policies limiting access.	✓	✓			
Interorganizational linkage does not change.	✓	✓		✓	✓

hospital's preexisting linkages with community-based organizations, the community's involvement in the sale process, and whether a foundation was formed). In addition, we indicate the specific subcategories of conversion effects that our community respondents reported in each case, with a check mark showing that at least one of our community respondents reported the effect. In the following discussion, we describe in more detail the categories of effects we observed, providing specific examples from our cases. In our conclusion, we synthesize our findings, identifying those themes that cut across sites and those factors that seemed to influence the conversion effects we observed.

Less Collaboration: Fewer Resources Flow to the Community

In all five of our cases, at least some of the respondents described the hospital's relationship with the nonacute care delivery system following the conversion as providing fewer resources. This was largely true because of one of two types of changes in the hospital: fewer material resources flowed from the hospital to specific local community organizations, or the hospital was a less active participant in communitywide planning efforts. Each of these changes affected the nonacute care delivery system in different ways.

Hospital Provides Less Financial and In-Kind Support. Before the conversion, four of our case study hospitals were described as providing varying degrees of financial assistance and in-kind support to specific organizations in their community. In two of these communities, some providers lost these resource contributions after the conversion. In one site, for example, the hospital no longer offered in-kind assistance to the local health department (case A). Before the conversion, the hospital had frequently provided equipment to the health department and had made available to the health department staff the hospital's professional seminars and training sessions. In another site, the hospital stopped funding the position of a translator at a health center (case D).

Hospital Is Less Involved in Community Efforts. Community respondents also told us whether our study hospitals had provided professional expertise and political legitimacy to communitywide health initiatives before the ownership change. Even though some hospitals were characterized as significantly more active than others, each was reported to play some sort of role in the community in this regard. Perhaps the most

pervasive impact we observed following the ownership change was the reduction or complete elimination of these resource contributions by the converting hospitals. Respondents in all five sites reported examples of this, and the losses were felt by a range of organizations, including advocacy and planning groups, social service and home health agencies, and primary care clinics.

For example, following the conversion, the hospital staff in one site no longer collaborated with the local health department in its annual health screenings and education campaigns (case A). In another site, the hospital staff stopped attending meetings and participating in subcommittees organized by a local elder services–planning agency, something they had routinely done before the conversion (case D). In still another site, statewide cutbacks in funding for behavioral health services prompted a communitywide effort to seek ways to minimize the effects. But the newly converted hospital did not participate (case E). In two other cases, some respondents indicated that hospital staff members were simply “less visible” in the community after the conversion (cases B and C).

A recurrent theme in these examples was the effect of staff turnover within the hospital. Staff reductions and turnover are documented outcomes of most hospital ownership changes (Cutler and Horwitz 2000; Manheim, Shortell, and McFall 1989; Mark 1999), and most of our case study hospitals exhibited this pattern. How staff turnover affected other providers in the community is less well understood. In four of our communities, the conversion resulted in a relatively large turnover of both senior and middle managers as well as those holding clinical positions. Community respondents in these sites complained that this staff turnover effectively severed preexisting linkages, made getting information from the hospital more difficult, and resulted in the absence of hospital staff at key community meetings.

More Collaboration: Community Gains Additional Resources

Although in all our cases, some respondents offered examples in which the conversion resulted in a loss of resources, in three of our cases, some respondents also reported instances in which the conversion provided an opportunity to leverage additional resources and initiate collaborative relationships where none had existed before (cases B, C, and D). According to some respondents, the resource gains were due to increased activity by the hospital itself. To others, the resource gains were a function of

the charitable foundation formed from the proceeds of the hospital sale. In these cases, public policy and active community involvement in the conversion process appeared to contribute to the value of these resource gains.

Converted Hospital Provides Additional Resources. In two of our sites, the respondents reported that the hospital ownership change was an opportunity for community groups to leverage additional resources directly from the hospital (cases C and D). In both cases, a health care coalition was established in response to the prospective sale of the hospital, in order to represent the community during the conversion process. In conjunction with the attorney general, the coalition members extracted commitments from the new owners to provide specific community benefits. In reflecting back on this process, some respondents saw the newly converted hospitals as more responsive to community needs than they had been under nonprofit ownership. Indeed, the new senior administrators were described as eager to demonstrate that the hospital would be a good corporate citizen.

For example, in one site, the hospital readily agreed to the community's request to expand the hours of operation of the hospital's outpatient clinic. The hospital also agreed to expand its translation services and work on issues relating to cultural competency, demands that seemed to fall on deaf ears at neighboring hospitals (case C). In another site, the final sales agreement committed the new owner to target more than \$100,000 a year for additional community benefits to be determined based on a process that involved community input and annual monitoring by an independent contractor (case D). This exceeded the preconversion contributions and marked a level of community involvement in hospital resource allocations that was not evident under the earlier nonprofit ownership. However, we should note that the contractual commitment had a time limit, expiring five years after the ownership change.

Conversion Foundation Provides Additional Resources. In three of our sites, the proceeds of the sale were used to establish a conversion foundation (cases B, C, and D). In one of these communities, the hospital under nonprofit ownership was described as having invested little in the community. In the remaining two sites, although the respondents characterized the hospital as relatively more active in the community, not all community respondents had benefited. In these cases, the newly formed foundation was a source of heretofore unavailable resources for a wide range of provider organizations, as other studies have observed (Collins, Gray, and Hadley 2001). But as with the resources gained from

the hospital, the relative value of these benefits from the foundation also appear to be connected to the level of community involvement in allocating resources.

For example, in one site, while the newly converted hospital stopped providing volunteers and health-screening services to a senior services agency, the conversion foundation more than compensated for this loss by giving grants to the agency to fund mental health services, child care, lunch programs, transportation, and wellness programs (case B). Moreover, the agency described the foundation as a better resource than the earlier, nonprofit hospital had been because it targeted “real” community needs, as opposed to hospital-linked services. However, according to other respondents, the new foundation board—described as “rich, white women”—did not represent the constituents it was intended to serve. Consequently, some of the organizations that served the poor, members of disadvantaged racial and ethnic groups, and other vulnerable populations viewed the foundation grants as unattainable.

In our other two cases, the foundation’s resource allocations were based on communitywide needs assessments and community input via community representatives on the foundation boards. In these sites, the value of the foundation had relatively more widespread approval. In one site, a home health agency and a Latino social service organization that had never received financial resources from the hospital before the conversion were among the recipients of the new foundation grant (case C). Finally, in another site, a struggling free care clinic that historically had relied on the hospital for a small operating subsidy and in-kind staffing assistance now also received a foundation grant (case D).

More Competition: Adverse Shifts in Patient Demand for Services

In four of our cases, some respondents reported that after the ownership conversion, the hospital adopted a more competitive stance in the local delivery system (cases A, B, C, and D). According to some respondents, this competitive posture was expressed by the hospital’s more aggressively pursuing insured populations or more systematically referring uninsured patient populations to community-based providers. To other respondents, hospitals behaved more competitively by limiting access to or closing services that tended to attract the uninsured and other costly patient populations.

Patient Referral Patterns Change. The competition for insured patients tended to rise with community providers who described their preconversion relationship with the hospital as both collaborative and competitive. These providers typically operated in a service area into which the hospital had expanded. Before the conversion, patient referrals ran in both directions, but the hospital and the community-based provider also competed for a certain subset of patients, mainly the insured. Following the ownership change, however, these types of providers were more likely to characterize their relationship with the hospital as increasingly competitive. This was true in three of our case study sites and applied to home health agencies and behavioral health facilities (cases A, C, and D).

For instance, in one community the newly converted hospital no longer allowed a home health agency to assign a nurse liaison to the hospital (case C). Instead, the new CEO offered to acquire the agency, telling the executive director that the agency could either accept the offer or be “driven out of business.” In the meantime, while the home health agency continued to receive the same number of referrals from the hospital, it reported that fewer of them were insured. At another site, a behavioral health facility described being approached by the hospital with a similar “sell or sink” proposition (case A). The hospital also assumed a more aggressive position regarding a long-standing “patient-dumping” issue between the two institutions. At yet a different site, another behavioral health agency reported that before the ownership change, it frequently received from the hospital especially complex case referrals, both uninsured and insured (case D). But after the ownership change, the hospital referred a different clinical mix to the facility (both complex and relatively straightforward cases), although most of the referrals now lacked insurance coverage.

Hospital Adopts Policies Limiting Access. Another sign of greater competition following the conversion was a hospital’s avoidance of costly patient populations. At two sites, providers that served the uninsured and other populations with especially complex and costly needs told us that access to inpatient services became more difficult after the hospital converted to for-profit status (cases A and C). The affected providers were a primary care clinic and an AIDS case management agency. The respondents indicated that the admission process at the hospital became more cumbersome after the ownership change and that the referring agencies were now required to demonstrate proof of payment before making a

referral. The respondents also indicated that the quality of discharge planning had declined dramatically following the ownership change, making the hospital a less suitable facility for especially complex cases.

In addition to establishing procedures that make access more difficult, hospitals can limit care to costly patient populations by eliminating services that tend to attract uninsured and underinsured cases. Indeed, earlier studies offer examples of this (Chollet and Kirk 1999; Collins, Gray, and Hadley 2001). In four of our case study communities, the hospital eliminated such services following the ownership change (cases A, B, C, and D). Affected services included HIV/AIDS, home health and home care, primary care, and behavioral health. For local community organizations whose clients used these services, these changes had a range of negative effects.

For example, in two sites, the newly converted hospitals closed outpatient primary care facilities that served mainly Medicaid patients (cases A and D). In one of these cases, the closure resulted in eliminating the community's sole source of free prescription drugs. In less extreme cases, a change in the hospital's service mix forced local organizations to form new alliances, thus shifting the demand for services. For example, in one site, the hospital closed its AIDS unit shortly after the conversion, which consequently severed the hospital's existing linkages with two AIDS case management agencies (case B). These agencies subsequently shifted their affiliations to another hospital in the community. In a final case, a community-based nonprofit agency assumed ownership of the hospital's mental health facility after the conversion (case C). Although the community considered the nonprofit to be a better agency than the hospital to provide these services, in this case as well as the others, these types of changes weakened the hospital's overall collaborative ties with local organizations serving vulnerable populations.

No Change: Interorganizational Linkage Remains the Same

In four of our cases, we spoke with some provider organizations that indicated their relationship with the hospital did not change following its conversion to for-profit status (cases A, B, D, and E). The types of organizations reporting this were a fairly representative cross section of our community respondents, including primary care and behavioral health providers, home health agencies, and advocacy and planning organizations. In general, these organizations attributed their "no change" status

to one of two factors. The majority of this group described their relationship with the hospital before its ownership change as nearly nonexistent. The main affiliations of these organizations were with other hospitals in the local community. For them, therefore, the ownership change was a nonevent. Another group's main affiliation was with the converting hospital, but more important, its main link to the hospital was via hospital staff whose positions did not turn over as a result of the new ownership.

Discussion

The utility of our interorganizational framework depended on the hospital's membership in a local network of care. Moreover, we focused on "community benefits," examining the network of care serving vulnerable populations. In cases in which the hospital participated only marginally in this network, the traditional measures of community benefits sufficiently captured the significance of conversions for local communities. Indeed, among our cases studies, the conversion of those hospitals that had few preexisting linkages with nonacute care providers serving vulnerable populations appeared somewhat less likely to affect the community compared with their more tightly linked counterparts (see table 3). More often than not, however, we had to expand our definition of community benefits to take into account not only the scope and intensity of hospital services provided but also the impact on community-based providers. Using this framework, we found that conversions affected communities and stakeholders differently. Three factors explain some of this variation: the degree of political organization within the community, the dispensation of the hospital's charitable resources, and the importance of shared mission.

The Political Context

The states and local communities we studied varied in the degree to which health policies and politics affected the conversion process. This variation, in turn, seemed to explain some of the differences we noted across sites with respect to if and how the conversion affected other providers. In a well-organized community that was suspicious of for-profit conversions, many community agency leaders found the for-profit hospital to be a better partner than the local nonprofit. It proved easier to mobilize community concerns about the behavior of the hospital as a for-profit than as a nonprofit, and in turn, the hospital leadership of the

for-profit was more receptive to the community's preferences. Hadley, Gray, and Collins (2001) reported a similar case. In contrast, community groups reported that nonprofit hospitals in general saw little reason to respond to their concerns: Quite the opposite, the nonprofits seemed to feel that their formal ownership status insulated them from criticism.

Hospital conversions could also drain resources from a community that was not politically active. In three of our case studies, the community had little or nothing to do with the sale of the hospital. In two of these cases, the proceeds of the sale were not used to establish a foundation but instead went to the previous owner of the hospital (in one case, a university medical school and, in another, an out-of-state nonprofit health system). Beyond the gain or loss of foundation resources, less organized and active communities may be missing opportunities to establish a relationship with a hospital when they may have had none before the ownership change.

The Role of Conversion Foundations

Foundations are by no means an adequate substitute for the collaborative efforts that hospitals undertake in their local communities, but they do seem to offer an opportunity to maintain or even exceed the level of financial resources that hospitals contribute to their communities. In one of our sites, the value of the foundation was reported in the media as woefully inadequate compensation to the community for the loss of nonprofit charitable assets resulting from the conversion. According to several of our community respondents, however, the foundation provided more community benefits—as well as benefits that were, in part, defined by the community—than did the previous nonprofit hospital, and so it was considered a gain, not a loss, resulting from the conversion.

At the same time, hospitals play certain roles in their local communities for which a foundation is not a substitute. Most important, the hospital, as a partner in community health care initiatives, provides both professional and hospital services. Four of our five case study hospital conversions were associated with relatively substantial and sustained organizational disruptions, as other conversion studies have documented as well (Cutler and Horwitz 2000; Manheim, Shortell, and McFall 1989; Mark 1999). Our study also found that these internal hospital changes might greatly affect other providers in the community. Linkages between the hospital and other provider organizations are lost when a key mid-level staff person no longer works at the hospital or has less

time to maintain collaborations with other providers. Senior administrators leave, and new ones are less receptive. If any of these changes substantially alter the amount of expertise the hospital contributes to the local delivery system or remove personal pathways to hospital services, it may have far-reaching effects, especially in smaller communities.

The Importance of Shared Mission

The greater cost pressures throughout the health care sector are motivating providers of all types to affiliate and integrate with one another. However, community-based providers, particularly those serving vulnerable populations, may perceive a for-profit hospital as an unlikely partner. We spoke to several community providers who acknowledged their inability to survive as stand-alone institutions as well as their reluctance (or refusal) to affiliate formally with a for-profit health system. Part of this reluctance seemed to stem from the practical concern that an affiliation with a for-profit institution might limit the provider's ability to secure grants. In other cases, their reluctance seemed to be based on more ideological concerns and the fear that such an alliance might compromise safety-net missions.

We also heard from community-based providers that our study hospitals were more competitive following the ownership change. Whereas the previous nonprofit may not have been an exceptional source of collaborative partnerships, the providers also generally described it as respecting the market niche of the community's nonacute care providers. In contrast, in several cases, the newly acquired hospital was quite explicit in its intent to directly compete with, as opposed to collaborate with, community-based nonprofits. It is possible that large, national health systems—*for-profit and nonprofit alike*—bring in new businesses, which in turn have more opportunities to compete with a broader cross section of nonacute care providers in the local community. Regardless of its tax status, if a newly acquired hospital's competitive behavior threatens the overall viability of essential community-based providers, the safety-net delivery system may indeed be hurt by changes in the hospital's ownership.

Conclusion

“Community benefits” is a sound foundation and touchstone for analyzing the impact of hospital conversions on a community. Conceptually

and practically, however, it is incomplete. Health care providers do not act in isolation but are part of a communitywide network of care. Hospitals are generally the largest component of a local care network and occupy a critical position. Changes in their behavior can thus affect the pattern of care in a community in two general ways: either by altering the scope and intensity of direct hospital services or by influencing community-based providers in the local network. Existing measures of community benefits measure the former but not the latter.

Once an interorganizational framework is accepted, the relationships among the components of the care network in which a hospital operates must be considered. Such relationships are interactive, with each party actively dispensing resources and pursuing its own strategies. One actor's effect on the system is not determinative but depends on the responses of others and the economic and political context. As we stated earlier, this greatly complicates the analysis. In one context, with one set of community providers, a conversion might lead to competitive practices and a decrease in cooperation that harmed safety-net providers. In a different circumstance, the benefits to a community might not be detected by traditional analysis.

Our findings produce two conclusions, one relating to policy and one to analytic frameworks. From a public policy point of view, our work suggests that the actions of community organizations and public policy can be critical to determining how changes in a hospital's ownership affect care for vulnerable populations. From an analytic perspective, our work underscores the need for future researchers to define and measure network characteristics, including the ways in which health care institutions interact, the stakeholders involved, and the types of resources that are exchanged. Given the growing complexity of local delivery systems, we believe this perspective is central to our understanding of the significance of health sector change for the providers and patient populations comprising a health care community.

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