# Capital Finance And Ownership Conversions In Health Care

A primer on the economics of for-profit and nonprofit conversions in the health care industry.

*by James C. Robinson*



**PROLOGUE:** The increasing presence of for-profit hospitals, nursing homes, and managed care organizations provoked expressions of concern in the health policy community during the 1980s. Since then turbulent change has continued to transform the American health care system, but Washington has taken no definitive steps to slow it down. One of the most visible activities has been the conversion of nonprofit health plans to for-profit status or the acquisition of nonprofit hospitals by for-profit hospital management companies. *Health Affairs* devoted a thematic issue to the subject of hospital and health plan conversions (Mar/Apr 1997), but, generally speaking, we receive very few manuscripts dealing with the business of health care.

In this paper James C. Robinson, a professor of health economics at the University of California, Berkeley, sets out the basics on the economics of for-profit and nonprofit conversions in the health care industry. As one of the few health economists who has sought to better understand the implications of the changing financial nature of American health care, Robinson has become a frequent contributor to *Health Affairs*. His work has been supported by the California HealthCare Foundation and the Robert Wood Johnson Foundation. An earlier version of this paper was presented at a Wall Street roundtable on business and health in March 1999 that was supported by the California HealthCare Foundation. Robinson recently authored a book entitled *The Corporate Practice of Medicine: Competition and Innovation in Health Care*, published by the Milbank Memorial Fund and the University of California Press.

**ABSTRACT:** This paper analyzes the for-profit transformation of health care, with emphasis on Internet start-ups, physician practice management firms, insurance plans, and hospitals at various stages in the industry life cycle. Venture capital, conglomerate diversification, publicly traded equity, convertible bonds, retained earnings, and taxable corporate debt come with forms of financial accountability that are distinct from those inherent in the capital sources available to nonprofit organizations. The pattern of for-profit conversions varies across health sectors, parallel with the relative advantages and disadvantages of for-profit and nonprofit capital sources in those sectors.

THE HEALTH CARE INDUSTRY RAISED CAPITAL historically from philanthropic donations, public grants, tax-subsidized operating surpluses, and investments from nonprofit organizations based in other industries. These sources now are in decline as philanthropists shift their giving to other sectors, the government backs away from grant programs, competition erodes operating surpluses, and even the largest nonprofit organizations face financial difficulties that limit their ability to invest in new products and markets. Nonprofit health care organizations are borrowing ever more heavily in the tax-exempt corporate bond markets, thereby generating insolvency fears, ratings downgrades, and credit rationing. The industry is continuing its search for alternative financial sources, which include venture capital, conglomerate diversification, public equity, convertible bonds, retained taxable earnings, and taxable corporate debt. Each of these comes with its own form of accountability to investors and creditors, and hence each offers distinct advantages and disadvantages in particular contexts. Differences in financial oversight influence organizational performance and thus constitute one—although certainly not the only—influence on conversions from nonprofit to for-profit ownership.[1]

This paper explores the role of capital markets in health care ownership conversions, highlighting the variety of financial instruments and mechanisms of oversight available to for-profit and nonprofit firms in emerging, growth, mature, and declining industries. I examine the divergent trends in the insurance and hospital sectors, where Blue Cross plans and other managed care organizations continue to convert to for-profit status while the hospital sector remains largely nonprofit. I also focus on ownership changes within the for-profit sector, as privately held biotechnology, Internet, and medical-device firms convert to investor ownership through initial public offerings (IPOs) and as publicly traded physician practice management (PPM) firms convert back to private, for-profit ownership through leveraged buyouts. The conclusion argues for active policy neutrality with respect to nonprofit conversions.

## The Life Cycle Of Capital Investment

Interest among firms for new investment depends on opportunities for future profitability, developing cautiously in emerging sectors where prospects are uncertain, accelerating in industries with high revenue growth, lessening in mature industries as sales level off, and evaporating as output falls and excess capacity comes to characterize a declining sector (Exhibit 1). New investment need not be funded through outside capital but may be financed by the firm's existing earnings stream. The supply of internal earnings is mismatched to the demand for investment funds, however, since profits are negative in emerging sectors in need of seed capital, remain modest in growth sectors where investment opportunities are most urgent, become significant in mature industries just when new investment tapers off, and diminish only slowly in declining industries that have falling sales but robust price/cost margins.[2] The demand for capital, which is the net effect of external investment opportunities and internal retained earnings, thus is highest in emerging industries, remains strong in growth sectors, but loses its significance in mature industries and becomes negative in declining sectors.



Emerging industries are financed predominately by direct private investment, organized either through venture capital firms or through start-up funds from corporations in related sectors (conglomerate diversification). They avoid the public stock and bond markets, which would demand excessive rates of return from the high-risk initiatives under consideration. As industries move from start-up to accelerated growth, however, leading firms consolidate

**EXHIBIT 1**
**Demand For And Supply Of Investment Capital Across The Industry Life Cycle**

| | Emerging industries | Growth industries | Mature industries | Declining industries |
|---|---|---|---|---|
| Investment opportunities<br>Retained earnings<br>Demand for external capital | Positive<br>Negative<br>Strong | Very strong<br>Positive<br>Strong | Positive<br>Strong<br>None | None<br>Positive<br>Negative |
| Finance: for-profit firms | Venture capital; conglomerate diversification | Initial offering; stock (IPO), convertible bonds | Earnings; secondary offering: stock, bonds | Earnings; asset-based debt; leveraged buyout |
| Finance: nonprofit organizations | Philanthropy; government grants; organizational diversification | Tax-exempt earnings | Tax-exempt earnings; tax-exempt bonds | Tax-exempt earnings; tax-exempt bonds |
| Health care industry sectors | Internet; specialty firms (for example, oncology) | Biotechnology; devices; home health; pharmacy benefit management | Insurance companies, HMOs; pharmaceutical manufacturers | Hospitals |

**SOURCE:** Author's analysis.
**NOTES:** IPO is initial public offering. HMO is health maintenance organization.

their competitors and present lower risks to outside investors, thereby gaining access to the public capital markets. This phase is characterized by IPOs of common stock and corporate debentures, often in the form of bonds convertible to stock at specified dates or trigger prices. Venture capitalists typically sell out during this phase, and some conglomerates spin off their subsidiaries. In some sectors and economies, however, close ownership and credit links continue between parent firms and their progeny.[3]

As industries evolve from growth to maturity, internally generated profits become an increasingly important source of investment capital, but secondary offerings of stocks and bonds continue to be made as investment opportunities present themselves. Mature industries tend to enter and exit the capital markets in a cyclical fashion, drawing on investment and credit during some periods and returning excess funds through dividends, stock repurchases, and bond retirements at others. Firms in declining industries face fewer investment opportunities but may enjoy significant profitability. They tend to be net contributors to, rather than users of, funds from the outside capital markets. They may redirect profits from declining to growth sectors through the establishment of subsidiaries funded by the corporate parent and buffered from direct oversight by the capital markets. To the extent that external finance is needed, asset-based debt often is the cheapest source, and firms may exit the stock market altogether via a leveraged buyout.



## Capital Finance In The Nonprofit Sector

Nonprofit economic sectors are subject to the same life cycle of emergence, growth, maturity, and decline as their for-profit siblings but face different sources of capital supply. They too need risk-tolerant financial partners during their infancy, see the opportunity for large returns on large investments during their adolescence, reach equilibrium with the external capital markets as maturity brings greater revenues but fewer opportunities, and may generate more income than they can usefully invest in their golden years. Nonprofit firms belong to the entire community rather than to any defined set of investors and cannot disburse excess revenues in proportion to capital contribution. This excludes them from access to risk-based equity from private investors such as venture capital funds, from the public stock markets, and from hybrid instruments such as convertible bonds. But nonprofit organizations can use retained earnings, nonconvertible debt, and investments from other nonprofit entities as capital in a manner analogous to that in the for-profit sector. They also enjoy several distinct sources. Philanthropic donations play a major role during some periods and in some industry sectors. Capi-

tal grants from local, state, and national governments have purchased bricks and mortar for many an eleemosynary institution. Retained earnings and bond offerings have been augmented by exemptions from taxes on property, income, and interest payments.

■ **Sources of finance.** Nonprofit start-ups are funded largely by grants and donations, as governmental agencies, philanthropists, and religious groups assume the role of venture capitalists, and by investments from nonprofit organizations that are based in mature or declining industries and enjoy free cash flows (for example, hospital-centered "integrated delivery systems") (Exhibit 1). Philanthropic donations and government grants often taper off as nonprofit organizations move into their growth phase, to be replaced by tax-subsidized earnings and, in some cases, by continued support from nonprofit parent organizations. As their markets mature, nonprofit organizations evince greater financial stability and thereby gain access to the tax-exempt bond markets as a major source of investment capital.[4] Tax-exempt earnings and debt remain the major capital sources for nonprofit organizations in declining industries, although they are in little demand unless the organization uses them to seed diversification efforts in emerging or growth sectors.



A comparison of the capital sources available to for-profit firms and nonprofit organizations draws attention to the comparative advantages and disadvantages of entities with different ownership structures in different sectors of the economy (Exhibit 1). Nonprofit organizations will populate emerging sectors to the extent that philanthropic or governmental grants are available, since these donors will supply capital without the repayment expectations imposed by venture capital firms, but will be disadvantaged to the extent that charitably minded financial partners are occupied elsewhere. Direct investment by nonprofit organizations remains a possibility but depends on the profitability of those charitable conglomerates in some other industry sector. Nonprofit organizations are at their greatest disadvantage in growing and mature industries, where access to risk-based equity can fuel rapid expansion by their for-profit competitors. Nonprofit organizations are likely to retain dominance of these sectors only if philanthropic and governmental grants continue, if tax exemptions for property and income are significant, or if for-profit firms are excluded by law or custom. The disadvantage suffered by nonprofit organizations with respect to capital finance diminishes as their industries decline, since profitable investment opportunities become rare and firms come to rely more heavily on the retained earnings and bonded debt where tax subsidies and exemptions are most significant.

## Corporate Governance Across Industry Life Cycle

Venture capital, conglomerate diversification, publicly traded equity, retained earnings, bonds, and hybrid financial instruments rely in different ways on market, organizational, and regulatory mechanisms to protect creditors and investors against the expropriation of their assets.[5] The varying mix of capital sources used in emerging, growth, mature, and declining industries thus entails changes in financial oversight, thereby creating or abating pressures for changes in ownership. The mix of nonprofit and for-profit firms across health care is strongly influenced by the position of particular sectors over the industry life cycle.

■ **Emerging sectors.** Firms in emerging industries are characterized by a high demand for outside capital but also by widespread uncertainty as to the true nature of their product and the management team's ability to implement its declared strategy. Market-oriented governance mechanisms, which rely on reputation, disclosure, and repeat purchase, offer only weak protections to start-up operations that have no track record, do not want to disclose their ideas to potential competitors, and may not survive long enough to enter the capital markets repeatedly. Venture capital firms serve as intermediaries, raising funds from institutional and individual investors and using them to purchase sizable ownership stakes and control authority in nascent sectors.[6] They demand board representation and a strong voice in selecting of senior management. Start-up funding though corporate diversification also relies on organizational rather than market form of financial oversight, with the conglomerate parent retaining partial or total ownership and control over its start-up progeny, which may be structured as a subsidiary or an independent entity. In either case, the original investment is protected by voice mechanisms such as board representation, selection of management, and internal auditing rights.[7]

■ **Growth sectors.** The transition from emergence to growth increases the volume of investment capital sought by particular firms but also reduces the risk and opens the path to new financial instruments. Growth firms have survived the Darwinian selection in emerging sectors; have consolidated erstwhile competitors; and can boast management, products, and strategies with at least some track record. Public capital markets will support initial offerings of equity and debentures, albeit with trepidation and consequent expectations of above-average returns.[8] Bond investors tend to prefer debentures convertible to stock over standard nonconvertible instruments, to share in the profit potential of growth-sector firms. The salient characteristic of growth industries, for present purposes, is

the substitution of market for organizational mechanisms of financial governance. Purchasers of publicly traded stocks and bonds protect themselves primarily by the ability to exit underperforming investments rather than by influencing management directly. Stockholders can vote for the board of directors and thereby indirectly select management, but shares often are distributed so widely as to prohibit effective coordination and exercise of voting rights.[9] Bondholders exert no control over directors and managers during the normal course of business. The greatest protection for public investors is the need for firms in growth industries to come back to the capital markets for new funds, which guarantees that management will be very concerned with its stock price and bond rating.

Some growth sectors fail to sustain themselves after their initial public offerings. Venture capital firms and the public equity markets made major investments in PPM firms, for example, with large private investments followed by IPOs of stocks and convertible bonds. The dismal performance of this sector has led PPM firms to revert from investor ownership to private, for-profit ownership through various forms of leveraged buyouts.[10]



■ **Mature sectors.** Firms in mature industries need less outside capital than do their growth-oriented counterparts, since investment opportunities are leveling off while internally generated investment funds are accumulating. New initiatives are financed by secondary stock or bond offerings and some contribution of internal assets. Firms come into rough equilibrium with the capital markets, issuing new stock at one moment and repurchasing it at another, investing excess earnings in new projects at one time and disgorging them as dividends in another, floating new bonds and then paying them down, and continually using one capital source to reduce reliance on the others. Their mix of debt and equity subjects for-profit firms in mature industries to a mix of market and organizational mechanisms of governance. Shareholders can exit or seek voice influence through block holding and proxy contests.[11] Bondholders can exit, litigate to ensure continued debt servicing, or seek voice if the firm encounters difficulties and requires refinancing. Repeated reliance on the external capital markets subjects mature firms to continual oversight by investment analysts from banks, brokerages, mutual funds, bond-rating firms, accounting firms, and newsletters that collectively burnish or tarnish financial reputations.

■ **Declining sectors.** Firms in declining industries have limited demand for external capital, since profitable investment opportunities are drying up at the same time that internally generated profits are peaking because of concentrated market structures or established brand names. In these contexts, publicly traded corporations

should disgorge excess earnings through dividend payments to shareholders. The frequently used alternative, however, is for firms in declining sectors to redirect free cash flows into emerging or growth sectors.[12] To the extent that conglomerates can use the same technological, intellectual, or brand-name assets across multiple sectors, this diversification can be highly profitable. However, to the extent that diversification occurs into unrelated products or geographic markets, economies of scope are unlikely to be achieved.[13] This independence lessens the effectiveness of market forms of financial oversight and expands the potential for expropriation of outside investors. Excessive diversification may reduce value for shareholders but favor management by increasing the overall scale of the firm and thereby enhancing salaries, perquisites, and career security.[14] A shift from equity to debt financing mitigates this form of agency failure since firms must service interest payments on their bonds. To the extent that firms in declining sectors have built up substantial physical equipment and facilities, asset-based external financing can be obtained at attractive rates. Creditors are protected from expropriation by the value of the underlying assets, which can be seized, in cases of management failure, to service the debt.

As firms in declining industries shift to retained earnings and asset-based debt, the financial structures of for-profit and nonprofit entities begin to converge. Bond-rating agencies maintain close oversight of leverage and cash flow in both forms of organization. There is less capital market incentive for nonprofits to convert to investor ownership. The tendency of nonprofit firms to hoard cash rather than paying out dividends to shareholders makes them particularly creditworthy in the eyes of bond-rating agencies, whose sole objective is to evaluate the potential for default. In the hospital sector, for example, bond ratings for nonprofit hospitals have tended to outshine those of the investor-owned chains because of excess cash reserves rather than superior operating performance.[15]



## Trends In Nonprofit Health Care Conversions

It is hazardous to predict ownership trends in the highly volatile and politicized health care industry. Policy fluctuations can be expected in the near term, as concerns for charity care stiffen opposition to for-profit ownership while the potential for new charitable foundations encourages conversions. The foregoing financial analysis does suggest some tendencies, however, that can be the basis for predictions if the existing ownership configuration is not simply set in regulatory stone. Most importantly, trends in ownership conversion will vary across sectors of health care.

■ **Emerging sectors.** It is unlikely that the current rise of ven-

*"To the extent that payment cutbacks reduce the growth potential of emerging sectors, venture capital firms will exit."*

ture capital as the primary financial instrument in emerging sectors will be displaced by a reversion to philanthropy and government grants. Philanthropists and governments will focus their giving on sectors where beneficiary payment is not to be expected and will eschew start-up financing for commercial nonprofit organizations.[16] Venture capital represents a financial innovation of the first order, has proved its mettle in the Internet and biotechnology industries, and is likely to retain a lasting role in health care services as well. To the extent that payment cutbacks from Medicare, Medicaid, and private insurers reduce the growth potential of emerging sectors, private investors and venture capital firms will exit. Retrenchment has occurred recently across the services sector, although not in the pharmaceutical and medical devices sectors, because of concerns over managed care and the Balanced Budget Act (BBA) of 1997. The most obvious emerging sector now is health care information technology and Internet applications, financed by venture capital and now in transition to its growth period through IPOs.[17]



■ **Growth sectors.** Growing industries such as biotechnology, medical devices, pharmacy benefit management (PBM) firms, long-term care, home health, and ambulatory surgery are ripe candidates for for-profit dominance, given the advantages of public equity and convertible debt compared with retained earnings and nonconvertible bonds. This transition could be stalled or reversed if public and private insurance entities crush growth opportunities and if nonprofit hospital conglomerates are willing and able to function as internal capital markets. Investor-owned home health and long-term care firms have taken a beating in the capital markets and undergone extensive consolidation; their future remains to be determined by Medicare payment policies.[18] The PBM sector has enjoyed phenomenal growth combined with roller-coaster earnings and stock prices and has gained an ever more prominent profile as drugs account for an increasing share of insurance coverage and costs.[19] The difficulties experienced by investor-owned firms in these sectors are not unusual for inherently volatile growth industries, and nonprofit organizations do not appear to be positioned to expand their presence. Bond-rating firms express great skepticism concerning the sustainability of conglomerate diversification by nonprofit integrated delivery systems, given their poor financial track records in physician, insurance, home health, and subacute care sectors.[20]

■ **Mature sectors.** Health insurance is changing from a growth to a mature industry and is likely to continue expanding in for-profit market share. Within the for-profit sector, the conversion from private ownership to publicly traded share holding is nearly complete, and investor-owned firms are consolidating through mergers and acquisitions.[21] Nonprofit health plans continue to convert to investor ownership, often with intermediary positions such as conversion to mutual or privately held for-profit status. Blue Cross and Blue Shield firms continue to consolidate across state lines, and many seek conversion to mutual status or completely to for-profit investor ownership. Statutory prohibitions, litigation, and regulatory barriers have slowed but not stopped the trend.[22] Many of the smaller nonprofit health maintenance organizations (HMOs), typically sponsored by hospital systems, are being closed or sold to investor-owned insurers, while large nonprofit plans such as Kaiser Permanente, HIP, and Harvard Pilgrim are retreating to core markets. The capital market advantage of investor over nonprofit ownership is modest in mature industries compared with emerging and growth sectors, suggesting a sustained ownership mix in regions where nonprofit health plans are well established.

■ **Declining sectors.** The inpatient acute care industry is evolving from maturity to decline as changes in technology, epidemiology, and economics shift care to subacute, ambulatory, and home settings. Many nonprofit hospital systems have created subsidiaries in these sectors and also have acquired physician practices and launched HMOs. They have fared poorly in their diversification efforts, and many now are retrenching. But established market shares, brand names, and tax subsidies should protect nonprofit organizations in the hospital sector and may even lead to growth in their share of industry bed capacity. The for-profit growth era of the 1970s is long gone, and Wall Street has learned how difficult it is to acquire even the most poorly performing nonprofit facility. The burst of acquisitions and joint ventures of the early 1990s seems to have abated. There are no capital-market advantages to for-profit conversion, and the literature has not documented any major advantages in operating efficiency.[23] Investor-owned chains such as Columbia/HCA and Tenet are exiting local markets where they have only a weak presence, often selling their facilities to local nonprofit chains. They may continue to retreat from the industry, shifting their capital and managerial resources to growth sectors, or they may sustain their overall share by entering local markets where entire networks of hospital facilities can be acquired in one gulp.[24]

## The Market For Corporate Control

Emerging and growth sectors in health care are already dominated by for-profit firms and hence are not the locus of ownership conversions, which are occurring primarily in mature and declining sectors such as insurance and hospitals. Experiences of comparable sectors within the nonhealth economy may offer insights for health care conversions. As railroads, tobacco, and steel passed into maturity and decline, their financial needs changed and their inherited ownership structures came under pressure. Many enterprises suffered deteriorating performance and became objects for competition in what is known as the market for corporate control, as erstwhile rivals in similar or related industries, leveraged buyout specialists, and incumbent management fought for the right to own the assets and control the destiny of the firm.[25] Competition in the market for corporate control is prey to its own set of imperfections but supplements competition in the product market as a spur to economic performance and innovation. It is particularly important in declining industries where oligopolistic concentration limits product market competition and the paucity of indigenous investment opportunities limits managerial dependence on the external capital markets.



■ **Leveraged buyouts.** The leveraged buyout is one strategy used by outside investors to wrest control of for-profit firms from insider management and thereby open the path to improved financial and operating performance. Changes in financial structure need not be hostile, however, and leveraged buyouts sometimes are initiated by incumbent managers in cooperation with institutional investors. Large volumes of debt capital are deployed to buy out a firm's publicly traded stock, typically at a premium above the shares' market price, and convert the firm to private for-profit ownership. Some of the debt is paid down through asset sales, but the acquired firm remains heavily leveraged and therefore is constrained to pay out free cash flows to bondholders rather than squandering them on conglomerate diversification or other forms of agency failure. The firm is controlled by a self-perpetuating board of directors, not subject to election or recall by shareholders but monitored by bond-rating agencies and bond investors. The for-profit firm subject to a leveraged buyout comes to adopt a financial and governance structure similar to that of the nonprofit organization, in which nonelected, self-perpetuating directors wield authority under the watchful eyes of their tax-exempt bondholders. Some firms remain privately held and debt financed; others are restructured and eventually returned to shareholder ownership through a new public stock offering.[26] This subsequent reversion to investor ownership is

analogous to the for-profit conversion of a nonprofit organization in the changes in financial structure (debt to equity) and governance (self-perpetuating to shareholder controlled) that it entails.

■ **Ownership conversions.** The policy guidance offered by the market for corporate control is that no single form of ownership is optimal at all times but, on the contrary, that changes in technology, consumer demand, and other factors will undermine the performance of one structure and increase the gains potentially achievable through a conversion to another. The optimal ownership structure cannot be predicted but must be ascertained on the basis of how much different sets of owners are willing to pay to own and control the assets at stake. Large firms in the for-profit sector are continually subject to implicit if not explicit bidding for control rights, as venture capitalists, leveraged buyout organizations, major creditors, large shareholders, incumbent executives, and others compete for control. Firms undergo changes in ownership only if outsiders value control more than insiders do, presumably due to the changes in strategy and performance they anticipate, and hence outbid them.

The process of ownership conversions in health care should be conceptualized as the workings of an incipient market for corporate control in the nonprofit sector. The heated public debate over methods of valuation and control over assets for nonprofit firms resembles the functioning of the corporate control market, which is characterized by complex bidding, grandstanding, overpromising, and doomsday prophesying. Most conversions are initiated by nonprofit trustees and hence resemble friendly leveraged buyouts. But in some cases, such as the Allegheny Health, Education, and Research Foundation (AHERF) hospital system in Pennsylvania and the Blue Cross insurance plan in Colorado, bidding wars break out, and conversions take on some of the features of hostile corporate takeovers. The policy process seems to be groping toward an acceptable methodology for analyzing potential conversions, estimating asset values, monetizing and transferring assets to a new charitable foundation, and structuring the mission and governance of the new foundation.[27] Just as leveraged buyouts often succeed in unlocking underperforming corporate assets and transferring them to new firms, managers, and sectors, health care ownership conversions hold out the possibility for unlocking community assets and making them available to finance new socially beneficial initiatives. This asset transfer also can be accomplished through the diversification by nonprofit firms from mature into emerging sectors. This diversification is likely to be more successful in activities closely related to the parent organization's core competencies.

Ownership conversion in the corporate and nonprofit sectors

inevitably produces instances of fraud and inurement, which provide grist for the mill of public skepticism and retention of the status quo. Some early health care conversions permitted the enrichment of nonprofit executives, but oversight mechanisms are improving, and recent conversions have endowed several very large charitable foundations.[28] Protections for community interests are required during nonprofit conversions, just as protections for shareholders are required during leveraged buyouts. But comprehensive prohibitions impose social costs through the insulation of incumbent managers and forced retention of nonprofit assets in declining industries.

■ **Direction for public policy.** The analogy to the market for corporate control suggests that public policy should neither encourage nor discourage ownership conversions in health care but, rather, establish an efficient and accountable process through which possible conversions are evaluated and actual conversions are managed. Ownership conversions should occur if and only if the social benefits of for-profit ownership exceed the social costs. Nonprofit organizations are valuable mechanisms to facilitate the pursuit of eleemosynary initiatives without direct expansion of the public sector. The economic assets available to nonprofit organizations are limited, however, and should be directed to sectors where the greatest benefits are to be obtained. Some nonprofit health plans are funding innovative initiatives in disease management, information systems, and other sectors related to their core activities.[29] Diversification by established nonprofit organizations is not the only means for accomplishing these ends, however, and the conversion to investor ownership and endowment of a new charitable foundation should be given fair consideration. Nonprofit organizations in mature and declining industries could be challenged, or challenge themselves, to embrace innovation as part of their central mission or else convert to investor ownership and allow their assets to be deployed to innovative activities by a new charitable foundation. Structured bidding for nonprofit organizations by interested corporate entities raises the value of the assets to which the charitable foundation will be entitled, and should be encouraged.[30] Nonprofit organizations should be held accountable not merely for the value of their tax exemption, which can be compared to the value of their annual charitable activities, but for the manner in which they deploy their assets, which belong to the community and not to the incumbent trustees and managers.[31]

THE ORGANIZATIONAL BOUNDARIES between the public, nonprofit, and for-profit sectors exert an important influence on the performance of the economy. Familiarity with inherited boundaries inevitably fosters inertia and skepticism concerning change. It seems natural that most hospitals and Blue Cross plans are nonprofit, while most physician practices and pharmaceutical manufacturers are for-profit. But the status quo need not be taken for granted, much less frozen in place by deliberate policy, and should be subject to periodic reevaluation. States could pursue active policy neutrality as a middle course between the extremes of laissez-faire and prohibition. Changes in technology, epidemiology, product market competition, and financial market oversight influence the socially optimal mix of organizational forms. Conversions from nonprofit to for-profit status are only one instance of this continual flux.[32] Transitions are difficult, and mistakes inevitably are made, sometimes leading to reversals and reconversions. All in all, however, the market dynamics and policy debate over ownership conversions represent a socially beneficial process of experimentation and innovation in the financing and governance of health care.

*An earlier version of this paper was presented at a policy roundtable on Capital Markets and Accountability, cosponsored by the California HealthCare Foundation and* Health Affairs *and held in New York City in March 1999.*



## NOTES

1. See B.H. Gray, "Conversion of HMOs and Hospitals: What's At Stake?" *Health Affairs* (Mar/Apr 1997): 29–47.
2. If declining industries do not consolidate and reduce excess capacity and have not established brand names, patents, or other barriers to market entry, they can face vigorous price competition that eliminates free cash flow and internal capital generation. Conglomerate diversification into new sectors by firms based in declining manufacturing and energy industries during the 1960s and 1970s is consistent with theories of oligopoly power and free cash flows, while their subsequent refocusing is evidence of an intensification of competition and erosion of free cash flows due to deregulation and globalization.
3. These continued ties are particularly strong in nations such as Japan, Korea, and Germany with large diversified conglomerates and "relationship banking" ties among the financial, industrial, and commercial sectors. M. Aoki, "Toward an Economic Model of the Japanese Firm," *Journal of Economic Literature* 28 (1990): 1–27; D.E. Weinstein and Y. Yafeh, "On the Costs of a Bank-Centered Financial System: Evidence from the Main Bank Relations in Japan," *Journal of Finance* 53, no. 2 (1998): 635–672; M.L. Gerlach, *Alliance Capitalism: The Social Organization of Japanese Business* (Berkeley, Calif.: University of California Press, 1992); A.D. Chandler, *Scale and Scope: The Dynamics of Industrial Capitalism* (Cambridge, Mass.: Harvard University Press, 1990); and M.J. Roe, "Some Differences in Corporate Structure in Germany, Japan, and the United States," *Yale Law Journal* 102 (1993): 1927–2003.
4. D.R. Cohodes and B.M. Kinkead, *Hospital Capital Formation in the 1980s* (Balti-

more: Johns Hopkins University Press, 1984).
5. See A. Schleifer and R.W. Vishny, "A Survey of Corporate Governance," *Journal of Finance* 52, no. 2 (1997): 737–783.
6. See B. Zider, "How Venture Capital Works," *Harvard Business Review* (November–December 1998): 131–139.
7. O.E. Williamson, "The Modern Corporation: Origins, Evolution, Attributes," *Journal of Economic Literature* 19 (1981): 1537–1568; J.C. Stein, "Internal Capital Markets and the Competition for Corporate Resources," *Journal of Finance* 52, no. 1 (1997): 111–133; W. Lamont, "Cash Flow and Investment: Evidence from Internal Capital Markets," *Journal of Finance* 52, no. 1 (1997): 83–109; and H. Shin and R.M. Stulz, "Are Internal Capital Markets Efficient?" *Quarterly Journal of Economics* 113, no. 2 (1998): 531–552.
8. See G.B. Shields and G.C. McKann, "Raising Health Care Capital through the Public Equity Markets," *Topics in Health Care Finance* 19, no. 1 (1991): 21–36.
9. The degree of effective control wielded by shareholders depends on the underlying statutory framework. R. La Porta et al., "Law and Finance," *Journal of Political Economy* 106, no. 6 (1998): 1113–1155; R. La Porta et al., "Legal Determinants of External Finance," *Journal of Finance* 52, no. 3 (1997): 1131–1150; and M. Roe, *Strong Managers, Weak Owners: The Political Roots of American Corporate Finance* (Princeton, N.J.: Princeton University Press, 1994).
10. Some practice management entities, such as MedCath and TeamHealth, have been taken private with support of large institutional investors. MedPartners and FPA have sold their medical groups to investors (including physicians) funded by bank loans and bonded debt. Pieces of MedPartners and PhyCor have been purchased by nonprofit hospitals using tax-exempt bonds.
11. P. Bolton and E. Von Thadden, "Blocks, Liquidity, and Corporate Control," *Journal of Finance* 53, no. 1 (1998): 1–25; J.E. Bethel, J.P. Liebenskind, and T. Opler, "Block Share Purchases and Corporate Performance," *Journal of Finance* 53, no. 2 (1998): 605–634; E. Maug, "Large Shareholders as Monitors: Is There a Tradeoff between Liquidity and Control?" *Journal of Finance* 53, no. 1 (1998): 65–98; and F.H. Easterbrook and D.R. Rischel, "Voting in Corporate Law," *Journal of Law and Economics* 26 (1983): 395–427.
12. M.C. Jensen, "Agency Costs of Free Cash Flows, Corporate Finance, and Takeovers," *American Economic Review* 76 (1986): 323–329.
13. D.J. Teece et al., "Understanding Corporate Coherence: Theory and Evidence," *Journal of Economic Behavior and Organization* 23 (1994): 1–30; and C.A. Montgomery, "Corporate Diversification," *Journal of Economic Perspectives* 8, no. 3 (1994): 163–178.
14. W. Baumol, *Business Behavior, Value, and Growth* (New York: MacMillan, 1959); O.E. Williamson, *The Economics of Discretionary Behavior: Managerial Objectives in a Theory of the Firm* (Englewood Cliffs, N.J.: Prentice Hall, 1964); and R. Marris, *The Economic Theory of Managerial Capitalism* (Glencoe, Ill.: Free Press, 1964).
15. D. Lee, "Rating Methodology: For-Profit Hospitals versus Not-for-Profit Hospitals—Explaining the Gap" (New York: Moody's Investors Service, May 1999).
16. Theodore Marmor and colleagues implicitly make this point. T.R. Marmor, M. Schlesinger, and R.W. Smithey, *Nonprofit Organization in Health Care: The Nonprofit Sector*, ed. W.W. Powell (New Haven, Conn.: Yale University Press, 1987).
17. A.B. Frisch, P.C. Hester, and B. Makcle, *An Overview of the Emerging Healthcare Online (HOL) Opportunity* (New York: Warburg Dillon Read, 20 July 1999).
18. Cain Brothers, *Home Health Care Hits a Brick Wall: Strategies in Capital Finance*, vol. 25 (New York: Cain Brothers, Fall 1998); and G. Harris and J.L. Lorenz, *Homecare Industry Update* (New York: Warburg Dillon Read, 10 June 1999).
19. A.T. Feinstein, L.C. Marsh, and J.R. Raskin, *Health Care Supply Management Distribution Outsourcing Guidebook* (New York: Lehman Brothers, 26 May 1999); and

S.J. Valiquette, *The Pharmaceutical Benefit Management Sector* (New York: Warburg Dillon Read, 8 July 1999).
20. F. Federbusch, *Not-for-Profit Health Care Sector: 1999 Outlook and Medians* (New York: Moody's Investors Service, Municipal Credit Research, September 1999).
21. J.C. Robinson, "The Future of Managed Care Organization," *Health Affairs* (Mar/Apr 1999): 7–24; G.E. Harris and M.J. Ripperger, *Managed Care Industry* (New York: Warburg Dillon Read, 22 June 1999); and C. Boorady and N. Pyle, *Managed Care Overview: Technology and Consumerism Increase Scale Advantage* (New York: Goldman Sachs Investment Research, 10 June 1999).
22. D. Sherlock, *Blues: Market, Financial, and Operating Statistics for Blue Cross and Blue Shield Affiliates* (Gwynedd, Pa.: Sherlock Company, July 1999).
23. B.H. Gray, *For-Profit Enterprise in Health Care* (Washington: National Academy Press, 1986); and F.A. Sloan, "Property Rights in the Hospital Industry," in *Health Care in America: The Political Economy of Hospitals and Health Insurance*, ed. H.E. Frech and R. Zeckhauser (San Francisco: Pacific Research Institute for Public Policy, 1988), 103–141.
24. See, for example, M.J. Coye, "The Sale of Good Samaritan: A View from the Trenches," *Health Affairs* (Mar/Apr 1997): 102–107; and S. Massey, "Anatomy of a Bankruptcy: The Rise and Fall of Allegheny General Hospital," *Pittsburgh Post Gazette* (Reprint), 17–23 January 1999.
25. M.C. Jensen and R.S. Ruback, "The Market for Corporate Control: The Scientific Evidence," *Journal of Financial Economics* 11 (1983): 5–50; M.C. Jensen, "Active Investors, LBOs, and the Privatization of Bankruptcy," *Journal of Applied Corporate Finance* 2, no. 1 (1989): 35–44; M.D.J. Denis, D.E. Denis, and A. Sarin, "Agency Problems, Equity Ownership, and Corporate Diversification," *Journal of Finance* 52, no. 1 (1997): 135–160; and S.N. Kaplan and M.S. Weisbach, "The Success of Acquisitions: Evidence from Divestures," *Journal of Finance* 47, no. 1 (1992): 107–138.
26. S.N. Kaplan, "The Staying Power of Leveraged Buyouts," *Journal of Financial Economics* 29 (1991): 287–313.
27. D. Shriber, "State Experience in Regulating a Changing Health Care System," *Health Affairs* (Mar/Apr 1997): 48–68; and N.M. Kane, "Some Guidelines for Managing Charitable Assets from Conversions," *Health Affairs* (Mar/Apr 1997): 229–237. The March/April 1997 issue of *Health Affairs* includes case studies of conversion policy making in a variety of states.
28. D.M. Fox and P. Isenberg, "Anticipating the Magic Moment: The Public Interest in Health Plan Conversions in California," *Health Affairs* (Spring 1996): 202–209; E. Hamburger, J. Finberg, and L. Alcantar, "The Pot of Gold: Monitoring Health Care Conversions Can Yield Billions of Dollars for Health Care," *Clearinghouse Review* 29, no. 5 (1995): 473–504; and "Conversion Foundations: A Listing," *Health Affairs* (Mar/Apr 1997): 238–242.
29. P.M. Nudelman and L.M. Andrews, "The Value Added of Not-for-Profit Health Plans," *New England Journal of Medicine* 334 (1996): 1057–1059; and D. Lawrence, "Why We Want to Remain a Nonprofit Health Care Organization," *Health Affairs* (Mar/Apr 1997): 118–120.
30. D. Sherlock, "New Strategy for Assuring Fair Market Value in Health Plan Conversions," *Pulse: Analysis* (Gwynedd, Pa.: Sherlock Company, May 1999).
31. R.G. Frank and D.S. Salkever, "Nonprofit Organization in the Health Sector," *Journal of Economic Perspectives* 8, no. 4 (1994): 129–144.
32. H. Hansmann, *The Ownership of Enterprise* (Cambridge, Mass.: Harvard University Press, 1996); and J. Needleman , D.J. Chollet , and J. Lamphere, "Hospital Conversion Trends," *Health Affairs* (Mar/Apr 1997): 187–195.

w