PRIVATIZATION & CORPORATE GOVERNANCE:

MINING SYNERGY FROM CONFLICT ACROSS SECTORS

A CASE STUDY

by

Ronald I. Sibert

A dissertation submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Urban Affairs and Public Policy

Fall 2005

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ABSTRACT

This research employed a case study approach to examine privatization, governance, regulation and organizational behavior in the context of a public hospital facility's reorganization to a nonprofit entity. The case study was completed at Tampa General Hospital (TGH) in Tampa, Florida. The study's findings indicate that many factors influence privatization's execution and effectiveness, including the political, social, legal and regulatory environments in which it takes place, as well as organizational governance, accountabilities and leadership.

The research methods utilized for this study were exclusively qualitative. Interviews were conducted primarily with expert respondents who were involved in the hospital's reorganization at the governance level, such as physicians and attorneys who served as board trustees pre- and post-privatization, and government officials. In addition, the investigation was supported by extensive research of topical literature on privatization and governance, relevant scholarly discourse, and more than 20 years of news media coverage of case-related events and occurrences.

The study also examined the hospital's privatization and governance in the broader contexts of the evolving U.S. health care industry and government health care policy—not from the customary public policy viewpoint but from the far less frequently explored perspective of the private service provider operating in a competitive marketplace. The study's findings suggest that the impact of privatization on a service provider is dependent on the degree of post-privatization government

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policy and/or regulatory influence, the skill of the organization's leadership, the compatibility of its governance and business policy structures with prevailing public policy, and the extent to which the organization remains dependent on public funds for solvency.

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PREFACE

The decision to research the topic of privatization evolved from my related interest in the influence of public policy on business conduct. A cursory review of the topic revealed the growing prevalence of privatization and suggested that while a good deal of research effort has been invested in understanding the dynamics of private sector delivery of public services, its pervasiveness and potential application across various types of public services suggests that there was still room for discussion about its general applicability and the optimal conditions for execution. Studying privatization in this context also represents an opportunity to contribute substantively to the body of knowledge about a phenomenon that is increasingly affecting the quality of people's lives worldwide, but about which there is still a good deal of uncertainty and, in some cases, controversy.

The impact of privatization on advanced and even emerging economies has been significant. Also, at a time when corporate scandals are occurring with increasing frequency, and all sectors are being pressured to take steps to obviate and/or control such occurrences, corporate governance and ethical business conduct have taken center stage as well. My initial exposure to corporate culture occurred as an administrative director of a physician liaison unit at a durable medical equipment, diagnostic service and home health care company. My unit was responsible for assisting doctors and their patients with identifying home health care options and equipment that would ameliorate symptoms of chronic and intractable medical conditions. Once the appropriate equipment and/or diagnostic services were identified and prescribed, the firm would provide them and bill insurance carriers, both public and private. The value of this experience in the context of this dissertation is that the

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selection and prescription processes themselves raised questions about the appropriate role of the firm vis a vis the patient-physician relationship as well as how the business model would fare relative to the prevailing standards of ethical business conduct in the health care arena. To the discerning eye, the business model itself might have been an interesting study in organizational behavior in the context of social service delivery—both in terms of the powerful role of business in health care, and the importance of ethical conduct on the part of individuals and the organizations they serve.

All of this was occurring in the mid-1980s, a time of rapid and significant change in the health care services industry. A number of disability-related social and legislative developments were changing the commercial and health care landscapes in interesting ways. The Americans with Disabilities Act sensitized the nation, and eventually the world, to the plight of individuals with disabilities, but the disabled community and disability advocates were becoming increasingly distraught with the difficulty people experienced in accessing legislatively mandated health care and rehabilitative services. Attempts to access and finance adequate interventions exposed a tremendously fragmented network of services fraught with service gaps and duplication. These experiences also highlighted troublesome aspects of the health care fee-for-service and third party payer systems such as policy and procedural barriers resulting in limited access to medically necessary products and services. In response, the federal government instituted a number of remedial research and technical assistance-related initiatives overseen by the National Institute of Disability and Rehabilitation Research (NIDRR) of the U.S. Department of Education. One of these provided substantial funding for a broad range of technical assistance projects in each state authorized under the *Technology-Related Assistance for Individuals with*

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Disabilities Act of 1988 (P.L. 100-407). Through the efforts of Dr. Beth Mineo Mollica, the University of Delaware's Center for Applied Science and Engineering became the State's designated federal grant recipient for what would be called the Delaware Assistive Technology Initiative (DATI). I joined the project in 1993 to conduct finance and systems change-related research aimed at improving access to assistive technologies. In the meantime, to facilitate that research, I pursued graduate-level studies in finance and earned an M.B.A. degree. These efforts culminated in the publication of two editions of the *Guide to Funding Resources for Assistive Technology in Delaware.*

Sometime later, I accepted an offer to serve as director of admissions and later program director of the M.B.A. program from which I had earned my degree. The decision was somewhat motivated by my appreciation of the impact of business on the world economy. The program's functions of selecting, training and influencing the business leaders of tomorrow were appealing as opportunities to increase the supply of talented and ethical business leaders in the marketplace. Facilitating their entry into business careers for which they would be ideally suited increased the likelihood not only of their individual success, but also that of their collective contribution to sustainable economic growth and quality of life.

In the wake of corporate scandals such as Enron and World Com, the business school at which I was an administrator, the Lerner College of Business & Economics at the University of Delaware, established the Weinberg Center for Corporate Governance. The person selected to head that center, Charles Elson, J.D., is a well-known and influential authority in the corporate governance arena and was the person with whom I initially consulted about my interest in researching how business

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is affected by public policy and law. As we explored the potential utility of such research, we agreed that it was an important area for exploration, and he suggested the topic of privatization as a useful point of departure. Subsequent preliminary research confirmed the importance of privatization and its growing prevalence, but also suggested that the literature contained little that specifically reflected or addressed certain important private sector perspectives on this phenomenon. It also seemed plausible that filling this conceptual gap could inform business strategies and relationships across sectors. Further exploration of salient cases and their characteristics yielded much useful information, but one case in particular, that of Tampa General Hospital (TGH), stood out as conceptually dense, information rich, and politically sensitive. The underlying rationale for choosing the case study approach for this research as well as the utility of selecting this particular case will be discussed in further detail in the Research Methods chapter of this paper.

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INTRODUCTION

Privatization, the shifting of government responsibilities from government to the private or nonprofit sector, has become increasingly important in the world and in the U.S., where most privatization involves contracting.

The privatization literature typically focuses on the perspective of the public sector in terms of, for example, the extent to which privatization may be applied to facilitate the delivery of services for which a public entity is ultimately responsible, and its impact on that entity and/or the (public) services provided. The two notable exceptions to this are a) the assumptions of privatization advocates that competition leads to profit-making organizations increasing their innovation and efficiency and b) the tenets of principal-agent theory, which details the ways that agents can fulfill their goals. But even the latter focuses more on governmental principals and objectives than the issues encountered by nonpublic agents when they attempt to reconcile private business practices with public accountability.

To explore and begin to develop an understanding of privatization from the perspective of the nonpublic organization, I selected a case in the industry where there is greatest governmental expenditure (health care), that involved a decision for a service provider to switch sectors (from public to nonpublic/nonprofit), and where there was reasonably good access to high level information despite the controversial nature of the case. This approach provides a view of privatization from the service provider's side, but also about motivations for a public service provider to seek private

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or nonprofit sector status. The central questions being considered from this perspective are:

- What, if any, are the issues that a private sector entity should consider when contemplating a decision to provide privatized public services?
- How, if at all, do public and private perspectives differ within the context of privatization, and how might the differing perspectives of public and private sector entities affect the privatization decision? …the execution of a privatization arrangement? …its effectiveness?
- How, if at all, are governance and operating conditions (e.g., finance and accounting, human resources, logistics, etc.) within the service provider organization affected by the terms and/or external accountabilities associated with privatization?
- What are some of the important determinants of a privatized service provider's business success or failure (e.g., competitive positioning, extent of visibility to competitors of tactical and/or strategic information, political support, and public [i.e., voter] support, and government financial support)?

These questions raise several additional related questions, many of which are addressed in the case study and others that could serve as foundations for future research. Nonetheless, the above questions begin to address issues that would be of direct and fundamental concern to private entities that are contemplating or are engaged in public service delivery under government oversight—a very different focus from the decidedly public perspective of most of the privatization-related discourse to date.

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Chapter 1

The Nature and Importance of Privatization

Chapter Overview

Privatization, because of its various forms and applications, has been defined in a number of ways and may in fact be viewed from a number of perspectives as well. This study, for example, examines privatization from the perspectives of regulation and governance. This chapter provides a broad look at privatization, some of its salient features, its various types and their general prevalence. Then, because privatization deals essentially with the public sector's cooptation of the other sectors to facilitate delivery of public services, and those sectors typically operate within different paradigms, the chapter examines certain resulting differences in perspective and their respective impacts on organizational relationships. Contractual privatization is given specific treatment in that respect because, from a practical standpoint, it allows a reasonably straightforward examination of similarities and differences in the characteristic operating assumptions of the public and private sectors. Privatization's prevalence in the United States is in many ways a testimony to the credence North American society places in free market enterprise and its associated assumptions related to the nature of competition in the marketplace. However, the contracting out of government services in a free-market economy does not necessarily abide by these assumptions. The chapter's discussion of contractual privatization in the context of competitive markets addresses that fact and some of its implications.

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The nature of the issues, challenges and opportunities presented by privatization also are determined in large part by the nature of the service(s) being provided, the industry segment or organizations involved, and the context(s) of implementation. For example, the issues raised by privatization of municipal services such as trash collection or road repair are often very different from those encountered in social service delivery. In addition, the economic, and political or public policy contexts in which privatization occurs significantly affects its implementation and what can be learned from it. Therefore a substantial portion of the chapter is devoted to a discussion of privatization from those perspectives as well. Along similar lines, since the privatization case being examined in this dissertation occurs in the health care industry, a portion of the chapter covers several important elements of that industry and their associated organizational behaviors as they relate to privatization. Examples of those elements include unique aspects of health care delivery as a business in a free market environment, government responsibility for and involvement in health care provision, and the challenges these and their reconciliation present to privatization.

Privatization Defined

Privatization[1] has, in the past several years, become widely accepted as a cost-effective strategy for government to affect, facilitate or divest delivery of a variety of public (e.g., tax-supported) services. Findings suggest not only a growing trend, but also that, to date, research related to the types of privatization in which

[1] "**Privatization,** in its broadest sense, is the transfer of assets or services from the tax-supported public sector to the markets of the private sector**."** [Excerpt from *The Privatization Revolution* – adapted from remarks by Lawrence W. Reed., President, Makinac Center for Public Policy, for The Future of American Business, a Shavano Institute for National Leadership Seminar, Indianapolis, Indiana, May 21, 1997]. See also Appendix I.

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government maintains regulatory or contractual involvement has been focused almost exclusively on how it has affected the public sector entities involved. Much of the literature on the subject of privatization addresses the virtues and evils of privatization relative to public sector service provision, and the discussions generally are couched in terms of how privatization compares with public sector service delivery along dimensions such as efficacy, public satisfaction, efficiency, cost-effectiveness and how it affects the government entity (see, for example, Savas, 2000). That is, discourse and research on privatization generally proceeds from the perspective of government and its effects on public administration. There has been little systematic examination of whether or to what extent a public sector entity's regulation[2] of the private firm's execution of contracted services in a privatization agreement affects organizational behavior and/or corporate governance.[3] The purpose of this paper is to begin to address this gap in the current discourse.

Privatization exists in a number of forms. E.S. Savas (2000) identifies three general types, each of which can in turn be executed in a number of ways:

- Delegation, of which contracting, franchises, grants and vouchers are forms;
- Divestment or transfer of ownership, which includes asset sale, free transfer, liquidation and perhaps reorganization; and
- Displacement, more passive relative to the other types, is simply withdrawal of government involvement in provision of a good or service that was previously provided. (Savas, 2000, pp. 125-138)

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[2] **Regulation** is meant to include any component of a privatization agreement that a public agency utilizes to control or to dictate the way a private firm conducts the business specified in that agreement.

[3] **Corporate Governance** is meant to include the governing body of a corporation (e.g., boards of directors) as well as the decisions of that governing body as they relate to the ways in which the firm conducts business—and presumes that its primary responsibility is to the firm's shareholders and their wealth.

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Focus of Privatization Research to Date

Global-scale systematic research on the relationship between governance and privatization has been focused overwhelmingly on divestiture—particularly the type involving the sale of government assets to the private sector, which is a preferred form of privatization in developing and transition economies. It has been observed and studied frequently because of the unique insights it provides about such economies. It appears to have generated such interest among researchers because of the dynamic, almost embryonic nature of the economic and social settings in which this approach has been so often observed. The appeal of privatization for developing countries is its promise of enhanced economic performance (Dixon & Kouzmin, 2001). For the researcher, such cases represent a unique opportunity to observe privatization's institutional and/or socio-economic impacts as they evolve from elemental to complex. Since in these instances the transfer of public enterprises to private ownership generally involves complete replacement of government structure and ownership with those that are privately owned and operated, it affords researchers the opportunity to observe privatization under conditions that might be described as privatization economics laboratories—complete with pre- and post-treatment performance comparisons. It is not surprising then that divestiture has attracted so much attention in the academic community. A relatively recent survey of international studies on privatization shows a proliferation of research covering several of the most prevalent approaches to divestment privatization, such as direct sale of government assets, share issue and modified voucher. However, the intent here is to examine privatization in relation to corporate governance—the mechanisms for which are practically nonexistent both in developing economies and in some that are in transition as well (Hessel, 1995; see also Shleifer & Vishny, 1997). While a more detailed

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analysis of privatization in developing economies is beyond the scope of this particular study, some of the general findings nonetheless warrant mention. For instance, to-date research suggests that government organizations that have undergone complete privatization by divestment, i.e., the sale of government-owned entities (GOEs) or state-owned entities (SOEs) to private ownership often perform better than their government-managed predecessors (Megginson, 2000). Performance in these cases was measured in terms of efficiency, profitability, and investment growth. Other studies have looked at performance in terms of revenue generation and enterprise growth as evidenced by increases in capital investment, dividends and even total employment (Megginson, 2000; Savas, 2000). These studies provide a reasonably straightforward means of comparing pre- and post-privatization performance; and the findings generally support privatization.

On the other hand, Auger and Raffel (2003) suggest that it is difficult to discern the effectiveness of privatization given the scarcity of formal/systematic research and the questionable validity of performance-related data reported in the literature to date—too much of which they say has been journalistic and/or reported by those who implemented the action. Instances of under- or over-reporting of data, reactive measurement, observer and non-response biases, and data misrepresentation (cheating) are not uncommon under such circumstances and, when present, seriously undermine the validity of performance measures (Poister, 2003). Other researchers and methodologists also have argued convincingly that pre-post research design applications in social science research are vulnerable to validity threats, primarily due to the possibility of outcomes (post-treatment effects) being explained by other factors than those hypothesized (Trochim & Land, 1982). Nonetheless, current research on privatization continues to contribute to a fairly prevalent perception of its

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effectiveness—at least by its supporters, and especially among those that also are government officials. Whether substantiated or illusionary, this positive perception appears to be gaining momentum—enough in fact to sustain, over the past several decades, a worldwide trend of privatization experiments or outright adoption at nearly all levels of government, from municipal to national.

Contracting, a form of delegation, is the most common form of privatization in the U.S. (Savas, 2001; Auger & Raffel, 2003), and has dominated the literature on the subject for more than a decade. Contracting has received a good deal of attention in scholarly discourse and has become a relatively popular government strategy for public service delivery because it represents, at least in the minds of advocates, a more efficient and economic means of public service delivery than traditional governmental approaches. From a practical standpoint, however, the challenge of formulating mutually agreeable contractual terms can be quite formidable—particularly when business objectives or central mission of the service provider are in conflict with those of the public agency. This can be the case, for example, when services that traditionally have been provided by government as entitlements are then assigned to private sector entities that are unaccustomed to public sector oversight, accountability or regulation.

As Table 1.1 reflects, there are fundamental differences between the foci and accountabilities of public and private sector entities.[4] In the private sector, firms compete effectively by positioning themselves to strategic advantage over their competitors. Doing so most often presumes (and generally requires) that firms'

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[4] While it is true that for-profit and nonprofit organizations belong to their own reasonably distinct sectors, the term private sector should be taken to include both types of organizations in the context of this discussion unless otherwise specified. That is, in this discussion of privatization, it is assumed that privatization refers to the shifting of government responsibilities to the non-public sector, which may involve private or non-profit entities.

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Table 1.1 – Characteristics of Public vs. Private & Nonprofit Entities

	Public Entity	For-Profit Entity	Nonprofit Entity
Treatment of Organizational Information	Operation is subject to public scrutiny	Operation generally is proprietary	Operation may or may not be open to public scrutiny
Accountability	Organization is accountable primarily to the public, i.e., the government, service recipients, the media (under public information statutes), etc.	Organization is accountable primarily to shareholders and secondarily to stakeholders and customers.	Organization is accountable primarily to its mission, its membership, its donors, and other stakeholders.
Performance Measurement	Conformity to standards and meeting public obligations, e.g., indigent care at designated hospital facilities	Profitability (increasing value of shareholder investments); optimal supply/demand balance; customer satisfaction.	Performance defined by mission and expectations of stakeholders.
Investment Spending	Spending and investment increases with political support, the needs of service recipients, and the agency's cost of meeting service standards.	Spending or investment decisions are based on the potential of an endeavor to generate revenues and/or profits.	Spending dedicated to mission-related activities; revenues are reinvested in the firm's activities and/or to maintain the viability of the organization.

strategic planning and operating decisions are privileged information, i.e., such that competing firms are not privy to each other's plans or resources. Public agencies, on the other hand, generally are required by policy or law to operate under clear public scrutiny. So what happens when public meets private in the provision of public services? Given the differences in the ways the public and private sectors operate and in the rules governing how they function, some degree of conflict might be expected.

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It is within this context that this study explores how public regulation operates in the privatization process and how it affects the privatized entity's behavior.

The factors that may motivate or contribute to the decision to undertake a privatization arrangement also are important considerations. It will be argued here that this decision is not always the exclusive province of the government entity that is ultimately responsible for insuring that public services are commonly accessible at acceptable levels of quality. In order for privatization to work effectively, the private sector participant in the arrangement must have the capacity and the willingness to devote the necessary resources to the public service enterprise—in which case the firm has to make informed business decisions about the feasibility of engaging in public service provision. In some instances, the decision to privatize may be a governance-related decision that is, in effect, an internal process of a single organization. Such is the case when a public entity elects to restructure itself as a private or nonprofit enterprise.

Public-to-private reorganization—the approach to privatization taken in the forthcoming case study, is less common than others but is interesting in terms of its regulatory and/or governance-related and tactical implications. It also is similar to contractual privatization from an accountability standpoint. Consider, for example, the fairly commonplace scenario in which two or more parties negotiate mutually agreeable terms of an agreement to which the principals mutually commit. Such arrangements are central tenets in the world of contracting and, like government regulation or charters of incorporation in the context of reorganization; the agreements define the rules of business conduct and generally are legally enforceable. In each circumstance, once the involved parties have committed or are otherwise compelled to comply with the defined terms, the parties are held accountable with respect to those

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terms. Another aspect that the reorganization being examined in this study shares with contractual privatization is the notion of leveraging the private sector's treatment of operating information as proprietary to protect the firm's strategic or tactical intent from competing entities that otherwise would use that information to gain a competitive advantage. To the extent that an entity elects to reorganize strictly for that purpose, the decision is a tactical one. Competition, as will be discussed shortly, is (or should be) a critical issue in any discussion of privatization.

Regardless of the type of privatization represented in the literature, however, it is nearly always treated as a tool for public agencies to provide public services. It should not be surprising then that the predominant focus of relevant literature to date has been privatization's efficacy from the perspective of the public agencies that are ultimately responsible for service delivery. A review of recent literature surveys on the topic of privatization suggests that, apart from organizations' pre- and post-privatization performance, competitive behavior and discussions aimed at resolving the principal-agent issues (to be discussed later), treatment of the private service provider's perspective in the research has been somewhat limited, i.e., in terms of understanding how nonpublic firms can reconcile their business or proprietary perspectives with public regulation or accountability (Bourbeau, 2004; Megginson, 2000).

The marginal representation of the nonpublic perspective in this regard certainly is understandable given that government, in its ultimate accountability to the tax-paying public for service provision, is vested in seeking information and supporting research that can help refine its efforts. Also, when one considers the urgency of correcting problems with public service provision as they arise, that many public sector entities retain primary responsibility for public services they have

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privatized, it would be foolhardy for a public agency to attempt to apply privatization remedies before understanding how they work and the circumstances under which their use would be most beneficial. From that perspective, it is not surprising that the academic community's efforts have been more focused on helping public entities discern the effectiveness of private vs. public sector service delivery in ways that might effectively guide public policy decision-making vis a vis privatization than on informing private sector business practices in that regard. Instead, the responses of nonpublic service providers to the prospect of privatization have been assumed and were limited mostly to behaviors that would be predicted for proprietary organizations operating in a competitive marketplace. The typical responses include, for example, innovation and operating efficiency for the sake of competing more effectively—with the marketplace, in the context of privatization, being conceptually retooled to contemplate government agencies as the primary customer. As will become evident in the following section that explores how certain characteristics of this retooled marketplace modify the assumptions of the standard market model, this typical view of the private sector's response to privatization is somewhat oversimplified. The internal organizational issues of the private service provider, such as the possible effects of privatization on the firm's business decisions, behavior and performance, its style of governance, and how these interact to impact business viability, should be important considerations for nonpublic organizations considering the possibility of conducting business under a privatization model. It is similarly important for them to understand the applicable contexts and/or conditions surrounding the privatization decision, such as the challenges, opportunities and/or constraints associated with operating in what may be a substantially modified competitive landscape and possibly restrictive public policy or regulatory environments as well.

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One exception to the public sector focus of the discourse in this regard is that which deals with resolving the principal-agent problem, which will be discussed further in the forthcoming section. It has been somewhat informative to private service providers with respect to helping them manage the principle-agent problem by helping them refine their approaches to agency. Nonetheless, the focus is arguably still on the effectiveness of the conformity of the private service provider to public policy (Kettl, 1993; Sclar, 2001; see also Osborne & Gaebler, 1992).

Competition under Contract vs. the Standard Market Model

Privatization proponents argue that the private sector is able to provide goods and services more efficiently and at lower cost than government because competitive forces in the marketplace furnish the necessary discipline to effectively maintain those conditions. That is, in order to win and maintain a sufficient share of the market to remain viable, businesses are compelled to offer products and services of superior quality at fair-to-bargain prices relative to those of their competitors. Therefore, to the extent that privatized public services are to be delivered in a competitive environment, competition and its associated dynamics are critical considerations for the private providers of those services.

Pro-privatization ideology characterizes the private sector as fleet and competitive while the government or public sector is seen as bureaucratic, burdened by red tape, slow and monopolistic. Competition, which is at once the primary operating principle within free market economies and the source of the discipline that controls costs and prices in the marketplace, is thought to provide all the incentives necessary for suppliers of goods and services to provide them at the desired levels of quality and price. It is presumed within this paradigm that if a supplier fails to provide

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a good or service of sufficient quality and at a price acceptable to consumers, those consumers will turn to other suppliers that are willing and able to do so. In this way the discipline of the marketplace represented in the standard market model eventually would cause an underperforming supplier to be replaced by others. Such is the way of opportunistic competition. Of course, this picture comes with a number of assumptions, several of which are flawed. Notable among those related to contracted public services are the assumptions of efficient flow of information, the consistent and sustainable availability of a competitive field of qualified vendors, that of minimal barriers to market entry, and the absence of political and social influences (Savas, 2000; Sclar, 2001).

One of several crucial challenges government is known to face in contracting out social services (and other public services in fact) is the "principal-agent" problem (Kettl, 1993; Sclar, 2001). That is, government (the principal) generally is tasked with insuring that it gets what it pays for from the contractor (the agent). Effective monitoring and oversight seems the obvious solution, but lofty transaction and monitoring costs can in fact cancel the expected economic advantages of privatization. In addition, services that warrant government contracting are often highly specialized, e.g., those for which there are unique specifications or policy restrictions like national defense or space exploration. Regulatory or policy standards imposed by government can create significant barriers to market entry or discourage potential bidders, thereby severely limiting the number of qualified prospective contractors that could (or would be willing to) provide legitimate bids for public contracts. Therefore government, the buyer, often must work in close partnership with its suppliers in such instances to insure delivery of the desired products or services within tolerance of agreed upon standards. Privatization in this context also may

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sometimes require government to artificially stimulate competition by subsidizing or otherwise assisting prospective contractors (e.g. by deliberately engaging in inefficient purchasing behaviors) in order to maintain a sufficient number of potential contractors to plausibly simulate competitive conditions in the marketplace (Kettl, 1993). Boeing Corporation's $1 billion loss of Federal rocket contracts in recent years to its (sole) rival Lockheed Martin, Inc., illustrates these points very nicely.

When it was learned that Boeing management had gained improper access to proprietary documents from its rival, Lockheed Martin, and had used the pricing information they contained in structuring its bids to the Federal Government, Boeing was punished with the loss of a number of lucrative defense contracts (Pasztor & Squeo, 2003; Boeing, 2003). Note in this case that the Air Force was the sole purchaser in a two-seller market. In order to retain a somewhat competitive environment, Boeing's presence was needed to avert a Lockheed monopoly. So, as opposed to barring Boeing from the bidding process altogether, the U.S. Defense Department only suspended Boeing's ability to bid on certain government contracts, which effectively reduced the number of awards to the firm. With the availability of so few providers of such specialized services in the marketplace, the Department of Defense was forced to exercise leniency in response to Boeing's transgression to maintain the department's ability to solicit competitive bids. This is an example of how government may sometimes employ artificial means to protect and/or simulate competitive conditions to maintain a sufficiently viable number of supplier options to avoid a monopolistic privatization arrangement. A similar outcome can occur when a government agency is unable to identify and/or induce contract bids from a suitable selection of competing firms, which severely compromises the government agency's bargaining position in selecting vendors and in negotiating favorable contractual

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terms, as was demonstrated in the Boeing/Lockheed scandal. Of course, such arrangements may also then become that much more vulnerable to principal-agent problems upon execution of the contracts to the extent that the principal is forced to abdicate control of the negotiations to prospective agents.

However, ideal competitive conditions do not necessarily guarantee smooth sailing either. Even when adequate mutually agreeable terms and conditions exist for the execution of a privatization contract, public sector-style oversight provisions and/or regulation may not be compatible with conventional business conduct, which can pose formidable challenges on either side of the contract. And the contracting process itself is not necessarily squeaky-clean and free of manipulation either. Oversight functions and related accountability measures can become cumbersome and difficult for a government agency to manage. If extensive, they can easily become cost prohibitive and sufficiently onerous to a business operation to discourage firms' participation—which, as indicated earlier, is anathema to maintaining a functional competitive landscape. It is not surprising then that cumbersome and costly contract and accountability provisions that have hampered contractors' performance and discouraged bidding are gradually giving way to innovations in contract design, e.g., performance-based contracting, share in savings contracts, legislation that reduces rigid government oversight provisions for its subcontractors, etc. (Denhardt, 2003; Martin, 2003). While in-depth descriptions of these innovations is beyond the scope of the current discussion, suffice it to say that they generally incorporate business-like financial incentives for providing (or penalties for failing to provide) the quantity and quality of services prescribed in their associated contractual agreements. However, from a conventional business

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perspective, unless economies of scale[5] or similar efficiencies can be achieved in product or service delivery, the competing objectives of quantity at low cost and high quality can eventually discourage providers from participation or, if withdrawal is not feasible, leave them with less desirable alternatives. On the other hand, as suggested earlier, the contracting process itself is not without its own challenges.

Conducting business in a free market economy provides access to a broader spectrum of opportunity for financial gain, deal-making and perhaps collusion than typically would occur in purely public sector transactions. Privatization opponents often site the prospect of malfeasance on the part of private sector profit-seeking firms as a significant risk to public agencies that may be considering privatization and as a contraindication for privatized public services (Savas, 2000; Sclar, 2001). However, such behavior is not necessarily confined to the private sector or to the private sector side of a privatization contract. Witness the recent case involving a former Air Force lieutenant general, Darleen A. Druyun, who happened to be the Pentagon's chief procurement officer during the 2003 Boeing scandal mentioned above. Druyun, in an unrelated case, admitted to giving favorable consideration to Boeing contracts in exchange for a lucrative vice president position at Boeing for herself (which reportedly included a $250,000 annual salary – approximately double her Air Force salary – and a $50,000 signing bonus), while protecting positions within the company for her daughter and son-in-law. Ironically, the lieutenant's admission of guilt and conviction came just before Boeing's bidding suspension from the Lockheed corporate espionage incident was about to be lifted (2004 autumn). It was not clear at the time of Druyun's conviction whether Boeing's

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[5] Economies of scale are achieved, for instance, when a product or service can be produced in high quantity at significantly lower per-unit cost to the producer than it would cost that producer to generate it in smaller quantities.

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suspension would be extended beyond the expiration date. It was reasonably clear, however, that Boeing would be subject to closer government scrutiny in any case. (Markon & Merle, 2004).

Perhaps because of its vulnerability to corruption or because the profit motive has pejorative connotations with respect to service delivery, privatization is sometimes met with a great deal of public resistance. The term public resistance is meant here to include resistance not only from the public at large but also from government (primarily state and local), from the media, and/or from private business concerns. Assuming that ethical and responsible conduct in business in general and in privatization specifically achieves desirable outcomes that insure public support, then what other conditions or approaches might be required to promote or increase the likelihood of these favorable outcomes? Savas (2000) argues that public confidence in privatization programs might be established under such conditions as informational and operational transparency with strong laws, enforcement and external monitoring to minimize corruption. However, without prudent and circumspect application of such policies, their implementation may also create barriers to entry to privatization and/or to the conduct of business under a privatized structure. Transparency is clearly a necessary component of accountability, but is there a point at which it can become obtrusive or counterproductive? Political accountability, such as what Dicke & Ott (1999) describe as that which is tied to public service demand, opinion, and/or satisfaction, may be a notable source of similar concerns.

Health Care: A Unique Challenge to Privatization

Health care represents an interesting framework within which to examine privatization in the United States. It is the largest single industry in the nation—and

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government pays a sizable proportion of the bill—seemingly independent of other social welfare-related spending. For instance, even during the period spanning the late 1970s through the 1980s when government spending on social welfare programs saw a 31% decrease, federal spending on health care continued to rise, growing by 61% between 1977 and 1989 (Salamon, 1999). In 1996, the combined health expenditures of federal, state and local government represented 46.7 percent of the total national health care spending, i.e., $483.2 billion of $1,035.1 billion (Patel & Rushefski, 1999). According to the Centers for Medicare and Medicaid Services, health care accounted for 37.3% of total (federal, state and local) government expenditures in the year 2000—equivalent to 13.2% of the U.S. Gross Domestic Product[6] (*Health Care Financing Review*, 2002). In addition, the health care industry was the largest single employer of all the industries monitored by the Department of Labor as of 1997; its growth outpacing overall employment in the economy and total population growth rates during that period (Kronenfeld, 1997b).

Health care also provides an interesting framework within which to examine how government regulation in privatization arrangements affects corporate behavior and governance. Savas (2000) argues convincingly that privatization's effectiveness depends not only on the nature of business practices and the markets in which goods and services are consumed, but also on the nature of the goods and/or services themselves. Some categories of goods or services can pose particular problems in developing and/or executing privatization contracts. (Savas, 2000; Kettl, 1993; Sclar, 2000). For example, Savas (2000) categorizes goods on continuums according to how they may be distributed and consumed (i.e., from goods used by

[6] Gross Domestic Product is defined as the Gross National Product less income from foreign investments.

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individuals to the exclusion of others to goods that are available for collective consumption). Figure 1.1 is a simplified excerpted version of Savas' Cartesian-type scatter plot that provides a two-dimensional graphical representation of this continuum that maps products by their place within the plane. According to the classification scheme articulated by Savas (2000), goods generally fall within four (4) major categories, which may be paraphrased as follows:

1. individual goods —those that an individual consumer may purchase for personal use and derive exclusive benefit and which the marketplace readily provides;
2. toll goods, which are jointly consumed by virtue of their simultaneous availability to large numbers individuals who pay individually for what they use, e.g., cable television;
3. common pool goods, which do not require payment and are available to everyone regardless of their ability to pay, so there is no incentive for a supplier to provide it; and
4. collective goods are those that are used simultaneously by many people and no one can be excluded from their use or consumption. Therefore there is no incentive for the market to provide them.

Note, however, that medical care is a bit of an enigma in this framework because it is comprised of a highly complex network of interrelated individual services in a competitive market where all sectors (public, private and nonprofit) are active participants. To some extent, medical or health care services pose a challenge Savas' classification scheme because, depending on the type of treatment and the circumstances under which a service is rendered, it can be considered either a collective good (from which persons other than primary recipients may benefit, e.g.,

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epidemiological treatment) or an individual good (Savas, 2000). Nonetheless, health care, when viewed as an individual good that is privately provided—and under circumstances in which that good also may be deemed an entitlement, provides an interesting backdrop against which to examine some of the complexities of social service privatization. Stakeholders are many, their interests are not necessarily aligned, and competition is imperfect. To make matters more interesting, the American regulatory environment as it relates to private businesses is unique among the capitalist governments of the world in its propensity for conflict. Fesler and Kettl (1996), in arguing this point, utilize a quote from David Vogel that underscores this concept:

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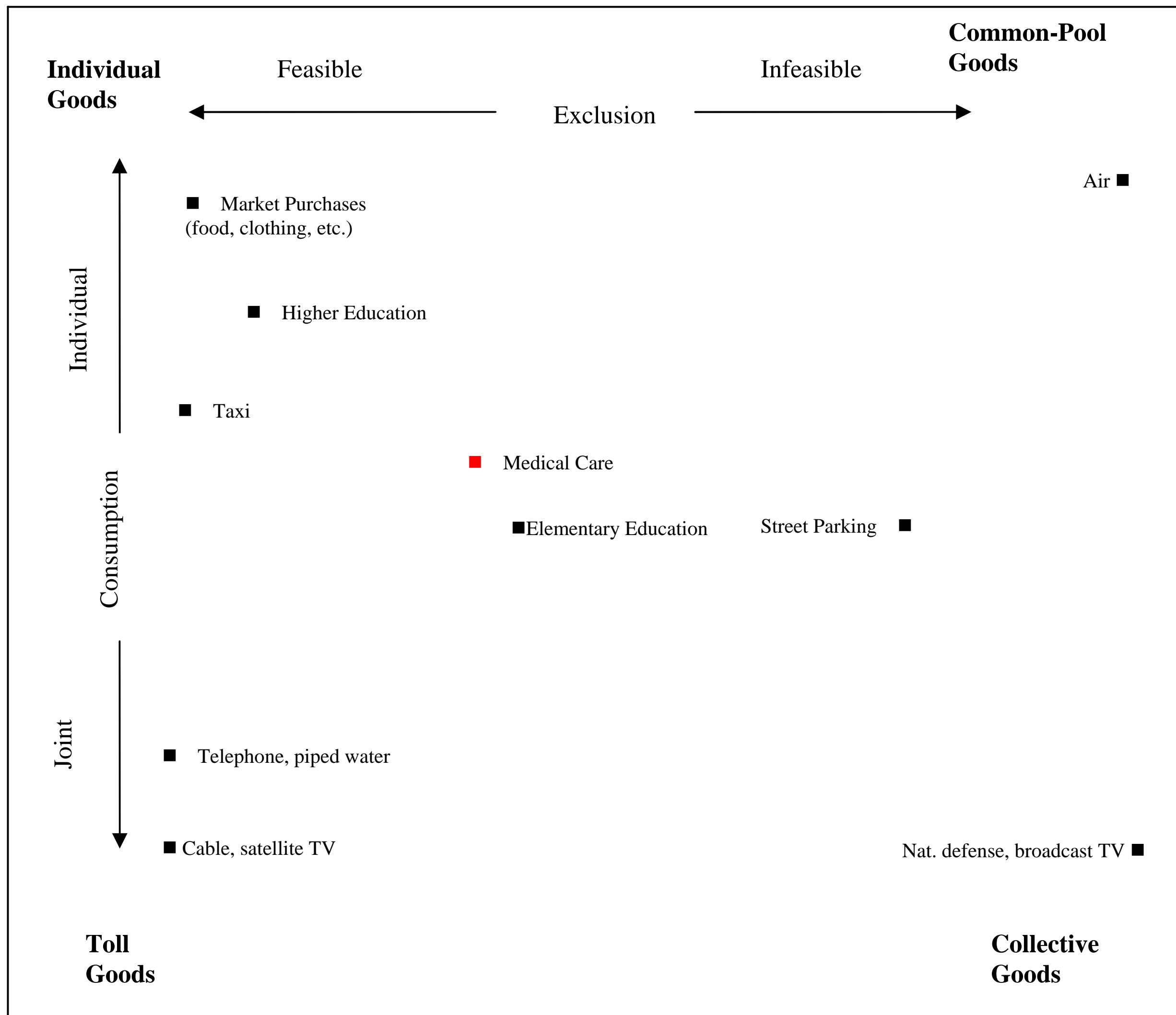
Figure 1.1 – Excerpted Version of Savas Scatter Plot of Product Classifications[7]



> The restrictions the United States has placed on corporate conduct affecting public health, safety, and amenity are at least as strict as and in many cases stricter than those adopted by other capitalist nations. As a result, in no other nation have the relations between the regulated and the regulators been so consistently strained (Fesler & Kettl 1996, p. 342).

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[7] From *Privatizing the Public Sector: How to Shrink Government*, by E. S. Savas, 1982, p. 34. Copyright 1982 by Chatham House Publishers. Adapted with permission of the author.

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Taken together, these notions and comments suggest that a potentially productive approach to examining regulatory impacts on the relations between public and private entities vis a vis privatization would be to explore these issues in the social services context. The U.S. health care industry in particular represents an interesting opportunity in that regard for many of the same reasons that it challenges straightforward classification in Savas' scheme. Its sheer complexity provides a data-rich framework with a view of service delivery across both service types and sectors, and the industry itself is imbued with many of the most salient issues affecting privatization, regulation and governance. It is therefore useful at this point to examine the U.S. health care industry.

The U.S. Health Care & Health Insurance Industries

The health care industry in the United States experienced phenomenal growth during the third quarter of the twentieth century—owing in no small part to the establishment and growth of private and public sector-controlled insurance and the business incentives (i.e., opportunities for profit) created by the insurance industry and the government subsidies eventually imbedded within them (Marmor, Schlesinger & Smithey, 1987). Business trends in the insurance industry along with government policy and regulation, the shifting governance of hospital facilities between and among sectors, and the roles of health care professionals each have evolved and interacted over the years in ways that have broadly influenced the delivery of health care services in the U.S.—especially in terms of access to care and its cost to consumers. Insurance has been a major player on the scene since the establishment of the third party payer system in the private sector with the advent of the Blue Cross® hospital insurance plan in 1929. This private nonprofit sector-initiated third party

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payer system steadily expanded in both scale and scope of coverage through the subsequent two decades. Government then took on a major role in the industry through the establishment of Medicare and Medicaid programs in 1965 (Kronenfeld, 1997a; Patel & Rushefsky, 1999).

The phenomenal rise in demand for health care services observed in the earlier part of the 1970s might be ascribed to the increased access to care afforded by the establishment of public insurance programs (i.e., Medicaid and Medicare). The skyrocketing of associated costs in the subsequent fifteen year period may be attributed to the confluent impacts of the profitable business opportunities afforded by a third party payer system in which cost control mechanisms were underdeveloped, there were permeable barriers to entry, and the system was vulnerable to costly manipulation. Of course, the speed of availability of state-of-the-art technology as well as its cost of adoption and use also has contributed significantly to cost. That is, typical private and public sector responses to successful innovations in medical technology are not unrelated to the cost driver that is business opportunity. To the extent that there is reasonable demand for a technology innovation and that it can be supplied profitably, the proprietary sector typically will provide it. Once it is then established as the profession's and/or the industry's treatment of choice, medical and societal norms compel standard distribution accompanied by treatment mandates. The public sector then typically has responded with subsidies to ensure equitable availability of the most effective treatment technologies (Marmor et al., 1987). This occurs because provision of these advanced treatment modalities to individuals in need who are uninsured and/or unable to afford them has cost implications over and above research, development and typical distribution. Absent sufficient subsidies, the

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enterprise is unable to generate sufficient revenues to cover operating and/or reinvestment costs.

Of course, to the extent that coverage criteria were reasonably straightforward with few barriers to entry—roughly the prevailing conditions in the days before the prospective payment systems were introduced in the 1980s to control costs, institutional health care was a fairly attractive business proposition. As Sloan (1998) notes of that earlier time,

> … hospitals were paid on a retrospective cost or charge basis. Under *retrospective cost,* the share of hospital cost attributable to services provided to insured patients was recovered after services were delivered. Hospitals with higher cost were paid more… An explicit payment to profit was sometimes made as a surcharge over cost. Under *retrospective charge* reimbursement, hospitals were reimbursed a percentage of billed charges; the remainder of the charge was collectable from patients. Generally, a hospital had both cost- and charge-paying patients. Depending on how the programs were structured, hospitals had little incentive to be efficient (Sloan, 1998, p. 154).

The promise of guaranteed payment, as one might expect, spurred unprecedented growth in the health care delivery marketplace. Also not surprisingly, this windfall of opportunity for profit drew enterprising proprietary and nonprofit health care providers into the market in droves. Products were promoted directly to physicians and, increasingly, to their patients as well. Government subsidies for medical treatments were generous in that suppliers typically billed insurers at levels that allowed the supplier to profit even when insurance paid only the standard 80 percent of the billed amount.[8] Coverage eligibility usually was conditioned on a loosely

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[8] Medicare Part B, which covers outpatient medical and home health care, typically covers 80 percent of the cost of items deemed medically necessary. Medicare required the balance to be billed to the patient or to privately purchased co-pay insurance (See Medicare Provider Policy Manual – U.S. Dept. of Health and Human Services). Providers could inflate the billing amount to profitable levels at 80

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defined criterion of medical necessity. Before the Medicare fraud-related Omnibus Budget Reconciliation Act (OBRA) instituted the statutory reforms of the late 1980s and early 1990s, the medical necessity criterion essentially was presumed to have been met on the basis of little more than a physician's prescription. In addition, insurance claims typically were processed by personnel who were not medically trained and made coverage determinations by comparing the prescription or other medical necessity documentation with decision logic tables contained in the insurance carrier's claims processing manual (Sibert, 1998). Suppliers of emergent technologies undoubtedly benefited as well in the midst of this trend.

Individual product markets left to their own devices generally have a way of reaching a point of saturation in which revenues either plateau or fall to a level at which it is only marginally appealing (i.e., profitable) for the provider to remain in that market. Of course, with respect to the health care marketplace, the market is rarely left to its own devices because of the presence of subsidies and other influences on pricing and supply. At the same time, spending constraints are a logical response of government to the need to control costs. The prospective payment system adopted by Medicare in 1983 and its related use of Diagnosis-Related Groupings (DRGs) is an example of a public sector-initiated cost-control measure that was intended to be a more efficient alternative to the retrospective payment systems of the previous decade (Sloan, 1998). These will be discussed in more detail in the forthcoming section in the context of their utility to government in its use of DRGs as a regulatory mechanism.

On the private sector side, privatized healthcare suppliers can be expected to continually adjust in varying and creative ways to maintain their viability. When the

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percent to hedge against the absence of co-pay insurance, which also facilitated distribution to a broader market of underinsured individuals.

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costs associated with providing a privatized health care service exceed the revenues the service generates and/or there are insufficient offsetting financial incentives to the provider to justify continuing to furnish that service, one or some combination of three general adjustments may be expected to occur—the service may be replaced with a less costly alternative, it may be abandoned altogether or, as indicated earlier, it may be subsidized (or existing subsidies may be increased). Replacement with a less costly alternative occurs, for example, when insurers limit treatment coverage to the least costly treatment option. Subsidies in the conventional sense, refers to government funding; but for the purposes of the current discussion, the concept can include broader approaches taken by the non-governmental sectors such as the shifting of costs by the supplier to paying customers (Sloan, 1998), or even more broadly, shared responsibility for service provision through partnership, referral, or dumping (i.e., refusing care to patients thereby forcing them to seek treatment at public facilities that are compelled to accept them).

Yet another important cost control measure that evolved in the health care marketplace occurred when people shifted from more expensive indemnity health insurance plans into less expensive managed care plans they believed to be adequate to meet their needs. On the tail end of the tremendous cost expansion seen in the U.S. roughly from the 1960s through the mid-1980s, government again intervened with legislative remedies that would ultimately change the face of health care financing and delivery. Included among these were the Health Maintenance Organization Act of 1973 that established the legal framework for managed care, and the Fiscal Responsibility Act of 1982, which provided much of the impetus for its growth by providing financial incentives for the establishment of pre-paid treatment programs (Gibelman & Demone, 2002). Managed care has since been credited with much of

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the decelerated growth in health care costs experienced in the 1990s (Kronenfeld, 1997b). Providers also may control costs by abandoning expensive treatment modalities or by specializing in ways that limit their ability to treat complex, high risk illnesses. Facilities also can locate themselves in areas where low risk well-insured high-margin patients reside (Marmor et al., 1987).

As earlier indicated, another possible way to control costs is for suppliers to provide, for government to underwrite and/or for insurance to cover less expensive, lower quality treatment. Such an approach, however, not only is contrary to basic tenets of the medical profession and to its moral sensibilities, it also raises equity issues about access to care for those who cannot afford it. In addition, because substandard care could result in reduced quality of life, illness or death, the stakes with respect to quality in the health care arena generally are very high. Therefore standards of care must be carefully designed and monitored. Furthermore, reduced quality of care may affect not only individuals but, in more extreme cases, such as a virulent contagion or an epidemic, impact whole communities. Yet, as the lines of responsibility (like those between sectors) have blurred, and managed care has become increasingly prevalent, consistent standards of care can no longer be assumed.

Cost and other business-related issues have become significant considerations in treatment selection (Kamoie & Rosenbaum, 2002). Therefore, treatment decisions are no longer necessarily the exclusive province of the physician and the health care standards upon which the decisions are based and the processes by which those standards are developed, especially as they apply to managed care and public health, are not purely scientifically determined. As government becomes increasingly dependent for health care provision on an industry that has in turn become increasingly enamored with managed care to meet public demand for care, the

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implications for consistent access of its beneficiaries to quality care when cost influences treatment selection are questionable at best—troublesome at worst. Remember also that because public health and managed care providers are essentially guaranteed payment for services provided, the financial base that supports agreed upon standards of care is reasonably stable. However, in instances in which delivered health care goes uncompensated and the associated costs are borne by the provider, that provider's capacity to deliver care in the necessary quantity and of sufficient quality to meet public need and/or demand is likely to be hampered.

When sources of funding, reliable health care standards and quality of care are not necessarily guaranteed, how much more vulnerable then might be indigent and/or uninsured individuals whose care is relegated to facilities that are tasked by government (and in public opinion) with the provision of care that may very well go uncompensated? The growth trend in this segment of the U.S. population suggests that this will be a very real concern for years to come.

Figure 1.2 below depicts rates of uninsured persons in the U.S. Poverty rates are depicted in Figure 1.3. The fact that the number of uninsured individuals is rising and that their representation as a percentage of the population has remained relatively stable for nearly two decades suggests that the demand for hospitals and other primary

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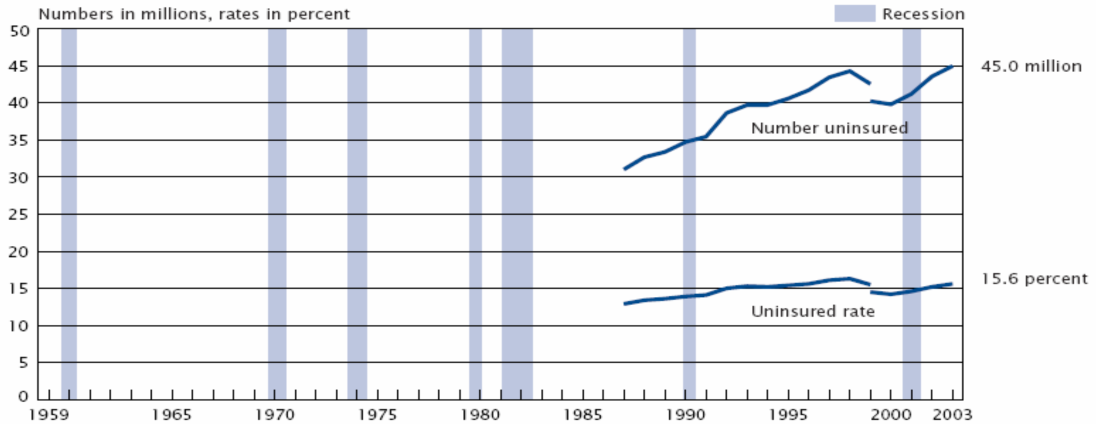
Figure 1.2 – U.S. Number Uninsured and Uninsured Rate: 1987 to 2003



Source: U.S. Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements.

health care providers to furnish health care services to persons who are poor and/or uninsured is likely to remain stable as well. Assuming that resorting to provision of less costly, reduced quality care is not a viable solution, the possible rise in demand for unreimbursed care has important implications with respect to the burden on the health care delivery system as a whole. In countries such as the United States, where access to healthcare is considered an entitlement regardless of one's ability to pay, reducing or withdrawing that access is considered untenable if it can be avoided. So the remaining alternatives for health care delivery—again, for indigent patients in particular—would be subsidization of one form or another or increasing capacity though cooperative arrangements such as partnerships or diversion of such patients through referral.

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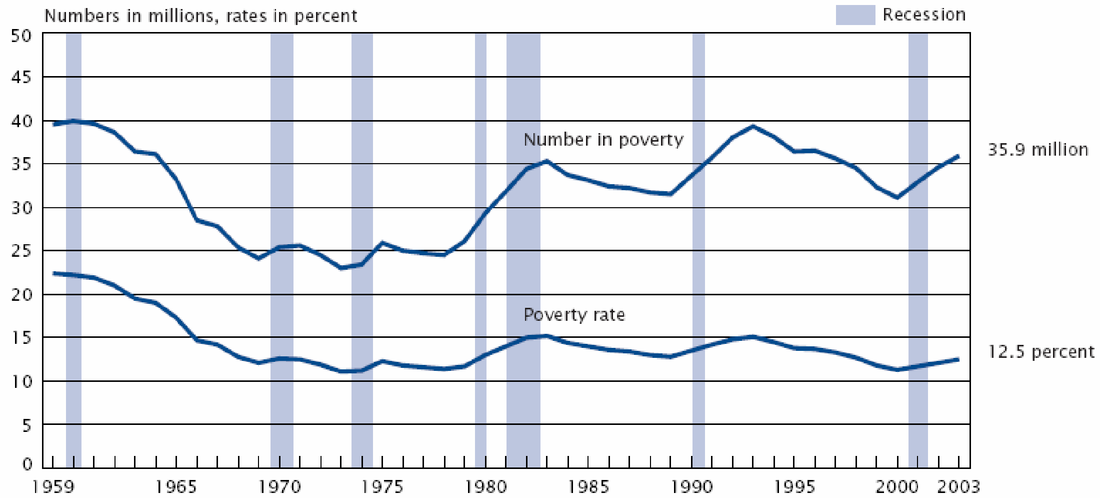
Figure 1.3 – Number of U.S. Residents in Poverty & Poverty Rate: 1959 - 2003



Strategies for increasing capacity as a means of meeting demand while controlling costs in an industry such as health care is distinctive in important ways from those of conventional business models. Conventional models may rely, as mentioned earlier, on leveraging economies of scale to increase volume of service or product output at reduced cost per unit. This is basic tenet of controlling costs in a competitive free market environment. The diagram in Figure 1.4 is a conceptual snapshot of a free-market enterprise in which economies of scale are realized by gleaning efficiencies from the supply demand cycle.

Price is affected by supply and demand. That is, as a rule, price is directly related to demand and inversely related to supply. Put another way, prices are elastic or responsive to demand in a free market/business environment. As long as there are profits to be made, suppliers enter the market and the supply of goods increases commensurate with growth of suppliers in the marketplace over time. As those suppliers compete for customers, prices are presumably maintained at

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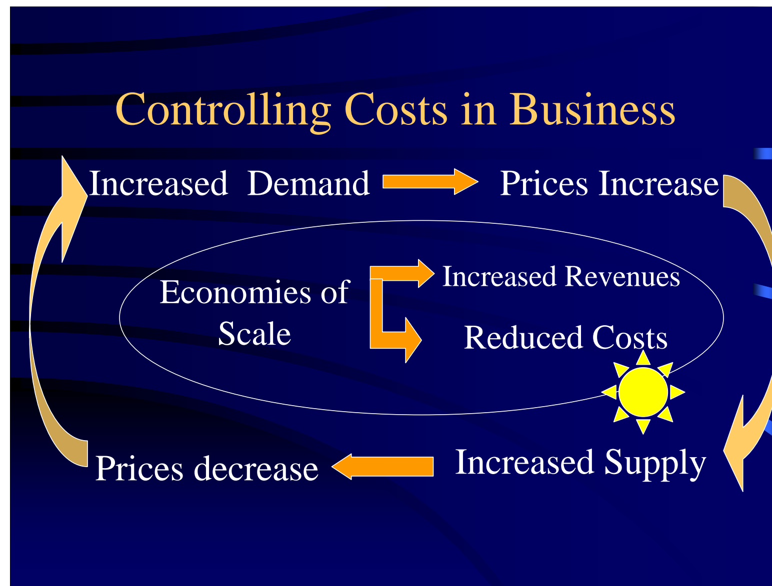
Figure 1.4 – Traditional Business Cost Control and Scaled Economies Model[9]



levels favorable to consumption. Suppliers then compete on quality and price. Those that can meet demand while incurring the least expense or cost will have established a competitive advantage. If they enter the market at the optimum point in the supply/demand cycle (roughly depicted by the position of the sun icon in the diagram, which, by the way, is also the approximate point at which investors may enter the picture) with sufficient productive capacity, they will be positioned to achieve superior market share—and win. The implicit objective then is efficiency – to produce the most with the lowest expenditure of resources. Efficiency results from manipulating capacity to achieve economies of scale, i.e., the leveraging of a firm's productive capacity and investor capital to produce higher quantities of a good at lower per-unit cost. This model, while somewhat oversimplified, also may explain the appeal of the market for service provision. However, efficiencies in the health care

[9] Diagram conceptualized and developed by Ronald I. Sibert for a Public Policy course presentation delivered at the University of Delaware, Fall 2002.

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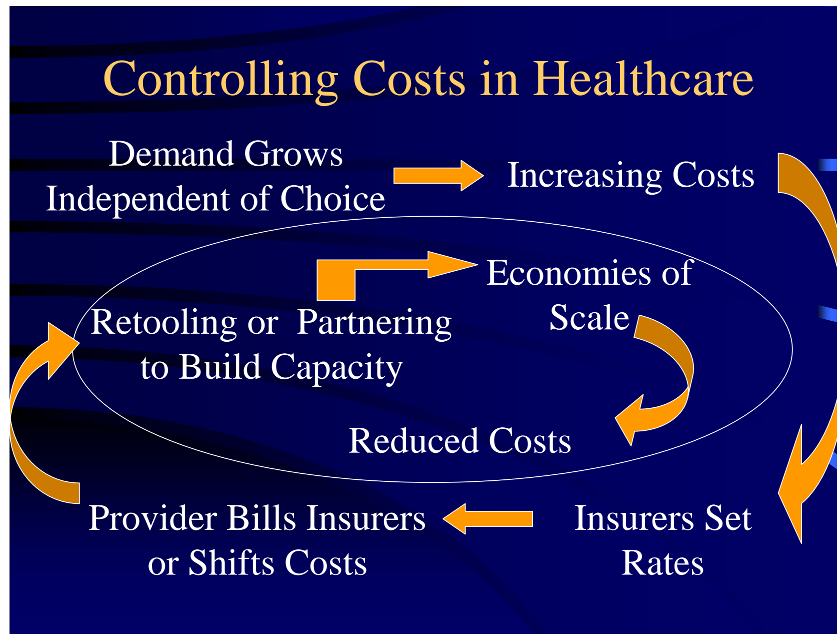
industry are achieved a bit differently because the competitive environment is very different in the healthcare business.

Figure 1.5 – Health Care Industry Cost Control and Scaled Economies Model[10]



As described in Figure 1.5, demand in the health care industry is self-sustaining, grows essentially independent of consumer wants, and prices are essentially inelastic (unresponsive) to demand. Possible explanations for this may be inferred from the diagrammed health care industry business model. Insurers set reimbursement rates and typically pay for the least costly treatment alternative. Providers secure revenues primarily via insurance billing and secondarily through direct patient billing and/or by cost-shifting, e.g., shifting charity care costs to self-paying or privately insured patients. Service providers compete effectively based on their ability to provide adequate services at the least possible cost and the least exposure to risk, which may take any of several forms. Examples include risk of

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nonpayment, high-cost/high-risk surgery (which carries its own risk of nonpayment because the conditions for which such interventions are indicated have a higher incidence in indigent populations), exposure to malpractice, etc. In several respects, much of a health care facility's or a network's financial viability may hinge on its capacity to maintain the appropriate repertoire of treatment options for the community it serves. However, that capacity is frequently at odds with the ever-accelerating technological advances in healthcare. While retooling facilities and retraining staff to increase capacity may be effective in isolated instances, these options can be quite costly (if not entirely cost prohibitive) in the long term.

In healthcare, therefore, economies of scale may be achieved more feasibly by capacity building through partnering—which can include partnering with insurers (e.g., to reduce administrative costs), but especially by partnering with other, perhaps specialty care facilities, to provide a wider range of services. Such partnerships, by leveraging each organization's unique capacities without necessarily merging their respective capital resources, achieve what may be termed 'economies of synergy' (Farrell & Shapiro, 2000) as opposed to the more conventional economies of scale, merger or integration (Bovbjerg, Marsteller, & Ullman, 2000). This in turn would obviate the need for the individual facilities to retool each time a new demand is created by a technological advancement.

The role of partnering in this model of health care delivery is roughly analogous to the capacity-building contribution of investor capital in the traditional corporate business model described earlier. This was in fact played out in a major trend of the 1990's which saw tremendous growth of multi-hospital systems—which accounted for more than half of the beds in the U.S. hospitals at the outset of the

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decade—and strategic alliances between hospitals, physician groups, insurers, etc. (Kronenfeld, 1997b).

U.S. Government Role in Health Care Provision

The government is required by law to maintain adequate levels of public health. The authority for laws mandating federal involvement in the provision of health-related services comes from three provisions contained in the U.S. Constitution. The first was applied to authorize health related services and facilities as required to maintain a viable military (see Article I, Section 8, clause 11). The second, i.e., Article 1, Clause 3 of Section 9, gives the U.S. government the authority to regulate foreign and interstate commerce (see U.S. Constitution, 1787). Government authority in areas peripheral to commerce such as control of food and drugs, occupational safety and the imposition of quarantines have been established under this constitutional provision. The third, Article I, Clause 1 of Section 8 (U.S. Constitution, 1787), otherwise known as the general welfare clause, is the most prominent and most often cited justification for government involvement in health care policy and provision. In essence, it holds government responsible for maintaining the welfare of American society at large (Kronenfeld, 1997a). Of course, because the association of health with human welfare is not a large leap of logic, the argument for health as a public entitlement was not a difficult one to make.

The role of government in health care provision in the U.S. has been significant since before the Civil War. Adoption was seen first at the federal level and that was followed swiftly by state and local government involvement. Several major pieces of 20th century legislation provided a broad range of support, which included financing for several categories of initiatives and programs from development of

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infrastructure to personnel training to direct service and treatment delivery. Examples include hospital and medical school facility construction, health care-related education, health care research, and of course, significant fiscal allocations for medication and a full spectrum of care for the poor and elderly. Kronenfeld (1997a) provides a comprehensive analysis of the many major legislative and policy initiatives undertaken by government in the U.S. from the eighteenth through the twentieth centuries. Table 1.2 below lists several of these with brief synopses of their provisions.

The two major pieces of health care legislation, the Social Security Act of 1935 and the Public Health Services Act (PSA) of 1944, were amended to gradually broaden the focus of care, i.e., beyond specific disease categories, etc. while introducing a level of administrative flexibility and holding state and local government agencies responsible for the planning and delivery of health services in the ways most consistent with the needs of the communities they serve. Examples include Title XIX of the Social Security Act of 1965 that established the Medicaid program; two sets of amendments to the PSA, the Comprehensive Health Planning Act (CHP) and Public Health Services Amendments of 1966, which authorized block grants for public health programs and included provisions for state and local health care service planning; and the National Health Planning and Resources Development Act of 1974, Title I of which consolidated several pieces of legislation and established national standards for state and local health care system planning, structure and regulation (Kronenfeld, 1997a). The devolutionary thinking reflected in the public policy decisions of the mid through late twentieth century, the notions of market efficiency and constitutionally mandated government responsibility for the public welfare ultimately converged to create a political environment that has supported and sustained public sector

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involvement in privatization—particularly types in which government offloads direct service delivery while retaining primary responsibility and accountability for service outcomes.

Health Care Subsidies, Regulation & Cost Control

Since the mid 1960s, government subsidies for health care have existed in the form of public insurance for at-risk populations—Medicare for the elderly and permanently disabled, and Medicaid for the poor and for children with permanent disabilities. Today, however, as will be discussed in the forthcoming case study, these subsidies do not necessarily cover the costs of providing care to the populations for whom the associated programs are intended, and the reasons may be at once economic (i.e., including the sheer scale of need and associated costs), regulatory (i.e., the focus of regulation) and/or political.

Direct public sector administration of programs that serve literally millions of people requires systematic, often standardized, management—which in the U.S. has traditionally involved installing bureaucratic processes and procedures for the sake of efficiency. Naturally, public insurance programs, because of their scale and

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Table 1.2 – Legislative History of Government in U.S. Health Care[11]

Major Legislation	Year	Provisions
Act for the Relief of Sick and Disabled Seamen	1798	$2.00 tax per month for health services and medical care; hospital construction; government enforcement of quarantines (1800)
Morrill Act	1862	Land grants for public universities and hospitals
Federal Food & Drug Act	1906	Consumer protection from tainted foods and drugs
Maternity & Infancy Act	1921	State grants for maternal and child health
Veterans Act	1924	Medical treatment to veterans (Veterans Administration created 1930)
Ransdell Act	1930	Public Health Svc. Hygienic Lab becomes National Institute of Health (NIH)
Social Security Act	1935	Federal aid to states for public health & welfare
National Cancer Institute Act	1937	Scientist and clinician training; educational fellowships; federal gvt. cancer research
Public Health Service (PHS) Act	1944	Hospital construction funds and consolidated a number of previous health-related legislation, including some provisions of the Social Security Act
Hill-Burton Act (Hospital Survey & Construction Act)	1946	Amends PHS—state grants for assessment of need and for construction of hospitals in post-WWII.
Medical Facilities Survey & Construction Act	1954	Assess need for and provide funds for construction of outpatient treatment & rehab centers, nursing homes; funding for chronic disease hospitals
Health Professions Education Assistance Act	1963	Facility construction aid for medical, dental and pharmacy schools
Mental Retardation Facilities & Community Mental Health Centers Construction Act	1963	Construction of research and custodial care facilities, community health centers
Nurse Training Act	1964	Construction grants to schools of nursing
Social Security Act Major Amendments	1965	Established Medicare (Title XVIII) and Medicaid (Title XIX)

[11] This table does not represent a complete accounting of the legislation that Kronenfeld (1997) discusses; nor did health care-related legislative activity end after passage of the Social Security Act amendments of 1965. The purpose here is to highlight the long-standing nature of government involvement in health care and an approximate chronology of the relationship's evolution.

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scope, have been steeped in bureaucracy. Even when government divests itself of the function of service provision by contracting out to private proprietary or nonprofit service providers as an efficiency measure or to leverage the competitive marketplace to control costs and quality, it often retains ultimate responsibility for service delivery and accountability for outcomes. When divestiture occurs, government typically adopts a regulatory role which may be established and maintained through legislative authority, contractual terms, or indirectly through compliance incentive arrangements. With respect to public insurance and health care, however, the *focus* of regulation is of material concern because that focus determines where in the privatization process government exerts its influence. For example, imbedded in the solicitation of competitive bids from a field of possible providers and underwriting the winning firm's service delivery are a number or opportunities for government to influence or regulate outcomes.

Examples of possible loci of influence include incorporating in the request for proposals to possible contractors the framework under which negotiations are to take place and/or the eligibility criteria for bidding. However, as will be discussed in the forthcoming section on privatization and competition, the exertion of "artificial" influence in the competitive marketplace can compromise the purity of competition and dilute its intended effects. Establishing and enforcing contractual terms of service delivery is simply another way for government to exert regulatory influence, as is providing incentives for compliance with those terms. A purer form of competition is engendered by placing the service purchase decision in the hands of consumers. Government can mediate this approach through the use of prepaid healthcare accounts or vouchers. While this still involves direct financial support from government, it is a departure from the earlier approaches in that it transfers the mechanism of control of

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vendor behavior and service delivery from government to the discipline of the marketplace. Some have argued that this approach is a more genuine and possibly more effective way of stimulating competition and is therefore more likely to generate the cost and quality control benefits generally ascribed to marketplace competition (Osborne & Gaebler, 1992).

Political considerations also are germane to the healthcare privatization discussion. Setting aside for the moment ideological preferences with respect to devolution and the conduct of business in laissez-faire economies, health care-related public policy is in effect an ongoing balancing act between various, often conflicting values—and the balancing act itself is therefore often rife with conflict.

> The health care system exhibits a continuous conflict and strain between the values of efficiency, access, equality, rights, and freedom. This is reflected in the contradictions between people's expectations for equal access to decent-quality health care, the failure of the private sector to provide equal access, and the inability of the public sector to compensate for the inadequacies of the private sector (Patel & Rushefsky, 1999).

Some measure of relief from these tensions, however, has been sought and found in the nonprofit sector. This has long been true in the health care arena. Note, for example, that the entire third party payer health insurance system sprang from the nonprofit sector with the establishment, for example, of Blue Cross® in the earlier part of the twentieth century. Then, as a result of rising costs associated with the rapid increase in complexity of medical technology, training, treatment and care from the early through mid-twentieth century, health care providers—both public and private—have engaged the nonprofit sector by various means to defray costs, to meet service demand or simply to manage caseloads. Nonprofits have even been employed as political buffers—as a means, for example, of enabling public officials to allocate

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government resources to indirectly support controversial activities or programs without incurring public ire. That is, nonprofits provide government with a discrete means of redistributing wealth, resources or services when direct government funding from tax dollars does not enjoy public consensus or majority support (Navarez, 1996; Salamon, 1999).

Since government services are funded primarily by public taxation, the government is accountable to the public for the way that those funds are to be spent. So there must be, at least in theory, public consensus about how those funds are utilized. Moreover, the government must be able to assure that the services it provides ostensibly in the public interest are being equitably distributed. Service provision by nonprofits bridges the gap. Since they are not yoked by public consensus constraints, nonprofits are uniquely positioned to provide services for which no clear public consensus has been established for investment of public funds. However, by lending financial support to nonprofit organizations, government can pursue the ideal of equitable distribution of public goods and services while sidestepping public accountability to some extent by using the nonprofit as a conceptual buffer to create an arms-length relationship between itself and service beneficiaries. By using nonprofits to hedge on the often conflicting notions of equity and free market distribution of wealth, government can discretely pursue distributive justice without public endorsement. It is interesting that such government actions are not scrutinized in the same way as services funded directly by the government—even though public tax support may be brought to bear in either instance. One plausible explanation for this apparent double standard is that nonprofits generally are associated conceptually with charitable services. Therefore, government support of nonprofits in the provision

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of public services may be perceived as an expression of public altruism, which is deemed justifiable on its own merit and therefore difficult to oppose.

Regulatory and political obstacles also can be considerable with respect to the actual implementation of privatization contracts themselves (Dicke & Ott, 1999)—particularly in health care and social services where labor issues, loss of control and bureaucratic inertia have been cited as the primary barriers (Savas, 2000). Interestingly enough, privatization advocates view privatization as a remedy to these very concerns—that is, these are the very issues some believe privatization is designed to remedy. Flexibility in hiring and freedom from inefficiencies and red tape associated with government bureaucratization are examples of those remedies (Auger & Raffel, 2003). At the same time, surveys of city and state officials reflect concern about the lack of methodological knowledge with respect to privatization and of enabling legislation (Savas, 2000). These findings suggest that in the absence of sound implementation methods that can be combined successfully with enforceable regulatory supports, privatization will (and perhaps should) be viewed with appropriate measures of skepticism and caution.

Of course, caution from a public sector perspective may play out in a number of ways. For example, it can be expressed in the form of regulatory measures that may incorporate performance standards and define accountabilities—which include, either implicitly or explicitly, consequences for noncompliance. It also may be manifest as coercion, such as when a public agency uses its control of a firm's revenue streams to influence or restrict that firm's behavior. Avoidance of conflict might then be expected to require care to be taken in the design of regulatory measures to ensure that they are compatible with the operating preferences and cultures of those

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being regulated. Of course, such consensus-driven decisions among stakeholders also should reduce the likelihood that any party would resort to coercion.[12]

Regulation & Insurance Coverage Criteria as Cost Control Measures

Encouraging vendor compliance while discouraging coercion are not the only objectives of regulation (nor are they necessarily the primary objectives). Some regulatory measures are established primarily to control costs. Criteria for public insurance coverage of medically necessary products and services are a good example. However, along with the burgeoning cost of health care, coverage restrictions on medically preferred but expensive treatments can make access to proper care problematic, particularly for the poor, elderly and underinsured. So while public insurance programs have been established to subsidize health care provision to those who need it most but can afford it least, such programs also limit the distribution of treatment by imposing diagnosis-specific controls on treatment selection. Treatment coverage decisions of insurers, public and private, often are based on the DRG (Diagnosis-Related Grouping) classification system mentioned earlier. The DRG system was developed in the 1960s to help the medical community organize and simplify the categorization of patients by their diagnostic profiles. It was accomplished by consolidating more than 10,000 distinct medical conditions into a much smaller and more manageable number (about 500 as of 2003) of broad diagnostic and treatment groups each comprised of clinically similar medical conditions and treatment indications (Diagnosis, 2004).This enabled the medical

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[12] It is conceivable, by the way, that those being regulated might prefer positive reinforcement and incentives to sanctions and/or coercion. That is, the regulatory relationship that results from an incentive-driven arrangement may be not only far less contentious, but possibly could yield better overall results—to the extent that the incentives are sufficiently attractive to encourage private and/or nonprofit sector participation and that mechanisms are included that obviate or neutralize enticements to cheat.

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community to understand and predict costs and resource utilization in terms of broad groupings of medical conditions and their associated treatment categories. The cost-control potential of the DRG classification system was not lost on the Federal Government. Rapidly rising health care reimbursement expenses through the 1970's prompted a re-tasking of the DRG classification system into a reimbursement system that would then be incorporated into the Tax Equity and Fiscal Responsibility Act of 1982 (Kronenfeld, 1997a). Given its cost control potential, it is not surprising that DRG coding was later adopted by insurers and then officially by Medicare in 1983. However, the adoption of DRGs as a medical service and treatment cost classification system was not just of economic or fiscal import. It introduced a new layer of accountability and regulation in the health care industry. Imbedded in the DRG system are not only standard costs of treatment alternatives for stated diagnoses, but the medical necessity criteria by which claims for insurance coverage are assessed. Kidney dialysis coverage for end-stage renal failure is a case in point. In addition, some policies such as Medicare's least costly alternative treatment modality coverage criterion indirectly regulate physicians' treatment selection. The least costly alternative policy applies, for example, when a doctor prescribes durable medical equipment to maintain her patient's functionality and a surgical intervention is judged to be a less costly alternative and at least as effective, the policy compels the insurer (Medicare in this case) to deny the equipment claim in favor of the surgical intervention (Sibert, 1998). This can have important implications from a regulatory perspective.

In addition to serving as the basis for insurance coverage criteria, the DRG system essentially defines the terms for treatment and/or circumstances under which treatment modalities are justified, i.e., deemed medically necessary. To the

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extent that these justifications or terms for medical necessity are employed by insurers as coverage criteria (in addition to their enforcement of least costly alternative policies), the insurance industry can exercise tremendous influence over doctors' and other service providers' treatment decisions (Diagnostic-related groupings, 2002, June 17) and over the repertoire of services that hospitals and other health care facilities may choose to provide. When insurers are then designated to execute government programs, as is the case when private or nonprofit insurers are contracted to administer public insurance programs, the coverage and reimbursement policy structure of the insurance industry, to the extent that it is sanctioned by government, is tantamount to direct government regulation.

DRG's and other cost control measures were in many ways a response to the costs of health care provision spiraling out of control in the years following the establishment of health care-related legislation under the 1965 amendments to the Social Security Act. Marmor et al. (1987) draw from Feder's 1977 account of the situation as follows:

> Government health insurance prompted a period of extended growth of American medical institutions. Medicare permitted generous depreciation allowances for capital and, by reimbursing capital costs which were then plowed back into the cost base, inserted an inflationary factor into its own payments, which were determined by provider dominant insurers. (Marmor et al., 1987, p. 227)

Concerns about the health care industry's ability to sustain itself, as was the case with other publicly provided services, seemed to engender a growing awareness of its compatibilities with private sector business. When public insurance programs began to privatize, such as when insurers like Blue Cross® and Blue Shield® began administering Medicare and Medicaid, private sector business philosophies were

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increasingly superimposed on the healthcare industry in the form of managed care and other mechanisms that incorporate cost control incentives.

Managed care, when applied in the public insurance arena, is in itself an interesting and complex form of contractual privatization. Under the managed care model, the health care provider and the insurer operate in tandem and share the cost-related consequences of treatment decisions. An important feature of these arrangements is their employment of treatment guidelines that bind doctors by contract to adhere to the insurer's predefined standards of care in which cost is a significant consideration. Quality of care may be compromised to the extent that the managed care-sanctioned approach is medically suboptimal, and the contractual arrangement provides the treating physician insufficient flexibility to make necessary adjustments (Kamoie & Rosenbaum, 2002). Physicians' ability to influence this (i.e., as a professional group or association) also is limited because they are constrained by U.S. antitrust laws from negotiating as a unit with health plans/insurers (Razor, 2003). Ironically, antitrust law, the mechanism that was established to preserve competition, and presumably product and service quality in the marketplace in the process, conceivably may have just the opposite effect in such instances. However, another perhaps more promising approach that has emerged recently from the private sector takes the form of financial incentives provided directly to individual and group medical practices. Their intent is to help insure quality of healthcare provision. Insurers and medical group owners have begun rewarding doctors with cash bonuses for adhering to treatment guidelines (generally accepted patient care guidelines within the medical and insurance communities) for good care (Landro, 2004). However, because of the variability of the treatment guidelines promulgated by insurers, adherence to them does not necessarily guarantee high quality care. The fact that

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these guidelines may actually carry the force of law in setting contractual standards of care warrants serious concern (Kamoie & Rosenbaum, 2002). Also, to the extent that managed care guidelines are allowed to exercise similar influence in the context of privatized public insurance, the application would be nearly indistinguishable from that of direct government regulation of health care delivery.

Privatization in the United States

The United States, the world's foremost bastion of capitalism, has had a long-standing affinity—some might call it a reverence—for private markets. Indeed the U.S. is home to the largest and most successful market economy on the planet. Privatization was formally established as Federal Government policy in nearly a half-century ago. Donald Kettl (1993) notes that so pervasive was the belief even then that the private sector could furnish goods and services more efficiently and therefore at lower cost than government, the post World War II Eisenhower administration's Bureau of the Budget mandated (in Bulletin 55-4, 1955) that

> the Federal government will not start or carry on any commercial activity to provide a service or product for its own use if such product or service can be procured from private enterprise through ordinary business channels (Kettl, 1993, p.41).

Despite the policy mandate, however, privatization infiltrated the existing federal procurement system very slowly. After nearly a decade of failed implementation the "refined" version of this policy was revived in 1967 as *Circular A-76,* a federal directive out of the Office of Management and Budget. A subsequent version, the 1983 revision, served as the template for federal procurement policy well into and through the accelerated devolutionary movement that characterized the Reagan and Bush Administrations of the 1980s (Kettl, 1993).

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Regardless of the mixed findings about the efficiency/savings and efficacy of Federal procurement programs, the ideology that drives privatization stands undiminished. A great deal of legislative effort, for example has been invested in "acquisition reform"—what amounts to efforts aimed at refining or sustaining government's privatization-related activities. Examples include the Federal Acquisition Streamlining Act of 1994 (FASA), the Federal Acquisition Reform Act of 1995 (FARA), relevant provisions in the Technology and Management Reform Act of 1996 and the Federal Activities Inventory Reform Act of 1998 (FAIR) (Gansler, 2003). Whether for ideological or pragmatic reasons, this legislation suggests that privatization in the U.S. (and worldwide) apparently is here to stay.

Privatization & Competition

As noted previously, the modus operandi of privatization is the discipline of the market, and the underlying premise of that discipline is competition—specifically, a competitive environment in which there are intrinsic inducements for sellers to provide the highest quality goods and services to consumers at the lowest cost to the provider. As Kettl (1993) notes, a competitive market also requires arms-length transactions among large numbers of buyers and sellers of relatively undifferentiated goods. Divestiture of a government-owned entity (GOE) or state-owned entity (SOE) can indeed consign a public service to the market environment where it would be subject to the competitive forces that presumably foster efficiency and cost effectiveness. However, that is true only to the extent that a critical mass of private or nonprofit sector providers is already present in the marketplace and they are prepared to compete (Sclar, 2001). Such is not always the case.

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It has been demonstrated that markets for complex public services such as certain defense-related services, municipal transportation, utilities, etc. are easily monopolized, i.e., characterized by the existence of a very limited number of qualified and competing suppliers in the marketplace. The World Bank, the premier proponent and financial supporter of privatization on a global scale, recently discovered that certain service areas, such as water and power utilities, may be characterized as natural monopolies that require vigilant monitoring (Phillips, 2003).These conditions often result in increased cost to government of providing those services via contractual privatization (Sclar, 2001; Kettl, 1993). There also are instances in which government plays a role similar to that of what economists term a "monopsony" – an organization acting as the sole purchaser in a market in which there are many sellers. More commonly, contractors may have to conform to very narrow, usually legislated, specifications—particularly for services provided for the public welfare. In these instances, the agency generally creates and sustains the market as previously noted, and pays very high costs.

Establishing or maintaining ideal competitive conditions may be particularly problematic in the social service arena. In contemplating a consumer responsive role for government, Osborne and Gaebler (1992) discuss several advantages to customer influence on business conduct and outcomes that happen to resonate well with arguments in favor of privatization. They argue, for instance, that customer-driven systems emphasize customer choice (followed by a consumer-favorable competitive response from possible providers), stimulate innovative approaches to service provision, increase efficiency and create greater opportunities for equitable service distribution. However, they also note that with respect to regulated public services, the primary customers are not individuals, but collective

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communities—similar to the monopsony scenario discussed earlier, and that the competitive landscape is less than ideal because of the dearth of competing service providers and pervasive barriers to entry. Privatization opponents cite profit-motivated tactics such as selective service provision (creaming) as well as opportunities for bribery, kickbacks, political manipulation and exploitation of contracts (Auger & Raffel, 2003). In each case, competition, the principle upon which the success of privatization is predicated, is compromised—or is, as economists say, "imperfect."

While it may be argued that the problems government faces in provision of services can be found in the private sector as well, privatization advocates claim that the discipline of the market eliminates firms that perform poorly in the private sector. On the other hand, they say, government agencies are shielded from this discipline—often receiving larger subsidies to remediate problems when they arise (Savas, 2000; Kettl, 1993). In this way, they argue, government is protected from sanction and rewarded for failure. Citing several studies regarding the effectiveness of contracting public services to private providers, Savas (2000) observes:

> Monopoly is generally inferior to competition in providing high-quality, low-cost goods and services, and most government activities are unnecessarily organized and run as monopolies (p.155).

Monopoly stands in direct opposition to the tenets of competition. Ironically, however, monopoly is also the exact condition to which firms generally appear to aspire. That is, firms strive in their behavior to eliminate their competitors (i.e., by dominating the market). So competition, even in the laissez-faire marketplace, is a transitory condition at best because in the act of eliminating competitors, firms are striving toward conditions of oligopoly or monopoly to maximize profits (Sclar, 2001). Their approaches may range anywhere from mergers/acquisitions and reorganization at one end of the ethical scale to collusion, fraud and malfeasance at the

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other. Attaining or maintaining ideal competitive conditions under contractual privatization can be similarly challenging. The point here is that the ideal competitive conditions often assumed by many privatization advocates are actually a moving target—and a difficult one to hit. Indeed, an examination of the U.S. experience, particularly in the areas that account for the most significant levels of government spending, i.e., health, education and defense, suggests that competitive conditions in privatization-related contracting are often hard fought, sometimes contrived or simulated and almost always less than ideal (Kettl, 1993; Sclar, 2000).

The Private Service Provider's Perspective

As noted earlier, very little systematic research has been conducted on how the privatized firms—the service providers themselves—actually behave. While much attention has been given to how this form of privatization affects government agencies and the consumer public, little has been given to its impact on contractors in terms of their governance, their structures or how these things impact contractor performance. Yet, to the extent that a privatization venture affects the private firm's operations, accountabilities, governance, and/or its ability to function—and its leadership appreciates those effects—such considerations should be of no small concern to any organization considering entry. In fact, one may effectively determine, from the contractor's perspective, the feasibility of the venture and its execution—ultimately, the advisability of entering into such an arrangement at all.

The external accountabilities[13] of contractors with delegated public service responsibilities sets them apart from their more independent counterparts that have purchased previously government-owned operations or those that simply provide

[13] This refers to accountabilities that are external to the organization, i.e., other than the organization's fiduciary responsibility to its shareholders and/or its governing body.

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similar services as wholly private enterprises. That is, to the extent that a contractor is subject to regulation, public sanction through the political process, media transparency and/or similar forms of accountability associated with government oversight, that contractor's movement in the marketplace may be constrained in ways not experienced by fully independent providers of similar services. The same is true of governmental service providers facing competition from the private sector. It can be argued that such conditions generally place governmental service providers, contractors or otherwise regulated enterprises at a competitive disadvantage. The terms of contractual or other privatization arrangements, if sufficiently restrictive (or incompatible with the firms' customary ways of conducting business), may either discourage firms' participation in privatization arrangements or cause them to formulate ways to avoid what they perceive to be the counterproductive effects of oversight. Understanding the ways in which private contractors respond to government regulation and other forms of pubic oversight can provide important insights about privatization's compatibility with the culture and tenets of the marketplace. Of course, logic suggests that the scenarios presenting the most formidable challenges to privatization would likely produce the clearest insights. The challenges associated with the privatization of health care, utilities, transportation and other infrastructural services are cases in point (Savas, 2000). As the foregoing discussion suggests, public accountability introduces yet another level of complexity and an important perspective from which to understand privatization. For that reason it would be useful to examine more closely certain relevant features of the infrastructural service models that fall under the rubric of public-private partnerships.

A number of contractual models, collectively described as public-private partnerships, have been advanced as solutions for governments seeking to provide

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suitable infrastructure—e.g., for utilities and transportation as well as for hospitals and educational facilities—in ways that can stimulate economic growth while meeting urgent social needs. These partnerships are of interest here because, with respect to the services and the mechanisms through which they are provided, government typically retains regulatory responsibility and varying levels of infrastructural ownership respectively. Also of interest is that while monopoly is somewhat common with this form of privatization, it is not problematic in many cases. A detailed description of these models is beyond the scope of this discussion (See Savas, 2000 for more detailed information). It is mentioned here, however, because it provides a general but useful insight about privatization. That is, although the public-private partnership is thought to be an effective approach to privatization, its success is conditioned upon a number of factors, and that success is by no means a foregone conclusion. For example, skillful regulation by government and contractors' management expertise are noted as crucial elements for success—which suggests that government regulation is not necessarily contraindicated or even problematic in all privatization arrangements, and that the private firm's management of the arrangement (which includes regulation) is an important consideration. As is characteristic of much of the discourse in privatization-related literature, however, the discussion is couched in terms of optimizing contracts relative to government's objectives vs. the business-related objectives of private service providers apart, that is, from their agency-related accountabilities.[14] Nonetheless, clearly defined roles for boards of directors and management along with those of government have been cited as important considerations (Savas, 2000; Williams, 2003).

[14] The term "agency" here is adjectival, i.e., refers to the role of the service provider as an agent to government (as in the principal-agent issue).

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Similar insights may be gained through an investigation of certain public sector enterprises that, under competitive pressures and/or out of a desire for greater autonomy, undergo restructuring to become private and/or nonprofit entities ostensibly to obviate public sector oversight. This would hold particularly true in instances where public oversight has been determined by the private entity's leadership to be a hindrance to the organization's competitive positioning as will be described in the forthcoming case study.

Summary

Under the right market conditions and with skillful execution and oversight, privatization can be both an efficient and effective means of providing public services. For instance, current research suggests that government organizations that have undergone complete privatization by divestment (i.e., the sale of government or state owned entities to private ownership) often perform better than their government managed predecessors. However, privatization comes in many forms and flavors. Research suggests that in order to succeed, the type of privatization being employed must fit the form of government and stage of economic development in which it is executed in much the same way as the structure of a project management function within an organization should be configured to match that organization's stage of development (Kendall & Rollins, 2003). Furthermore, these conditions, while necessary, still may not be sufficient for privatization to work. Ideal conditions, either internal to organizations or in the marketplace in general are difficult to achieve—and then there is the challenge associated with reconciling the fundamental differences between the public and private (and nonprofit) sectors in their treatment of public accountabilities and in their behavior in the marketplace.

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In the private for-profit sector, firms compete effectively by positioning themselves to strategic and/or tactical advantage over their competitors, which generally requires their strategic or tactical business information to remain concealed from their competitors. In addition to stories of corporate scandals involving accounting and disclosure improprieties, media reports also are rife with reports of industrial espionage undertaken by businesses for the express purpose of obtaining privileged information from competing firms to establish their own competitive advantage. Public agencies, in stark contrast, are required by policy or law to operate under clear public scrutiny—particularly in the United States, where a fundamental wariness of governmental power is so deeply ingrained that the country itself exists as a federation of states with an elaborate system of checks and balances designed to limit the power of government. However, both public and private service providers have been known to employ rather elaborate strategies—including reorganization of their governance structures or cooptation of nonprofits to maintain administrative hegemony and/or to circumvent public accountability.

Competition, the principle and disciplinary mechanism that, in theory, insures efficient and effective delivery of services in fact often operates imperfectly. It can be compromised by a number of factors, including but not limited to uneven information flows, regulatory barriers to efficient service delivery and the de facto formation of monopolies around complex contractual services (e.g., defense and aerospace) whose complexity itself represents a barrier to market entry. In the zero-sum game of the competitive marketplace, uneven information flows can bestow competitive disadvantages upon those whose operating plans and activities are relatively transparent while creating commensurate advantages for those whose strategies and operations are more discrete. The disadvantaged party is then compelled

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to seek ways to level the playing field. Remedial approaches that have been discussed here such as restructuring to obviate public scrutiny (or partnering with an organization that can) are germane to the case study being examined in this dissertation. Far less legitimate approaches, such as corporate espionage or malfeasance, are very much present in the marketplace, but often have resulted in far less desirable outcomes for all concerned. In any case, when the flow disparity is brought about by public disclosure policies, the affected parties are likely to seek adjustments of one form or other. Similarly, publicly imposed standards of service delivery can be problematic if not properly supported or subsidized.

Health care presents a number of formidable challenges to effective service delivery irrespective of the sector from which services are delivered. However, government-sponsored health care services delivered in the context of privatization take that challenge to another level of sophistication—one that requires the involved sectors (i.e., public, private and/or nonprofit), to reconcile some of their most fundamental differences to work in tandem toward common objectives. As might be surmised from the title of this dissertation, its thesis presumes the existence of conflict between sectors in the context of privatized service, in this case, health care delivery. This conflict, however, is not always a barrier to industry entry. The presumption is that conflict will emerge only to the extent that features of a privatization arrangement test the differing, sometimes opposing, expectations of the arrangement's stakeholders. Of course, these expectations are based upon the assumptions, operating cultures and paradigms of the principal parties and, in this case, the sectors involved. What remains in question, however, is how these divergent assumptions, cultures and paradigms might affect (or be affected by) organizational governance, behavior, and performance. Also, to the extent that a privatization arrangement is able to function

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effectively amid the conceptual fracas that could emerge within any or all of these areas, it would be useful to understand the nature of the conflict as well as whether and/or how the discordant factors may be reconciled in practice. Then it will be possible to discern the impacts that these factors (including their differences and their reconciliation) may have on the feasibility of privatization.

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Chapter 2

Governance from Public & Private Perspectives

Introduction

Mention of governance usually conjures fairly uniform notions of sanction and control, power and influence, rules and accountability, etc. Yet, the conceptualization of governance often differs according to the perspective of the sector from which it is viewed. In addition, there are varying styles of governance within each sector, some of which bear striking similarities in form and function to their counterpart models in other sectors. The notions of governance and organizational form (i.e. for-profit vs. nonprofit vs. public) are somewhat related in that certain styles of governance and board structures may be more characteristic of one sector than the others. By the same token, however, some board configurations and associated styles of data gathering and treatment of information that are predominant in one sector may be useful in others in which such configurations and characteristics are far less prevalent (Bowen, 1994). Still, the notion of governance has distinct connotations depending on whether it is being examined under public, for-profit or nonprofit models. For example, the sector to which an organization belongs determines the rules under which it operates and therefore its behavior in the marketplace. It can also present opportunities. That is, one organizational form may be more advantageous than others for administrative purposes or in cases where a particular model offers operational or economic advantages to the organization that

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outweigh the incumbent model's characteristic constraints. Such considerations are the basis for decisions to privatize, to enter partnerships (and with whom) and/or to reorganize a firm's governance structure.

Models of privatization in which government plays a regulatory role or in which the private sector participant remains subject to public oversight may require the differences in perspective and/or style between the sectors involved to be reconciled in order for the arrangement to function properly. If reconciliation is needed but fails to occur, the resulting conflict can doom the endeavor to failure. In order to understand whether and under what circumstances governance-related conflict may arise from differences in public and private sector approaches to service delivery when the two are thrown together vis a vis privatization, it is useful to examine more closely some of the differences in the three sectors' perspectives on governance and accountability. Also, because the central premises of this study call for examination of the possible impacts of regulation on privatization's feasibility or success, it is appropriate to focus on the types of privatization in which some level of government regulation remains after privatization occurs. Therefore the forthcoming discussion and associated case study analysis will focus on selected forms of privatization in which government maintains an administrative relationship with the private sector participant, i.e., contracting or reorganization.

Governance from the Public Sector Perspective

Kettl (2002) defines governance as a way of thinking about the strategies that governments employ to minimize their direct involvement in meeting their publics' service demands and/or as a way for government to administer its responsibilities in the collective interest through its broader social, political and

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economic environments. For public administrators then, governance is a process that, interestingly enough, may be quite separate from its regulatory activities and authority. Some authors, in describing governance from the perspective of public administrators, treat this distinction as one that exists between the notions of *governance* and *government*.

> For Robert O. Keohane and Joseph Nye, governance is "the processes and institutions, both formal and informal that guide and restrain the collective activities of the group." "Government," they explain, is the portion of the activity that "acts with authority and creates formal obligations." "Governance" describes the processes and institutions through which social action occurs, which might or might not be governmental." (Kettl, 2002, p. 119)

From this perspective, although government's regulatory institutions and functions may have roles to play in the execution of public sector governance, the distinctions set forth by these authors suggest that there can be a conceptual separation between a agency's regulation of a service provider and its own internal mechanisms and processes through which the agency's goals are accomplished and its responsibilities met. The independent execution of these functions sets up the possibility for the two functions to diverge to the point of opposition or conflict. This may occur, for example, when a government entity institutes and/or strictly enforces regulations that conflict with its contractors' ability to provide the very services that firm was engaged by that agency to provide. Similar conflicts may arise when regulatory constraints create barriers to market entry to which government responds by using tax revenues to subsidize nonprofits' provision of public welfare services that are necessary, but for which clear voter support has not been established. In such instances, government would be serving conflicting or opposing objectives. It follows logically then that this conflict presents a dilemma to affected agency officials in relation to how they

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perceive and exercise their regulatory/enforcement vs. their governance/oversight functions—particularly when, in practice, the two functions may be exercised in tandem or in ways that suggest that the functions are inexorably commingled.

The foregoing discussion also suggests yet another distinguishing characteristic of public sector governance. That is, apart from how an agency manages or administers its own regulatory responsibilities, its governance-related activity typically is *externally* facing—which differs from the private sector notion of governance, which is focused on internal organizational oversight. It is externally focused governance that poses both agency and political challenges. Again, the notion of agency here is meant in the context of the principal-agent problem in which the government entity is faced with the challenge of establishing and enforcing measures to insure that it gets exactly what it has charged the private entity to provide (Sclar, 2001). However, again like much of the privatization-related discourse to date, the definition and conceptual treatment of the principal-agent issue has been focused primarily on public sector concerns. Other than somewhat peripheral discussions of the expected opportunistic behavior of agents or their superior access to information relative to their public sector counterparts about the services that they themselves are charged with providing, the principal-agent problem has been examined primarily from the public sector perspective (Savas, 2000; see also Kettl, 2002; Milward, 1996; Sclar, 2001). Exploration of this phenomenon from a more private sector perspective—that is, in terms of its implications for private sector service-providers—is warranted as well.

As suggested earlier, one notable departure from the nearly exclusive public sector focus of privatization in the discourse is the discussion set forth by Milward (1996) and Milward & Provan (1998) on the application of principal-agent

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theory as it applies to privatized contracts in the field of public mental health. Their discussion first defines the central role of government in privatization as not just a regulator or enforcer of contractual terms with individual service providers, but as a coordinator or manager in a hierarchical network of private for-profit and/or nonprofit entities for delivery of an array of mental health-related services.[15] The discussion contemplates more of a *governance* role for government in this situation than that of governing or regulation per se. In addition, it focuses on the service provider network's behavior in the context of a rather specialized network model involving a dominant service provider acting as an intermediary or secondary principal controlling a number of smaller service providers as agents. The government entity (the primary principal) and/or the dominant service provider (the secondary principal) each act as monopsonies. The service provider network, which includes the intermediary, operates essentially as a monopoly with respect to service provision—a situation that the authors concluded was the most successful among those they had examined. While this treatment of privatization has a certain utility when applied to principal-agent theory (a point to which we will return later), it has certain limitations in terms of the extent to which it can be generalized to broader discussions of privatization because many of the outcomes may be ascribable only to the isolated model under discussion. Also, apart from the private sector perspective reflected in the treatment of this model, the true focus of the discussion is the public sector, i.e., the development of strategies for government to control its service providers.

Another long-standing burden to the U.S. government, vis a vis its governance function, is the ambivalence of public opinion with respect to regulation

[15] Public mental health services generally include an array of administrative case processing and monitoring functions, each of which may be outsourced to a non-government service provider.

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or imposition of similar controls on private sector activity. This is an expression of the well-known paradox created by the exercise of power by government in a democratic society. The U.S. Constitution's guarantee to its citizens of the right to the free pursuit of happiness implicitly encourages self-interested behavior. The crux of the problem, however, is that society is rife with opposing interests—particularly when the discussion turns to government regulation. Conceptually, regulation is the mechanism government employs to insure that the activities in which organizations or individuals engage in their self-interest do not infringe upon the rights and/or privileges of other members of the society in which those activities are executed (Fessler & Kettl, 1996).

American public sentiment historically has been ambivalent about regulation of business. That is, it has not been favorably disposed to limiting free enterprise through tighter regulation of business, but has had just the opposite sentiment when the discussion turns to government provision of societal needs such as health and safety or similar protections (Fesler & Kettl, 1996; Kettl, 2002). Regulation, in other words, is favored as a protective mechanism but not so much when it is perceived to be a hindrance to activities the majority of the citizenry considers fair and legitimate. Of course, fairness and legitimacy also are moving targets and, probably far too often, have been subject to the winds of circumstance and/or interpretation. While opinions following the rash of corporate scandals around the turn of the 21st century seemed to shift in favor of more and better regulatory safeguards to foster increased accountability and to insure ethical conduct in business, and class action litigation has been somewhat successful recently in securing substantial monetary damages from former directors of a company (Eichenwald, 2005), it would seem unlikely, given the history of the U.S. in this regard as well as its

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culture and sensibilities regarding size of government, that the public at large will embrace a wholesale increase in government regulation of business overall.

Privatization, however, muddies the waters a bit. That is, while privatization is supposed to leverage the efficiencies of free enterprise, there still are instances, particularly with respect to privatized health care and other forms of social services, in which public opinion may favor tight regulation and/or the imposition of other public accountabilities when such measures are perceived to be more consistent with the public interest than the alternative. However, certain current trends in public administration, specifically with respect to business' access to information relative to that of government, have softened government's willingness and/or ability to respond effectively to that sentiment. Factors such as the ever-growing ease of access to information in an increasingly globalized and/or integrated marketplace, and the deployment of networks of organizations as opposed to individual firms in the marketplace have combined to create an interesting dynamic from which has evolved yet another level of challenge to regulating the activities of organizations charged with the delivery of public services. Government, once exclusively privy to sensitive political and economic information, no longer enjoys that monopoly (Kettl, 2002). To the extent that knowledge truly is power and that a significant measure of that knowledge now resides in a growing and increasingly complex private sector, government's ability to exercise regulatory power and/or authority might be expected to erode and, perhaps for a time, government may be less effective in its regulatory or governing role.

The act of devolving public services or responsibilities to non-government entities has been a mainstay of U.S. public policy since World War II, with much of the policy emphasis defaulting to effective approaches in which government may

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engage to insure that services are being delivered in accordance with established government standards. At the same time, as the practice matures, we may eventually reach a point at which devolution and privatization will be approached and studied proportionately less in terms of government-initiated action and more in terms of the private sector's willingness and preparedness to take up the proverbial gauntlet. If so, this study will have some utility for understanding the dynamics of privatization as a private sector-initiated action or from the business-related perspective of a non-government provider of public services.

The Private Sector Perspective – Corporate Governance

Depending on the context of the discussion (and the perspective of the speaker), the term "private organization" may refer to any of a class of profit-seeking investor-owned businesses or nonprofit organizations. Their common characteristic is that they are nongovernmental or non-public, but they are entities over which government exercises varying levels of jurisdiction. However, each of those entities has distinct characteristics—especially in terms of the ways that they interact and/or operate within society, as well as in the nature of their relationships with government. Nonprofit organizations, for instance, have played such distinct and integral roles in society that they collectively and over time have come to define a discrete sector in and of themselves. Nonprofit or "third" sector organizations differ in many respects from both public and private-for profit organizations. Not only do many receive preferential treatment in the U.S. tax code, they also generally are distinctive in their organizational structures, in their fiduciary responsibilities, and in their styles of governance (Bowen, 1994; Wolch, 1990; Wood, 1996). Despite the fact that a number modern business and government practices—privatization in particular—feature

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behaviors that tend to blur distinctions between sectors (Salamon, 1999; Wolch, 1990), the sectors themselves are in fact distinct. For the purposes of the current discussion, however, the term "private sector" should be taken to include both the proprietary for-profit and the nonprofit or "third" sectors unless otherwise indicated.

As suggested earlier, the private sector corporate governance paradigm stands in deep contrast to that of public sector governance in terms of the former being primarily internally facing and concerned with how an organization operates, administers and governs itself in isolation of direct governmental involvement in these affairs. In addition, private sector corporate governance typically is exercised (for better or worse) through a board of directors or trustees who, ideally, concern themselves primarily with the strategic direction and viability of the organization—specifically in terms of the organization's ability to meet its objectives.

It has been argued by some that corporate governance concerns how an organization allocates power to investors in ways that protect their investments and obviate withdrawal of capital (Bowen, 1994; Shleifer & Vishny, 1997). This seems a reasonable assumption given that a sense of power and control is generally an effective psychological hedge against risk, and the protection of an organization's primary sources of capital is tantamount to its survival. A similar argument can be made with respect to the relationship between nonprofit governance and the allocation of power to trustees and stakeholders in the sense that these groups, as fund donors, grant benefactors and/or other sources of capital are somewhat analogous to corporate investors. While nonprofits may differ from their for-profit counterparts in the nature of the expected return on investment, the primacy of stakeholders vs. shareholders, etc., they are similar in their focus of power or decision-making on whether the "invested" funds are being applied effectively toward their intended purpose(s). Also

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the notion of risk associated with the desired return on corporate shareholders' personal assets in the for-profit arena is somewhat analogous to certain risks associated with a nonprofit's ability to satisfy stakeholders' expectations in ways that insure their continued financial and/or in-kind contributions and other commitments affecting the organization's ability to generate revenues. Success or failure in that respect will determine the nonprofit's ability to sustain itself just as surely as return on investment determines the continued viability of an investor-owned organization.

Similarly, from a governance standpoint, the ways in which power is allocated and exercised is of material concern to both types of organizations in terms of the roles and influence of their investors, directors and/or other stakeholders. There is implicit debate, however, about whether an organization's interests are best served when a power-oriented perspective is employed in decision-making versus one that is more focused on organizational structure and information management processes. It has been argued that proper governance should be less about power than about installing mechanisms that insure effective decision-making. For instance, John Pound (2000) in his analysis of governance in the for-profit arena draws a distinction between *managed* corporations and *governed* corporations. The former is characterized by insular decision-making in which the internal management maintains exclusive responsibility for charting the strategic direction of the organization primarily by limiting or denying shareholders and directors access to information they would need to make effective decisions. This is diametrically opposed to basic universally accepted governance principles.[16] Accurate and timely sharing of

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[16] In 1999, the International Corporate Governance Network (ICGN) endorsed the corporate governance principles set forth by the Organization for Economic Co-operation and Development OECD. A firm's profile relative to these principles has become an important consideration for investors (See Monks & Minow, 2001 p. 252-255).

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information with shareholders to facilitate informed decision-making in exercising their fiduciary voting responsibility is considered a central tenet of effective governance. Others include board independence (i.e., from the firm's management) and the board's accountability to shareholders (Monks & Minow, 2001). Pound's conceptual framework suggests, however, that even when the board of a managed corporation is endowed with independence in its decision-making and even when it has access to expert industry information, its influence is nonetheless limited in that the board only can affect the organization by setting and enforcing the conditions of employment of the chief executive officer (CEO), which in turn is typically based on performance measures, which, in managed corporations, ultimately are determined by the CEO. That is, performance measures ideally are based upon goals and objectives derived from the organization's strategic planning and management (Poister, 2003).[17] Such processes, in a managed corporation framework, generally are controlled by the internal management of the organization (Pound, 2000). In that sense, the CEO controls the strategic direction and operation of the organization. So the board's influence is relegated to management through its selection and evaluation of the CEO—hence the term managed corporation.

Governed corporations, on the other hand, feature empowered boards and processes that encourage and facilitate shareholder input to decision-making. Pound argues that governed corporations are preferable to their managed counterparts from a governance standpoint because the latter variety isolates boards and shareholders from strategy formulation and policy setting. The distinction between the power-oriented paradigm and Pound's dispersed decision-making model may seem at first glance to

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[17] Poister distinguishes between strategic planning and strategic management such that the former, which provides the "big picture," is a subset of the latter, which is very broad in its impact on both the direction and the actual operation of the organization (See Poister, 2003, p. 159-60)

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be too subtle to discern. After all, power and influence are closely related. The difference, however, has to do with the way that information is treated—whether and with whom it is shared and the extent to which it is accessible to and/or applied by the organization's leadership in its decision-making. For instance, when critical organizational information is shared with investors and/or stakeholders for the purpose of involving them in planning or decision-making, it provides a sound basis for their decision-making. Decisions representing diverse opinions and concerns can be more informed and address a broader range of issues—some of which may be critical to the viability of the firm. A power orientation is less desirable from that perspective because power has a way of reinforcing insularity. That is, the more concentrated power becomes, e.g., in an individual or to a small internal group of an organization, the higher the likelihood that decisions will be made in self interest or, if there is a dispute, settled politically (Ferris, Galang, Thornton & Wayne, 1995).

Political decision-making typically occurs when there are competing interests to be reconciled. Compromise solutions are negotiated that, in the end, may bear little resemblance to any side's proposed position (Patel & Rushefski, 1999). Power-motivated political decision-making differs from the consensus decision-making characteristic of what will be termed, for the time being, the more democratic model in that the former is generally less informed and primarily involves the exercise of power. By contrast, the latter is associated with informed decision-making. In addition, the self-interest aspect of power-motivated decisions tends to narrow the scope of influence such that the resulting decisions may not necessarily be representative of those favored by a majority of the shareholders or stakeholders; nor may they be in the best interests of the organization. By the same token, shareholder consensus may not always be a reliable basis for decision-making either.

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In an April 2004 panel discussion of prominent business leaders convened by the University of Delaware's Weinberg Center for Corporate Governance on the subject of corporate governance guidelines, Robert Miller, former CEO of Bethlehem Steel and a director on the board of United Airlines, fielded an interesting question from a faculty and student audience. The question was: "What should be done when the shareholders favor a move that is judged (i.e., by the board) not to be in the shareholders' best interests?" Mr. Miller responded that directors, as a matter of course, are obliged and empowered to run corporations in their shareholders' best interests. The moderator and subject matter expert, Charles Elson, Esq., added that board members are elected to exercise good judgment even if they do not agree with shareholders. Another prominent panelist, Supreme Court Justice Myron Steele, agreed. Citing the "business judgment rule," he stated that the board is responsible to follow its own conscience in acting in the shareholders' best interests (Biggs, Elson, Emen, Jadick, Miller, Sherman, Steele, & Ward, 2004).[18] So the existence of a more democratic governance model in which there are mechanisms for keeping shareholders informed and encouraging their participation in decision-making does not guarantee that the shareholder vote will determine the outcome since it can be legitimately trumped by a board decision. However, that board decision may still be considered more circumspect than one made by a power-oriented board because the former, at least in theory, would have taken its shareholders' sentiments into consideration.

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[18] The participating panelists and their affiliations at the time were: John Biggs, Former Chairman & CEO, TIAA-CREF—also serves on boards of JP Morgan Chase, Boeing; Michael Emen, Senior Vice President, NASDAQ Listing Qualifications Department; Ted Jadick, Vice Chairman, Heidrick & Struggles; Robert S. Miller, Former CEO, Bethlehem Steel, & board director at United Airlines; Howard Sherman, CEO, Governance Metrics International; The Honorable Myron Steele, Justice, Supreme Court of Delaware; Carol Ward, Corporate Secretary & Compliance Officer, CIGNA

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While the principles set forth by the Weinberg Center panelists and those represented in Pound's treatment of governance are actually couched in terms of for-profit enterprises, several of these principles may be valid for the nonprofit sector as well—particularly in terms of their treatment of company information and the impact of that information on decision-making. That is, the roles these principles suggest for nonprofit boards of directors or trustees as well as benefactors or stakeholders that are otherwise financially committed to the nonprofits' activities may be considered roughly analogous to the roles described for their for-profit counterparts—namely those of investors and boards of directors.

However, a distinction should be drawn between primary stakeholders of nonprofits and those who may be thought of as secondary stakeholders in terms of their relative roles in organizational governance. Primary stakeholders generally include those that directly influence the operation or administration of the organization such as financial benefactors or agents of contract (and/or regulation). Secondary stakeholders are the beneficiaries of the services that the organization provides. Primary stakeholders would be more likely to play a direct role in organizational governance, and to a great extent, represent the interests of secondary stakeholders in much the same way as for-profit boards represent the interests of investors or shareholders. However, if we accept the premise that information access is crucial to effective decision-making, and that the information afforded to consumers is of far less administrative utility to the firm, then direct involvement of secondary stakeholders in governance-related decision-making would be, at the very least, somewhat ill-advised.

Just as there are usually functional segments and levels of organizations that correspond to discrete functions, so too are there corresponding depths and types

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of information germane to those functions. Boards, for example, function ideally at the governance or strategic level. That is, their responsibilities and decisions are associated with issues such as the purpose and direction of the organization, leadership and succession, and external organizational associations. This focus is distinct from that of management, which operates more at the tactical level, where decisions typically focus on the actual approaches and/or activities associated with executing a firm's strategic intent.

With respect to appropriate information flows then, secondary stakeholders, who are analogous to consumers in the for-profit arena, while very able to contribute reliable information about their product and service preferences that can in turn inform tactical management-level decisions, are not ideally positioned to inform those made at the governance level. To the extent that board decisions are primarily strategic, consumer (i.e., secondary stakeholder) sentiments should remain mostly peripheral to decision-making at that level. In addition, shareholder voting conventions such as the one-share-one-vote rule do not easily translate into an equivalent governance input mechanism for secondary stakeholders in the nonprofit arena, and the fiduciary obligations often differ as well. Nonprofit secondary stakeholders do, however, have recourse. Stakeholders as consumers can exercise influence, albeit less directly, through political, public policy and market-related processes. When sufficiently organized, the influence of these input sources may be felt at all levels of an organization.

Private Sector Governance & External Relations

A corollary to the importance of organizational form is that of organizations' external relationships—the quality and effectiveness of which depends heavily on the compatibility of the internal organizational culture with those that

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comprise its business environment. One of the most telling commentaries on the reciprocal impacts of privatization and governance concerns the extent to which the private sector organization depends on government funding. Most studies on the subject conclude that, at least with respect to nonprofit organizations, reliance on government funding typically leads to greater control by internal management and staff and a lessened leadership role for the board (Wood, 1996). Assuming Pound's assessment (i.e., that such conditions are anathema to effective governance) applies reliably to nonprofits, then one can expect nonprofits that rely on public sector funding to face governance-related challenges.

Also of concern are relationships that are formed with government apart from those that are financial and/or regulatory in nature. As Kettl (2002) observes, when government interacts with external partners, those partners most often are compelled to interact with a bureaucracy that is comprised of different individuals performing various functions at different levels of the organization making different decisions for different reasons to achieve diverse, sometimes conflicting objectives. One agency level's decisions, for example, may focus on reconciling operations and budgets, another level on managing or controlling service delivery, and yet another on managing public perceptions and/or protecting the agency's political position. To make matters even more complex, because of the prevalence of subcontracting in all sectors, the government agencies themselves may in turn encounter any matter of external bureaucracies as a matter of course. The likelihood of such eventualities increases in the context of privatization arrangements—particularly those in which regulation and other accountabilities are at issue.

The analogous situation in the health care arena involves how government health care programs interface with private sector service providers. The Medicare and

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Medicaid programs each represent multi-level bureaucracies that are faced with the intrinsic and perennial dilemmas associated with maintaining equitable distribution of services at acceptable quality levels and at reasonable cost. Because of the broad scope and massive scale of these programs, their management and the related policy issues are almost always politically charged. This bureaucracy interfaces on the private side with an equally complex administrative, economic and political framework in which, for example, variable regulatory approaches may be indicated depending on the type of service provided and the organizational form of the service provider.

The question of whether a hospital is organized as a public, a nonprofit or as a proprietary institution, for instance, has significant implications with respect to whether and/or to what extent government may exercise control over the facility's activities and service mix. This in turn may be influenced significantly by public expectations regarding the levels and types of service the facility provides. It follows then that the involved government agencies and programs and the service organizations would engage each other—often at various levels simultaneously—as a result of the social, administrative, economic and political considerations associated with implementation, e.g., the provision of services. However, operational policies are reasonably centralized within individual hospital facilities. So while the perspectives at different levels of the individual organization may vary, policy centralization may reduce the challenge to intra-organizational communication relative to those found in a governmental framework. Nonetheless, the relationships between the public and private sides of the equation can be quite complex and daunting to manage—particularly when other inputs or constituencies influence the selection of organizational form. Take, for example the influential role that physicians have

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played historically in influencing the nonprofit vs. for-profit organizational status of hospitals (Marmor et al., 1987), and the evolving role of insurance administrators in setting standards of treatment in the context of managed care (Kamoie & Rosenbaum, 2002).

Government regulation is a particularly specialized and important form of external relations with which firms both within and outside of privatization arrangements must contend. Fesler and Kettl (1996) distinguish between economic and social types of regulation. The former includes activities authorized under antitrust laws that guard against unfair business practices and methods of competition as well as certain industry-specific activities that control market entry and pricing. For-profit businesses are the primary recipients of this form of oversight, and its tenets hold whether or not the firm is otherwise engaged with government in a privatization arrangement (See Table 2.1). However, as indicated earlier, the introduction of privatization can sometimes set up tensions between the firm's loyalty to investors and government-mandated service standards. The social variety of regulation, on the other hand, focuses on issues such as public health and safety, equity, fair employment, etc. To the extent that for-profit and nonprofit enterprises become engaged in privatized social service delivery, they become subject to the brand of scrutiny characteristic of social regulation. While this form of regulation may not typically concern itself as directly as the economic form with respect to a firm's business practices such as competitive behavior and pricing, it introduces yet another layer of influence and/or accountability to those practices—that of consumers. Table 2.1 provides a useful way

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Table 2.1 – Accountabilities by Sector & Privatization Status

Accountabilities	Conventional For-Profit	Privatized For-Profit	Conventional Nonprofit	Privatized Nonprofit
External	Creditors, equity shareholders and other investors; product markets; financial markets	Creditors, equity shareholders, government, and service recipients (stakeholders)	Constituents and other stakeholders; private donors	Constituents and other stakeholders; private donors; government agency
Internal	Board of directors, investors and/or creditors	Board of directors; administering government agency; regulatory agencies, investors or creditors	Board of directors or trustees	Board of directors or trustees; administering government agency
Legal/Regulatory	Corporate bankruptcy courts, antitrust and disclosure laws;	Corporate bankruptcy courts, antitrust and disclosure laws; government service standards	501 c. provisions of Federal tax code	501 c. provisions of the Federal tax code; government service standards

of comparing consumer roles across broad organizational categories arrayed against the three major types of accountability to which organizations may be subject under regulated privatization. The outline is somewhat artificial in that it assumes, for the sake of simplicity, a fixed repertoire of services. That is, each organizational type is viewed in terms of the internal, external and legal accountabilities that would be

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brought to bear assuming that each organizational type provides the same services of comparable cost and quality. However, it is a clear conceptual display of the pervasiveness of external accountability among the privatized organizations, and suggests that the additional layer of consumer influence associated with social regulation under regulated privatization may be ideally "positioned" to have a significant impact on a firm's business conduct, its outcomes and, as indicated earlier, its governance.

Finally, the impact of environmental influences on the behavior of organizations (and their relationship with an organization's preparedness for change) has been long established. In their groundbreaking work, Lawrence & Lorsch (1967) argued that organizations thrive largely by developing and implementing strategies to effectively control their external environments. This suggests a rather intimate relationship between organizations and the environments in which they operate and has interesting implications in the context of privatization—particularly in instances in which government oversight or regulation are factors. One might expect, for example, a government organization to employ regulation to establish control of a privatization relationship, and for the corresponding service provider to employ strategies to circumvent or avoid such regulation to maintain its own autonomy. In any case, these assertions suggest that organizations must not only be aware of the environments in which they operate, but must understand how the idiosyncrasies of their environments impact organizational effectiveness and incorporate that knowledge into their strategic and tactical decision-making.

Corporate Governance, Fiduciary Issues & Market Behavior

In Anglo-Saxon economies (i.e., the U.S. and U.K.), the corporation, its management and its board of directors in particular have primary fiduciary

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responsibility to the shareholders of the firm (Allen & Gale, 2000). In their *Survey of Corporate Governance,* Shleifer and Vishny (1997, p.737) state that

> Corporate governance deals with the ways in which suppliers of finance to corporations assure themselves of getting a return on their investment.

What all of this means in practical terms is that all activities of the firm, contracts, investments and the treatment of the firm's assets should be directed toward increasing the value of the company's shares and hence the company's value to its shareholder investors. While it is certainly in a company's best interest to attend to and address the needs, demands or preferences of its various stakeholders (e.g., customers, employees, suppliers, etc.), including those supported by contract or public service regulation, its primary fiduciary responsibility is to its shareholders. It is in that regard that one might expect that privatized delivery of public social services—particularly those considered entitlements—would be potentially problematic.

From a regulatory standpoint, a private contractor may conceivably be constrained (e.g., by contractual terms, charter, or by legislated standards of public service delivery) in ways that force it to adopt business practices that compromise or undermine the firm's value in terms of its profit-making potential. This might be regarded as the principal-agent problem in reverse—a scenario in which the firm's service delivery meets public agency standards but does so to its own detriment, e.g., at the expense of optimal efficiency and/or profitability. In the context of a publicly traded firm that actually has shareholders, this would be considered tantamount to placing the needs or demands of the firm's stakeholders (e.g., government agency and consumers, etc.) above those of its shareholders. Yet the private service provider may be compelled to do so in such instances, at least in the short term, in order to comply with contractual terms and/or minimum government-regulated performance standards.

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The dilemma represented here is a classic *Catch-22*. The U.S. regulatory environment (not to mention the business culture and traditional model of publicly held firms in the U.S.) essentially mandates firms' fundamental allegiance to their shareholders. This stands in direct opposition to the notion of firms prioritizing the interests of stakeholders over those of shareholders. That is, strong legal precedent upholds the primacy of shareholder over stakeholder consideration in instances where the two are in conflict. The Delaware courts, arguably the most influential purveyors of business policy and law in the nation, have strongly upheld shareholder primacy—both in the State's Chancery and in its Supreme Court (Monks & Minow, 2001).

Nonetheless, under circumstances in which markets are imperfect or incomplete, a stakeholder orientation may be superior to the traditional shareholder-oriented model of corporate governance (Allen & Gale, 2000). Note again that the traditional governance model emphasizes the primary fiduciary responsibility of the firm's officers—board and management—to their shareholders. However, when firms are subject to imperfect competitive conditions as may be the case in privatization of a number of public services, an approach that balances stakeholder interests with those of shareholders may be appropriate and perhaps more effective. Case research on imperfect competitive service markets such as health care, education and the like could discern whether privatized firms flourish and/or perform more effectively when their behavior is more consistent with a stakeholder governance orientation. If so, reason suggests that U.S. social and/or health care service privatization arrangements would be more effective if drawn in compliance with the stakeholder standard, that privatization in this industry area may represent an exception to the traditional shareholder primacy rule, and that a more holistic (in terms of information inputs) approach may be indicated.

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Summary

Governance from a public sector perspective is a way for government to exercise power in the public interest. Regulation is an important mechanism by which this occurs, but because it can either protect or hamper free enterprise, it must be carefully and prudently executed. Public and private sector styles of governance differ in several respects but may be both similar and compatible in others. They generally differ in terms of their foci, i.e., the public sector's focus is primarily (but not exclusively) externally facing. Even its internal governance-related activities ultimately are likely to result in the exercise of authority external to the agency.

Private sector governance is focused internally in the sense that it is concerned with the firm's own leadership, internal information flows and/or their influences in exercising control over the organization's strategic direction and operation. Still, as is the case with public sector agencies, external environmental factors may have a significant impact on private sector organizations as well (Lawrence & Lorsch, 1967). Proprietary firms, for example, must contend with the whims of the marketplace and public policy. Nonprofits may be even more so vulnerable to environmental influence in those regards. However, with respect to governance, the ability of private sector boards of directors and/or trustees to deliberate and/or to make decisions in private provides a measure of insulation from environmental influence that public agencies typically do not enjoy.

Proprietary firms, in contrast to government entities or nonprofits, are primarily accountable to their shareholders, whose principal interest generally is to receive an adequate return on their investments. On the other hand, public entities often must adhere first to standards of public service delivery, particularly as it applies to providing for the public welfare. In other words, government entities, and

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nonprofits to some extent, are significantly more accountable to their *stakeholders* than are their proprietary counterparts.

Services that are provided to maintain the public welfare generally are regarded as entitlements by government and, just as importantly, perceived as such by a large proportion of American society. Of course, entitlement also implies equitable distribution—a notion that is completely incompatible with the traditional notion of a free competitive market economy in which the presence of inequity is not only assumed but arguably necessary for maintaining the class divisions that sustain this type of economy. With respect to entitlements, even when comparable goods/services are available for purchase in the marketplace, societal expectation and, in many instances, constitutional mandate, compel government intervention to the extent necessary to insure equitable access to such services to its citizens regardless of individuals' ability to pay. Government, for example, is held responsible for providing sufficient health care services for its indigent citizens, i.e., the poor and uninsured to maintain acceptable levels of health in the community. Just as monopoly is anathema to competition on the supply-side of the equation, equitable distribution of goods and services is similarly opposed to the zero-sum game philosophy of the laissez-faire marketplace on the demand-side.

Governance in the private for-profit and nonprofit sectors may be viewed either as the allocation of power in ways that protect the interests of investors and/or stakeholders, or as organizational structuring to control and leverage information flows in ways conducive to effective decision-making, which presumably protects their interests as well. Securing the trust of investors/financiers as well as suppliers, workers and other stakeholders is crucial to the viability of any firm—and trust is won by establishing credible mechanisms that insure accountability and ready access to

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information by all concerned parties (Dyck, 2001). Theoretically then, it would be possible to effectively serve the interests of a number of constituencies simultaneously—as long as proper reporting and/or accountability mechanisms are in place. In other words the best interests of contractors could still be served even when governance styles or priorities deviate from the more traditional shareholder primacy model.

A distinction has been drawn between managed vs. governed corporations in some governance-related discourse. The foregoing analysis suggests conceptual linkages between managed corporations, power orientation, restricted information flows and insular decision-making vs. those between governed corporations and decision-making informed by shareholder/stakeholder inputs that facilitate governance. From this perspective, the analysis supports the notion that prudent and timely information sharing may be superior to a power-oriented approach to governance because it results in more informed decision-making at both the governance (strategic) and management (tactical) levels of organizations. However, sometimes decision options that are informed by and/or representative of the interests of investors (financial or otherwise) are not always conducive to optimal outcomes. Therefore boards must be both effectively informed beyond immediate organizational inputs and sufficiently empowered to decide in ways that may oppose the opinions of their organizational investors and stakeholders when such actions are indicated. All of this simply underscores the importance of establishing not only effective approaches to governance but also effective and reliable board member selection and officer succession policies.

This dissertation provides interesting insights about what happens when public sector sensibilities, rules and regulatory requirements encounter the fiduciary

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characteristics, governance styles and competitive considerations idiosyncratic of private sector provision of products and services. It does so by examining salient aspects of the paradigms under which public, private and nonprofit sectors each function while examining some of the interesting ways in which they may interact operationally in privatization scenarios. The upcoming chapter will explore how the research methods and strategies employed in this study were designed to effectively mine information about the salient characteristics of the three sectors in order to answer the study's central research questions.

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Chapter 3

Research Methods

The Case for Case Study

As indicated, privatization can be a relatively complex multifaceted organizational phenomenon that may be initiated in a number of ways and/or exist in a variety of forms. Contractual privatization arrangements, while representing only one type of privatization, can be as varied as the types of public services and private sector firms that are prepared to furnish them. The sheer volume and variety of possible approaches to contractual and other divestment forms of privatization also pose unique research-related challenges.

For a business firm considering participation in a privatization arrangement, having access to a variety of options means tremendous flexibility and potential for creativity. This is a tactically ideal situation from business or entrepreneurial perspectives. However, from this wealth of possibilities has sprung an absolute plethora of contractual and/or divestiture models that pose the very challenges to traditional quantitative research I just mentioned. Wide ranging variability in both the terms of agreement and the business or service models to which they may be applied defies and confounds traditional comparative analysis. To the extent that causal relationships between inputs and outcomes vary with the composition of the models being compared, the notion of assessing or even identifying meaningful correlations across models becomes increasingly untenable. Fortunately,

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the traditional quantitative, experimental research design is not the only option. A strong case can be made for taking a more qualitative approach or perhaps even a pragmatic blending of qualitative and quantitative data to gain useful insights about complex concepts and issues such as those germane to privatization.

In his seminal text, *Qualitative Evaluation and Research Methods,* Michael Patton captures the utility of the qualitative approach for the type of research represented here by describing the work of the qualitative methodologist, who

> …attempts to understand multiple interrelationships among dimensions that emerge from the data without making prior assumptions or specifying hypotheses about the linear or correlative relationships among narrowly defined operationalized variables. (Patton, 1990, p. 44)

This dissertation incorporates a naturalistic case study approach as a practical means of observing privatization *in situ* and understanding both its nature *and* its context. My objective and the overarching approach to execution of the current study is one of discovery, which has major implications with respect to my selection of research design and approaches to data gathering. For instance, the emergence of additional pieces of information during the course of the study prompted refinements in my approach. I made tactical adjustments and even changes in the focus of my interviews and other research when I uncovered information I believed warranted further investigation. Thus I was able to maximize my ability to discover—to learn of issues of which I was previously unaware, and to plumb in-depth into those that I judged to be relevant or meaningful. To my positivist colleagues who are accustomed to controlling variables and hypothesis testing, this might seem a bit like an erratic loosely structured pursuit of disparate bits of information random and, at

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very least, unacceptable. However, while decidedly inductive, flexible and iterative, the approach is neither erratic nor unstructured.

Patton argues, and quite effectively, for a "paradigm of choices" with respect to research design; an approach that he says

> …rejects methodological orthodoxy in favor of *methodological appropriateness* as the primary criterion for judging methodological quality. The issue then becomes not whether one has uniformly adhered to prescribed canons of either logical-positivism or phenomenology but whether one has made sensible methods decisions given the purpose of the inquiry, the questions being investigated, and the resources available. The paradigm of choices recognizes that different methods are appropriate for different situations. Situational responsiveness means designing a study that is appropriate for a specific inquiry situation. (Patton, 1990, p. 39)

In that same spirit, proceeding purely *sans* thesis or without presuppositions or hypotheses to frame the research is not always desirable either. For example, the research supporting this dissertation was conducted within a predefined framework of possible scenarios that were sufficiently broad to provide an effective yet flexible way to organize information regardless of whether or in what form that information emerged. This approach is similar to a qualitative research strategy used increasingly by futurists and even by the General Accounting Office (GAO) of the U.S. Government to help policymakers understand the possible implications of proposed laws. This practice falls under the broad category of prospective or anticipatory research, which often utilizes scenario construction to outline alternative approaches to or lines of questioning (Patton, 1990). Several examples of research scenarios are presented in the Analytic Memo in Appendix B of this dissertation. The memo outlines, for example, how one might expect to proceed with the investigation depending upon what was learned about the primary revenue source(s) of the

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organization being examined and/or factors like political or logistical concerns that could have influenced outcomes.

Treatment of Key Research Questions

This study seeks to answer several important questions or to verify existing answers about how privatization can affect the private service provider, especially with respect to governance and accountability. In order to do so each broad question was, to the extent necessary, deconstructed into component issues and/or operational questions that, when posed to subjects or explored in the literature, elicited answers to the broader questions. Note, as will be discussed shortly, that the iterative nature of qualitative inquiry encourages the use of probative questioning, which requires a certain level of flexibility (not to mention art) in the formulation of questions during the interview or in the process of executing other data gathering approaches. Therefore the questions outlined below are by no means an exhaustive listing of those employed, but are representative of what may be termed the 'logic of inquiry' embedded in this study. So the central questions and/or issues, in that context, may be stated as follows:

- What are some of the key factors to be considered by service providers that are considering entry into (and/or maintaining a successful role in) a privatization arrangement?
- How, if at all, do public and private perspectives differ within the context of privatization, and how might the differing perspectives of public and private sector entities affect the privatization decision? …the execution of a privatization arrangement? …its effectiveness?

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- How, if at all, are governance and operating conditions (e.g., finance and accounting, human resources, logistics, etc.) within the service provider organization affected by the terms and/or external accountabilities associated with privatization?
- What are the important performance indicators that a privatized service provider should monitor to assess its success or failure—vis a vis the privatization arrangement as well as its organizational viability?

Given the complexity and interrelatedness of questions and issues in this milieu, the case study method seemed an ideal approach for soliciting the depth, context and detail these questions demand. Of course, the questions themselves were not posed directly in the e-mail survey or in the Interview Guide (See Appendix C: Other Research Instruments). However each instrument was designed to address these questions and/or underlying issues.[19] Similarly, the approaches taken with respect to the literature and media research components of the study also were informed by and based upon these questions. While the availability of an interesting and relevant case for study was somewhat serendipitous, the occurrence might be considered analogous to the role played by accident and luck in many landmark scientific discoveries—and certainly no less legitimate or productive.

Case Selection

The subject of the case study selected for this paper is the privatization of Tampa General Hospital (TGH). From a methodological standpoint, selection of the

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[19] Note again that because interview questions are iterative (i.e., sometimes building one upon the other) and/or probative in nature, interviews often included questions not represented in the interview guide. However, additional questions, even when purely extemporaneous or exploratory, were purposive in terms of addressing the above listed questions or issues.

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reorganization of TGH for case study was unabashedly purposive. The story of the privatization of this particular hospital, a public entity until its privatization in 1999, provides insights about privatization from the standpoint of its feasibility within the political, social and economic milieu in which the reorganization took place. The case also is interesting in the sense that privatization was considered and employed by the hospital's leadership ostensibly as a tactical measure to circumvent a regulatory policy that was perceived as a threat to the institution's survival. This tactical application sets TGH apart from more conventional privatization scenarios but highlights important differences in the operating assumptions of the public and private sectors that can increase our understanding of privatization. It also demonstrates why a shifting of governance through privatization in and of itself may be an effective, but not necessarily sufficient, measure for reducing regulatory influence and/or public sector oversight.* TGH's privatization is a salient case in this context because it represents an opportunity to discern and examine some of the challenges and conflicts associated with the privatization/reorganization of a hospital facility that was embroiled in controversy as well as the nature of conflict that occurred after reorganization when regulation of the private enterprise went somewhat awry. The conditions surrounding TGH's post-privatization recovery are similarly instructive.

The privatization of TGH also was contextually rich. It features, for example, private sector-style organizational governance and competitive behavior in the context of regulatory and public policy-related accountabilities. Understanding the complex political, legal, social, economic and competitive business environments in which Florida hospitals operated in the years surrounding TGH's reorganization

* This statement refers specifically to instances in which regulation or public oversight impedes performance or threatens organizational viability, which is not always the case.

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provides a fascinating backdrop against which to examine critically relevant features of organizational behavior, privatization and governance. Also, part of what makes the case so fascinating is that, while it is a somewhat unique privatization scenario that does not easily map to any one particular model for purposes of comparison, it also is a conglomeration of several sometimes disparate characteristics of privatization and governance that may be revealing from each of the perspectives represented. For instance, the factors influencing decisions and outcomes in the case of TGH are in some ways comparable to those found in infrastructure privatization through leasing (Savas, 2000). However, the contributions to the case by the courts, local government, the hospital's administration and even the public at large all made for a somewhat eclectic mixture of outcomes, each by exerting significant levels of influence in the privatization decision itself and/or during and after implementation. While this added to the richness of the case, it also presented yet another methodological challenge—the appropriate selection of the unit(s) of analysis.

The complexity of the case and the number of contributing variables and relevant questions raised make such a selection far from clear-cut. The factors being examined required the selection of the unit(s) of analysis to be sensitive not only to the gist of the research question (i.e., the nature of conflict engendered by public oversight in privatization), but also to the multiple perspectives from which the phenomenon might be examined most effectively. From the perspective of hospital governance and the decision to privatize, for instance, the small group of individuals that comprise the hospital's board of directors and administration are a legitimate unit of analysis. If, however, the true objective was to examine the hospital's privatization in terms of its performance and/or effectiveness, the unit of analysis would the hospital itself, which might include the facility's financial performance, the interplay between the hospital's

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board and administration, as well as its employees and patients (e.g., rates and types admitted and discharged). Of course, since the hospital also does not exist in a vacuum, several other potential foci could be of considerable relevance. Examples include, but are not limited to, the hospital's competitive positioning relative to its service area, government regulation of the hospital's activities, and political support for decisions about the hospital's governance that may impact its service to the community. Such considerations might expand the unit of analysis to include other hospitals in the community with which TGH competes as well as the collective units of government and community stakeholders. However, the unit(s) of analysis, like the design of the case study, should be selected on the basis the research question(s) the investigation sets out to answer or elucidate (Yin, 2003). Ideally, the research question and subsequent investigation should in turn seek to address an unresolved problem, prove a theory that has yet to be proven, answer an unanswered question, or make a substantive contribution toward any of those ends. With respect to the current study, the decisive questions were: what substantive issue(s) about privatization and governance might this study elucidate and what relevant factors would be most useful to examine in that regard?

Kettl (2000), in his discussion of the evolution of administrative theory, provides a bit of a clue in his reference to the perspective of Hebert Simon, the Nobel Prize-winning social scientist, who argued that decision-making, not organizational structure, is the central problem of administration. The TGH case study seeks to elucidate why privatization was the hospital leadership's solution of choice as well as the nature of the resulting conflict and its reconciliation. So while the hospital's competitive, political and regulatory environments are relevant and important for achieving a true appreciation of the case of TGH's privatization, the central theoretical

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focus of the case rests on the decision to privatize. Therefore the unit of analysis for the case study is the decision itself.

Imbedded in any decision process are antecedent conditions that comprise the rationale for its pursuit, the salient aspects of its execution, and its expected outcomes. With respect to business and/or government decisions, outcomes may be viewed in terms of performance-related factors such as efficacy, cost benefit, return on investment and environmental impact—all of which are conducive to an enhanced understanding of the phenomenon in question—in this case, the decision to privatize. The research task then was to ascertain the optimal approaches to data gathering, i.e., the most accurate and productive ways to observe and catalog these conditions given the availability of the information and the expected utility of analysis.

Sampling Approaches: Respondent Selection & Data Gathering

Successful establishment and implementation of a privatization arrangement depends on a number of factors—not the least of which is the context in which it is established and implemented. The TGH privatization case embodies several contextual variables that are generally present to varying degrees in many privatization scenarios. In the case of TGH, however, they are intensely present and therefore particularly vivid. For example, the political, regulatory, financial, economic, competitive, and sociological contexts within which privatization occurs each may exert varying levels of influence from one case to another, but they are factors that generally warrant consideration. Viewing a case in which a given set of variables (contexts in this instance) exert significant influence facilitates analysis of those variables. The analogous practice in the natural sciences might be the examination of a specimen under a microscope at multiple magnifications to view its

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composition and behavior at the cellular level to understand more fully what is happening to the associated organism at the macro level.

The advantage of this approach, called "intensity sampling," is that it can elucidate more fully the phenomena under study than cases in which the effects of such phenomena are more subtle and therefore more difficult to observe or analyze (Patton, 1990). Social services and healthcare in particular bring rather vivid examples of possible challenges to privatization in terms of the political, economic, regulatory and competitive business contexts in which these services are delivered. Part of what lends additional utility to the case of TGH in that regard is the fact that it takes place in what has been identified as one of the most restrictive regulatory environments of any capitalist economy on the planet (Fesler & Kettl, 1996). While one cannot assume that the challenges faced by TGH will exist broadly in the same form or intensity evident in the case to be presented, its richness provides useful insights about the challenges and contexts themselves. In fact, the case of TGH may be particularly useful because it both the failure scenario and the success scenario are represented in this single case. That is, it demonstrates organizational and political conditions under which privatization was neither viable nor effective as well as those under which it was able to thrive. From a research perspective and in the context of this dissertation, understanding the conditions under which privatization may fail or thrive in the provision of healthcare services is especially desirable.

The research model of this study is comprised primarily of interview combined with review of public documents, press articles and scholarly literature (i.e., books and journals). Interviews were conducted both by telephone and in person. Most interviews were tape-recorded. Telephone interview(s) were conducted in the privacy of my own office via speakerphone. In-person interviews also were conducted

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in private and generally at quiet locations to minimize distractions. Written or verbal consent was obtained from each subject prior to their participation in the study. The consent request also secured permission for audio-taping while disclosing the nature of the research and intended use of the information collected (e.g., literary referencing, publication as a dissertation or journal article, archiving for future reference, etc.)

A chain/snowball sampling approach was utilized in the selection of suitable interview respondents. That is, data collection proceeded in an iterative fashion, i.e., in "phases" such that information gathered from one source informed and defined the direction of queries of other subjects and sources in subsequent phases of the research.

- Phase I: an initial exploratory interview with an expert followed by preliminary literature search, topic/case selection and initial interview subject identification..
- Phase II: document/literature reviews combined with in-depth interviews of several subjects identified in Phase I, and
- Phase III: site visit and tour of hospital facility with opportunistic on-site interviews if possible; e-mail survey to selected TGH staff; and return debriefing "member check" interviews with expert subjects.

The Phase I interviewee was Charles Elson, an attorney as well as a professor and the director of the Weinberg Center for Corporate Governance at the University of Delaware's College of Business & Economics. Professor Elson is a well known legal expert in the field of Corporate Governance, a central variable in this dissertation. In addition to his appointment in 2003 as an advisor to the board of

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directors of Freddie Mac, Professor Elson is the vice chairman of the American Bar Association (ABA) Business Law Section's Committee on Corporate Governance. He also is a member of the ABA Committee on Corporate Laws, and has served on various commissions of the National Association of Corporate Directors (such as Audit Committees, Strategic Planning and Director Compensation commissions). Professor Elson currently serves as a director on several company boards and has written extensively on the subject of boards of directors.

The initial interview with Professor Elson was exploratory in nature and conducted in person in an isolated office where possible interruptions or distractions could be minimized. An exploratory line of inquiry with this particular respondent played a pivotal role in the research. While he did not play a formal or direct role at TGH, he was familiar enough with the case to appreciate some of its policy- and governance-related implications. His expertise in these areas also proved to be an invaluable resource in terms of its capacity for framing the research, helping to define the relevant questions and for providing insights from those perspectives that informed the direction of subsequent research activities. For example, his input directed attention to cases or instances in which core principals of governance and privatization were being applied in ways that might be instructive or in which generally accepted notions were being challenged.

Of course, as an attorney, Professor Elson's input proved to be indispensable with respect to its potential for casting light on the legal contexts and implications of any corporate or government action germane to the case(s) under examination. The assumption operating here is that legal activity is a reasonably reliable indicator of conflict—another important research variable in this study. Therefore, the associated research tactic of choice involved investigating the existence

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of privatization-related legal disputes, which could then inform the selection of the most suitable case(s), i.e., featuring aspects that would warrant closer examination in the context of the topics under research. Also, from a very practical standpoint, information about legal disputes involving organizations generally is both voluminous and accessible. Such documentation then would be a reliable information source against which to triangulate findings from other sources. Also, because of Professor Elson's renowned expertise and extensive experience specifically in the area of corporate governance, his contributions to the research represent a level of sophistication that encompasses both the theoretical and the applied aspects of the topic.

Much useful information was gleaned from several of Professor Elson's corporate governance-related lectures, panel discussions and seminars, but a great deal also was revealed in informal exchanges as well as in his statements to the media on the heels of corporate scandals such as those of Enron, Arthur Andersen and WorldCom. Most material, however, were the two formal interviews to which Professor Elson submitted—an initial exploratory interview followed by a member check interview—an approach typically used in program evaluation to verify or clarify information previously gathered. In the initial encounter, questions were preceded by an overview of the intended research topic. During the course of the interview his suggestions for representative cases, documents and even interview subjects were solicited. In response, he cited two cases in which organizations experienced governance-related disputes in their transitions toward privatization as well as possible case law references possibly germane to the stated research questions. He also provided contact information and furnished references that could later facilitate actual data gathering from several corporate board members of those organizations—the

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implicit presumption being that these individuals, given their direct involvement in oversight and transition of these organizations, would represent rich and reliable data sources with whom it could be advisable and productive to conduct additional interviews.

Phase II research activity entailed a review of selected legal briefs from LexisNexis ™ and other Internet sources to determine whether the previously referenced cases had generated legal activity relevant to the research and, if so, to gather more detailed information about how those cases transpired. Examination of media accounts as well as topical academic journals and other relevant literature provided valuable contextual information. This preliminary research made it possible to establish TGH as the case that was most demonstrably captured the aspects of governance and privatization represented in the selected line of research. This case then would serve as the basis upon which the second round interview questions would be formulated; questions, incidentally, that also comprised the survey instrument that eventually was to be administered via e-mail to other possible respondents.

The selection criteria for respondents in this second phase included factors such as the candidate's familiarity with or involvement in Tampa General's reorganization from a public to a private nonprofit hospital, active participation in the facility's governance before, during and/or after privatization, or those who otherwise would be in a position to provide informative insights about the circumstances surrounding the reorganization. Again, quite fortunately, Professor Elson was able to identify from his personal network of business and academic contacts, other expert-level respondents who met (actually, in several ways surpassed) the selection criteria for respondents for this case study. He provided the appropriate contact information and references.

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What followed then were in-depth interviews of two subject matter experts—high level insiders who served as hospital board directors around the time that TGH was privatized. These respondents each were intimately involved in the hospital's governance and/or played pivotal roles in virtually every phase of the hospital's privatization. In addition, the depth of their respective contributions to the case study was greatly enhanced not only by the political insights that they were able to share by virtue of their involvement specifically in hospital affairs, but also because they both had distinguished themselves in the legal profession, and one of the individuals is also a physician.

The initial Phase II respondent, who will be called Director L., was a TGH board director at the time that the hospital was undergoing reorganization, served as the Board Secretary, and also was a member of the Executive Committee at the time—meaning that she had a voice in matters of hiring and firing the hospital's top-level administrators, namely the CEO. In addition, she also is an attorney and former law school dean. Finally, at the time of the interview (November, 2001), she was serving as chair of the Law School Accreditation Committee of the American Bar Association (ABA), as well as an additional ABA Committee charged with reviewing nonprofit corporation law. Note again that the privatized version of Tampa General Hospital was to be that of a private, nonprofit corporation. While she understood, from the terms to which she had agreed under Human Subjects-related policy, that she could possibly be identified by her former or current professional positions, she preferred not to be identified by name.

The second Phase II respondent, Dr. Jay Wolfson, was recommended by both of the aforementioned interviewees. He was, in every respect, a high level insider at TGH before, during and after the hospital's reorganization. He served for 12 years

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as trustee and Chair of Finance to TGH's pre-privatization (public sector) board of directors [Hillsborough County Hospital Authority], which was responsible for the hospital's financial and operational oversight. He also served as vice-chairman of the board during his final 3 years. After the hospital was privatized, Dr. Wolfson served for 2 additional years as a trustee (board member) of the private nonprofit corporation (Florida Health Sciences Center) that acquired TGH's assets. In addition to being a physician and medical researcher, Dr. Wolfson is also a public health attorney. At the time of interview he was a professor of public health and medicine at the University of South Florida's Health Sciences Center. His impressive credentials aside, Dr. Wolfson brought an extraordinarily deep understanding of the operational, financial, political, medical and legal contexts within which TGH's privatization occurred. In addition to having submitted to several hours of interview and consultation during the data gathering phase of this study, his depth and intensity of involvement in the case combined with his intimate understanding and talent for explanation brought a great deal of clarity (not to mention credibility) to the research.

As was the case with the preceding expert respondents, Dr. Wolfson also furnished leads to other potential respondents. The difference in his case, however, was that he was able to facilitate the contact with another willing high-level respondent who happened to have led the opposition to the privatization decision. This was an important development because virtually all of the expert respondents interviewed to that point had been moderate to strong proponents of privatizing TGH. Jan Platt, who served with Dr. Wolfson on the Hillsborough County Hospital Authority for his entire tenure and beyond, had a long and intimate association with TGH. She was elected in 1978 to the County Board of Commissions, which at the time was the public sector governing board for TGH. In the early 1980s, she took the

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lead in introducing legislation that ultimately would create the Hillsborough County Hospital Authority, the hospital's public sector governing board comprised of non-elected officials. Ms. Platt maintained her involvement in the governance and/or oversight of TGH for more than twenty (20) years until her retirement from public office in 2004. Ms. Platt also is well known in the community as a patron of the community's children and persons with disabilities. In 2001, a regional library was dedicated in her name, the Jan Platt Regional Library. A reading program for people who are blind and disabled was transferred to the premises upon completion of the $7.7 million facility that year (Jackson, 2000; Peterson, 2001).

In contrast to the preceding high-profile respondents, Ms. Platt was a strong proponent of Florida's Sunshine Law provisions, opposed the privatization of TGH, and led the struggle to maintain the hospital's public accountability. She was indeed a valued addition to the Phase II group of respondents. Like the expert respondents who had preceded her in the investigation process, Ms. Platt not only provided unique insights, but substantive historic information and a clear rationale for her opposition of privatization. She also provided additional informational references that brought tremendous clarity to the case description.

Phase III encompassed research conducted on-site, including a walking tour of the physical hospital facility and campus as well as a geographic and logistical examination of the access points to the facility by automobile. The purpose of this type of facility inspection was to verify comments made by respondents regarding access to the facility by ambulance and/or auto and to discern the hospital's structure and layout, its ambiance, and individual patient accessibility. Several opportunistic interviews also were conducted on hospital grounds, the most substantive of which involved a physician (cardiologist) and an emergency room patient services staff

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person (Edna). Both subjects had been associated with the hospital for several years pre- and post-privatization. These discussions were followed by brief exchanges with several patients who voluntarily shared their general impressions of the services they and/or their family members had received at TGH over the years. Whenever feasible, respondents were first informed of the nature and purpose of the research and of their human subjects' research-related rights. In fact, in many instances, the identities of these individuals, apart from their relationships or affiliations with the hospital, were purposely not sought to encourage their candor. While none of the opportunistic interviews were audio-taped, again to maintain subject comfort and perhaps an air of informality, discussion notes were taken via voice recording immediately after each interview. The audiotaped notes were then transcribed on the same day as each interview to ensure accuracy.

Subsequent to the site visits and on-site interviews, several of the expert respondents were engaged again in face-to-face "member check" interviews to vet information and impressions gathered since their prior interviews. The objective was to seek clarification of issues or to address questions that emerged from the interim research, which was somewhat extensive given that the member checks were conducted several months to a year after each of the expert subjects' initial interviews. Interim research, like that of Phase II, drew from a broad array of sources, which included media (newspaper) and other literary sources as well as the interviews of other subjects at TGH and the additional information and impressions gathered at the hospital site.

The literature review associated with Phase III was more in-depth than in that of Phase II. The Phase III effort involved a review of purposively selected newspaper articles spanning a period of just over 20 years (1980 – 2001). The major

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local newspapers, the *Tampa Tribune* and the *St. Petersburg Times,* actually played significant roles in shaping public opinion and the political environment surrounding the hospital's privatization. While perhaps politically biased, the newspaper stories were factually consistent with the information provided by each of my live respondents. The readings provided both materials from which to formulate interview questions and a means by which to verify/triangulate interview data.

Contextual Performance Measurement

Organizational performance may be viewed from a number of perspectives or through a number of models that vary more or less in their degrees of sophistication and utility. A general and relatively straightforward approach was applied in this study using inputs and/or outputs. Poister (2003), in his discussion of performance in public and nonprofit organizations, describes outputs as what an entity actually does and outcomes as results produced. Poister notes, however, that it is not always easy to distinguish between the two because there may be overlaps or contextual distinctions, i.e., those that would make an output in one context an outcome in another. In the context of this particular study, depending on one's perspective, even inputs may be regarded as outputs, or surrogates for the same. For example, changes in the amount of indigent care-related expense over time may be regarded as a service-related input from an investment perspective or as an output from the perspective of costs incurred from services rendered. In this case, indigent care expense was deemed a plausible surrogate for changes in the amount of indigent care provided (service output). Inputs and outputs generally are simpler to discuss because they are associated with observable and localized behavior—localized in the sense that the behaviors are confined to a discrete organization, group, or an

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individual. Outcomes, such as improved community access to health can be more difficult to ascertain or measure, particularly in health care and other social services, because they are often subjective and sometimes dispersed throughout the population being served. Still, it is possible to gain an acceptable appreciation of an organization's performance simply by viewing certain input and output variables and placing them in the context of intended outcomes.

In the context of the case of TGH, for example, it was most useful to view the hospital's performance in terms of input/output scenario described above. Using two levels of financial data—one being reflective of the hospital's performance with respect to its public service obligations, and the other, its overall financial performance, it was possible to capture the hospital's performance along two important case parameters. First, because indigent care was not only a significant responsibility for TGH but a material factor in the case itself, examining annual changes in the hospital's indigent care-related expenses during and after the hospital's transition seemed a reasonable approach to understanding the hospital's level of compliance in that regard and how it may have been impacted by its reorganization. Similarly, the hospital's annual total assets (i.e., the difference between revenues and expenses) during that same period provided a way of understanding the facility's overall financial solvency and how, if at all, that also may have been impacted by the hospital's transition from public to private. Since the resulting analysis applies these measures across several performance contexts, the approach itself is being termed contextual performance measurement.

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Methodological Strengths and Weaknesses of the Research Model

The foregoing sections of this chapter described the elements of my methodological approaches to the study and how they were executed. I turn now to the underlying rationale for use of those elements or approaches in terms of their relative strengths and weaknesses. In this section, the research model itself, case selection, sampling (respondent and literary source selection) and the instruments utilized for data collection are specifically examined.

The Case Model

The case of TGH is unique. Therefore several aspects of the case are idiosyncratic and may not be generalized to other privatization scenarios. Nonetheless, an examination of the observable antecedents (i.e., the circumstances that comprise the context) and consequences of activities undertaken with respect to the hospital's privatization provides useful insights and perspectives from which to view other scenarios that share similar elements or contexts. For example, it would be difficult to identify a privatization scheme, particularly in the human services arena, in which political, social, economic and/or regulatory issues are not present and active to some degree. It is from these very broad conceptual perspectives that the case of TGH is both compelling and instructive.

Still, at the end of the day, the study cannot claim to have established discrete statistically significant causal relationships between or among the variables that are material to the case. In fact, the design of this study precludes the ability to do so. However, it nonetheless advances compelling evidence suggesting that the conflict surrounding the privatization of TGH is likely to have been engendered by the prevalent regulatory and public policy environments and the multi-faceted resistance to prospective changes in governance. The case does not establish with statistical

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certainty whether the ensuing conflict surrounding privatization-related activities was a direct result of public regulation or whether regulation was simply part of a confluence of several factors that worked in tandem to produce that particular outcome. Such a feat might be accomplished by conducting follow-up case studies to which the TGH case could contribute substantively as a baseline among others in ways that would permit statistical correlations among discrete variables across several similar cases. However, that could only be done effectively to the extent that the principle variables had been identified and understood—a role that the TGH case study could easily play in an expanded statistically-oriented research project.

However, the TGH case study itself can stand on its own merit because the establishment of causal relationships is not the exclusive domain of statistical analysis. As Maxwell (1996) notes, a number of researchers in both the qualitative and quantitative camps of research have long disputed the traditional notion that qualitative research cannot identify causal relationships. Apparently the source of the dispute is that quantitative and qualitative types of research pose entirely different types of causal questions. The former is concerned with whether and to what extent an independent variable causes a variance in a dependent one. The latter is focused more on examining *how* or the process by which one variable played a role in causing a change in another. Maxwell captures this point quite nicely in his quote from Miles and Huberman's 1984 edition of *Qualitative Data Analysis: A Sourcebook of New Methods* in which they argued that

> …much recent research supports a claim that we wish to make here: that field research is far *better* than solely quantified approaches at developing explanations of what we call local causality—the actual events and processes that led to specific outcomes (Maxwell, 1996, p. 132).

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Maxwell further asserts that there are five particular research purposes for which qualitative studies are particularly well suited: understanding the meaning of behavior, events and situations, understanding the context in which they occur, identifying unanticipated phenomena and influences, understanding the process by which actions and events take place, and developing causal explanations.

Still, the value of the current case, that of TGH, is it can serve as a basis for subsequent research—qualitative *and* quantitative—by providing a sufficiently deep look at what appear to be important enough case elements to suggest items upon which to focus for follow up—both for identifying similar cases and for examining causal relationships. This, of course, is why discovery is so very important at this stage of the research. There is a severe opportunity cost associated with isolating and controlling for variables in a case of such complexity and subjectivity—the loss of crucial and relevant information to the distillation process.

Research Instruments

Also of significance from a methodological standpoint are the primary research instruments—the actual tools being utilized for data gathering. Patton notes that

> In qualitative inquiry, *the researcher is the instrument.* Validity in qualitative methods, therefore, hinges to a great extent on the skill, competence, and rigor of the person doing the fieldwork. Guba and Lincoln comment on this aspect of qualitative research ("naturalistic inquiry") as follows:
>
> *Since as often as not the naturalistic inquirer is himself the instrument, changes resulting from fatigue, shifts in knowledge, and cooptation, as well as variations resulting from differences in training, skill, and experience among different "instruments," easily occur. But this loss in rigor is more than offset by the flexibility, insight, and ability to build on tacit knowledge that is the peculiar province of the human instrument. (Guba and Lincoln, 1981, p. 113)*

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> Because qualitative and quantitative methods involve differing strengths and weaknesses, they constitute alternative, but not mutually exclusive strategies for research (Patton, 1990, p.14).

In contrast to more traditional research models, which would attempt to isolate, suspend or otherwise control for human variables such as judgment, cultural bias, contextual interpretation, etc., the phenomenological research represented in this study *leverages* those characteristics of the researcher to achieve a level of data capture and understanding that would not be possible otherwise.

In their chapter "The Evaluator as Instrument," Guba and Lincoln (1981) also outline several characteristics of the human as an instrument of research that are material to this discussion, which may be summarized as follows:

- Responsiveness – the ability to interact with and respond to the environment and the context in which the research is being conducted
- Adaptability – the ability to absorb and conceptualize abstract information, interpret its meaning and make appropriate adjustments, consciously or unconsciously, to ferret out what is relevant from the mass of available information being presented
- Holistic Emphasis – as opposed to the typically segmented approach of scientific inquiry, a holistic approach allows the researcher to perceive, integrate and incorporate multiple aspects of information inductively and in an unbounded fashion as it emerges
- Processual Immediacy – the ability to "process data immediately upon acquisition, reorder it, change the direction of the inquiry based upon it, generate hypotheses on the spot, and test them with the respondent or in the situation as they are created." (p. 136)

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- Capacity to Clarify and Summarize – the ability to qualify and generate meaningful synopses of information as it is being generated
- Exploratory Capacity – the ability to discern and explore atypical or idiosyncratic (i.e., expert or otherwise unique) responses
- Expanded Knowledge Base – the amount of knowledge, familiarity or relevant expertise that the researcher may bring to the data gathering and analysis processes. (Guba & Lincoln, 1981, pp. 129-138)

Characteristics such as responsiveness, adaptability and abstract conceptualization are presumed, from the perspective represented, to be legitimate approaches to data gathering. They are the means by which people routinely process perceived information. They are, in other words, intrinsically human capabilities that one might recognize upon brief reflection as functioning almost automatically, and probably most often below the threshold of conscious awareness. A sufficiently introspective, insightful and sensitive researcher then would appreciate these characteristics as not only present but essential.

In the course of authoring this dissertation and in conducting the related research, I drew extensively from my own relevant educational background and professional experience. These inputs, that I later realized were both conscious and unconscious, affected the research project's execution and outcomes significantly. In addition to my doctoral studies in urban affairs and public policy and the research associated with this dissertation, the knowledge and perspective gleaned from previous academic and professional pursuits contributed materially to its framing and composition. Undergraduate studies culminating in a B.S. degree in psychology eventually led to an initial career in social service delivery, which included behavior modification and psychotherapeutic program development and administration. A prior

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internship, which involved service as an urban public health epidemiological program manager, provided what would eventually prove to be valuable and functional insights about public health service delivery. Working in this capacity shed intimate light on the internal workings of the public health care system that could not be appreciated otherwise. My later pursuit of a career in psychiatry involving extensive pre-med studies in the biological sciences followed by medical school provided an appreciation for the some of technical challenges associated with health care delivery. While I eventually abandoned my psychiatric career pursuit, I did not leave the health care field entirely. I eventually was recruited by a medical equipment supply firm that specialized in delivery of home health care equipment and diagnostic test services. As director of the Client Services division of the firm, my scope of responsibility included the physician liaison/diagnostics and insurance claim processing departments. This experience provided insights about the business side of health care delivery that also were invaluable in framing the research for this dissertation.

In 1988, U.S. Congress passed the Technology-Related Assistance for Individuals with Disabilities Act, P.L 100-407, the "Tech Act." This law authorized millions of dollars of funding to states to develop technical assistance projects aimed at creating or improving access to and use of durable medical equipment and other assistive technologies by persons with disabilities to ameliorate their functional deficits. While various public service and financing options for equipment and services had been in established, sometimes decades earlier, they were fragmented, uncoordinated and largely either invisible or inaccessible to those who needed them most. I eventually was called upon by the Tech Act project of Delaware to conduct health care finance-related research in tandem with a national coalition comprised of a cadre of similar experts from other states while earning an M.B.A. degree in finance

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with a sub-focus in organizational behavior. This combination of pursuits, culminating in the publication of two editions of a manual on healthcare and durable medical equipment funding strategies for persons with disabilities, proved quite effective, both in terms of the quality of the research and the resulting improvements in worldwide appreciation for, and national access to, assistive technologies. The contributions of these pursuits to this dissertation, in terms of the industry insights they have provided, are undeniable and should be evident throughout.

Also of some import are the contributions to qualitative work of inconspicuous mental processes and perspectives that I understand, in hindsight, to have been working, often below my level of consciousness. While conscious inputs are more conspicuous and readily accessible to the researcher, those that are unconscious are not directly observable but often are discernable only upon careful introspection and/or reflection. In my case, they were inferred in hindsight following reflection about my own behavior and decisions in the contexts of my personal background—educational, professional and cultural acclimation and history—factors that comprise our perceptual filters and define the mental context(s) through which we interpret what we perceive.

Abstract conceptualization, the ability to formulate a coherent conceptual framework from a conglomeration of disparate facts, observations and perspectives typically occurs below the conscious level. Yet it plays a significant role in the way that human beings gather and understand information. Arguably, the more robust the knowledge base from which the researcher draws in conceptualizing information, the richer and perhaps the more complex and somewhat obscure the inputs. A researcher who is reasonably familiar with the psychological dynamics of perception, who is a trained observer of human behavior, and who has undergone graduate-level training in

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qualitative research methods, might be capable of anticipating (or at least later recognizing) how his or her associated skills, biases, proficiencies and limitations could impact research in which they are likely to be brought to bear. My own academic training and professional experience as described would suggest at least the potential for generating such insights in the current case. Indeed, the knowledge base I brought to a case study involving issues related to business, politics, regulation and governance in the privatization of a hospital facility is fairly extensive. It is therefore reasonable to assume that the unique sensibilities engendered by my academic and professional background would have informed and enhanced the way I sought, gathered, filtered, analyzed and converted my research data into information.

For instance, as a result of the medical insurance finance-related research I conducted for my assistive technology funding publication, my knowledge base enabled me to conceptualize more quickly and clearly the importance of Medicaid service reimbursement to the hospital's well-being as well as the financial and political implications for state and county government of Medicaid matching arrangements. My inquiries were not burdened with the opportunity costs associated with having to discern that information while conducting the study. I could bypass the logistical details in my inquiries to explore more deeply the motivations behind county government decisions to withhold from TGH the Medicaid reimbursement to which the hospital was entitled. Similarly, my understanding of organizational behavior and group dynamics greatly influenced my line of questioning—and, perhaps as an outcome of my psychological service-related training and experience, I also tend toward introspection and objective observation. While these things might be considered irrelevant at best (more likely, liabilities) in traditional "controlled

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variable" research environments, they were absolutely indispensable to the research represented here.

Other instruments employed in this study include interview guides, a survey, an analytical memo, and a project outline, all of which contributed both structure and uniformity to the study. Templates and/or examples of these appear in Appendix C. Interview guides were used to capture individual responses in a reasonably standardized fashion for ease of comparability and analysis. An e-mail survey of TGH employees was attempted but eventually abandoned. One could speculate that TGH's history of difficulty with the media and public disclosure of hospital information has engendered an insular and cautiously communicative environment that ostensibly had created sufficient discomfort among employees to prompt them to decline participation or to relay the survey to others for response. Despite assurances to potential respondents of anonymity and the fact that responding to the survey questions did not constitute a policy violation, some indiscernible yet apparently widely accepted policy discouraged individual employee communication of hospital information to parties external to the hospital. As a matter of policy, surveys or queries generally are routed through the hospital's office of Public Affairs. Despite TGH public affairs staff assurances that requests for information would receive immediate attention, neither questionnaire responses nor requested financial records were furnished upon request. The planned research model was compromised as a result, but this shortfall was offset by the quality of information gathered from expert first-hand and media accounts of the case.

Research Subjects & Sources

Three of the four expert respondents in the case are attorneys, one of which is also a physician, and all, by virtue of their service on governing boards,

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represent both functional and conceptual expertise in the area of organizational governance. Three of the four experts were hospital board insiders who had been personally and intimately involved in the case both before and after the hospital's reorganization. In addition, the respondents' accounts were factually consistent—both between the respondents themselves in separate interviews and with the literature.

Note that three of the four expert respondents hailed from essentially the same general philosophical perspective—one supporting the private conduct of business to bolster competitiveness and performance. Their bias toward the privatization of TGH was clear. It also was clear that there was significant opposition to it, and the rationale for that opposition needed to be represented and understood as well. Therefore, it was necessary to identify and incorporate into the investigation sources representing the opposing perspective—that which espoused, for example, full public scrutiny and disclosure. One of the respondents, Jan Platt, matched that profile. The perspective of yet another Tampa Bay Authority trustee who was opposed to privatization, Pat Frank, was captured from an article she authored in the *Tampa Bay Business Journal* (Frank, 1997).

To the extent that both proponent and opponent perspectives could be given balanced treatment, the accounts not only represent a more circumspect view of the case, but also created interesting opportunities to examine how those perspectives may have affected the way respondents perceived and reported the facts. If, for example, opponents' accounts of actual events and occurrences were consistent in spite of their disparate positions and conclusions, it is reasonable to infer that the sources of information and the information itself were reliable. Such was the approach taken with all data gathering associated with this investigation—e.g., via interviews, literature search, and/or media reports. For instance, individuals' quotes and accounts

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published in print media before, during and after reorganization of TGH not only provided a way of verifying information provided by respondents, but served as reasonably reliable source surrogates when personal interviews were not feasible. The balanced approach to literature search also provided important insights regarding public opinion and the political contexts of the case under study.

Still, even when best efforts are put forth to avoid bias, it is not always completely feasible. In that sense, incorporating reports from the local print media into the current study was a bit of a mixed blessing. Since public access to information was at the center of the controversy, the newspapers had a vested interest in the outcome of the case. This means that on the one hand, their involvement may have been a significant source of bias—specifically on the part of the *Tampa Tribune* and the *St. Petersburg Times,* the newspapers that brought the Sunshine Law-based lawsuit against the hospital in the first place.

On the other hand, newspapers and their reporters are bound by the tenets of the profession to report news truthfully and objectively. The fact that one of the papers was directly involved in the case, and other papers and broadcast media stood to be affected by the outcome, simply could have served to focus the media's attention on the case, resulting in more information from which to draw. From that perspective, the newspapers might be regarded less as biased data sources than as particularly informed ones. The evidence supports the latter. The consistency of the newspaper accounts with those of several TGH insiders, suggests that one can be reasonably confident of the newspaper accounts' reliability. The interview research, however, is likely to have been far more productive had more of the literature and media research been conducted in advance of the personal interviews. While it is also true that the interviews provided excellent leads for productive literature research, greater

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familiarity with the materials in advance of the interviews would have better informed the inquiries and enabled more effective probative efforts.

Finally, in an ideal world, the research would have been more comprehensive had data been drawn from a larger sample of respondents. An e-mail survey that was designed to accomplish that was attempted and eventually abandoned. Apparently the risk associated with selecting a controversy-filled case is the chance that involved parties may be unwilling to speak candidly if at all about their involvement or experience. Intended survey respondents proved to be noncompliant or otherwise inaccessible for a number of reasons—many of which evidenced an atmosphere of caution and "caginess" that may simply have evolved after long years of dispute around issues of disclosure and public access to hospital information. To illustrate, while the on-site hospital personnel interviewed represented different levels of the organization and worked in very different departments (cardiology, emergency medicine and communications); each expressed concern about violating hospital confidentiality policies in responding to questions. The survey attempt yielded a null result despite the fact that the survey questions were reasonably innocuous and that responding to them would not have constituted a hospital policy violation (according to the TGH Public Affairs Office). Interestingly, however, the subjects who were approached on-site at the hospital, while cautious, were reasonably forthcoming. So while there was considerable reluctance among staff and administrators to respond to the e-mail survey, the few that submitted to face-to-face impromptu interviews were apparently more comfortable with sharing their views. There could be several reasons for improved results with face-to-face encounter. One could speculate that subjects were made to feel more at ease when provided personal assurances of human subjects research-related protections and were more responsive as a result. The fact that the

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survey effort yielded no willing participants and the face-to face queries were more productive suggests that the latter approach was clearly superior—far richer information was produced in the end from interviews than the survey instrument ever would have permitted.

Summary

Privatization, governance, and regulation (sunshine laws in particular), each are interesting topics in their own right and prevalent concerns in the exercise of both business and government today. This study represents an opportunity to examine important aspects of each of these—but as they operate not in isolation but in tandem. It also takes the less common approach of examining privatization from the perspective of the service provider vs. that of government agencies.

The appeal of the case of the privatization of TGH rests in its richness, its topical relevance, and its intrinsic complexity. The case study method is an ideal approach to exploration because of its utility for in-depth capture of the rich store of data to be mined from this case and it is entirely consistent with the need to examine the various historical, financial, social, legal, political and organizational nuances that combined to form the basis for a line of research that was at once fascinating and incredibly challenging.

Chapter 4, the case study proper, examines the privatization of TGH from each of the perspectives mentioned by mining the wealth of information provided by expert and engaged respondents that was then triangulated with information drawn from other credible sources. Of course, the richness of the data captured in this study owes much to the rapt participation and candor of the expert respondents who provided uncommonly clear and credible accounts of the key events and

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circumstances that made the privatization of TGH well worth studying. The result was a research model whose strengths overshadow any apparent weaknesses by far.

Respondent and literature quotes incorporated in the Chapter 4 narrative often were selected on the basis of their ability to most effectively convey the salient issues and circumstances of the case. Information that was repeated or verified across sources was omitted for the sake of flow, clarity and brevity. So, while Chapter 4 represents a somewhat distilled account of the tremendous amount of information gathered in the three phases of research, it is in every respect representative of the entire body of data collected.

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Chapter 4

The Case of the Privatization of Tampa General Hospital: The Trouble with Sunshine

Issue Synopsis

The case recounted in this chapter explores the administrative, political, social, regulatory and governance-related factors that are both historically relevant and contemporaneous to Tampa General's privatization. It highlights respondents' and media sources' accounts of events and issues related to organizational management and to the hospital's competitive position in the marketplace that many believe provided the impetus for privatization. Information from several sources reveals conditions that appeared in the case to engender conflict or to be detrimental to the hospital's operational welfare in the context of the decision to privatize.

Case Overview

TGH, a financially embattled overbuilt patchwork hospital facility, had been publicly owned and operated for decades until its reorganization as a private nonprofit in 1997.[20] TGH privatized ostensibly as a means of freeing the hospital from the financial and public policy burdens. Charles Elson, Esq., Director of the Weinberg Center for Corporate Governance at the University of Delaware's Lerner College of

[20] Today, TGH is organized as a private nonprofit corporation, the Florida Health Sciences Center, which is governed by a 15-member volunteer Board of Directors.

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Business and Economics, framed the issues and named individuals who played key roles in the privatization.

> Public entities, because they are publicly funded, their board meetings and proceedings were required to be open to the public. This compromised the facility's ability to compete favorably with other facilities. It was a pretty nasty case… the hospital couldn't compete effectively and its location was an issue as well. It also had to stay where it was on Davis Island, which also hurt operations. Bruce Siegel, the doctor who was invited down from New York to run this facility, was really sorry he accepted. He had thought it would be a great opportunity, but it turned out to be a real mess. A former student of mine, Jay Wolfson, also was involved in the case but on the public side. (Elson interview, September 11, 2001)

So burdens under which the hospital labored were, according to Elson, largely by-products of TGH's status as a public hospital subject to public sector oversight, which was in turn preventing the hospital from operating independently and competing effectively with other area hospitals. It also was presumed that doing so would relieve the hospital's fiscal woes. However, attempts at privatization (reorganization) were met with strong public and political opposition that only served to deepen the hospital's financial exposure. The reorganization to private nonprofit status eventually was executed, but amid negative press accompanied by long-standing and, according to hospital administrators, unfounded public outcry. As a result, the hospital continued to absorb significant financial losses, which, interestingly enough continued for several years even after the hospital was privatized. However, TGH's fiscal and competitive positions gradually improved under new leadership that, ironically, executed the previous administration's plan to privatize the hospital, but with an approach that was ostensibly far more politically astute than that of its predecessor.

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The public at large and several important community stakeholders believed that TGH, as a recipient of public funds, was a public facility and always should function as such—regardless of whether it was governed publicly or privately. As a public entity, the conventional wisdom was that the hospital should be subject to and held accountable to all state laws that apply to public facilities—specifically, Florida's strict disclosure-related statute, the Sunshine Law. This law makes it illegal for the board members of public agencies to meet privately or to make decisions about operations outside of public scrutiny. This, according to commerce analysts and to several board members at the time, undermined the hospital's ability to operate and compete as a business (Elson interview, November 1, 2001). It was primarily for that reason that the hospital administration, after years of desperate attempts to mitigate the hospital's intractable financial difficulties, opted to reorganize TGH as a private nonprofit.

Findings of the case study suggest that TGH's status as a public hospital, along with attendant public sector controls over institutional revenues, a combative political environment and public scrutiny associated with imposition of the Sunshine Law not only hindered the hospital from functioning effectively as a public hospital, but initially compromised the competitive advantage privatization was expected to provide once implemented. In spite of privatization's promise, the hospital's situation initially worsened under private governance to the point of nearly being forced to close after operating for more than two years as a private nonprofit. However, TGH suddenly reversed its deficit and turned a $9 million profit in its third year of private operation (Testerman, 2001). The organizational and political circumstances surrounding the hospital's transition to private governance, its initial struggle as a

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private institution, and its subsequent turnaround provide interesting perspectives with which to frame a contextual discussion of privatization and governance.

This case, developed primarily from interviews with the hospital's board officials, legal counsel and from local news reports, examines the circumstances under which TGH's privatization evolved as well as the antecedents and possible causes for the hospital's difficulties and successes with the privatization process. Note again that the contribution of this case study to privatization-related discourse relates to its examination of the privatization experience from the perspective of the private entity—a clear departure from the government focus reflected in much of the literature to date. It also provides interesting insights about organizational governance, behavior and business conduct under financial and political duress.

TGH History & Case Context

Florida's Tampa General Hospital sits on Davis Island off the western coast of the Florida peninsula (see Appendix E: area, regional and campus maps). TGH boasts a long and distinguished history of more than 70 years as a public hospital charged with the provision of medical emergency and indigent care services to the Hillsborough County community. In addition to its long history as Tampa's primary community hospital, the longstanding role of TGH as the designated indigent care provider for the area's poor black population has continued to shape public opinion (and policy) even years after the hospital's role in relieving the Tampa area of its segregationist health care policies and practices of the 1920s and 30s had been long forgotten. Vestiges of its influence can be detected in the community's expectations in the 80s and 90s with respect to the hospital's role in providing care to the poor and uninsured, many of whom were black. Historic influences may also be seen in the

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public resistance to a proposed relocation of the hospital and to privatization, particularly by the area chapter of the NAACP (National Association for the Advancement of Colored People), and perhaps even in the selection of its first and only black CEO appointed by the county commission in 1996. It fell to this person to lead TGH in its tedious efforts to strike a difficult balance between community responsiveness and financial viability. Table 4.1 below outlines some of the major milestones and events in the history of TGH.

Table 4.1 – TGH Institutional History and Role in the Tampa Bay Community

1927	Tampa General opens as the 250-bed Tampa Municipal Hospital on land deeded to the city by Davis Islands developer D.P. Davis. A $ 1-million city bond issue financed the facility.
1937	The city opens "Tampa's Negro Hospital," later named Clara Frye Memorial Hospital to honor an African-American nurse who opened her home to those who could not get treated at Tampa's white hospitals.
1948	TGH begins treating black patients but transfers most to Clara Frye for long-term [and essentially hospice] care.
1967	The city closes Clara Frye Hospital because of unsanitary and inadequate conditions. Its patients turn to TGH.
1971	The Hillsborough County Commission agrees to supplement hospital revenues with property taxes. The commission, as the area's largest government agency, had taken over control of TGH from the city in 1961.
1981	The Hospital Authority issues a $ 166-million bond to renovate TGH, construct new buildings, and increase beds to 1,024. The additions include a 550-bed tower, a rehabilitation center and a physician's office building.
1985	County commissioners pass a quarter-percent sales tax to fund indigent health care at TGH, after a task force of the Greater Tampa Chamber of Commerce warns of a looming financial crisis. The tax lasts until April 1987.
1990	The hospital board rejects plans to take TGH private. Activists fear a private hospital would abandon care for the poor.
1991	The Legislature allows the County Commission to pass a new one-half percent sales tax to fund indigent care at hospitals across Hillsborough, including TGH. The commission establishes the Hillsborough County Health Care Plan, which operates as an insurance health care plan for the poor (Harvard University, 1995).
1996	Dr. Bruce Siegel, 35, is hired in July at a record $ 335,000 a year to run TGH. He is the hospital's first black chief executive. Three months later,

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	authority members begin a series of closed-door strategy meetings.
1997	Siegel announces plans to lease the hospital to a new private, non-profit corporation, which he says will allow it to better compete with private hospitals that do not face the scrutiny of public hospitals. The plans also call for closing the Davis Island facility and opening a new 450-bed, $ 153-million research and teaching hospital near the University of South Florida by 2002. Two months later, the board approves the deal on a 12-3 vote.
1999	The Florida Supreme Court rules that a former public hospital that had been leased to a private, non-profit corporation in Volusia County must abide by the state's public records and open meetings laws. The Tampa Tribune and St. Petersburg Times sue the hospital [TGH] for access to records and meetings.
Source: Karp, D. (1999c)	

Comments from interview respondents indicate that the privatized TGH retained its public reporting responsibility, but the timing and forum responsibilities, i.e., the 'when and where' requirements for information availability or delivery, were modified to better accommodate the tactical privacy concerns of the hospital administration. That is, while the hospital's board meetings are no longer public forums, meeting proceedings and the financial performance records are made public after a delay of several months to a year (Director L. interview, November 28, 2001; Wolfson interview, November 30, 2001).

Indigent care, the provision of medical services to uninsured and/or underinsured individuals, was (and continues to be) an expensive proposition for hospitals—for TGH in particular. As the largest public hospital in the Tampa Bay area, TGH became by default a regional hospital that received indigent patients from across county lines. The problem, however, was that it received government subsidies principally from Hillsborough county government, nothing from the additional counties whose patients it served, and the State legislature was slow to respond to the hospital's need for additional funds to cover other counties' patients (Kleman, 1987b). The 1980s and early 1990s saw U.S. hospitals scrambling to create health care

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programs and financing mechanisms to offset or diminish costs. Largely due to TGH's decades-long history of providing millions of dollars of unreimbursed care to the poor and uninsured of the Tampa bay area, TGH Administrators and county government began searching for ways to secure sufficient funding for TGH to continue executing what had become a financially burdensome responsibility (Wolfson interview, November 3, 2001). However, trouble for TGH may actually have begun as early as 1968 when a private hospital, St. Joseph's, moved into the area and began attracting the most prominent doctors as well as affluent and/or well-insured patients. Other private hospitals gradually sprang up in the area creating an environment in which TGH, as a public facility providing a disproportionate share of charity health care, was ill-prepared to compete with the entering private facilities.

By 1983, TGH was posting financial losses in excess of $11 million and was on the brink of bankruptcy before obtaining public funds and implementing cost control measures such as a hiring freeze (Good, 1987b). State and county officials intervened in 1984 and established two remedial measures designed to ameliorate some of TGH's indigent care-related difficulties. The first was essentially a heath care revenue redistribution scheme, which involved the creation of a cash reserve account comprised of a 1.5% tax on the net revenues of Florida hospitals. Monies were redistributed to hospitals that provided high levels of uncompensated care. Since TGH also was a fund contributor, the net disbursement back to the hospital from the fund, $3 million, was only $1million over its initial $2 million contribution to the fund. The second measure was the county's award to TGH the proceeds of a special quarter-cent sales tax to help fund its indigent care expenses (Dolan & Good, 1987). This would become the basis of the county's health care fund that would be used to finance the

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county's contribution to the State Medicaid match and other health care-related innovations.

In fact it was one of these innovations, the Hillsborough County Health Care Plan (HCHCP), a public-private partnership established through county government and business community in 1991, which apparently had the most significant short-term financial impact in terms of reducing the immediate indigent care burden to TGH. An award-winning program, HCHCP was financed by a half-cent sales tax and had a preventative care focus that effectively reduced the demand for expensive emergency room care. While it was by no means the panacea that TGH required for full financial recovery, it ostensibly created some breathing room for the hospital—room perhaps to make changes in the hospital's leadership and governance structure that some thought to be long overdue. In fact, the success of the public/private partnership in the context of desperate efforts by the hospital leadership to identify viable solutions to the hospital's financial difficulties up to that point indeed may have softened public resistance to privatization sufficiently to turn the political tide, albeit tenuously, in favor of privatization.

TGH was privatized in 1997 after more than thirteen years of grappling with extreme financial difficulty—ostensibly exacerbated by disputes surrounding hospital oversight, governance and TGH's status as a public hospital legislatively obliged to provide unreimbursed medical care to the poor and uninsured. According to one member of the TGH board of directors at that time, TGH, like other hospitals, was able to offset those costs for years by "cost shifting, i.e., overcharging privately insured and paying patients. But the tightening of insurance reimbursement policies through the 1980's, essentially nonexistent public funding, and an inability to compete effectively with surrounding hospitals, found TGH desperately searching for

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solutions" (Wolfson interview, November 30, 2001). In spite of the recommendations favoring privatization in a 1984 private sector task force study, privatization was hotly contested by the public at large and by political opponents for more than a decade. But why was privatization of TGH so strongly favored by its proponents and resistance to it almost equally intractable? Analysis of the case suggests that the respective answers are fiscal distress and conflict—conflict in terms of:

- TGH's perceived function and role in the community—i.e., as a public institution obliged to provide free care to indigent citizens vs. a privately controlled facility not as fettered by such constraints.
- conflicting goals—competitive privacy vs. public transparency and accountability, as well as the need to invest in becoming an attractive prospect for paying patients vs. the need for parsimonious treatment of the operating finances.
- conflicting public and private sector philosophies regarding the oversight governance and/or management of the hospital.

Furthermore, each of these points of conflict was linked in some way to public oversight and/or regulation of the hospital.

The Financial Impetus for the Privatization of TGH

The central stated reason for Tampa General's privatization was financial. There is every indication, both from interviews and from more than a decade of newspaper accounts, that Tampa General chronically found itself in deep financial trouble from which it seemed unable to extricate itself (Johnson, 1988; Karp, 1988, 1999b, 1999d; Nickens & Landry, 1987). Interestingly from the standpoint of the hospital's reorganization, financial reports in the periods immediately before and after privatization indicate consistent losses. For instance, Karp (1999b) reported a steady

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decline in the hospital's net worth from $102 million in 1994 to $74 million in 1998. Likewise liquid assets generally needed to cover immediate expenses dropped from $42.9 million in 1994 to $7 million in 1998 against an expense increase over the corresponding period of about $33 million (Karp, 1999b).

Dr. Wolfson, former member of TGH's pre-privatization board, the Hillsborough County Authority, and a trustee of the board after the hospital's reorganization, described the situation as follows:

> There was as much as $22 million of indigent unfunded care the hospital had to somehow absorb into the budget every year. While it's true that the Hillsborough county government can set aside up to $19 million to pay for bonafide indigent health care required by Florida law, that money was not given over to the hospital. It was reimbursed to the hospital after the service had been provided and bills had been submitted, and at a rate that was below Medicaid. So we weren't getting any subsidies for the provision of indigent care, and that county care—guaranteed county care—was only a small portion of the total amount of unfunded care that was coming to the steps of Tampa General Hospital (Wolfson interview, November 30, 2001).

Media accounts by Testerman (1990) and by Stobbe (1999b) corroborate Dr. Wolfson's account—and with interesting views of the pre-and post-privatization treatment of the hospital's financial shortfalls in those respective timeframes. Based on Testerman's account, one particularly evident source of the financial fall-out with respect to the hospital's charitable and indigent care activities was the disproportionate share of indigent patients to whom TGH was prevailed upon to provide free medical services. Many of those indigent care-related costs derived from patient dumping, i.e., inappropriate or circumstantial patient diversion, transfer and/or referral across county lines; but that was only part of the problem. In addition to being forced to treat indigent residents of nearby counties (of the $16 million of indigent

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care TGH provided in fiscal year 1990-1991, $9 million was spent on patients from other counties), the hospital apparently was treating a disproportionate share of Hillsborough county's own indigent patients as well. According to statements made to the media by Florida State representative Glickman, TGH was providing 75 percent of Hillsborough County's indigent care while the balance was being distributed among 10 private hospitals in the area. There also was a distinction drawn in this account between the county government's treatment of indigent care and that of uncompensated charity care. Whereas the former may be reimbursable under Medicaid at some level and/or qualifies for county government subsidies (and rarely at the actual spending level), there was no similar legislative provision for recovery of uncompensated charity care. The term charity care may apply, for example, when the patient is not demonstrably impoverished (e.g., Medicaid eligible) but has been disabled due to accident, perhaps unable to work and is therefore unable to pay the medical bill; or the bill exceeds the permissible insurance reimbursement amount and there is no viable income source available to cover the balance. In such cases the institution is forced to absorb and write off the balance. In reality, a good deal of overlap exists between indigent and charity care expenses such that their disaggregated amounts (and even aggregate totals) could vary by the accounting methods and criteria applicable at the time. Also, the hospital's financial performance records were far less reliable before around 1998 when they were being more closely scrutinized as a consequence of privatization. However, the annual $22 million shortfall Dr. Wolfson mentioned appeared to have been assigned in 1990 to the category of uncompensated charitable care (Testerman, 1990). This category of expenses would later become a point of contention with respect to the hospital's right

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to recover such costs under Florida's Lien Law, which will be covered in more detail in the forthcoming discussion.

According to Stobbe's more recent (i.e., 1999b) account, Hillsborough County withheld from Tampa General $22 million in payments for services provided by Tampa General Medicaid recipients, finally agreeing to release the money only after the hospital handed over financial records and endured what was described as an ugly public battle at a county commission meeting in December 1999 (Holewa, 2000). This represents the 1999 iteration of TGH's aforementioned annual $22 million shortfall. This time, however, the funds were Medicaid-related and therefore would fall into the category of indigent care. Public reports indicate that the county commission, in response to rumors that TGH might become too financially insolvent to provide indigent care, proposed reallocating the county's intended $11 million contribution to the State Medicaid match to local county programs.[21] However, both the media reports and interview respondents indicated that the commission's true intent was to leverage the Medicaid matching funds as a condition for gaining access to the financial records of the then privatized TGH (Stobbe, 1999b). Similar political leverage appears to have been at work in a dispute between the hospital and county with respect to the Lien Law.

The County Commission, in addition to withholding its contribution to the Medicaid match that would help fund indigent care at TGH, used its control over other significant sources of the hospital's revenues to either gain political leverage or force the types of disclosure and transparency of hospital finances and operations to the

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[21] A portion of Florida's Medicaid matching funds comes from individual county contributions. Florida's federally designated state match level was 50 percent. Therefore, Hillsborough County's withholding its $11 million share would effectively deprive TGH of $22 million of Medicaid funding (Stobbe, 1999).

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public that privatization was supposed to circumvent. One such revenue source was provided under the Lien Law, a 1980 Florida state statute. The Lien Law gave TGH, as a public hospital, the right to place liens on money that accident victims recovered from third parties in, for instance, personal injury suits, to cover charges for medical treatment victims received at TGH. Dr. Wolfson's discussion of the Lien Law provides insights about how it was defined and applied.

> Many communities in this State and elsewhere have a lien provision that allows for hospitals in particular—but it can also affect others—but in this case hospitals, to attach the proceeds of judgments or settlements made against third party tort feasers… Now I'm speaking like the lawyer that I am. Let me translate that…
>
> If someone has an automobile accident, and they get badly hurt, and they come to Tampa General Hospital—and either they or the person who hit them has automobile insurance, the person who is responsible for the accident is called the tort feaser. They're the ones who caused the tort. The third party is the one that pays for the damages either voluntarily or as a consequence of a judgment or settlement—and it's usually an insurance company.
>
> When you get hurt at my hospital, and I treat you and you incur all these bills, I'm going to take care of you. But when all is said and done, you may have to sue the other party to collect the combination of health care expenses you incurred, lost wages, pain and suffering, and all that other stuff that goes with a personal injury suit.
>
> Now when you do that, you bring to court a complaint and a set of allegations and documents. Included in those allegations are all the hospital bills and lost wages … the lost consortium you had with your wife, and all the terrible things. Either by way of a settlement or a judgment as a consequence of a trial, an award is made. And that award is based, in great part, on the actual incurred hospital expenses that were involved in your care.
>
> What generally happens is that we follow that case all the way through. We're involved in it and we attach that case [i.e., attach the settlement for the amount of the hospital bill]. But plaintiffs' attorneys are sometimes not very nice and they want their piece of the action too.

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They get 30% off the top of any settlement, and sometimes 40% off the top of any judgment, because they have to spend time in court—and they want their piece first. That's fine—they're certainly entitled to that. But the hospital is also legally entitled to the money that it spent providing services—the bill—and we're not talking discounted services here, because the actual bill was used in court to serve as the basis for the settlement for the judgment. And that's what it actually cost the hospital. (Wolfson interview, November 30, 2001)

Tampa General's ability to recover bad debt under the Lien Law had been a significant revenue source for the hospital prior to its reorganization. In 1996 for instance, the year prior to the hospital's privatization, TGH recovered $30 million through the lien process—an amount approximately equivalent to 10% of the facility's total revenues that year (Stidham, 1997a; Palosky, 1998). However, this ability of the hospital to recover funds under the Lien Law subsequently became one of the opportunity costs associated with TGH's privatization pursuit—because the statute itself made lien attachments an exclusive privilege of public entities, and the attorneys engaged by the TGH board to oversee the 1997 reorganization happened to overlook this small detail. Wolfson's account provides insights about the legal considerations and how they were viewed during the hospital's transition.

… in instances when the money was not automatically transferred to the hospital as it was due, then we would be able to attach that settlement, go to court and show that we had a bonafide lien, in other words, a bonafide basis for receiving that money. The court would either award us that money, or we'd go to trial, or we would demonstrate factually that we had a legal basis for the lien, which is the attachment of that settlement. Well that was a statutory lien… and it was based upon the fact that we were a public institution, and that the statute said that our public hospital had this "lien authority."

But when we went through reorganization, there was a question raised about whether or not the lien would follow the reorganization…and I'll be honest, I had just gotten out of law school at the time—even though I'm an older guy—I went to law school late in life. We had a team—a team of 18 attorneys at the time… bond attorneys and finance attorneys

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and corporate attorneys… and the attorneys had their attorneys… it was quite amazing. I asked the question—'I'm a little concerned here, folks… I'm not convinced that the lien is going to follow the reorganization.' And I was assured over and over again, publicly and privately—'yes it does… we checked it out… it's going to happen.' And over and over again, I said—'I hear what you're saying and I trust your judgment, but I missed it… you know, I read the law… I'm pretty fresh reading the law…, but I just don't understand how you do this.' Before the public meeting at which the hospital authority actually voted to reorganize, I was fairly intimately involved with the lease documents and the budgetary issues surrounding the lease documents… sitting around with the attorneys for hours and hours and hours. You have to realize that I was doing this not only because I had a fiduciary obligation as a chair of finance, as the vice chair of the hospital authority and as a board member. But because it's what I do—I do health care management, health care finance and health care law. So it was something that was a lot of fun for me. I had a genuine personal and professional interest in participating as much as I could in this stuff.

And that very night beforehand, I was sitting with the attorneys and you know, once again, I had to raise the issue, and one of the attorneys said: 'Well, Jay there may be some problems here, but we think we can overcome them with some political maneuvering.' And I said 'WHOA! Whadaya mean!?' He said 'Well you know, we really haven't addressed the thing as carefully as we could… we're not sure.' I said 'Wait a minute—that's some 12 – 15 million dollars a year of cash that this hospital has gotten; upon which it has depended—and you're now telling me that you're not sure the night before the board meeting that its going to pass?'[22] 'Well, you know, we're not sure; we can't guarantee it.' So, I felt in some respects that I had been put in a compromised position, because I believe then and I believe now that the best interests of the hospital and the community were for us to reorganize and become a 501(c)3 in order for [the hospital] to conduct business more efficiently, more effectively, be out of the sunshine, which had no sense, and be able to establish business relationships that would allow it to prosper.

However, if I were to have stood up at the board meeting the next morning and said – folks I got a problem with this, and I think this is

[22] Media accounts, presumably based on public records, suggest that in 1996, the year prior to reorganization, the amount recovered was approximately double the amount Dr. Wolfson reported as the annual estimate.

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> such a serious issue that we ought to postpone the meeting – that would have killed it [the privatization vote]. And I could not have let that happen. (Wolfson interview, November 30, 2001)

And so it came to pass that the hospital's ability to recover funds under the Lien Law was effectively suspended and became a casualty of privatization when TGH reorganized. Apparently, the battle to privatize the hospital had been so long and hard fought and the support for it so tenuous that board members who were aware of the attorneys' failure to address Lien Law debt recovery in the reorganization proposal elected to ignore it for fear that raising the issue would effectively, and perhaps permanently, derail the hospital's reorganization.

Their fears were not unreasonable. Discussions entertaining the notion of privatization began in the mid-1980s on the heels of a 1984 study conducted by a special task force of the Greater Tampa Chamber of Commerce that recommended privatization as the most feasible remedy for TGH given its circumstances (Kleman, 1988). The report noted that pursuit by TGH of joint ventures or similar business proposals was prohibited due to its status as a public hospital and that existing revenue streams could not adequately sustain hospital operations. Also, according to hospital administrators and several trustees, the level of public scrutiny and organizational transparency associated with public hospital status would have been undesirable to prospective private institutional partners. Yet, for several reasons, the hospital was rarely able to obtain sufficient public subsidies to cover the financial deficits it incurred ostensibly by carrying out its public service responsibility, indigent care.

It is interesting to note that the hospital was served by several presidents in relatively quick succession after the notion of privatization was first seriously considered. This is in some ways a testimony to the chronic nature of the financial difficulties in which TGH was mired, the seemingly multifaceted dilemmas associated

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with nearly all possible alternatives, and to the turbulence of the political environment that characterized each of the presidents' tenures. Table 4.2 below lists the TGH presidents whose tenures fell within the period in which privatization was being considered at TGH—a period that appears to have been the most uniformly tumultuous in the hospital's more than 70-year history.

Table 4.2 – TGH Presidents in Pursuit of Privatization

Newell France	Served from mid 1980s through 1991 – A controversial bill filed by the hospital under his leadership called for more autonomy of CEO in negotiating contracts and in spending. France also advocated privatization as a means of reducing debt.
David Bussone	Served 1991-'94. Established limited ability for the hospital to conduct some business planning in private. Commissioner (Jan Platt) later recommended his resignation for allegedly entering into unauthorized discussions with a private firm to sell off TGH assets.
Fred Karl	Interim president, 1994-'96; Secured board approval of partnership with Columbia, which Bossone had attempted and failed.
Bruce Siegel	Served 1996-2000; Controversial recruit from New York who actually oversaw the privatization of TGH. Resigned under pressure from the county commission for failure to resolve the long-standing difficulties of TGH.
Ron Hytoff	Served as president from 2000 and is current president as of this writing, (March 2005). More politically savvy than his predecessor, and was able to secure sufficient support from the board and public sector allies to lead the hospital toward substantial profitability.

Several approaches to financial recovery (including at least two forms of privatization—i.e., divestiture through asset sale and the reorganization approach) were attempted by the TGH administration over the roughly 25-year period following what many believed to be its official designation as a public hospital under the 1980 legislation that established its governance by the Hillsborough County Authority. This

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same statute charged the hospital with explicit responsibility for the provision of indigent care. Over the years, the hospital's leadership wavered between considering complete divestiture (sale) of hospital assets to downsizing to reorganization and augmentation and/or relocation of the facility and/or diversification of its treatment repertoire. These approaches enjoyed varying levels of receptiveness by county government officials—but the approaches involving privatization—and seemingly even those that appeared business-like—were met with by far the most apprehension and resistance. The views of county commissioners often differed sharply with those of the business-minded hospital administrators—sometimes with respect to the hospital's accountability to the Commission for its use of public funds and at other times around control and appropriate use of public funds in the hospital's spending and investment strategies (Kleman, 1987a, 1987b). These issues become clearer upon examination of the approaches taken by the successive TGH presidents with respect to hospital finances, the legal and political landscape and privatization through the 1980s and 90s.

In the mid 1980s TGH president Newell France became convinced that privatization of TGH was in fact the answer to its financial woes. His opinion was based on the findings of the 1984 task force of the Greater Tampa Chamber of Commerce and on the success of surrounding hospitals that had subsequently privatized (Kleman, 1988). Not only had these hospitals flourished, but they also each saw gradual and significant increases in their provision of indigent care. Bayfront Hospital in particular went from $1.6 million in indigent care expenses in 1983 (the year in which TGH nearly went bankrupt) to $16.7 million of indigent care expenditures in 1988. France also saw privatization as a way for the hospital to diversify revenue streams. Privatization, for example, would permit TGH to market

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and sell specialized lab services (Testerman, 1989). France's administration came under fire in 1987 when two bills were filed with the legislature simultaneously on behalf of the hospital, one of which proposed increased public funds to cover indigent care and treatment expenses, and the other requesting spending approval for entertainment expenses. The rationale given for the entertainment expenses was to help attract prominent doctors and in turn paying patients, which would in turn improve the hospital's image and competitiveness relative to other area hospitals while generating additional revenues that would reduce the hospital's dependency on public funding. The latter bill also proposed more autonomy for the CEO in negotiating contracts and in spending. As of that time, the then public sector board, the Hillsborough County Authority, had to approve all expenditures in excess of $10,000 (Kleman, 1987a).

The notion of sale of hospital assets, on the other hand, first came to the forefront under the leadership of France's successor, David Bussone, who presided over hospital operations 1991 through 1994. Bussone, like his predecessor, believed that the hospital's public status seriously hampered its ability to compete effectively with surrounding private facilities. However, Bussone's divestiture-by-sale approach to leveraging the private sector apparently exceeded public and political tolerance for such a change. His tenure was marked by advocacy of business-like behavior, limited political facility, an affinity for privatization, and a disdain for Florida's sunshine provisions. Bussone in fact had a propensity for holding private business discussions and for making decisions outside of public scrutiny. He was criticized by the board on more that one occasion for his failure to abide by the sunshine laws. Jan Platt called for his resignation in 1993 over what was called a public relations fiasco. The incident involved Bussone's unilateral approval of a $120,000 marketing expense for hockey

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game advertising just after he had lain off 213 workers to cut costs (Rosen, 1994). Bussone remained at TGH but in the following year (1994) he entered into private discussions involving a possible partnership with and/or sale of TGH assets to the Columbia/HCA Healthcare System, a huge multi-hospital conglomerate (Flower, 1995). This did not sit well with the board. County commissioners were understandably concerned after they learned that unauthorized negotiations were being conducted in which the sale of hospital assets to private ownership was being discussed. If successful, such a move would have effectively relieved the commission of its control over those assets, which meant that the commission could not have executed as effectively its stewardship of indigent care.

The County Commission and the community at large, sensitive to the need to maintain the hospital's presence in the community to meet the ever-rising demand for indigent care, were adamant that the hospital should remain accountable to local government and to the public in that regard. This was a real concern for them in spite of the fact that all Florida hospitals, public and private, were obliged under State law to treat any patient who presented with a need for urgent care regardless of their ability to pay for treatment (Testerman, 1990). Bussone, who had been criticized by the board for failing to abide by the Sunshine Laws, eventually was ousted before a suitable long-term replacement could be located.

In the meantime, the board appointed an interim president and CEO, David Karl, who agreed to keep the position "for a year or longer" but, perhaps more importantly, also promised to keep TGH public. Ironically, that simple assurance, perhaps in combination with Karl's long history of exemplary public service as a former Florida Supreme Court justice with insurance industry expertise (Berger, 1995), apparently earned him sufficient political capital to accomplish two feats that

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his predecessor, Bussone, had tried but failed to accomplish. First, effective October 1, 1995, approximately one year after Bussone's departure, the CEO and hospital administration were given the ability to discuss marketing-related strategies in private. This was in effect a selective suspension of the sunshine rule, albeit restricted to marketing. Karl also was able to secure board approval for and to negotiate a business network contract with Columbia/HCA Healthcare Corporation despite hints of challenge from the TGH board and prevalent fears of defacto takeover of the hospital by Columbia (Berger, 1995; Rosen 1995b).

The hospital administration eventually was able to execute the reorganization of TGH under hospital president Bruce Siegel—but, as indicated, the process was characterized by tremendous political in-fighting, power struggles, difficulty navigating emerging federal and state statutes affecting hospital revenues as earlier indicated—all culminating in mixed results with respect to hospital performance under privatization. Siegel, who served as TGH president from 1996 – 2000, the term within which the hospital's privatization finally occurred, came to TGH with solid credentials and experience in managing complex public hospital issues. Prior to coming to TGH, he served as the head of a large public hospital corporation in New York under Mayor Rudolf Giuliani, whose policies, interestingly enough were very much pro-privatization (Fein, 1995). However, Siegel was a good fit for TGH at the time in that regard, because he happened to favor the public hospital model. When Fred Karl, aging and in failing health, suggested that the board begin searching more aggressively for his long-term successor (Rosen 1995a), Jay Wolfson ended up in charge of the search. In recounting his initial impressions of Siegel as a candidate, Wolfson recalled being impressed in several respects.

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> He's a physician, with a masters degree in public health—in maternal and child health—he'd been born and bred in the public sector – New Jersey Commissioner on Health, New York City Health and Hospitals Corporation, you know – he's written and published about public sector issues… you know – this is perfect … he's African American. He's like a dream candidate. He's smart, he's articulate, he understands how big hospitals work… he understands the budgeting, the finances… you know – who could ask for more? And, from a political perspective, he made it very clear that he was committed to the concept and reality of a public hospital. We all kind of were committed to the concept and reality of a public hospital. (Wolfson interview, November 30, 2001)

As head of New York's Health Hospital Corporation (HHC), a public entity, Siegel was responsible for what were initially 16 public hospitals, 76 clinics, a $3.8 billion budget, and 41,000 employees. He was a Princeton graduate, had earned his medical degree at Cornell Medical School, and a Masters in Public Health at Johns Hopkins (Mooney, 1995). As a person of African American descent, Siegel was attractive to the TGH leadership and community because of the institution's history of service to the black community—a community from which many indigent patients hailed. Siegel also was favored because his public policy record suggested that he was sympathetic to public hospitals and indigent care. While his work in New York involved implementing Mayor Giuliani's aggressive privatization plan, Siegel objected to the plan, seeing it primarily as a tool to limit hospital services to the poor (Fein, 1995).[23]

Ironically, through an interesting turn of events, it was a provision of the Sunshine Law that actually put Siegel on the TGH radar screen and ultimately in the president's chair. Through Dr. Wolfson's description of the circumstances surrounding the search for a hospital president and the decision to hire Siegel, one

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[23] Dr. Wolfson also commented during interview that Siegel objected to the Mayor Giuliani's approach and thought it was wrong. Siegel and the Mayor finally reached an impasse, which Wolfson suggested prompted Siegel's departure from New York's HHC.

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gains an even clearer appreciation for both the scope of the Sunshine Law and the adversarial climate surrounding many administrative decisions at TGH.

> We initiated a search, a national search for a new administrator for the general hospital, and we did it through a private search firm. We went through all the machinations, we started interviewing people, and then the newspapers sued us and said you can't do that – you have to do it publicly, and you have to do it in the sunshine.
>
> Our attorneys at the time had made a mistake. There had been a case six months prior to that that was on all fours… it was the exact same thing that had happened in another county, and […] the Supreme Court said – of course you've got to do it publicly; you're a public institution.
>
> So our attorneys ended up eating the legal cost, and we wound up having to reinitiate the search… I took personal control of the search. I called up Clark Bell, who was then the editor and publisher of *Modern Health Care*. And I said – Clark, I need your help… I need a full-page ad this week in *Modern Health Care* advertising for a President for Tampa General Hospital… I told him the whole story, and he said, "We'll squeeze it in."
>
> Well, I got a whole new flood of applicants… including a faxed application from one Dr. Bruce Siegel. (Wolfson interview, November 30, 2001)

Siegel also happened to arrive with some of his own political baggage. Apparently, he had resigned his prior position as president of HHC due to what might be described as his lack of fervor for implementing the city's emerging privatization policies. His actual departure, however, was accelerated when an employee charged him with sexual misconduct (Rosenthal, 1995). Siegel denied the charges, which were never actually substantiated, and others who worked closely with him over a period of time publicly expressed disbelief about the allegations (Purdy, 1995). Nonetheless, he vacated his position earlier than expected under a cloud of controversy. Some even speculated that the scandal may have been instigated by the mayoral administration as a way of hastening Siegel's departure because of his opposition to what he considered

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an overly aggressive approach taken by the mayor to divest the city of its expensive indigent care burden (Mooney, 1995). Contemporaneous news reports suggest that Siegel had already decided to leave the New York-based HHC after he saw the mayor's administration moving to dismantle the public sector enterprise, and because of fundamental disagreements that he had with the mayor's privatization policies. To Giuliani, indigent care represented a huge expense to the city that it could no longer afford. So he sought largely, by passive means (e.g., via withdrawal of support, encouraging attrition though inducements, etc., to dismantle the public corporation and/or offload it to private enterprise (Fein, 1995; Mooney, 1995).

Apparently, Bruce Siegel's public sector sensibilities and perhaps his experience with privatization (albeit an opposing position-and perhaps *because* it was an opposing position) appealed to the board at TGH. However, Siegel's position somehow softened toward privatization after he had had an opportunity to understand what he eventually came to view as strong indications for privatization at TGH. Jay Wolfson's account suggests that it was a matter of his having perceived problems with the public model that existed at TGH when he arrived, and the possibility of resolving those problems with private intervention while preserving the hospital's community service role as a priority—a model that Siegel may have seen as far more benign than what he had experienced in New York.

> Even during the throes of our earlier discussions publicly about reorganizing the hospital, I maintained that the principle of the public hospital had to remain in tact. We had an obligation to our community… preserve that public function even if we were a not-for-profit corporation. And we should do that explicitly as part of our charter, our by-laws and everything else. And shortly after Bruce came, I think he got the lay of the land very quickly. It doesn't take a pediatric cardiovascular valve specialist to understand when you look at the numbers and the relations that this is not able to function the way

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> a hospital should because of the sunshine law and because of the lack of tax support. There had to be a way of crafting this in a different way and the only reasonable way of doing that was to reorganize the institution. (Wolfson interview, November 30, 2001)

Wolfson's comments also suggest that reorganization was as much the board's vision as it was a conclusion drawn by Siegel and Wolfson himself, who happened to have been the head of the hospital board's finance committee at the time.

A subsequent reconfiguration of the board that gradually incorporated external and private corporate representation appears to have contributed significantly to reorganization.

> Well, there was a groundswell of support for that [the reorganization]. We were successful in acquiring a new board member… who was a very powerful and very prominent member of the community, a guy named H.L. Culbreath… who had been the president of Tampa Energy Corporation, which is the regional power company. HL had actually built TECo into a major corporation, was very well respected and really understood finance and large corporations… Getting somebody like that on the Board raised the prestige and stature of the board… substantially.
>
> HL was, I think, early on clearly committed to the concept of reorganization for business purposes... and we were able to create, I think, a board—even though there were the public members of the board—cause there were three statutory members of the board… there were 2 county commissioners and then the representative in the University of South Florida, who by law had to sit on the board.
>
> I served that latter function as the representative of the University of South Florida. The two public members were always complaining…well two of them were – we had had some rotations. There was one, Commissioner Tom Scott, who was able to understand the realities of the finances and didn't buy into the political basis of doing this [privatizing] just because it was able to get him sound bytes. In fact, he ran into opposition with members of his own community [Scott represented the low-income Black community] who felt that he was betraying their interests by supporting the idea of privatization. Then he said – 'Hey look, you know, if I don't do this, this hospital has

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a chance of going under, and I'm not going to let that happen.'
(Wolfson interview, November 30, 2001)

However, in order to effectively manage the reorganization successfully, it was necessary to understand the feasibility of such a move in terms of costs and revenues. Unfortunately, the hospital's senior management under Dr. Siegel's leadership lacked an adequate grasp of those issues. Also, the reorganization of the hospital was, in several respects, very poorly timed. The confluence of a number of factors actually made the TGH privatization stall literally before it ever got started. For instance, the Balanced Budget Act of 1997 significantly reduced Medicare reimbursement to hospitals, which had been a significant revenue source up to that point. The timing and scale of foregone associated revenues—a reduction of about $35-million for TGH over the succeeding 5-year period—would contribute significantly to neutralizing the positive impact privatization was intended to have once it was finally executed (Testerman, 1999).

One of Siegel's rationales for the privatization of TGH was to facilitate moving the hospital to a site adjacent to the University of South Florida (USF). TGH had already been serving as the primary teaching facility for the USF medical school. The move was at once an opportunity to upgrade the facility and to provide a better geographic location that, as Director. L indicated, had superior patient access relative to Davis Island (Director L. interview, November 28, 2001), and would have eased the hospital's advancement toward notoriety as a state of the art medical teaching and research facility while maintaining comparable proximity to the community of indigent patients who depended on TGH for their primary and emergency care (Cummins & Berger, 1997). However, the success of these plans depended greatly on a number of factors, including cost and revenue controls and fundraising. At the same time that the hospital was losing money on costly procedures for which it was not

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being adequately reimbursed, it was incurring unanticipated costs associated with increased overtime and recruitment costs related to a rampant nursing shortage and the growing prevalence of managed care claims had cut significantly into hospital revenues. In addition, the hospital was only able to raise less than $100,000 of the $100-million that Siegel's plan contemplated the hospital being able to raise from private sources—money he anticipated combining with over $60-million of hospital revenues the hospital was to generate as a private institution to cover the cost of the new facility that were estimated at $153-million (Testerman, 1999). In addition, as noted above, the hospital had lost its lien power upon privatization due to an oversight of the attorneys who oversaw the privatization process (Wolfson interview, March 4, 2004). Again, without this lien power, the hospital was unable to collect its bad debt, which, according to audited financial statements, had risen about $ 9 million in 1998 to $ 23.7 million. It is also significant that the severe Medicare reimbursement reductions contained in the Balanced Budget Act of 1997 mentioned earlier were executed the very same year that the hospital became a private entity (Karp, 1999d).

Untimely Disclosure: 'The Trouble with Sunshine'

As previously indicated, public scrutiny and rules of disclosure associated with Florida's now infamous Sunshine law gave TGH's competitors advance notice of the hospitals' sensitive operational and strategic planning—information which competing facilities were then able to use to outperform TGH. Dr. Wolfson, during an interview, characterized Florida's Sunshine Law as

> …one of the most severe in the country …provided that virtually every aspect of hospital operation—including board meetings and board members' hospital-related activities—were subjected to public scrutiny. So that I, for example, was unable to meet a fellow board member for lunch and discuss aspects of hospital policy without notifying the press 5 days in advance and having a member of the press

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> present. And what that did is it placed the hospital at a profound disadvantage in the marketplace. …Indeed we would sometimes spend hundreds of thousands of dollars on a consulting contract to obtain information about the feasibility of proceeding with a particular project, and the only time that we as board members would get the see the results of that project, after which we paid for, was at a public meeting when our competitors would be sitting at the table—they'd get copies of it. So the hospitals in our community would get a quarter million dollars of consulting free, they would take the results of that—and they could of course act upon it with far more expediency, privacy and business sense than we could [because they are private facilities and] because we were subjected to this "artificiality" of Sunshine based on the legal fiction that we were a public hospital (Wolfson interview, November 30, 2001)

The issue of control of the hospital to insure its service to the community is a central aspect of the hospital's history. Several changes in hospital governance and/or oversight have occurred at TGH over the years—starting with hospital board governance in 1931 to City Council oversight in 1949 to a city/county Hospital and Welfare Board created in 1963 and then to a public hospital authority created by the State of Florida in 1980 under which its board delegates were appointed by elected officials of the Hillsborough County Commission (Karp, 1999c). Nearly from its inception in the early 20th century, TGH had ostensibly been a publicly governed institution. In tandem with the State legislature's creation of the Hillsborough County Authority, however, came a legislative mandate that TGH provide care to the poor, which cemented the hospital's obligation to provide indigent care as well as the public's perception of TGH as a public facility fully responsible for providing that entitlement (Imperfect solution, 1990). Once the hospital was privatized, however, it was Dr. Wolfson's contention that TGH, while still obliged to deliver indigent care, was not a public hospital and therefore should not have been subject to the transparency provisions of the Sunshine law. He explained that the public's perception of TGH as a public facility lingered even after privatization partly due to a

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misunderstanding. Wolfson touched on it in part of his discussion about the reasons why the privatization effort took such a long time, which he estimated at nine years.

> … it was a sensitive issue because Tampa General was the community's only public hospital—one of the few remaining public hospitals in Florida. Yet there was significant misunderstanding about the nature of the public hospital status of Tampa General. It was the only hospital in the United States that was designated as a public hospital that received no funds from the legislature or from the county government in the form of tax revenues.
>
> There had been a brief period of time in 1983 and '84 when an emergency city tax had been instituted to bail Tampa General out. But before that time and after that time,, there was no tax revenue… Cook County Hospital, or Shanz Hospital in Gainesville or in Miami, Jackson Memorial all have tax revenue bases that are assured—that go directly to those institutions for either designated or discretionary use. Tampa General never had that, and there was a gross misperception within the community that somehow public monies were being used to support, sustain, and build the entity—even with respect to the 1984 decision of the board of trustees then to substantially enhance the physical plant of Tampa General with a $160 million bond issue and the construction of a new hospital, which is a beautiful facility that's brought up to almost 1000 beds. The perception was that somehow public monies had been used to build that hospital, and that was categorically untrue.
>
> The monies that had been used to purchase the bonds were those of private corporations, union trust funds, and some wealthy individuals. Not a penny of public money was used to build that new facility. There was only an underwriting through a public bond underwriting entity that would have provided a guarantee were the hospital to default on those bonds. (Wolfson interview, November 30, 2001)

Wolfson also suggested that TGH's exposure to public scrutiny discouraged potential partners, e.g., other teaching hospitals and specialty care facilities, from establishing relationships with TGH. This is important because, in the health care business, partnering affects a facility's capacity to serve a range of reimbursable medical conditions (e.g., obstetrics, renal and cardiac care, etc.) to offset

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some of the expense of charity care provision and to control costs. Partnering with facilities that have complementary capacities, for example, can enable a hospital to serve a wider range of patients and reduce costs associated with upgrading technology. (Possible advantages include economies of scale in technology purchase, training, or treatment delivery.) Other area facilities and physicians were very hesitant to work/partner with TGH—primarily because they too were sensitive to doing business "in the sunshine." Aligning themselves with TGH would have meant just that. In Wolfson's words,

> If you're looking to salvage the financial viability of an institution that has been beaten up for many years, and has been subjected to a market a marketplace where it was really at a tremendous disadvantage—in part because everything it had to do in the sunshine… and because of that, physicians and other health care institutions simply refused to craft relationships with us for joint ventures. They'd say, "I don't want to do this because I don't want to appear in the newspaper the next day, and I don't want the documents associated with this to be subject to public review." So nobody would do business with us. Nobody would engage in creative relationships with us. And we were kind of stuck in this bizarre situation where we were a public hospital in name only. And we were competing with some very successful and very savvy other institutions that didn't have anywhere near the clinical competencies and scope of service that we [TGH] had, that were located in better areas of town, and were able to beat our pants off (Wolfson interview, November 30, 2001).

Wolfson's comment about TGH being a public hospital "in name only" refers to the dissonant situation in which TGH was viewed as a public hospital even after its privatization with respect to its accountability to state and county government (ostensibly because it was a recipient of some public funds). For example, the hospital and its leadership were (and, to some extent, are still) subject to restrictions under the Sunshine Law that applied exclusively to public facilities. Yet, on the other hand, Wolfson insisted, TGH never received the level of county subsidies for indigent care

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that were par for Florida public hospitals, nor did it enjoy the Lien Law rights afforded to public facilities.

The competitive landscape shared by Tampa area hospitals to which Wolfson referred includes a number of facilities. Hillsboro County's largest hospital facilities are St. Joseph's Hospital, University Community Hospital and Brandon Regional Hospital. As indicated in Chapter 1, the repertoire of services a hospital facility selects defines its capacity to meet the community's health care demands. Similarly, a hospital's competitive position rests on how it compares with other area hospitals in that regard. Partnerships or facility consolidations affect that landscape in that they can enable a facility to extend its treatment capacity and compete more effectively. The principal competitor for TGH, for example was St. Joseph's Hospital.

> St. Joseph's hospital, which is considered by most the hospital of choice in Hillsboro County, for a lot of political and other reasons, went back into the business of maternity care. They had gotten out of it back in the 60's because of abortions and because of other birth control issues—tubal ligations, etc. Humana had built a women's hospital across the street from St. Joseph's hospital.
>
> Around 1988, St. Joseph's acquired that hospital and went back into the business of providing maternity services. Literally overnight, Tampa General Hospital, which up until then had been providing the previous year, 8,500 deliveries a year –most of those, buy the way, being Medicaid…dropped to 2,500. My financial analyses years before had indicated that we were making money off of Medicaid deliveries. In fact we were making money off of a lot of our Medicaid services. …that huge base of service plus the revenues associated with it just disappeared as St. Joseph's resolutely pursued not only the general maternity business, but the Medicaid maternity business… and they cleaned the house! (Wolfson interview, November 30, 2001)

It is interesting to note that similar competitive issues are likely to have existed with respect to treatment options for another significant Medicaid-eligible population—children. Note from table 4.3 below that TGH faces competition from at

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least two hospitals in that regard—Tampa Children's Hospital housed at St. Joseph's hospital, and Shriners Hospital. Other hospital consolidations in the Tampa area that may have impacted the competitive landscape include Memorial and Town & Country hospitals, which were acquired in a 1999 bidding competition by Iasis Healthcare, and this was preceded in 1997 by a 10 area hospital acquisition by BayCare Health Systems.

Table 4.3 – Hillsborough County Area Hospitals

Hospitals	Features &/or Specialties
Brandon Regional Hospital	General acute care
Memorial Hospital	---
Moffit Cancer Center (USF/TGH–affiliated)	Cancer treatment center
Shriners Hospital for Crippled Children	Children's chronic care facility & pediatric cancer treatment center
South Bay Hospital	Acute care
South Florida Baptist Hospital	Acute care
St. Joseph's Hospital	Emergency, maternal/obstetrics
Tampa General Hospital	Highest level trauma center & only burn unit in Tampa area
Town & Country Hospital	---
Tampa Children's Hospital (at St. Joseph's)	Pediatric cancer center
Vencor & Transitional Hospitals	Long-term rehabilitation
James A. Haley Veterans Hospital	---
(Source: Stobbe, 1999a)	

Partnering also was seen as important for the viability of TGH because its long-standing reputation as an indigent care provider was thought to have eroded the facility's patient base. Because the hospital had been perceived by potential patients as a "poor person's facility," the general public did not want to go there (Testerman,

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2001). Since maintaining a viable patient base is another important determinant of hospital revenue generation, the board and administration took into consideration several approaches to accomplishing just that.

As a private nonprofit hospital, the TGH administration saw an opportunity to recreate their hospital, improve its image and forge partnerships with other facilities to enhance its ability to compete, etc. Valiant attempts to accomplish those things were in fact made immediately following reorganization, but were largely unsuccessful due to lack of public and government support, and the hospital's finances could not cover the costs associated with the scale of the intended change initiatives.

Resistance to Privatization

In the mid 1990s, after more than a decade of providing charity services under a perceived public mandate but with limited public support and with about a third of the facility's hospital beds lying fallow, serious questions were being raised about whether TGH could ever be restored to financial viability (Berger, 1994). Several approaches had been tried with varying degrees of success and/or public support. However, the privatization options still raised concerns, particularly in the public sector. Jan Platt, the second county commissioner appointed to the TGH board and vocal opponent of privatization, believed that changing the governance of the hospital to private ownership would obviate transparency of hospital operations to the public, and secondarily risk losing the hospital as a dependable resource for indigent care. She shared those views during an interview:

> … Florida has a sunshine law that requires public bodies to conduct their meetings and discussions completely 'in the sunshine' … and that the records of the meetings must be open. Tampa General is funded by a substantial amount of public money. And I am a strong believer that with the public investment, that the public has the right to know everything that is occurring in the management of the hospital. So, one

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of my major concerns was closing the door to the public on the decisions that were going to be made by the hospital. That was my primary concern… Secondarily, there had been concerns over the years that major health care providers were interested in possibly taking over the ownership of Tampa General. (Platt interview, January 30, 2005)

Public resistance to privatization was aggravated when Bruce Siegel alienated the press and made a number of political blunders in the process of planning the TGH's reorganization. According to an account in the *American Medical News,*

> Tampa's local leaders, pleased with his fight for public hospitals in New York, thought Dr. Siegel was the perfect person to lead a public Tampa General to financial security. But within three months of his hire, Dr. Siegel and the hospital board began holding a series of closed-door strategy meetings. Soon, he announced plans to lease the hospital to a private, nonprofit corporation. Just two months later, the deal was approved in a 12-3 vote… Critics say Dr. Siegel was brought in specifically to push through the privatization plan. And because the plan was approved so quickly, it never gained widespread support throughout the community (Holewa, 2000, p. 13).

So, in spite of the hospital administration's having garnered sufficient conceptual support for reorganization, there was still significant resistance to it—justified or not. According to Director L., TGH's privatization was hampered because it proceeded under highly contentious political and legal conditions—which were very visible, even central on Tampa's political landscape. For example, soon after the hospital's privatization, the *Tampa Tribune* sued TGH to gain access to the hospital's financial records under Florida's Sunshine Law. Bill McBride, candidate for Governor who happened to be actively campaigning for office at the time and who also had served as former president of the Chamber of Commerce, was a partner in the law firm representing the Tampa Tribune in its lawsuit against TGH. Director L., who was a trustee of the TGH board at the time, viewed this as a clear conflict of interest and use of the hospital as a political football, to be treated favorably by the media and to win votes in the then upcoming election. TGH ultimately lost the lawsuit. The decision

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was appealed and affirmed in the lower court "without opinion," which, according to Director L., disallows the case being taken up by the Supreme Court, thereby obviating further appeal (Director L. interview, March 4, 2004).

In the meantime, another series of political and legal confrontations occurred following the hospital's privatization in the face of administrative adjustments to the severe post-privatization financial setbacks that left Bruce Siegel desperate for ways to recover. Siegel proposed closing four family health centers to control costs (Palosky, 1998), implemented an employee buy-out that resulted in 99 staff leaving the hospital, cut an additional 22 staff hospital positions, and affected an undisclosed number of voluntary resignations and retirements (Stobbe, 1998a). Efforts were later launched to reestablish the hospital's lien power that you may recall had been a casualty of the hospital's reorganization effort. However, like other hospital-related measures mediated by county government at the time, the necessary approval by the County Commission of an ordinance that would be needed to return lien rights to the hospital as a private entity was mired in legal and/or political controversy.

Just prior to the hospital's reorganization, the Lien Law itself had already been subjected to legal challenge in 1996 when a judge authorized a class action suit against TGH on the basis that hospitals' lien power (even that of public hospitals) might constitute interference between the beneficiary and the insurer (Stidham, 1997a). TGH attorneys, however, were successful in forcing the judge to drop the case on a somewhat questionable but effective technicality (Stidham, 1997b). This of course had to have been reasonably fresh in the minds of elected officials when TGH filed a request the following year for county approval of an ordinance that would extend lien power to private hospital facilities. When approval of that ordinance was substantially delayed, a contentious and politically sensitive exchange ensued. Bruce

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Siegel accused commissioners of delaying authorization of the ordinance in retaliation for Siegel's refusal to purchase medical equipment from Bekhor, an active campaign fundraiser for commissioners Tom Scott, an ally of Siegel's to that point, and Jim Norman. Siegel referred evidence of the alleged extortion to federal prosecutors, which sparked an investigation, but no charges were ultimately brought (Dougherty, 1999; Karp, Testerman & Dougherty, 1999).

Shortly thereafter, the County Commission referred an unrelated set of allegations about Siegel to State authorities and formally requested a probe of Siegel's actions during his tenure. Specifically, they accused Siegel of breaking State public records laws by misleading tax payers and misrepresenting the facts to public officials when he promised that indigent care would remain a priority in order to get an affirmative vote from the commission on privatization, and then appeared to reverse his position after gaining the vote (Karp, 1999a; Koehn & Howard, 1999). The basis of their argument was Siegel's comments in a court deposition suggesting that the hospital's priorities had turned from indigent care, saying that care for the poor was important, but no longer the hospital's top priority (Karp, 1999a). Siegel's comments to the Commission in support of indigent care were a major consideration that eventually won the commissioners' approval to privatize the hospital. When Siegel later stated that indigent care was not the hospital's top priority, his statement was perceived by some commissioners as reversal of his earlier promises and cited him for ethics violations and other breeches of trust related to what ostensibly were conflicting statements he had made before and after privatization. To some commissioners, this constituted a not-so-elaborate bait and switch tactic. Siegel, in his own defense, indicated that his post-privatization statements had been taken out of context and that neither his nor the hospital's commitment to indigent care had diminished (Karp,

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1999a). Related interview comments by Director L., a TGH board member at the time of these incidents, tended to corroborate Siegel's story (Director L. interview, March 7, 2004). Also, notwithstanding the absence of indigent care performance data prior to 1999, there is no indication that the hospital's indigent care delivery had diminished, and it continued to increase through 2003 (See Appendix G). Siegel's later comments apparently were related to his vision of moving the facility from Davis Island, where it was relatively isolated and prone to flooding, to a smaller but more efficient location closer to the University of South Florida, the medical and nursing students of which TGH had served as the teaching hospital. Sources indicate that Siegel wanted to see the facility become a world-class medical teaching and research facility thereby upgrading the hospital's regional notoriety, ability to compete and ultimately to better serve the community (Bovbjerg et al, 2000; Stobbe, 1998b).

Political Conflict & the TGH Privatization

Because of TGH's perceived role as a public facility, there was a great deal of public and political pressure for the hospital to continue fully exercising its role as the community's premier provider of indigent care regardless of its financial condition or its ability to absorb the expense. Dr. Wolfson reported that TGH

> … got bombarded with millions and millions of dollars worth of unreimbursed… expensive services. It had a mandate to provide those professional services as a teaching facility, and it was kind of stuck between a sponge and a soft place because it was being told that it had this obligation to be responsive to the comprehensive health care needs of the community at the highest level—at the quaternary[24] level, and to

[24] Medical care is classified along a continuum of complexity comprised of four levels with each level representing increasing degrees of sophistication. The levels range from primary to secondary to tertiary to quaternary levels of care. A primary care facility provides basic hospital care and the quaternary level of care, which may include, for example, specialist care supported by state-of-the-art technology and elaborate ancillary support services, which may in turn be delivered through a network of facilities and may often include a significant educational and/or research component (see, for

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> behave like a big boy in terms of budgeting, management and financing, and that you have this obligation, but we're not going to give you any assistance through tax [revenues]. (Wolfson interview, November 30, 2001).

The principle stated reason for public and government resistance to privatization was that private ownership of the hospital was perceived as a strategy for the hospital to divest itself of its (public) responsibility for providing indigent care. That apparently was never the intent, but there was strong public resistance on the basis of that sentiment. So after his arrival at TGH in 1996 and after several failed attempts at obtaining adequate public funding, Siegel took the board into private session for several months. The board emerged from those meetings with a plan to privatize, which it did in early 1997. However, public response and government support became major stumbling blocks. The public responded with mistrust—ostensibly due to the privacy of the meetings at which the board discussed privatization and the public's basic mistrust of Bruce Siegel, who was generally perceived to be the engineer of the privatization agreement. The *American Medical News* draws an excerpt from a June 1999 *St. Petersburg Times* editorial article which describes the political climate following the months of private meetings.

> Siegel caused his own grief by forcing through privatization in 1997 despite serious questions about public oversight, financial forecasts, indigent care and conflict-of-interest rules. Had these disputes been resolved or even adequately addressed during the mad rush to privatize, Siegel might have been able to count on local leaders to rally behind him rather than question his candor and commitment (Holewa, 2000, p. 13).

There is evidence, however, that several of the issues about which the public at large and the media claimed ignorance had in fact been addressed publicly.

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example, Rabkin, 1996; or the categorization offered by the Joint Policy and Planning Committee of the Ontario Hospital Association as referenced by the Manitoba Centre for Health Policy, 2003).

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For example, while county government and the public at large perceived privatization as an attempt by the hospital to dodge its indigent care responsibility, the privatization plan, already under development for several years at that point, actually incorporated indigent care and included good faith provisions to maintain pre-privatization care levels (Port, 1990). Dr. Wolfson explained this in the aforementioned1990 news article and elaborated the same point in his case study interview as well.

> I must have sat in a hundred different community forums with small and medium groups, and what I said to them was—look, let me show you this lease agreement… the lease agreement is the contractual agreement between the Hillsborough County Hospital Authority, which has the statutory ownership rights over all the assets of Tampa General Hospital, and the newly formed Florida Health Sciences Center, which would serve as a not for profit corporation managing and leasing those assets for a period of 99 years. Let me show you these provisions within that lease document that relate to default.
>
> A default means that if the new lessees—the newly formed nonprofit—Florida Health Sciences Center fails to meet the terms, the organization reverts to a public institution. You tell me, folks, what kind of things you want to make sure happen, and I will put those terms into the lease as default provisions. I will write language and I will say the hospital is required on a quarterly basis to report the following things publicly. As long as it doesn't violate our strategic plans, and … the confidentiality we need to maintain in order to do business, we'll do those things. And we'll [include] some benchmarks. If we fall below some level of providing unfunded care based on what we know about the community, which could be a default provision… So we were prepared to build in just about any kind of language that would assuage the concerns of the public and of the public entities in the State [and] make sure that those could become default provisions, and those default provisions would then signal the transition from a privately held institution to a publicly held institution.
>
> Now, in fact, it would never happen that easily or that quickly. I was being more glib in my sale of this, but the fact is that in order for that to happen somebody would have to sue us. So what I did was put aside a bunch of money, and I said—We're going to give the old hospital authority a budget, and we're going to set aside funds for them so that,

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> in the event they believe we are not meeting the terms of the contract or the lease agreement, we will basically finance the lawsuit against us. (Wolfson interview, November 30, 2001)

Wolfson's plan, which the local press characterized as complex, was laid out in a letter to the Hillsborough County Hospital Authority chairman in 1990 after he (Wolfson) had studied TGH finances for a number of years as the Authority's finance chairman. The plan involved the establishment of an indigent care account into which appropriate government agencies and, if permitted, the privatized version of the hospital, would be obliged to deposit equal to the portion of their historic contributions to hospital revenues that traditionally had financed indigent care—plus a small good-faith increase from the hospital side to demonstrate its good intentions.

If implemented the plan essentially would have guaranteed the hospital's continued provision of charity care at historic levels. However, the hospital-side contribution to the account would be contingent upon the continued flow to the hospital of public funds to which the hospital, in Wolfson's view, would be entitled as a provider of public services. Therefore, the hospital's response to any reduction in public funds under this plan would have been a commensurate reduction in levels of indigent care provided. An important implication of this approach, based on Wolfson's statements to the press, was that responsibility in the eyes of the public for any reductions in indigent care resulting from inadequate funding would have rested squarely with the involved government agencies as opposed to the TGH leadership (Port, 1990).

Of course, secret board meetings and Dr. Siegel's forcing the issue of privatization only worsened the situation. A number of unexpected changes the hospital underwent on his watch also damaged his credibility. For example, Dr. Wolfson noted in his interview comments that shortly after Dr. Siegel made public

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assurances that TGH's commitment to indigent care would not falter, TGH was forced to close a number of free clinics—primary sites for indigent care—because the hospital could no longer afford to support them. His plan to partner with and relocate the hospital closer to the University of South Florida—a bold and costly move that he believed would increase patient access, improve TGH's patient base, and enhance its status as a teaching hospital—polarized the community and raised suspicions that TGH was bent on indigent care abandonment. However, TGH lacked adequate financing for a project of that scale, and Siegel apparently lacked the political backing (not to mention a financial and public policy climate) conducive to securing the necessary public funding. These would later prove to be decisive factors both in TGH's initial failure and its eventual success as a private nonprofit. But success was not to occur until some time after Siegel's tenure as CEO.

The denial of its Lien Law privileges and loss of Medicaid funding aggravated TGH's financial losses, which amounted to around $40 million between 1998 and 2000. Not surprisingly, the hospital also remained mired in political and legal disputes during that period as well.

Table 4.4 – TGH Privatization-Related Politics & Finances

1990	Tampa General board is swayed by public opinion to remain a public institution.
1991	David Bussone is named president of Tampa General, replacing Newell France.
1994	Fred Karl takes over as president.
1997	• Tampa General board votes to go private in May. Its first official day as a private facility is Oct. 1. • Ron Hytoff is hired as chief operating officer. • Siegel announces a plan to move the hospital to a site near the University of South Florida.
1998	• The hospital reports a $4.1 million profit for fiscal year 1997.

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	• Grand jury investigates allegations by Siegel that county commissioners Jim Norman and Tom Scott attempted to strong-arm him into doing business with a medical supply business run by David Bekhor, a campaign contributor.
1999	• Tampa General reports $17.3 million in losses for fiscal year 1998. • Hospital board votes unanimously to end plans to move to site near USF. • Siegel attempts to have Hytoff replaced.
2000	• Siegel goes public with news that the hospital lost $6.2 million in the first quarter of the fiscal year, raising its losses to $28 million in 27 months. • Board forces Siegel and Chief Financial Officer Shirley Gamble to resign. He is replaced by Hytoff. • Tampa General reports $10.2 million in losses for fiscal year 1999. • State Legislature approves a $29.5 million funding package that includes $23 million in one-year funding and $6.5 million in recurring dollars.
2001	The hospital reports $7.1 million in losses for fiscal year 2000.
2002	• The hospital reports a $9 million profit for fiscal year 2001. • Tampa General celebrates its 75th anniversary.
2003	• The hospital reports a $56.2 million profit for fiscal year 2002. • A $103 million expansion is approved by the city council.
Source: (Jones & Boulton, 2003)	

TGH Performance & The Turnaround

As stated, TGH was mired in financial difficulty ostensibly due to foregone indigent care charges. Yet, it is clear that, despite fears to the contrary, the hospital's indigent care expenditures[25] continued to rise during and after the hospital's transition from public to private nonprofit status. See the performance figures provided in Appendix G and depicted in Figure 4.1 below.

[25] These represent the hospital's total indigent care-related expenditures of which the previously noted $22 million Medicaid-related shortfall that Hillsborough County government controlled was a significant portion.

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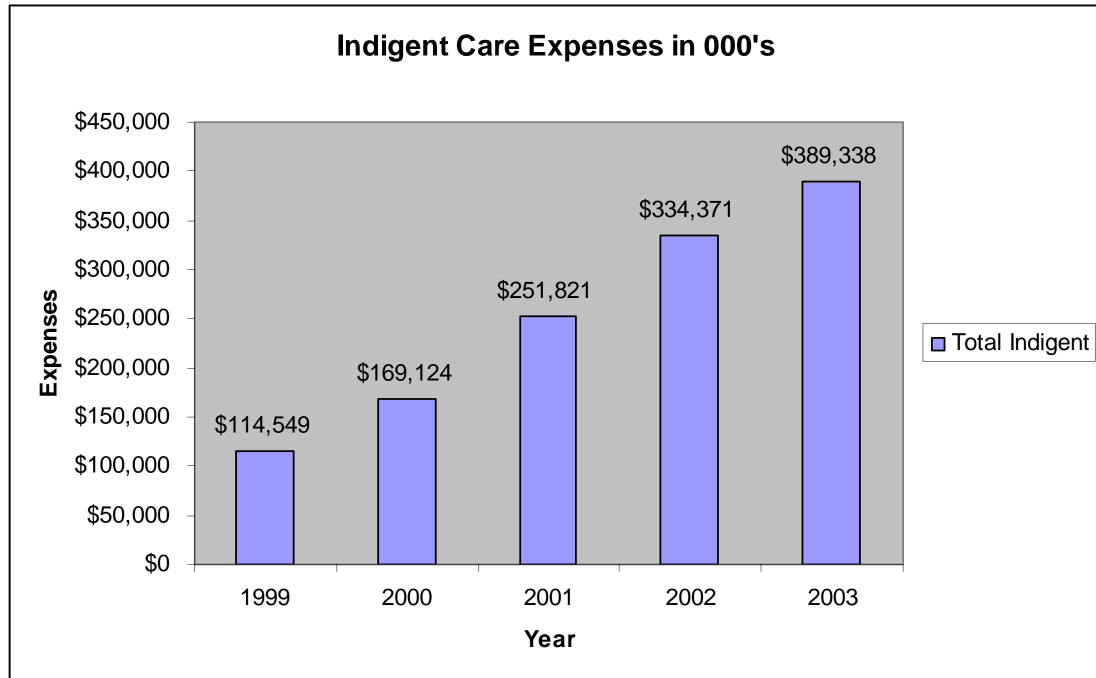
Figure 4.1 – Tampa General Hospital Indigent Care Performance



While no similar financial data on the hospital's performance in this regard was available for the period prior to 1999, anecdotal media and interview accounts suggest that the hospital had complied with its public mandate in earlier years and that service levels had been adequate. The major shared concern among hospital officials, public officials and even the public at large for many years, however, was TGH's financial viability. The fact that the hospital's indigent care burden was a significant drain on hospital resources and that the hospital was struggling under the weight of that burden was common knowledge, which is likely to have catalyzed community fears that TGH would take the logical course of action for relief, i.e., reduction of indigent care. However, that was never the case.

As shown in Figure 4.2, TGH operated at near net losses for a full two years after the hospital's reorganization, but the outlook gradually improved. Initial

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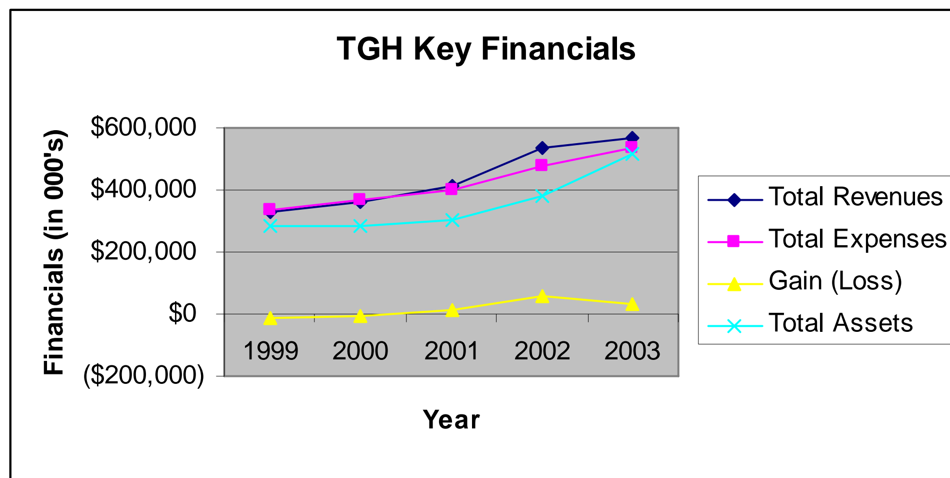
improvements came after the hospital made dramatic cuts in operating expenses under Dr. Siegel and the private governing board, slashing about 600 staff positions, changing pensions and cutting teaching and service contracts (Holewa, 2000). These changes had the effect of reducing the deficit and improving the bottom line, but the deficit still stood and, for TGH, it was still too little too late.

Figure 4.2 – Tampa General Hospital Financial Performance



Siegel eventually was replaced by Ron Hytoff who, ironically, is credited with turning TGH around essentially by operationalizing much of Siegel's vision for Tampa General. Coincidentally, however, this turnaround occurred in the midst of an industry-wide economic upturn for hospitals. Their successful lobbying efforts to Congress resulted in substantial relief from the Balanced Budget Act cuts enacted in 1987. The relief came in the form of government funding to the tune of $6.5-billion in October 2000 and another $11.5-billion in April 2001. TGH was showing a $4.3-million surplus in the first five months of its 2001 fiscal year on the heels of the first infusion of funds (Hundley, 2001).

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However, good solid management and political savvy also played significant roles, e.g., overhauling the hospital's patient admission and billing processes, negotiating better deals with health insurers and suppliers, pursuing debts more aggressively and upgrading the hospital's computer systems. The small moves collectively helped improve cash flow and slashed admission errors from 85 percent to 12 percent (Garena-Morales, 2001). Under Hytoff's leadership, TGH also enhanced its association with USF, established a steady stream of public support, initiated capital improvements, and restored TGH's profitability as well as its credibility with public officials as well as within business and general communities (Testerman, 2001).

However, the turnaround may also have been helped along by less legitimate means as well. TGH was placed under investigation for improper billing practices. Apparently, the hospital had improperly billed Medicaid for facilities fees (essentially overhead charges) for a number of years after Medicaid had ceased covering such charges. Hospital officials admitted to what they characterized as a "mistake" and agreed in a settlement to repay $2.9 million in improperly billed fees and an additional $1.1 million in penalties. While accepting responsibility for the error, hospital officials maintained that the complexity of Medicaid regulations and the difficulty of keeping up with the frequency with which they are updated were the primary reasons for the error. According to at least one independent health care expert, the reasons provided more than likely were legitimate (Jones & Boulton, 2003). In spite of hospital officials' ability to offer credible and perhaps legitimate explanations for the associated errors, several factors suggest that the hospital's failure to make necessary Medicaid billing code modifications may conceivably have been purposeful.

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- The hospital received multiple government notices calling for billing code adjustments, which the hospital failed to make. Comments to the media by the TGH director or public affairs about the complexity and frequency of Medicaid procedural and billing code changes suggest that the hospital had "set up entire departments" to track and manage billing code changes (Jones & Boulton, 2003). It is highly unlikely with the described level of internal scrutiny the hospital was completely unaware of the policy change over such an extended period.
- Institutional costs (staffing, capital expenditures, etc.) associated with the management of billing regulations could be significant. An administrator might view ignoring code changes as an acceptable risk on the basis of a simple risk-cost analysis. That is, by estimating the risk of unlikely detection for code violations along with the cost of having to pay associated penalties and comparing that to the cost to the hospital of maintaining reliable administrative mechanisms for proper implementation, an organization under financial duress is likely to choose what ostensibly is the least costly option. In this situation, policy compliance would appear more costly if the risk associated with ignoring the government policy and of being detected is perceived to be low, and the potential financial benefits of ignoring the policy high. If one accepts the view that large national government bureaucracies (and the programs they oversee) are notoriously inefficient, unwieldy and unlikely to enforce what in the broad scheme of things, might be considered within tolerance of acceptable error, the perceived level of risks of detection and enforcement also might be deemed acceptable. Could that not be true of an institution fighting for its very

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survival when the charges associated with the coding changes were relatively obscure because they constituted only a small percentage of individual case charges?

- The timing of the policy change (1996 – 1998) corresponds directly with the time in which the hospital was embroiled in privatization-related disputes that indirectly limited the institution's access to state Medicaid and county government funding for indigent care. Limiting the TGH's access to these funds was among the approaches Hillsborough county commission employed to force the privatized hospital's public accountability and to garner greater control over hospital operations (Stobbe, 1999b)
- The hospital was posting significant financial losses during the exact period over which the office of the attorney found billing irregularities (1998 - 2001). Recall from the previous case discussion that the hospital, after posting modest profits immediately following its privatization in October 1997, posted millions in losses in the subsequent two fiscal years. These losses may have been the impetus for the hospital administration to selectively ignore billing code changes that would have meant revenue losses for the hospital.

On the other hand, expert reports of the complexity and frequency of regulatory adjustments posing real challenges to institutional billing mechanisms, and the administration's insistence that the TGH administration was too focused on the challenge of insuring the hospital's survival to be concerned about smaller administrative details may both be plausible explanations for the error. Also, TGH was only one of several Florida hospitals that were investigated for similar and, in some cases more costly, infractions. Regardless of the rationale or of whether the

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errors were inadvertent, however, the fact remains that the hospital, acting under financial and political duress, engaged in improper business practices to sustain its operation—and the same may have been true for the other hospitals that were placed under investigation.

Summary

The case of privatization of Tampa General Hospital is a revealing study in public and private sector relations as well as organizational behavior and management executed in a public policy context. An examination of the evolution of the facility and the challenges faced by its successive hospital administrations reveals a picture of an embattled facility caught between incompatible aspects of public sector accountability, private sector competition, legal constraints, and untoward political and/or stakeholder influences—in short, conflicting agendas and perspectives gone awry.

Florida's Sunshine Law, characterized as one of the most restrictive disclosure laws in the U.S., created a cascade of reactions and events that affected not only the hospital's competitive position, but the behavior of its board and its members' ability to communicate and provide effective strategic leadership. The presence of the statute also created a contentious public policy environment by setting the stage for very public legal disputes and political in-fighting.

The hospital leadership's decision to reorganize the hospital from public to nonprofit status, ostensibly a means of insulating the hospital from the Sunshine Law and its many ramifications, aggravated already long-standing disputes about the hospital's accountabilities and role in the community. The circumstances under which that decision was made form the substance of the case study. Resistance to the

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privatization effort and its subsequent impact on the hospital's performance as a private entity created opportunities to study important financial, administrative, governance-related and environmental factors that impacted organizational decision-making and management from the perspective of the service provider.

The outcomes that may be ascribed to the hospital's privatization were both mixed and iterative. That is, the results immediately following reorganization were less than satisfactory, apparently owing to faulty preparation, communication and execution. Also, in the interim period between difficult and improved times for TGH, hospital administrators delayed Medicaid billing policy changes that would have decreased its revenues at a critical time in its transition. The evidence as to whether this was inadvertent or purposeful is inconclusive. Nonetheless, the benefits of reorganization were gradually realized following changes in the hospital's leadership, its management of stakeholders, and its ability to forge alliances—all of which appear to have contributed to the success of the hospital's privatization and subsequent improved performance over time.

The following chapter analyzes case findings from the standpoint of the various public policy environment-related impacts on organizational behavior and their governance-related implications. It also examines the known implications of operating within one sector vs. another and what the case findings suggest in that regard. The chapter then closes with a summary of the findings and responses to the study's key research questions that were articulated in Chapter 3.

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Chapter 5

Case Discussion & Findings

Hiding in Plain Sight: Operating Out of Public Scrutiny

The role of Florida's Sunshine Law, particularly prominent in the case of TGH, is by no means an isolated phenomenon. As of 1981, all 50 states had enacted sunshine laws and the U.S. Federal government had enacted similar legislative disclosure provisions under the Freedom of Information Act. The purpose of these laws, like the Florida sunshine statute, is to make visible to the public actions and decisions of government entities. Also, like Florida, many states are grappling with the implications of its sunshine laws in complex areas of service delivery—health care and education in particular (Schwing, 2000). To the extent that proprietary or nonprofit organizations are engaged in public service delivery, the issues and concerns raised in this study are likely to apply.

One of the purposes for and outcomes of vetting government operations and decisions publicly is to solicit and measure public opinion to obtain popular sanction. Policy measures for which no clear consensus can be established may be particularly challenging to manage. A situation in which there is, for example, both majority opposition and significant popular support, or where there is substantial opposition to a policy in which the prevailing government administration is intractably invested, poses an interesting political dilemma. The tactic of reorganization in general and that of restructuring to nonprofit status in particular may be applied either

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separately or in tandem to resolve such dilemmas. With respect to reorganization, Nevarez (1996) recounts a case in which local government officials, in reaction to federal and state legislation that mandated complete visibility to the public of an agency's decision-making, modified county governance structures to permit private decision-making to obviate or nullify opposition.

Salamon (1999) notes that nonprofits historically have stepped in to provide collective goods demanded by a significant segment of the population when neither government nor the markets are optimally positioned or prepared to provide them. Also, as noted earlier, this can serve as a convenient means for government to inconspicuously provide public services that are necessary, but for which there is not clear public consensus.

For a public service with the broad scope and scale of health care, which comprises a range of services that are provided to a variety of market segments, public sector oversight and accountability, i.e., the *governing* functions of government, are essentially unavoidable in the U.S. context—particularly given the importance and impact of health care on the public welfare. Therefore many of Tampa's public officials and the public at large have deemed the associated visibility to the public of the hospital leadership's decision-making to be critical. For that reason, public policy disputes surrounding the transparency of TGH's operations to the public eye and the hospital's need for what was perceived to be a higher-than-permitted level of privacy called into question the appropriateness of the hospital's organizational form—as well as its accountabilities and its governance. The dilemma for TGH, however, was that this very same visibility had a negative impact on the hospital leadership's ability to communicate and to plan effectively, which in turn compromised the facility's competitive positioning and performance. In other words, TGH needed to be able to

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behave and compete like a business but was constrained from doing so by its public accountability mandates. The question then was whether a means of meeting these seemingly conflicting goals could be devised. The compromise strategy that eventually evolved gave TGH the ability to delay its reports to the County Commission and public record to obviate its market strategies being usurped by the competition before the strategies could be fully implemented. This also made TGH a more attractive prospect for partnership that, from a competitive standpoint, was a tremendously important consideration.

Privatization & the Promise of Reduced Regulation

Privatization by reorganization was not an altogether uncommon survival tactic applied by struggling public hospitals in the final decades of the twentieth century. Like a number of other public U.S. hospitals concentrated mostly in Florida, Georgia, Texas, and California (Needleman, Chollet, & Lamphere, 1997), TGH sought privatization as a way establishing the strategic and managerial flexibility and control their leaderships believed they needed to weather the facilities' financial difficulties. Desai, Lukas, &Young (2000), in their discussion of privatization as a survival strategy for public hospitals struggling to keep up with demand for uncompensated care, note that 347 public hospitals converted to private ownership between 1980 and 1993. Public to nonprofit reorganizations were the dominant form—seventy-five percent between 1980 and 1990—and the motivations or reasons cited for the conversions included the promise of increased efficiency to be achieved by freeing the hospitals from onerous public oversight and procurement rules. More often, however, it was a response to refusal by communities and local government to provide the tax support needed to sustain the facilities (Needleman, et al., 1997).

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Similar motivations for privatization in health care also have been identified by local public health departments as privatization catalysts. Bechamps, Bialek, & Chaulk (1999) isolated four factors in their survey of public health providers:

- Medicaid managed care;
- cost savings or other fiscal issues;
- quality improvement and efficiency; and
- organizational streamlining.

Medicaid managed care was found to be a significant consideration in terms of the stimulus it provided for strategic partnerships between health care providers of varying specialties in order to meet the demand for these services most efficiently. The fiscal justifications cited included decreased demand for clinical services arising from a change in Federally Qualified Health Center (FQHC) status; and the increased fiscal flexibility associated with conducting business as a private sector entity. Quality improvement, while by no means at the top of the list of considerations, was viewed primarily as a by-product of efficiency measures, i.e., outsourcing to providers with better equipment and specialty knowledge resulted in the provision of more efficient *and* better quality services. Similarly, organizational streamlining, often spurred by the need to control facility costs and resource utilization, was an outcome of service outsourcing (Bechamps, et al., 1999).

TGH case evidence suggests that the motivations for the privatization of TGH were generally consistent with the analysis put forth by Bechamps et al. (1999) in spite of obvious differences in the privatization models applied, i.e., outsourcing in the public health instances versus public-to-nonprofit reorganization in the case of TGH. Also, the TGH privatization decision was indeed tactical in that it represented

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an opportunity for the hospital to establish a measure of operational privacy with associated managerial flexibility and control. Ultimately, privatization enabled TGH to operate in a less constrained fashion than it had as a public facility. For instance, it was possible for the hospital to proceed more rapidly with adjustments in its treatment repertoire to limit or hedge against losses under the privatized model, i.e., without the need for county authorization. Such was the case when the hospital was able to drop out of the Medicaid heart transplant program to stem millions in losses (Testerman, 1999). While certainly regrettable from the perspective of patients in need of such specialized services, the move saved the hospital millions of dollars. As a public facility, the hospital would have been required to seek approval from the County Authority, which was typically a slow, bureaucratic process. Lengthy delays in decision-making can be quite costly when the service provider is forced by regulatory or other constraints to endure losses throughout the time that it takes to secure the required government authorizations. Similar authorization-related delays in tactical shifts of treatment focus to more profitable areas (e.g., establishing the kidney/renal treatment center) represented considerable opportunity costs to the hospital.[26]

The reorganization of the hospital also broadened the scope of the hospital's revenue-generating options. For example, as a 501 (c)3 nonprofit, TGH could receive philanthropic contributions. While fundraising efforts were not nearly as successful as they could have been or needed to be to sustain Siegel's ambitious plans for upgrading the hospital, these efforts might have succeeded under more favorable circumstances. Fundraising efforts were not properly resourced because the hospital lacked sufficient revenues to invest in building its capacity in that regard. H.L. Culbreath, who served as board president both before and after Dr. Siegel's departure,

[26] These costs are the revenues foregone due to the inability to pursue a more profitable option.

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agreed that the turnaround would not have occurred without privatization. This assertion is consistent with an audit report issued by Deloitte and Touche in 1999, which estimated that the financial losses incurred at TGH in 1999 ($11-million) would have more than quadrupled without the privatization-related changes brought about by Siegel and the private board (County's posturing, 1999). However, what this all suggests from a broader perspective is that, in order to perform optimally in a competitive environment, service providers need to be in a position to respond nimbly to market conditions and facility needs.

While the preponderance of research evidence suggests that private nonprofit hospitals are significantly more likely than for-profit facilities to adopt services used by indigent patients and less likely to screen or divert indigent patients to state or county hospitals (Marmor et al., 1987; see also Desai et al., 2000), the prospect of transitioning TGH from a public to a private nonprofit governance model appears to have been perceived by the public as no different from a transition to for-profit status.

Insiders at TGH agree that privatization ultimately was effective, but what this case also suggests is that privatization needs to be implemented in a supportive environment—one in which public trust, good media relations and adequate political supports play pivotal roles. Good relations on the regulatory side might exclude to the greatest extent possible, regulatory coercion. A principal factor in the case of TGH, for example, was the county's use of its ability to withhold Medicaid matching funds and to control the hospital's right to collect bad debt under the Lien Law to force the hospital to open its books and to answer performance questions. This arrangement was intrinsically contentious—a condition that is not only undesirable, but counterproductive. The case evidence suggests that the hospital would have fared

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better had it been less dependent on public funds. A more diversified revenue portfolio would have rendered the hospital less vulnerable to sweeping policy changes and political manipulation. This appears to have been the intent of the privatization decision. Arguably, the hospital's difficulties were shown to be at once a product of its residual dependence on public funds and its inability to garner sufficient political support to go it alone.

Impact of Environmental Influences

Differences of opinion and perspective shared by public and private sector representatives in the case, the existence of competing and sometimes conflicting objectives in a politically sensitive and contentious environment, and varying abilities among those involved to effectively navigate it all created formidable obstacles to fostering constructive change and to maintaining an effective operation once the privatization finally occurred. Case findings affirm that public sentiment can favor tight regulation of a business enterprise when it delivers services in which public health and/or safety are key considerations—which suggests that political saavy and strategic thinking would be indispensable in facilitating the success of a privatization effort.

The France administration's dealings with the County Commission as described in the case narrative illustrate the importance of politically astute decision making. Setting aside for the moment that submitting simultaneous requests to the County Commission for public funding and entertainment expenses was not particularly prudent, this incident was indicative of a major set of similar challenges with which each successive CEO at TGH since 1980 had had to grapple; that of managing the paradox that is TGH—a facility that was at once a treatment center for

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the poor that required public support, and one that needed to tout its successful business management and notoriety as the premier trauma and primary care teaching hospital in the region in order to compete effectively for staff and patients—all the while obscuring its need for the public support on which it depended for survival (Tale of two hospitals, 1987). This was a recurring theme that becomes increasingly apparent in examining successive administrations at TGH during the roughly thirteen year period in which privatization was being considered there.

The challenge of balancing political considerations also was reflected in the hospital's public relations around this issue. That is, in order to advance and maintain an attractive image in the medical professional community, the hospital's public messaging was designed to emphasize the facility's operational viability and service achievements to create the illusion of success, i.e., an aura of ideal service provision and professional opportunity. This objective was diametrically opposed to the need for the hospital to build a case for its ever-present and growing need for public funds. Obscuring this need in its market-facing messaging while having to appeal to government officials for increased financial subsidies was tantamount delivering mixed messages to its would-be benefactors. Similarly, the hospital administration's failure to acknowledge the important role public sector actions played in the hospital's successes incurred the ire of public officials, which in turn decreased the likelihood that authorization for additional public subsidies would be forthcoming. Such considerations proved to be of particular importance in the politically sensitive environment of TGH where elected officials were known to take offense, for instance, when not afforded immediate access to the CEO upon request and in which there were existing (and very public) disputes between hospital administrators and elected

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officials about the terms of the hospital's entitlement to public funding (Tale of two hospitals, 1987; Stobbe 1998b).

Of course, the hospital's public relations-related struggles also were aggravated by Bruce Siegel's strident pursuit of secrecy (i.e., to obscure hospital strategic and tactical planning from public scrutiny), which alienated the press, the public and several potential political allies. Thus the initial launch of what some contend was a brilliant plan and vision for TGH, which included privatization was problematic from the start. Its initial failure, however, underscores the importance of open and advanced communication with crucial constituencies. In fact, according to several isolated news reports and case study interview responses, the resistance to privatization in some ways may have been the acting out of resentment toward Bruce Siegel himself by a handful of very influential individuals. Obscuring the planning process from public view, while perhaps desirable from a business perspective, was damaging in the sense that it rendered the motives for the privatization subject to speculation. To the extent that such speculation is comprised of misinformation, the results conceivably can be more damaging than full disclosure of proceedings. This aspect of the case suggests that if privatization is to succeed, care must be taken to avoid alienating those upon whom its success is likely to depend—namely elected officials and public administrators. The prudent application of discretion and selective disclosure such that these individuals are included in the planning process could achieve the necessary buy-in. When conflict occurs, meaningful dialogue among disputing parties to establish mutually acceptable accountability and reporting standards would have been indispensable in this case. In fact, dialogue among the various stakeholders would have afforded opportunities to understand, anticipate and perhaps avoid sources of conflict before they were manifest as problems.

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Hytoff, who was later able to repair and restore crucial relationships through cooperation and open communication, essentially implemented Siegel's plan, which enabled the hospital's return to profitability within a year. Hytoff also was successful in making prudent and well-timed management decisions while refocusing the public's attention on what seemed to have been obscured amid the years of controversy: TGH's crucial role as a community resource, and its need for public help to continue in that role. By mending relationships with the press and the public as well as with state and county officials, Hytoff was able to essentially restore some of TGH's crucial funding streams. This in turn enabled the hospital to make capital improvements, recover its credibility in the business and public service communities and, as a result, attract partnering facilities as well as physicians, patients and more (Testerman, 2001).

TGH's situation was further complicated by its long-standing role in the community as its primary indigent care provider. As such, the facility has been charged by local government and the community at large with providing a significant amount of charity healthcare. In addition to absorbing millions of dollars in free care for those for those who are poor and/or uninsured, TGH also competes with other facilities for personnel and financial resources, including public insurance (i.e., Medicaid), that would offset some of the expense of indigent care. These effects were magnified during the hospital's somewhat tumultuous transition period, which was roughly 1997-99.

TGH is located in an area in which city and local community politics exert tremendous influence. It is not known at this point what might explain this phenomenon or whether it is unusual relative to other locations. It is known that the

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local news media, the *Tampa Tribune* in particular, was actively involved both in confronting the hospital's leadership over access to facility information and in shaping public opinion over privatization. The extent to which individual's may have been influenced by media accounts of the dispute, could understand the underlying issues well enough and were sufficiently motivated to weigh in on the argument over the hospital's obligations to the public in that regard might conceivably be a function of educational background, political sensibilities and/or personal interest in the issues at hand. Valid insights in that regard may be gained by examining at a macro level certain well known and widely accepted education-related theories of human personality development and motivation—particularly those advanced by Maslow and later by Alderfer as referenced by Huitt (2004). The aspect of these theories that is relevant to the current discussion suggests that people grow toward their highest potential by traversing and satisfying an increasingly sophisticated continuum of needs, from basic to abstract, before becoming self-actualized. At the point of self-actualization, people actively seek knowledge and are likely to be both willing and equipped to externalize that knowledge for the benefit of the community (See Appendix H, Figures H1 – H3).

In Hillsborough County, which is comprised of the Tampa-St. Petersburg-Clearwater metropolitan area, political activism is high, the per capita income and percentage of individuals who hold college degrees is slightly higher than that of the State of Florida overall, and the percentage of the population living below poverty level is slightly lower than the State's general population (U.S. Census Bureau website: http://quickfacts.census.gov/qfd/index.html). In any case, the prevalence and role of public opinion in TGH's privatization suggests that the county's populace was

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intensely vigilant and active in local politics. Also it is evident that TGH itself, apart from its role as one of the area's major health care providers, also is intensely present in the community as a major player in the local area economy and political scene. This overarching organizational role converged with public opinion in a contentious dispute marked by political gamesmanship in ways that significantly affected the hospital leadership's ability to execute its strategic intent to privatize TGH. The Sunshine Law-related lawsuit brought under questionable political circumstances and the public outcry in the wake of the hospital board's private meetings to plan the hospital's reorganization both served to effectively delay privatization and hamper its effectiveness once established.

More recent events not only support the notion of the community's predisposition to political activism, but shed additional light on the hospital's political import and presence in the community as well. TGH's being an integral part of the community and the influence of public opinion on the hospital's business activities reemerged recently in the hospital's attempts to purchase the parking facility adjacent to the hospital. The parking garage in question is owned by the city of Tampa, but is located on Davis Island and is attached to the hospital. This more current situation illustrates how popular influence, political motives and the hospital's economic role in the community have continued to converge in a somewhat controversial standoff that could spell additional trouble for the hospital (Reid, 2005).

Governance-Related Implications

The *Harvard Business Review on Corporate Governance* notes that an important characteristic of empowered boards is that "Members communicate freely

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with one another in both committee meetings and board meetings and outside such settings—with and without management" (Harvard Business Review, 2000, p. 37).

From a governance perspective, the TGH board members were constrained from communicating openly with each other because doing otherwise would have very real economic and legal implications. That is, they communicated conservatively at board meetings to keep their strategic and tactical intentions hidden from their competitors and refrained from communicating with each other outside of that setting to avoid legal censure. This severely hampered the board's ability to provide the strategic and reasonably confidential leadership that the hospital so sorely needed. Exposure of the hospital's strategic intent to public scrutiny clearly gave competitors a tactical advantage that they otherwise would not have had. The findings of this study then appear to confirm that not only is an empowered board needed for effective execution of a service provider's obligations under a privatization arrangement, but that empowerment may be compromised when board members planning activities are constrained by public policy or government influence or their ability to communicate effectively with each other is otherwise hampered.

The reorganization of TGH was in part the hospital's tactical solution to its unfavorable competitive position in the marketplace precipitated by the immediate visibility to the public of its board's strategic planning and input to management's tactical decision-making. Also, the ability of directors to engage in frank communication with each other as well as with management is a crucial condition for board effectiveness (Bowen, 1994; Wood, 1996). The direct constraints that Florida's Sunshine statute placed on board members' ability to communicate openly with each other and with management did in part compromise the board's effectiveness. The

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hospital's leadership sought privatization ostensibly to obviate these constraints. However, the attempt was only marginally effective in that respect.

Some of the difficulty the hospital experienced with reorganization may be explained by certain dysfunctional aspects of the hospital's governance structure and function as a public entity. The Hillsborough County Authority was established to function as the public hospital's board of trustees. Assuming the ideal situation previously discussed in which a board's governance responsibilities generally should be more strategic than operational, the governance structure of the Authority would have to be considered somewhat dysfunctional. That is, its responsibilities, which included signature authorization for staff expenses, State law-mandated responsibility for insuring that annual inventory was taken at the hospitals the board oversees, and financial oversight of those institutions, which included submission of hospital budgets to the County Commission for approval, were tactical and operational considerations (Good, 1987a). Such responsibilities generally are the domain of an organization's administration, not its board of directors. Once the hospital was privatized, the Authority was to serve primarily an oversight function that had no real say in the hospital's day-to-day operations. This prospect may not only have served as part of the impetus for privatization but also may have contributed to its ultimate success.

The TGH governance configuration may be instructive from yet other standpoints as well. From the public sector perspective, Hillsborough County's treatment of the hospital was consistent with the dissonant model suggested in Chapter 2 in which the public sector's governance/oversight function appears to have been operating separately from and out of sync with its governing/regulatory/enforcement function such that they diverged to the point of opposition. That is, on the one hand,

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the county's treatment of TGH from a regulatory standpoint, i.e., holding the facility to its Sunshine Law- and indigent care-related mandates as a public hospital, was an exercise of its regulatory authority over the hospital's revenues and administration. The county's mechanism for doing so, however, was to withhold insurance, tax, and tort revenues to which the hospital should have been entitled as a public service provider—ostensibly punishing the hospital for having become a private entity. On the other hand, in its governance or oversight function, the county's withholding of Medicaid and Lien Law revenues that the hospital needed to underwrite indigent care delivery hampered the hospital's ability to deliver the very services the county was obliged to provide through TGH—services that the county, from a governance (and strategic) standpoint, should have displayed a stronger interest in facilitating financially.

Calls for a number of governance-related reforms for U.S. corporations have been spawned in the wake of recent public and regulatory responses to corporate scandals. Ironically, several of today's commonly recommended reforms for for-profit organizations, e.g., separation of board chairperson and CEO functions, selection of the CEO by the board, and the CEO leaving the board upon retirement are somewhat common practices among nonprofit charitable organizations (Bowen, 1994). TGH's post-privatization governance structure departs significantly in terms of composition and function from that which is typical of nonprofit charitable organizations. Because TGH operates as kind of a business/public service hybrid, it functions as neither a traditional corporation, nor as a traditional charitable organization. The hospital, governed as of 1997 by a private nonprofit board, has operated in an environment that shares a number of characteristics with the for-profit corporate world as well—the most salient of which is market-style competition.

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The competitive conditions under which the hospital labored before privatization actually provided much of the impetus for modifying its governance structure and, indirectly, the subsequent removal of its CEO. This is consistent with the notion that the hospital's dependence on government funding being anathema to effective governance. It was this very dependency that left TGH vulnerable to Hillsborough County government's undermining influence on the privatization effort through its ability to control Medicaid and Lien Law revenues.

Also, secondary stakeholder influence of the strategic decision-making of the hospital's board contributed significantly to the hospital's difficulties before and through transition as well as after privatization. Demands by the media for information reinforced by the Sunshine Law and the media's power in shaping public perceptions, which in turn engendered negative political and public sector responses, both may be seen as substantive secondary stakeholder input to strategic decision-making. An examination of the roles and impacts of this class of stakeholders in the case of TGH both on the decision to privatize and on the success of implementation confirms the contention that their direct influences at the strategic level at which boards operate can indeed be counterproductive. This, as earlier indicated, is analogous to customers in the for-profit arena being invited to vote on equal terms with shareholders—a governance arrangement that this analysis suggests is clearly contraindicated.

Organizational structures and the characteristics of their key staff members influence governance and leadership styles as well. TGH, for instance, can be described as a *professional bureaucracy,* which Miriam Wood (1996, p. 8) defines as a model in which

> …specialists and professionals work relatively independently of one another but closely with the clients they serve, and performance

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> standards are strongly influenced by professional associations, state regulators, and other external agents.

This organizational form affected TGH's governance in interesting ways both before and after its privatization in terms of the roles played by public opinion, the media and county government. Also, as detailed in an earlier section entitled *Regulation as a Cost Control Measure in Health Care*, variable influences on treatment selection guidelines, criteria for insurance coverage and hospital reimbursement for delivered services also influence governance in terms of the positions taken by the leadership of a facility like TGH where similar issues were in fact points of contention.

William Bowen uses a similar observation in discussing the need for stronger external presence on nonprofit boards, noting that

> … in most nonprofit organizations, it is assumed that many of the professionals on the staff (the faculty at a university, the curators at a museum, the doctors at a hospital) owe allegiance to their professions as well as to the particular institution for which they work (Bowen, 1994, p. 111).

While the external influence to which Bowen refers is that of external directors, it also points more generally to the impact of external influence. We understand from analyzing TGH's privatization that external parties did indeed have tremendous impact on the decision to privatize and the reorganization itself. TGH's move to reorganize from public to nonprofit status met with staunch public resistance over concerns that the hospital would use its private nonprofit status to divest itself of indigent care responsibility in favor of behaving more like a business. The impact of this resistance was, from a governance perspective, devastating. The fact that secondary stakeholders were allowed to influence the strategic decision-making that should have been the exclusive purview of the board of directors was demonstrably counterproductive. On the other hand, we also saw that later as the process of

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reorganization evolved, when conditions were more favorable, the reorganized governance structure facilitated external influence of a more appropriate and effective kind—such as that which is evidenced by the representation of USF on the board, which may be seen as de facto external board-level strategic influence by primary stakeholders, which was clearly advantageous for TGH.

Organizational Behavior & Management

Another distinct theme evidenced in the case that was in fact repeated in successive administrations of hospital presidents was the difficult challenge to hospital administrators of operating simultaneously under a public oversight model and a business gestalt. In this instance, actions by hospital administrators such as incurring large entertainment and marketing expenses in the face of budget deficits for which subsidies were being requested was confusing to public officials. The practice of increased marketing and outreach investment in a competitive market during financially troubled times is an accepted practice in the public relations and marketing disciplines and is recommended because it is considered a viable tactic for increasing or recovering market share (Deleersnyder, 2003). However, this approach apparently is somewhat counterintuitive even to some segments of the business community. Public relations and marketing budgets are frequently among the first casualties of revenue and/or economic downturns (Gray, 2002; Maddock, 2001). It should not be surprising then that public officials, who generally are less directly involved in navigating in turbulent competitive markets would be less comfortable with it than private sector entities. In that context, public officials' difficulty reconciling the mixed messages being promulgated by the TGH leadership is entirely understandable. Nonetheless, TGH engaged in a number of marketplace behaviors that were conducive

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to its positive turn-about. Many of the most significant of these, however, can be traced back to the hospital's reorganization from public to nonprofit status. Doing so, for example, reduced public scrutiny of hospital planning and operations and allowed the hospital to operate in a far less constrained fashion than it had as a public entity.

Recall from the Chapter 1 discussion that the viability of health care facilities and their ability to provide a sufficiently broad range of services to meet community needs turns on their ability to achieve scale economies. Recall also that because of the unique economic factors such as government intervention via subsidization and insurance industry rate setting, that a hospital's ability to achieve scale economies in today's health care marketplace hinges not only on its discretionary ability to invest, but also to establish partnerships or similar agreements with other facilities. One relevant point with respect to TGH is that its public hospital status and the associated restrictions on its strategic and business activities hampered discretionary investment and either restricted or rendered unfeasible partnerships or strategic alliances. For example, public agency control of significant potential revenues essentially eliminated retooling and capital investment as options for improving the hospital's service capacity. Potential partners avoided TGH because private providers were extremely reluctant to conduct business under public oversight, which they perceived as a competitive disadvantage. Accordingly, these very same facilities were also more able to compete more effectively than TGH for patients. Unable to generate or recover funds effectively as a public entity, TGH's administration opted to reorganize as a private non-profit.

The reorganization gave the hospital access to philanthropic contributions and enabled it to establish important relationships or partnerships with other organizations. Examples include the University of South Florida and other area

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hospitals as well as Florida's Agency for Health Care Administration (AHCA) and a public-private initiative involving Pfizer pharmaceuticals. Through these partnerships, TGH was able to provide specialty treatments, medical outreach, and information services far more efficiently and profitably than it had previously, i.e., when it was hampered by its public status (*PR Newswire,* March 13, 2002).

Competitive positioning also is affected by the costs of producing and providing services and the extent to which revenues exceed those costs. Uncompensated care happens to have been a material concern along several dimensions for TGH—in terms, for example, of hospital's responsibility as a public hospital, the decision to privatize, public perception of and response to the decision, government regulatory influence and locus of control and more. Uncompensated care is also of broader concern given the proportion of the U.S. population that is poor and/or without insurance. As of 1990, an estimated 150,000 of Hillsborough County's 850,000 residents—nearly 18% of the county population—were uninsured (Health care, 1990). The hospital's uncompensated expenditures in meeting the medical needs of a large proportion of this population cut significantly into its capacity to compete with private facilities for high profile medical personnel and for insured and other revenue-generating patients. Again, a health provider's financial viability will depend, in large part, on its ability to compete effectively in the health care marketplace for patients as well as staff, facilities, location, etc. Privacy is an important component of that equation as well.

Third Sector Politics & Privatization

TGH's reorganization apparently was not atypical. As of 1994, most U.S. hospitals were organized as private, not-for-profit (NFP) organizations, and

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constituted the largest category by far of nonprofit institutions in the nation (Sloan, 1998).[27] While the explanations offered for this phenomenon are complex, the nonprofit form of hospital's prevalence in this country to date suggests that this model has social and political strengths that may sustain its prevalence over time. This might be explained, at least in part, in terms of the ease with which nonprofits lend themselves to privatization of social service delivery, and in terms of both the political and the entrepreneurial appeal of the nonprofit organizational form.

From the political perspective, government officials commonly consider privatization of public services to nonprofits a convenient cost control strategy (Nathan, 1996). As noted previously, privatization of this kind is also sometimes a convenient way for government to avoid equity dilemmas. That is, redistribution of wealth through nonprofits may be more acceptable to the public than if it were accomplished through direct government subsidies. Since government services are funded primarily by public taxation, the government is accountable to the public for the way that those funds are to be spent. So there must be, at least in theory, public consensus regarding the services the government provides before it is politically empowered to do so. On the other hand, government is subject to structural (re: societal structure) and institutional pressures to provide for the social welfare (Wolch, 1990).

Achieving equitable distribution, be it of wealth or of social services, is tricky business. In instances where there is insufficient consensual support from the

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[27] While experts and researchers sometimes distinguish between not-for-profit organizations, e.g., those that engage in activities not necessarily intended to generate funds or profits such as clubs, fraternities, etc., and nonprofit organizations, i.e., those with tax exempt [e.g., 501(c)] status accompanied by inurement restrictions on profit distribution (Alvarado, 1998), the terms are used interchangeably here (and apparently in many other places as well) to connote organizations that are private and enjoy tax-exempt status with inurement restrictions.

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public at large for government to authorize direct funding to achieve equitable access to goods or services, government may do so indirectly by funding those services through nonprofits. Such measures are sometimes necessary in capitalist economies because not only is there unequal distribution of wealth or resources, but the power to influence political decisions in American society is also quite narrowly distributed. Political decisions in the U.S., including those related to the nature and distribution of social services, is constrained by what has been called the "tyranny of the majority." Put simply, this is the notion that minority needs and preferences can be, and often are, set aside in favor of those of the majority (Guinier, 1994). This irony of democracy represents another interesting dilemma for government and its agent organizations—that involving the occasional necessity for them to execute approaches to service provision that may help insure equitable distribution of public services but that do not necessarily enjoy popular support.

Part of the difficulty the TGH administration experienced in securing public funds to maintain the hospital had to do with the difficulty of securing sufficient support from elected officials. In the case of TGH, an apprehensive cadre of elected officials and their constituents may have perceived privatization as a way for the hospital to sidestep its accountability to majority opinion. Similar logic suggests that avoidance of majority accountability represented by the perspectives of elected officials, county government officials in particular, was part of the appeal of privatization to the hospital administration.

Biased perspectives on the nature of business also appear to have played an active role in the case. The pervasive difficulty experienced by public officials in understanding increased investment in public relations and marketing activities in response to financial duress is a good example. Commissioner Jan Platt, for instance,

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in a 1987 newspaper article expressed difficulty understanding how the hospital could at once be in sufficient financial difficulty to request public funds for operational support while requesting spending approval for entertainment—ostensibly to help attract prominent doctors and paying patients (Kleman, 1987a). Again, the rationale for such investments is similar to that which is recommended often by business consultants for resolving similar problems experienced by failing businesses (Deleersnyder, 2003; Maddock, 2001). The fundamental source of the conflict surrounding this issue appears to have been that Platt and others of a similar mind saw the two needs as conflicting and perhaps diametrically opposed while hospital officials simply saw the two as operationally complementary.

Similar thinking appears to have been evident in, and may even at times have precipitated, public confusion about the intent of privatization, e.g., the belief that TGH's change to a private nonprofit was either synonymous with for-profit reorganization or the first step in the hospital's eventual transition to for-profit status (*Medical Industry Today*, 1997). The ways in which proprietary or for-profit organizations are perceived to differ from both nonprofits and public sector entities in terms of their accountabilities (as well as very real inurement restrictions) could explain at least some of the vehemence of public resistance to privatization. As indicated earlier, private for-profit businesses are primarily accountable to their shareholders—possibly suggesting to the public that service recipients and quality of care could be expected to take a back seat to the profit motives of TGH if it were to become a proprietary entity. The fact that nonprofit status precludes distribution of profits to shareholders, and that the terms of reorganization provided for indigent care did little to quell public resistance to TGH's privatization. The fact that the board's intent was to reorganize TGH as a private nonprofit with essentially the same

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emergency and indigent care responsibilities apparently mattered very little. The reasoning and perception was that if TGH were not under public control, the community's interests would not be served.

So how does government reconcile the constraints imposed by an opposing majority with its responsibility for insuring equitable distribution of services that generally have been deemed entitlements? With respect to social services, arms-length delegation of programs to nonprofit organizations is often the solution of choice. Again, nonprofits are uniquely positioned to address minority or controversial services the government cannot politically justify providing directly. Also, nonprofits generally are not constrained in terms of public accountability to the same extent as government. By employing the tactic of supporting nonprofits, government can simulate equitable distribution of public goods and services while sidestepping public accountability by distancing itself from concerns not sanctioned by the majority (Douglas, 1987; Navarez, 1996, Salamon, 1999). Interestingly, the public is far more tolerant of subsidies to nonprofits than it is of services funded directly by the government—even though public tax support is brought to bear in either instance. In addition, nonprofits are often positioned better *philosophically* than government agencies to provide social services because of their traditional or perceived supportive, care-giving role in the community. Apparently, this is especially true with regard to the relationship between patients and health care providers (Marmor et al., 1987). Finally, because nonprofits, particularly nonprofit hospitals, are known for providing charity or uncompensated care, they have broad social appeal.

As indicated, organizing as a nonprofit also may be appealing from a managerial or entrepreneurial perspective, i.e., because of the relative freedom it

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offers the firm to operate with limited governance-related monitoring (Morrisey et al, 1996). Sloan (1998) also observes that

> "Except for removing tax-exempt status or refusing to issue tax-exempt securities on its behalf, there is little government can do to change the behavior of a nonprofit" (Sloan, 1998, p. 152).

TGH's conversion from a public hospital to a nonprofit provided a measure of insulation from government regulation and public scrutiny. In TGH's case, both political and managerial motives appear to have been at work.

It is also worth noting that privatization in the social services arena faces its own idiosyncratic challenge—one involving institutional self identity and mission. The conceptual boundaries between philanthropic activity, public service and proprietary privatized service delivery are not always as clearly defined as analysts tend to indicate—particularly with respect to health care. Today's health care services are provided by a variety of public and private entities. Managed care and specialized health care services often are provided by private firms, but these same firms also may be under contract to provide government-subsidized health care services to the indigent, which is generally perceived as a community responsibility—and appropriate for philanthropic intervention. Moreover, there are increasing instances of nonprofits behaving like profit-making organizations and/or sub-allocating work to private for-profit entities—behavior that is making it increasingly difficult to distinguish between sectors (Nathan, 1996).

However, the role of nonprofits in the exercise of American government policy and the ways in which business is conducted in the U.S. is undeniable. Because of nonprofits' unique operating position in the gray area between the public and private sectors, they often can operate within either the public or the private sector without necessarily being as affected by those sectors' characteristic constraints. It is

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then reasonable to conclude that the use of nonprofit status to gain competitive, political or operational advantage may be a tactically sound approach. Perhaps it is in this space that the original meaning of competition may be realized. Ironically, the Latin roots of the word compete, i.e., *com* – together and *petare* – to strive, suggest that the true meaning of the word is to strive together—as in toward a common goal vs. its more pejorative zero sum-oriented exclusionary connotations (McDonough, 2004). It seems that this particular take on the meaning of competition may be nowhere more appropriate than in health care. In spite of the fact that the more traditional interpretation is probably more likely, hope indeed springs eternal.

Summary & Responses to Research Questions

While several questions have yet to be fully answered about privatization and corporate governance from the perspective of the private service provider, the findings imbedded in the foregoing case study suggest interesting and plausible responses to several of the important questions this study was designed to answer. Those questions are repeated below in italics for ease of reference.

What are some of the key factors to be considered by service providers that are considering entry into and/or are interested in maintaining a successful role in a privatization arrangement?

The findings of this study suggest that the most conspicuous of the key factors to be considered include financial viability, discretion and/or privacy, competitive positioning, and the economic and political or public policy contexts in which privatization occurs. However, closer examination of the case actually reveals an additional set of key factors that, while related to those mentioned, may be of more practical import to service providers with respect to: a) the decision to privatize or b)

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assessing the feasibility of remaining in a privatization arrangement. Analysis of the TGH case study data suggests that the key factors the hospital's leadership should have considered from that perspective included:

- the optimal organizational and/or governance structures for successfully negotiating the idiosyncrasies of its own competitive business environment;
- the financial, economic or opportunity cost implications of operating within a given organizational structure or for adopting and transitioning to another;
- the political, legal, and/or regulatory implications of the decision to privatize;
- the hospital's sources of information, their level of influence with respect to hospital policy, and the hospital's use of (or response to) that information; and
- the extent to which the hospital was financially dependent on subsidies and other public sector sources of funding.

As stated previously, one of the principle motivations for the decision to privatize TGH was its chronic financial difficulty. The hospital's financial condition was in turn engendered by several factors, principle among, but not limited to, the hospital's indigent care load—especially relative to competing facilities—the hospital's inability to compete effectively with other area hospitals, and the dependence of TGH on government funding (or legislatively controlled funds subject to political decision making) for solvency and operational viability.[28]

[28] Other significant contributors to the hospital's financial duress include early overcapitalization (which created surplus capacity), suboptimal facility location and, according to the hospital's privatization proponents, excessive and ineffectual public oversight.

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Because of its role in public service provision and its de facto legal status as a public agency—TGH's meetings and strategic intent were a matter of public scrutiny—and public record. As a consequence, the hospital's competitors could design and implement countermeasures that effectively eroded and, in some instances, completely displaced the facility's competitive position. Privatization offered a possible way for TGH to operate more like its competitors—i.e., out of public scrutiny—presumably to recover and maintain reasonably sound competitive positioning. Reorganization—conversion to private non-profit status proved to be a somewhat viable tactic for avoiding, or at least controlling, some of the confounding elements of public scrutiny.

Clearly, the hospital's board and administration believed privatization represented a viable solution, at least in part, for its competitive and financial woes—presumably by controlling the flow of proprietary hospital information and by shifting the locus of facility control from external to internal. The decision to privatize, while promising a means of circumventing public oversight and regulatory control, also triggered public ire—due in no small part to the decision having been planned behind closed doors at a time when the legality of doing so was still in contention. This aggravated the already intractable public resistance that had plagued the hospital's leadership for more than a decade before.

Information flow and its treatment is a key factor in the case for other reasons as well. Take, for example, the relevant issues raised by the flawed analysis and information provided by the TGH legal team that mediated the hospital's reorganization. The pre-privatization board could have been far better advised about the possible legal and financial implications of the decision to privatize. For example, while the possible post-privatization loss of the hospital's ability to recover bad debt

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under the Lien Law appears to have been an oversight by the legal team retained by the board, the board ultimately was responsible for overseeing the team, for making the privatization decision itself and for establishing the terms under which the hospital's reorganization would proceed. While it is difficult to discern whether the board members' ability to communicate effectively with each other was still being compromised at the point of reorganization and whether this further hampered the privatization effort, the board's access to accurate information and its timely communication was of paramount importance nonetheless.

Next, by outsourcing legal counsel, the hospital suffered exposure to its own principal-agent problem, both in traditional terms and in what may be thought of as the 'agency problem in reverse.' That is, from the more traditional point of view, the board (the principal) did not receive the quality of service it needed for optimal decision making from its contracted legal team (the agent). In addition, however, the legal team's flawed analysis of the situation posed an interesting dilemma for the board. That is, when the board chose to proceed with privatization, the hospital was forced by regulatory constraints to surrender an important revenue source (which is contrary to basic business practices) in order to achieve privatization. However, the hospital already had been committed to privatization for a number of compelling reasons, most of which having to do with its need for greater autonomy in managing its competitive positioning.

Finally, the treatment of information also was important from a governance standpoint in terms of the external influences on the TGH board's strategic decision making. A variety of TGH stakeholders ultimately influenced board decisions in ways that were neither necessarily appropriate nor conducive to effective strategic decision-making.

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How, if at all, do public and private perspectives differ within the context of privatization, and how might the differing perspectives of public and private sector entities affect the privatization decision? …the execution of a privatization arrangement? …its effectiveness?

The case of TGH highlights some striking differences between the public and non-government sector perspectives on service provision. Their respective views on performance are a case in point. The public sector perspective with respect to performance involves meeting a public service objective independent of cost. That is, the community and public officials appeared to place greater emphasis on the amount and quality of indigent care provision—regardless of cost, which contrasts starkly with the corporate perspective of maintaining a whole-number revenue/expense ratio.

With respect to the specific decision to reorganize the hospital as a nonprofit vs. a for-profit organization, one might speculate that the board and hospital administrators were aware that public sentiment generally favors nonprofit for delivery of social services and that adopting nonprofit status might incur less public resistance at a time when political tensions were running high. They also simply may have chosen to do so out of an appreciation for the favorable treatment nonprofits receive under U.S. tax law and other public policy.

The hospital administration's paradoxical dilemma of needs, i.e., the need to be viewed as both a successful and technologically sophisticated facility while attempting to argue its ever-present need for public subsidization to sustain its indigent care responsibilities, is one example. The hospital administration failed to effectively convey the rationale for investment in marketing and public relations concurrent with public fund solicitation. Public officials had little appreciation for the impact of the hospital's public image on its ability to attract a profitable mix of staff

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and patients or for the need for substantial investment in public relations and marketing to do so. Public officials therefore were hesitant to support it. Similarly, the conflict between constraints imposed on the hospital board and its activities by the Sunshine Law and the strategic and/or tactical need for privacy in order to compete effectively are indicative of the competing public and private sector needs (and perspectives) with respect to information (organizational transparency) and accountability. This conflict very likely contributed to public officials' failure to appreciate the hospital's need for operational and planning privacy as well as board independence.

With respect to how these differences in perspective may affect a firm's decision to pursue a privatization arrangement or its execution, the case findings suggest that these differences may compel a public hospital or other publicly controlled service provider to pursue privatization to avoid regulation or public influence to the extent that they represent constraints to the organization that are incompatible with its business model or otherwise threaten its ability to function effectively. Likewise, an existing non-governmental service provider that is considering or is already engaged in a privatization arrangement should carefully examine the arrangement to appreciate the presence or potential for such constraints as well as the compatibility of associated regulations or accountabilities with the organization's governance or operating standards.

Again, private providers of public services should have a clear understanding of the regulatory and/or legal, financial, and political implications of the decision to privatize as well as what it will mean to the firm operationally. This information also can inform any business rule adjustments needed to insure compliance with the terms of engaging in the privatization arrangement and to sustain

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optimal performance. In the end, effective performance also was positively related in the case to responsible fiscal planning and management, a proactive approach to understanding, negotiating or defining terms of accountability, and positive public/media relations. Interestingly, however, the factors that appeared to be most responsible for TGH's dramatic performance turn-around are, not surprisingly, similar to those that are known to be effective organizational management strategies. Examples include strong and prudent leadership, clear and timely communication, effective management, and political savvy. Also, while it is not clear whether or to what extent the benefits associated with nonprofit tax status were a factor in the decision to reorganize, public policy legislation associated with nonprofit status may provide certain competitive advantages to qualifying organizations.

> Many of these policies have been explicitly designed to promote nonprofit organizations, either by enforcing less stringent regulations on them or by providing subsidies not available to their for-profit counterparts (Marmor, et al., 1987, p. 223).

How, if at all, are governance and operating conditions (e.g., finance and accounting, human resources, logistics, etc.) within the service provider organization affected by the terms and/or external accountabilities associated with privatization?

The constraints to TGH's operation, market positioning and governance associated with provisions of the Sunshine Law and the hospital's chronic and intractable financial difficulties brought about in large part by its publicly-mandated indigent care-related responsibilities to the community (and its associated dependence on government funds to subsidize those activities) are two examples of external accountabilities that adversely affected the hospital in each of the areas mentioned. Similarly, conflicting public vs. private sector perspectives about the extent to which the hospital should be subject to such constraints also had a multi-layered and

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decidedly negative impact on the hospital's governance, management, operations and market positioning. These effects in turn were exacerbated by ambiguous application of government policy—especially with respect to controls over major revenue sources upon which the hospital was heavily dependent.

Governance also was compromised by what might be considered improper secondary stakeholder influence engendered by a legally mandated accountability to the media and to the community at large by extension. Conflict between the public and private sector perspectives regarding the hospital's status as a public hospital played out in contentious legal and political contexts in what might be considered a somewhat activist community. While some of the difficulties experienced at TGH also may be traced to the hospital's privatization efforts themselves and the manner in which the reorganization was executed, i.e. steeped in secrecy and misinformation, which only aggravated an already adverse and suspicious public and government response to privatization, the hospital's external accountabilities and their associated constraints on its strategic positioning and revenue-generating activities were sufficient conditions for compromised performance.

What are the important performance indicators that a privatized service provider should monitor to assess its success or failure—vis a vis the privatization arrangement as well as its organizational viability?

Case findings suggest that, in addition to the traditional key organizational finance and revenue-related performance measures, organizations engaged in the provision of public services may also measure performance in terms of compliance to relevant government standards, the extent to which predefined (e.g., contractual) terms have been met, and/or the quantity of services delivered relative to public demand for those services. TGH, both in its public and in its nonprofit iterations was the Tampa

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Bay community's primary emergency and indigent care provider. So with respect to the public service provider function, the appropriate performance indicator(s) ideally would be both observable and a valid reflection of the effectiveness of service delivery. Absent data such as clinical treatment success rates, etc., the important performance indicators for TGH, i.e. factors that would be illustrative of or conducive to the facility's ultimate success as a public service provider, are the facility's competitive positioning (including factors such as market share maintenance and scale, and breadth and quality of services), changes in revenue and total assets over time, nature, scope and effectiveness of strategic alliances, and its comparative (year-to-year) rate of indigent and emergency care delivery to the community at large.

It is interesting to note at this point that TGH's diminished performance appears to have been confined to those that were essentially business-related, i.e., its inability to maintain the facility's financial viability, its failure to establish a profitable client base, and/or its failure to compete successfully in the health care marketplace. In contrast, the hospital's performance with respect to its delivery of indigent care, its publicly mandated responsibility, apparently never wavered. That is, there is no indication that indigent care levels at TGH ever diminished following the government's indigent care mandate in the early 1980s. In spite of the fact that all available performance records indicate increases—even though the facility was almost consistently under financial duress over nearly the entire period in which privatization was being considered and implemented, the hospital's compliance with public policy apparently was not a sufficient condition for favorable treatment by the county. This behavior of the organization constitutes what has been termed in this study "the principal-agent problem in reverse" or "the agency problem in reverse," which is defined here as a risk to the service provider of having to comply with regulatory or

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contractual terms that are anathema to the fiscal or operational viability of the organization—that is, a dilemma like that of TGH in which the hospital was forced to absorb financial losses in order to carry out its public service-related responsibilities.

Chapter 6, the upcoming and concluding chapter of this dissertation, discusses what the findings of this study suggest we now know about privatization, organizational behavior, stakeholder influence and governance that would be important for service providers to understand as they relate to the conduct of business across sector lines—which privatization generally entails. The chapter also discusses the possible implications of the findings while offering theories of explanation. The chapter then closes with a discussion of the as yet unanswered questions and suggestions for future research.

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Chapter 6

Conclusions

The findings of this case study suggest that organizational ownership and/or governance structure do in fact affect business-related performance in a privatization context. However, the issues affecting the feasibility of the decision of non-government organizations to engage in public service provision under government oversight (or the viability of remaining involved in such arrangements) are not confined to institutional performance, financial solvency or simple resource capacity. Of equal relevance are competitive landscape, political climate, governance structure and performance, primary stakeholder interests and the compatibility of the service provider's public sector accountabilities with its critical business functions—particularly as they relate to public service delivery. These findings also may inform and perhaps have implications for the focus of discourse in the areas of public administration, corporate governance, and organizational behavior.

The Service Provider's Perspective

The case of TGH provides several insights from the perspective of the service provider while generating several interesting questions. For example, its findings suggest that in order to perform efficiently and effectively under privatization, the board of the service provider organization must be relatively free of regulatory and/or political constraints that conflict with the organization's established approaches to conducting business or with its ability to work and negotiate freely

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within its business network in the routine performance of its public service-related obligations. Note, however, that when there is residual regulation or government oversight in privatization arrangements, there is some indication from the research that the government's ability to impose and enforce rules may itself be regulated or constrained to some extent by public opinion. Furthermore, this influence can be both variable in its direction and intent and subject to manipulation by external 'secondary' stakeholders.

The ambiguous application of Florida's Sunshine Law and Lien Law on the basis of TGH's status as a public hospital is a case in point. Public opinion (that of several elected officials) held that TGH was a public hospital even after it was privatized. Accordingly, the hospital was expected to comply with public disclosure requirements. Yet, at the same time, Lien Law-related privileges to which public entities in Florida are entitled were denied to TGH. Also at the same time, local newspapers were able to wield remarkable influence as secondary stakeholders.

For privatized public service providers, this suggests that they should make level assessments of current or expected influences of this kind on their primary business processes in order to make informed and effective decisions about the feasibility of entering into and/or sustaining a privatization arrangement. This is especially true for those processes that affect the firm's strategic planning and/or delivery of public services for which they are, or ultimately will be, held accountable. In that regard, the findings of this study suggest compelling indications, or perhaps conditions, for entering a privatization arrangement and factors that would be conducive to the service provider's performance success. Furthermore, the obverse of these conditions might be considered contraindications for entering into such arrangements.

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One important condition for entry of a non-government organization into a privatization arrangement, for example, is the ongoing ability of that firm's organizational leadership, its board members in particular, to communicate freely and openly. On the other hand, the board also must be relatively free of untoward political influences and/or regulatory constraints that conflict or interfere with its ability to guide the organization through nimble adjustments that may be necessary, for example, to accommodate frequent or mission critical changes in the marketplace.

Another very important consideration is the nature of the community in which privatization takes place and the political sensibilities of its members. The extent to which the public (including the media) is able to directly influence the decisions of organizational leadership in privatization scenarios (which again, may depend upon the organization's tolerance for such input, i.e., its ability to select and manage the information the board and administrators elect to act upon), can either enhance or undermine governance-related performance.

Theory & Possible Implications

Privatization can in fact work well in public service delivery—but, if TGH is any indication, public interest and opinion, the prevailing political or regulatory environments in which it is implemented, and the political sensibilities and operational skills of the principal players can easily determine either success or failure. The sensitivity of privatization to conflicted government intervention, public opinion and especially the organization's dependence on government funding may in fact have been its most significant vulnerabilities. This case examination of a contentious privatization process provides a glimpse at the potential power of politics and public opinion as well as the conditions under which public sector oversight and influence

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can (again, depending on the circumstances) either undermine or bolster a privatized entity's performance. The prominent role played by public opinion and the political environment in the case of TGH begs the question of whether their presence in similar cases would have any predictive value with respect to the success or failure of 'reorganizational' privatization.

In addition, as Wood (1996) notes, an organization's history and culture affects its governance and leadership. TGH's long history of dispute surrounding the notion of privatization hampered the reorganization effort, compromised the ability of both the board and the organization's administration to lead effectively, and threatened the facility's financial viability. Hessel (1995) makes a similar assertion in his discussion about the difficulty of selecting an ideal governance model. Absent the existence of conditions conducive to tandem operation of public and private sides of the privatization equation that, not surprisingly, includes effective leadership, the effort is likely to fail. For example, the notion of building a consensus among stakeholders in the execution of the hospital's reorganization was found to be of particular importance—perhaps as much so as the issues arising from the regulatory, political and public policy environments in which the privatization occurred. This consensus building, as the case study suggests, requires firm and skillful leadership.

According to a working paper currently being published by researchers at the Yale School of Management, the corporate governance reforms suggested in the Sarbanes Oxley Act for proprietary firms have long been standard practices of nonprofit boards. However, these important structural remedies have borne mixed results for nonprofits, and their findings suggest that the strength of the executive can have a significant impact on board effectiveness and its governance by extension (Oster & O'Regan, 2002). This certainly seems to have been confirmed in the case of

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TGH. If one compares and contrasts, for instance, the leadership-related impacts of post-privatization TGH presidents Siegel and Hytoff, one might reach that very conclusion.

In addition, public and private sector approaches to governance in general, and to decision-making in particular, may conflict in ways that could devastate even the most robust operation—and, as the case demonstrates, resolution of that conflict can buoy marginal operations into a state of sustained viability. However, conflict resolution involving government entities invariably involves balancing inputs from varying constituencies to arrive at a solution that usually satisfies none of them (Patel & Rushefsky, 1999). Hessel (1995) makes a similar point specifically with respect to corporate governance.

> … in its report on corporate governance in the United States, the Business Roundtable, which represents the largest US corporations, observed, "Legislative bodies … represent and give expression to a multiplicity of constituent interests. Our political system is designed to create compromises between competing interests … This system of governance would be fatal for an economic enterprise (Hessel, 1995, http://www.cipe.org/publications/fs/ert/e18/corp_gov.htm).

Compromises, for a regulated organization under financial or political duress, may be manifest as selective compliance to regulatory policies, circumvention of the rules, or outright nonconformity. The 2003 finding that TGH had engaged in Medicaid billing irregularities stands as a possible case in point. However, while this study confirms that such compromises do in fact occur, the answer to the question of whether they are uniformly counterproductive is inconclusive.

Next, while it is evident from the case findings that privatization may be employed tactically, the findings of the case are not entirely conclusive with regard to the tactical effectiveness of reorganization to private nonprofit status. However, there

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are strong indications that operating as a nonprofit under a privatization arrangement can conceivably boost an organization's competitive position. With regard to the provision of goods and services to the public at large, a nonprofit organization may, for example, have a bit more operating flexibility. That is, depending on its mission(s) and the environment(s) in which it operates it may behave as a public sector entity or more like a private business firm. This flexibility enables a private nonprofit to operate effectively in the public arena (e.g. vis a vis public service provision) while competing in the private sector much like a business or corporation.

Perhaps one of the more significant findings of this study involves the economics-related principal-agent theory—or problem—depending on one's perspective. That is, to the extent that a private firm experiences some level of regulation or similar constraints on its business conduct vis a vis its delivery of public services, the firm may be faced with an agency-related problem, or what has been called in the foregoing discussion 'the principal-agent problem in reverse," which again is essentially the risk of organizational harm borne by the service provider in a privatization relationship when law or public policy conflict with prudent business practice and decision making. This may occur, for example, whenever a service provider engages in dysfunctional or unprofitable business practices in order to remain in compliance with public policy, but at substantial risk of harm to its organizational solvency or to the interests of its investors.

The aforementioned networked contractual model is a case in point and provides certain interesting insights from the service provider's perspective. For instance, it suggests that service providers bidding on contracts that are bid out frequently, a characteristic of this model, may fall victim to the "bidders curse" by submitting an unprofitably low bid to undercut the competition to win the contract. By

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doing so, however, the winning bidder then assumes an untenable business position, which may include, but not be limited to, the loss of secondary contractors. When this situation exists in a high-turnover bid environment, an incentive is created for the bidder-turned-service provider to be uncooperative with respect to contractual terms—because doing so may provide an opportunity for a more favorable re-bid or access to a more pliable principal (Milward & Provan, 1998). However, the utility of this framework for understanding an individual organization's behavior and role in a privatization arrangement is limited in the sense that it is model-specific. That is, the unit of analysis is not an organization or even a decision, but a network of organizations. Also, the discussion, like so many others that are privatization-related, was couched primarily in terms of its utility to government entities for controlling its agents. Still, as will be discussed in the upcoming section on future research, a similar framework may be useful for analyzing more conventional privatization models.

Finally, while the intent of this study has been to provide information that would convey the perspective of the service provider, a portion of the findings may have organizational behavior-related implications for public agencies engaged in overseeing privatization arrangements. That is, the perspectives and behaviors of public administrators in response to dilemmas that may be engendered by conflict between their governance vs. governing roles could provide useful insights for public servants and their agencies in managing such dilemmas. The county's aforementioned governance-government dilemma may be likened to that of an individual experiencing cognitive dissonance in learning. That is, a person faced with new information that is dissonant with, i.e., obverse to or otherwise in conflict with, previously held beliefs will work to reduce the dissonance—for instance, by reducing the importance of the new conflicting information, by enforcing previously held beliefs, by resisting the new

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information, or by taking some combination or variation of those approaches (Atherton, 2004; Harmon-Jones & Mills, 1999). The privatization of TGH cast county government in the role of a learner who, believing TGH to be subject to the rules of public entities, resisted the new information and, faced with the difficulty of accommodating the new information, behaved in ways suggesting that it did not recognize the distinctive and incompatible qualities of the new information relative to the previous paradigm in which TGH was viewed purely as a public entity.

Future Research

Service industries that account for a significant proportion of U.S. government spending have been, and continue to be, privatized ostensibly under conditions not necessarily ideal for privatization. Yet, the practice is becoming increasingly prevalent. Political and ideological considerations aside, the fact is that privatized service delivery in crucial areas such as health care and education is not only likely to continue but also shows every sign of increasing. Therefore, further examination of privatization cases, particularly in these service areas, can yield important insights—not only about how government can deliver such services more effectively, but also about how organizational structure, governance and/or contractual provisions may be positioned to optimal advantage. Furthermore this research is likely to have additional utility, not just for governmental entities, but especially for private and nonprofit sector service providers.

The foregoing case study and discussion suggest that further investigation is both warranted and would provide important insights about how firms can position themselves when considering privatization-related contracts or organizational

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adjustments. Chamberlain and Jackson (as cited in Kettl, 1993) discuss the subject in a 1987 journal article as follows:

> "Privatization works best where markets are lively, where information is abundant, where decisions are not irretrievable, and where externalities are limited. It works worst where externalities and monopolies are abundant, where competition is limited, and where efficiency is not the main public interest." (Kettl, 1993, p.39)

It might be useful to ascertain through additional research whether these authors' assessment could be further qualified to include other conditions borne out by the current study, i.e.,

- the need for channels of information to be evenly available to the service providers sharing the market (such that no organization may take unfair competitive advantage of uneven access to privileged information)
- the need for service delivery to conform to acceptable industry and governmental quality standards (service providers should be afforded sufficient information resources to make this so), and
- the need for sufficient consumer and political support to buttress the privatization decision itself.

The foregoing case study suggests that when these needs go unmet, inefficiencies result from their impacts on access to capital and other resources, such as qualified personnel. Such obstacles can not only hamper the privatization transition, but reduce the provider's capacity to deliver services.

The line of research represented in this study can serve as a basis for productive and useful research on several related fronts. Examples include additional research toward understanding the environmental factors affecting privatization

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efforts; the compatibilities or optimal matches of governance styles and organizational forms with particular types of privatization scenarios; and the generation of fresh insights or theories of organizational behavior.

Sociopolitical Environment-Related Research

While the current case suggests that a contentious environment is likely to produce unfavorable organizational and performance results, such outcomes are more conditional than inevitable. The role of the prevailing sociopolitical conditions in Tampa during the reorganization of TGH discussed earlier is a case in point. It might be interesting, for example, to ascertain from similar case studies whether the conditions prevalent during the TGH reorganization bear any predictive value with respect to the feasibility for service providers of engaging in privatization arrangements—public-to-private reorganizations in particular. Similarly, it would be useful for reorganization candidate organizations to understand whether and under what circumstances certain types of communities may be more inclined toward activism, e.g., to engage in activities intended to influence the privatization decision, public regulation or oversight of the service provider.

If, for instance from a research standpoint, the Tampa community's apparent affinity for or tendency toward political activism could be explained by prevalent environmental and social conditions, these conditions could then be employed to determine the feasibility of privatization by reorganization. Variables in the research model might include average level of educational attainment as a surrogate indicator of a community's prevalent motivation level for seeking knowledge and understanding. Then, if political activism is treated as an externalized expression of self-actualized altruism, and if personal income is treated as a rough but

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valid indicator of the extent to which a person's basic needs are being met, one might expect a positive correlation between levels of political activism, personal income and education level. If so, might one find higher levels of political activism at locations where residents have higher average per-capita income and/or a higher average level of educational attainment, ceteris paribus? Further, would one observe in such communities corresponding levels of community demand for operational transparency and public accountability from service providers engaged in privatization arrangements? Could one also reasonably assume that privatization efforts in such communities would fail to the extent that public to private reorganization is likely to mitigate advanced public access to the organization's business strategies and tactics? Would a privatization attempt be contraindicated under these circumstances in such communities? Perhaps needless to say, understanding the predictive validity of these variables for privatization success could be useful to both the public and non-public sides of the privatization arrangement.

Organizational Behavior & Governance-Related Research

Useful information about the relative effectiveness of organizational types as well as governance and management styles might be gleaned from comparative case research to determine whether or to what extent private nonprofit service providers are more effective than their for-profit counterparts in terms of public service delivery performance, and maintenance of organizational viability under public sector oversight. Similarly useful would be broader case research on the interplay between public accountability and market competition. The intent of such research would be to look for possible patterns in the ways service providers behave in the context of regulation or public oversight associated with privatization. Then, as the foregoing case study suggests, patterns of organizational behavior may correspond to

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(or have interesting implications for selection of) the governance style a service provider may adopt in a privatization context. For instance, is a stakeholder governance model indicated for what may be termed 'reorganizational privatization?' Should a stakeholder governance model remain the exclusive province of nonprofit service providers or could the model possibly be extended to include for-profit entities? The answers to these questions could form the basis for future research aimed at understanding whether and/or under what conditions service providers may effectively leverage organizational forms and governance styles to achieve competitive advantage.

If a stakeholder orientation in corporate governance is as important a consideration in privatized social service delivery as this study appears to indicate, similar additional case research about privatization in complex competitive service markets such as health care could be illuminating in several respects. For example, it could discern whether privatized firms flourish and/or perform more effectively when they have a stakeholder governance orientation. Along similar lines, such research might also determine whether and/or to what extent public (i.e., shareholder) ownership represents a barrier to entry or a feasibility concern with respect to privatization for for-profit service providers—or whether a shareholder orientation can be reconciled effectively with the significant stakeholder-oriented concerns intrinsic to social service privatization.

These issues in turn call into question whether privatization of social service or entitlement programs should be confined exclusively to nonprofit service providers in instances in which stakeholder governance is either prominent or clearly indicated. The foregoing case study has shed some light on the circumstances under which such a decision might be warranted. However, systematic case research, e.g., on

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privatization arrangements that would compare nonprofit and for-profit public service providers by analyzing correlations between or among variables such as governance and administrative structures with those like compliance with public standards as well as service quality and financial performance, would be advisable before attempting generalization. However, this case study and subsequent discussion may very well have laid the groundwork for systematic pursuit of more definitive answers by raising some of the important questions about the potential synergies and conflicts at the conceptual interface between privatization and organizational governance.

Next, the possible existence of a reverse principal agent issue for service providers in privatization arrangements warrants further investigation. First, with respect to the networked principal-agent model discussed earlier, it is possible that research from the perspective of either the primary principal or that of the agent could provide valuable insights for service providers about what might comprise optimal approaches to managing the associated array of concerns within this model. From the primary principal's perspective, for example, the solution might contemplate how to devise contractual terms and bidding schedules that would curtail low-ball bid behavior. However, because of the relative complexities arising from its dual role in a networked privatization model[29], the issues and solutions for the primary agent may not apply in the more conventional single-layer service provider model. However, it would be useful to pursue an analogous line of research within the single-layer service provider model to the extent that similar conditions exist. For example, do high-frequency bidding environments like those discussed earlier for networked privatization arrangements (i.e., where there are incentives for dysfunctional behavior

[29] Recall that this organization, as an intermediary between the government and its own network of subcontractors, plays the dual role of secondary agent and primary principal.

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in the marketplace) exist for individual service providers in more conventional, less convoluted, privatization arrangements? If so, systematic research to examine their antecedents, occurrences and consequences would be indicated—and could inform solutions for prospective bidders.

In a broader sense, however, it would be interesting to explore the relative prevalence and nature of the reverse principal-agent problem in various types of privatization arrangements and the conditions under which service providers might be exposed to that or similar dilemmas. Within the context of the current study, for example, it would be worthwhile exploring the prevalence and appeal of privatization, by reorganization specifically, and the existence of common findings across instances. Common features would imply the existence of one or more variations of a 'model' that has sufficient merit to inform approaches to effective privatization engagement. Of course, if this line of research is undertaken, history suggests that it is likely to be undertaken from the public sector perspective, perhaps because privatization is intrinsically a public sector tool and such arrangements are so frequently initiated by government entities. However, the possible tactical appeal of privatization via reorganization suggests that private sector-initiated privatization arrangements are not beyond the realm of possibility. Also, the information to be gleaned from follow-up research on this type of privatization could conceivably generate interesting insights about the behaviors and motivations of public administrators charged with oversight of the arrangement. The behavior of Hillsborough County officials vis a vis its oversight of TGH is a case in point.

A determination of whether or to what extent the county's behavior may be seen as organizational behavior's analog of cognitive dissonance in classical

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learning theory is beyond the scope of the current discussion. However, the similarities between outcomes associated with cognitive dissonance and those that may occur when a public entity's regulatory and governance functions are functionally commingled but misaligned in their execution under privatization are striking. Given the variability of the types privatization schemes in which such dilemmas might conceivably exist, the questions of whether correlations exist between learning theory and organizational behavior and/or whether those correlations have any utility, i.e., predictive value with respect to organizational behavior, may represent both challenging and interesting topics for follow-up research.

Finally, given the damage Florida's Sunshine Law inflicted on TGH's governance functions, and the pervasiveness of disclosure statutes affecting public service providers in the U.S., it would be prudent to consider what terms or conditions of this or similar statutes could be modified to ameliorate the performance of public sector service providers that are adversely affected or at risk. Friendly amendments to disclosure statutes might conceivably obviate the need to pursue privatization as a survival tactic—particularly in instances in which privatization would be a less than ideal solution or even contraindicated.

TGH was able to derive some benefit from the compromise disclosure delay policy that was eventually established. Other adjustments might be considered as well. Disclosure laws might contemplate, for example, allowing governing bodies of affected organizations to hold a reasonable number of private strategy meetings during the course of the year—similar to executive sessions common to private sector boards. Furthermore, allowing organizational discretion with respect to the scheduling of such meetings to accommodate the need for spontaneity also could be

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advantageous. While the difficulty of legislating, regulating and/or managing such solutions must be acknowledged, workable compromises typically can be struck with meaningful dialogue between mutually informed, suitably motivated parties. In any case, follow-up research to develop and/or ascertain the efficacy of creative solutions to the dilemmas experienced by public service providers engendered by disclosure mandates is most certainly warranted.

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Appendices

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Appendix A: Useful Privatization-Related Definitions

Table A.1 – Useful definitions

Competition	Occurs when two or more parties independently attempt to secure the business of a customer by offering the most favorable terms. In relation to government activities, consider (1) public versus private, in which public-sector organizations compete with the private sector to conduct public-sector business; (2) public versus public, in which public-sector organizations compete among themselves to conduct public-sector business; and (3) private versus private, in which private-sector organizations compete among themselves to conduct public-sector business.
Contracting Out	Hiring of private-sector firms or nonprofit organizations to provide a good or service for the government. The government remains the financier and has management and policy control over the type and quality of services to be provided. Thus, the government can replace contractors that do not perform well.
Managed Competition	A public-sector competes with private-sector firms to provide public-sector functions or services under a controlled or managed process. This process clearly defines the steps to be taken by government employees in preparing their own approach to performing an activity. The agency's proposal, which includes a bid proposal for cost-estimate, is useful to compete directly with private-sector bids.
Outsourcing	A government agency remains fully responsible for the provision of affected services and maintains control over management decisions while another entity operates the function or performs the service. This approach includes contracting out, the granting of franchises to private firms, and the use of volunteers to deliver public services.
Privatization	Generally defined as any process aimed at shifting functions and responsibilities, in whole or part from the government to the private sector.

Source: U.S. General Accounting Office (March,1997). *Privatization: Lessons learned by state and local governments*. (GAO/GGD-97-48) Washington, DC: Author. p. 44

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Appendix B: Scenario Construction for Anticipatory Research

Analytic Memo

Research Question

What conflicts, if any, does a public agency's regulation of its contracted firm's execution of their agreement pose to that firm's governance?

Case Study

"Effect of Privatization & Government Regulation on Governance and Performance at Tampa General Hospital"

Analytic Commentary

While my expert respondent asserts that governance-related conflict engendered by public agency regulation is a significant factor in Tampa General's woes, his comments also suggest that several other factors could represent equal or perhaps even more significant barriers to performance. It is also just as possible that those factors were simply links in the regulatory "causative chain," i.e., themselves occurring as a consequence of public regulation. Possible interactions among these factors also must be considered. Factors such as the hospital's location, primary funding source(s), competitive market focus (primary service constituency) viewed separately, sequentially and/or in terms of their possible interactions could yield either alternative or reinforcing explanations for governance/privatization-related conflict at Tampa General (TGH). The following scenarios are examples of the issues that might be explored.

Scenario I

The number of indigent patients TGH serves could determine the amount of indigent tax revenues to which it is entitled. If those revenues constitute a significant portion of its operating budget, then competing with other facilities for

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indigent patients would be of critical concern to the Tampa General's fiscal viability. Factoring in the hospital's location, i.e., the hospital's being isolated on an island in an affluent suburban neighborhood that can only be accessed by a single bridge could, to indigent patients, represent a real or perceived access barrier. Their reluctance to use the facility then would reduce TGH's indigent service numbers, thereby reducing the amount of public funding to which the facility is entitled.

Scenario II

On the other hand, if the non-indigent, privately insured market is the facility's primary source of operating funds, then the non-indigent population would be the logical point of focus (or of primary competitive concern). Then there would be the question of whether there are regulatory factors that prevent the facility—directly or indirectly—from competing in the non-indigent market. Furthermore, from that perspective, it even would be conceivable that the hospital's mission (i.e., service facility for the indigent) is alienating the non-indigent segment of the hospital's service area/market, thereby discouraging insured individuals from selecting TGH at all. [Is there some sort of balance to be maintained re: allocation of services/beds to indigent vs. privately insured patients…e.g., a quota to be maintained?]

Scenario III

Returning to the issue of location… If hospital's being located on publicly owned land is a condition of the privatization arrangement, location becomes a source of strategic (and therefore governance/privatization-related) conflict. Likewise, the extent to which regulatory constraints prevent the facility's relocation, and the current location is undermining performance, there is evidence that public regulation is adversely affecting the hospital's ability to compete effectively in an open market (and that it might perform more favorably independent of such regulation.)

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Scenario IVa

However, if the governing board's decision that the facility remain in its current location is primarily a response to "public outcry" or grassroots resistance to relocation, and if we assume the board has the authority/exclusive right to determine hospital location & operation, then public regulation is much less an issue…

Scenario IVb

…unless, of course, the source of public resistance to relocation is related primarily to the perceived indigent service-related mission of the hospital, which again is a condition of the privatization arrangement.

Scenario V

Seemingly non-regulation-related internal factors such as the hospital management's perception of (or compliance with) the board's or directors' authority, the condition of the facility (e.g., barriers to facility expansion, upgrades or repairs), and perhaps other as yet undisclosed obstacles—all could be more or less responsible for the hospital's woes. As in the prior scenarios, the role of regulation/privatization, if any, should be assessed as well. In summary, if a preponderance of the evidence suggests that any of the "other" factors are squelching the hospital's ability to compete with other area facilities (regardless of scope or nature of competition), I would need to determine whether they are indicative of (i.e., occurring secondary to) governance/regulation-related conflict, or whether they are significant but completely unrelated alternative explanations. In any case, I am hoping literature review and examination of data obtained from interviews with one or more of the involved principle respondents will provide the missing insights.

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Appendix C: Other Research Instruments

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Field Notes Template

Introduction

Data Collection Date:
Data Type:
Respondent:

Purpose of Data Collection:

Type of Data Report: Verbatim transcript from tape recording.

Field Note Completion Date:

Summary/Highlights

Data: Interview Transcript
I = Interviewer; R= Respondent; […] = unintelligible

Analytic Comments

Methodological Comments

Attachments

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E-mail Survey

- Approximately how long have you been affiliated with TGH? ____ years
- Job Title
  ____
- Would you describe briefly the nature of your affiliation and/or your duties at TGH?
  ____
  ____
- Please check one response to each of the following questions
- Are you aware that TGH was once a public hospital that was later privatized (became a private nonprofit hospital) in 1999? ___ Yes ___ No
- What is your impression of the quality of care that patients currently receive at TGH? ___ Excellent ___ Good ___ Fair ___ Marginal ___ Poor
- What did you think of the quality of care when TGH was a publicly run hospital? ___ Excellent ___ Good ___ Fair ___ Marginal ___ Poor
- Were you first employed by or affiliated with TGH

  ___ when it was a public hospital? ___ after it was privatized?
- When do you think TGH treated more low-income patients?

  ____ before privatization ____ after privatization ____ don't know
- Do you think TGH operates better as:

  ____ a public hospital? ____ a private nonprofit hospital? ___ don't know
- When did TGH employees seem to be more satisfied?

  ____ before privatization ____ after privatization ____ don't know

Thank you for responding to this survey. You may direct comments, questions, requests or clarifications to the principle investigator, Ronald I. Sibert, via e-mail (sibert@udel.edu) or call 703-627-7687.

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Interview Guide: TG-1 (TGH-Exp. Resp. 2)

Hello, __________

Thank you very much for agreeing to speak with me. As you know, I am conducting research to examine how public sector regulation affects corporate governance. In my discussions on the topic with Charles Elson, the case of Tampa General Hospital emerged as an especially interesting one for case study. In addition, he identified you as the best person from whom to gather information on this case. Therefore I would like to spend the next 20 or so minutes learning some of what you know about Tampa General.

- First, I'd like for you to tell me a little about yourself. What is your current occupation?
- What is/was your affiliation with the hospital?
- For how long?
- As I understand it, Bruce Seigel privatized Tampa General as a private non-profit corporation. According to the media, there was lots of controversy surrounding that decision. What do you recall about it?
- In your opinion, what prevented the hospital from performing as well as expected?
    - Was competitive position of the hospital the issue? [confirm]
    - How, if at all, did the Florida Sunshine Act (mandate to hold board meetings open to the public) affect the hospital's ability to compete?
        - How crucial do you believe it was for those meetings to remain private?
        - Nature of competition? For non-indigent privately insured? For indigent patients?
            - Does hospital's receipt of tax revenues hinge on the number indigent patients it serves? How important are the tax revenues to the hospital's viability?
    - Were there internal disputes e.g., between the board and CEO that might be traced back to the privatization arrangement?
    - At one point, Dr. Seigel wanted to relocate the hospital. Why was location an issue? What role might the hospital's location (e.g., limited access to the facility) have played?
    - How about the hospital's physical condition?
  - How, if at all, has the privatization arrangement contributed to these difficulties?

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Project Outline:

Privatization Regulation & Corporate Governance

Project Context
Privatization[30] has, in the past several years, become widely accepted as a cost-effective strategy for government agencies to facilitate delivery of a variety of public (e.g., tax-supported) services. Preliminary investigation suggests that, to date, privatization-related research has been focused almost exclusively on how it has affected public sector entities. [I plan to support these assertions via literature reference(s) in the final write-up.] Little if any attention has been given to the private sector's perspective. That is, it is not known whether the level of the public sector entity's regulation[31] of the private firm's execution of contracted services in a privatization agreement affects corporate governance[32] in ways that may impede that firm's execution of agreement terms or, in a broader sense, its operating efficiency. This project will explore whether such regulation/governance conflicts exist and, if so, provide at least one in-depth description of an example.

Research Questions
What conflicts, if any, does a public agency's regulation of its contracted firm's execution of their agreement pose to that firm's governance? In what ways would a firm respond to such conflict if it occurred?

Data Sources
- Professor Charles Elson, Esq., an expert in corporate governance and Director of Center for Corporate Governance, University of Delaware, College of Business & Economics
- Legal briefs and media reports, internal documents and other relevant literature
- One or more corporate board members or high-level "insiders"

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[30] **Privatization,** in its broadest sense, is the transfer of assets or services from the tax-supported public sector to the entrepreneurial initiative and competitive markets of the private sector**.** [Excerpt from *The Privatization Revolution* – adapted from remarks by Lawrence W. Reed., President, Makinac Center for Public Policy, for The Future of American Business, a Shavano Institute for National Leadership Seminar, Indianapolis, Indiana, May 21, 1997]

[31] **Regulation** is meant to include any component of a privatization agreement that a public agency utilizes to control or to dictate the way a private firm conducts the business specified in that agreement.

[32] **Corporate Governance** is meant to include the governing body of a corporation (e.g., boards of directors) as well as the decisions of that governing body as they relate to the ways in which the firm conducts business—and presumes that its primary responsibility is to the firm's shareholders and their wealth.

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Methods
I will utilize both interview and literature/document review as my primary research methods. Data gathering will be conducted in three phases:

- Phase I: an initial exploratory interview with an expert,
- Phase II: document/literature reviews combined with in-depth interviews of one or more of the subjects identified in Phase I, and
- Phase III: return debriefing interview with initial subject.

Interviews will be conducted both by telephone and in person. Most interviews will be tape-recorded. Telephone interview(s) will be conducted in the privacy of my own office via speakerphone. In-person interviews are to be conducted in private at quiet locations to minimize distractions. I will secure written or verbal consent from each subject prior to their participation in the study. The consent request will include permission for audiotaping while disclosing the nature of my research and my intended use of the information collected (e.g., literary referencing, publication as dissertation or journal article, archiving for future reference, etc.)

The Phase I interviewee is a professor at the University of Delaware's College of Business & Economics. He is an established legal expert in the field of Corporate Governance, an important variable in my research. This initial interview was exploratory in nature and conducted in person at his campus location.

Phase II research activity will entail a review of selected legal briefs from Lexis-Nexis and other Internet sources as well as other relevant literature. From this preliminary research I will formulate my second round interview questions and/or a survey instrument for selected TGH employees. I then will conduct in-depth interviews with two subject matter experts—high level insiders who served as hospital board directors around the time that the hospital went private.

Finally, Phase III will comprise return face-to-face "member check" interviews conducted in person with my legal expert and hospital board respondents after the additional research that was conducted subsequent to their initial interviews. The purpose/objective is to seek clarification of issues or questions that emerged from my interim research of accounts in the media, other literary sources and surveys, interviews of other subjects at TGH or additional information and impressions gathered at the hospital site.

Rationale/Approach
Given that Corporate Governance forms the basis of my research question, I decided to start by interviewing a legal expert in that field. Since my objective was to explore the possibility of regulation-related conflict affecting corporate governance, I reasoned that an exploratory interview with an attorney would be a productive initial data

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source—both because legal action is a reasonable indicator of conflict, and because accurate records are generally accessible in legal cases. My initial interview will solicit suggestions for document review and professional references. These will inform subsequent steps in my research. The initial (expert) subject will: 1) provide leads for literature and legal case reviews germane to my research questions, and 2) determine, by reference, the subject(s)/respondent(s) with whom I will conduct the second round interview(s). I have chosen to allow respondents to choose their interview site for in-person interviews to accommodate each respondent's preferences in terms of comfort with the process and ready access to whatever reference materials they may need to provide accurate responses during the interview.

Reviewing one or more legal cases, related literature and/or case synopses from among those the attorney suggests as being relevant to my research should provide a firm basis for developing the focus and questions of my Phase II interviews. In Phase II, interviewing a member of the company's board of directors or other high-level "insider" should provide a deeper understanding of the nature of any observed conflict and the surrounding circumstances. The Phase II interview is also an opportunity for me to ascertain whether factors other than public sector regulation might explain that conflict.

The Phase III "return interview" with my initial subject, Professor Elson, constitutes a member check. That is, it represents an opportunity for me to share my impressions and interpretations from the second round interview(s) (as well as from the supporting literature/document reviews) to debrief and to perhaps adjust my presumptions or conclusions based on information gathered in Phase II.

It is my hope that this project will serve as the basis for subsequent dissertation (or even post-doctoral) research. If, for instance, my project investigation suggests a cause-and-effect relationship between public sector regulation and corporate governance conflict, I could then pursue external validity by conducting additional case studies over time. That is, I would identify other case studies in which similar conflicts (i.e., conflicts in corporate governance engendered by privatization) appear to exist—and then search for common attributes. Such an investigation might conceivably yield specific "conflict variables." Subsequent research could then explore whether a negative statistical association exists between one or more of these variables and corporate performance in privatization arrangements.

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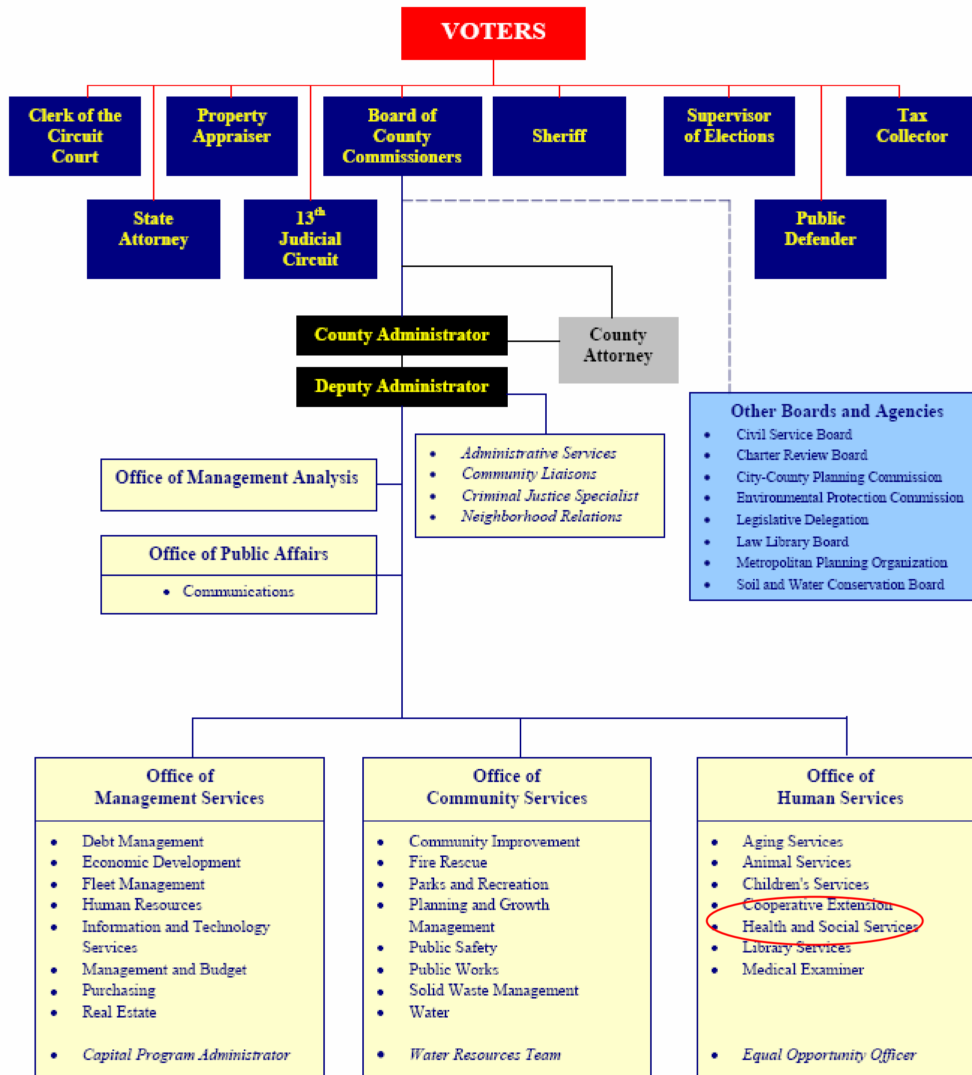
Appendix D: Government Organization of Hillsborough County, FL



Source: Hillsborough County, Florida Budget Office (October 2000), Adopted Annual Budget for FY 01, Volume I Operations and Funding Guide.

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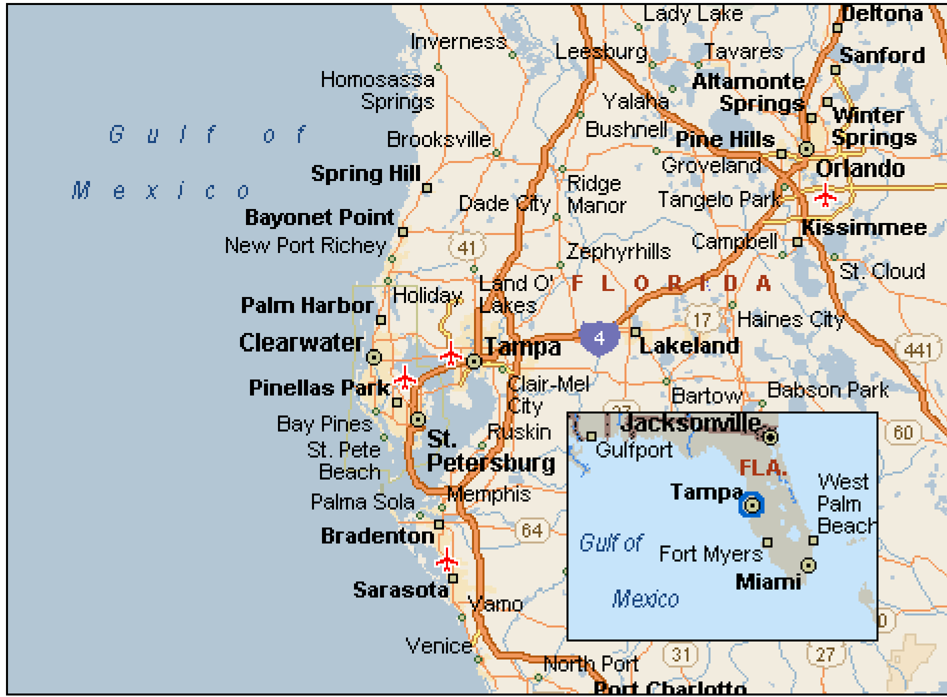
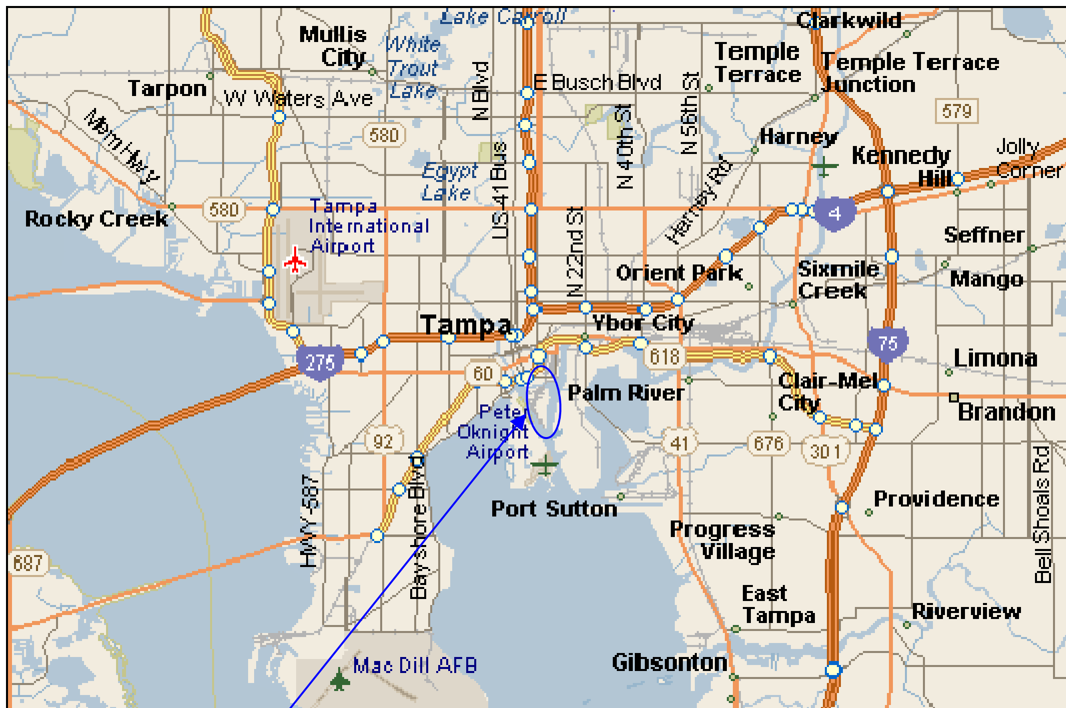
Appendix E: TGH Location – Hillsborough County and Tampa Area Maps





Davis Island

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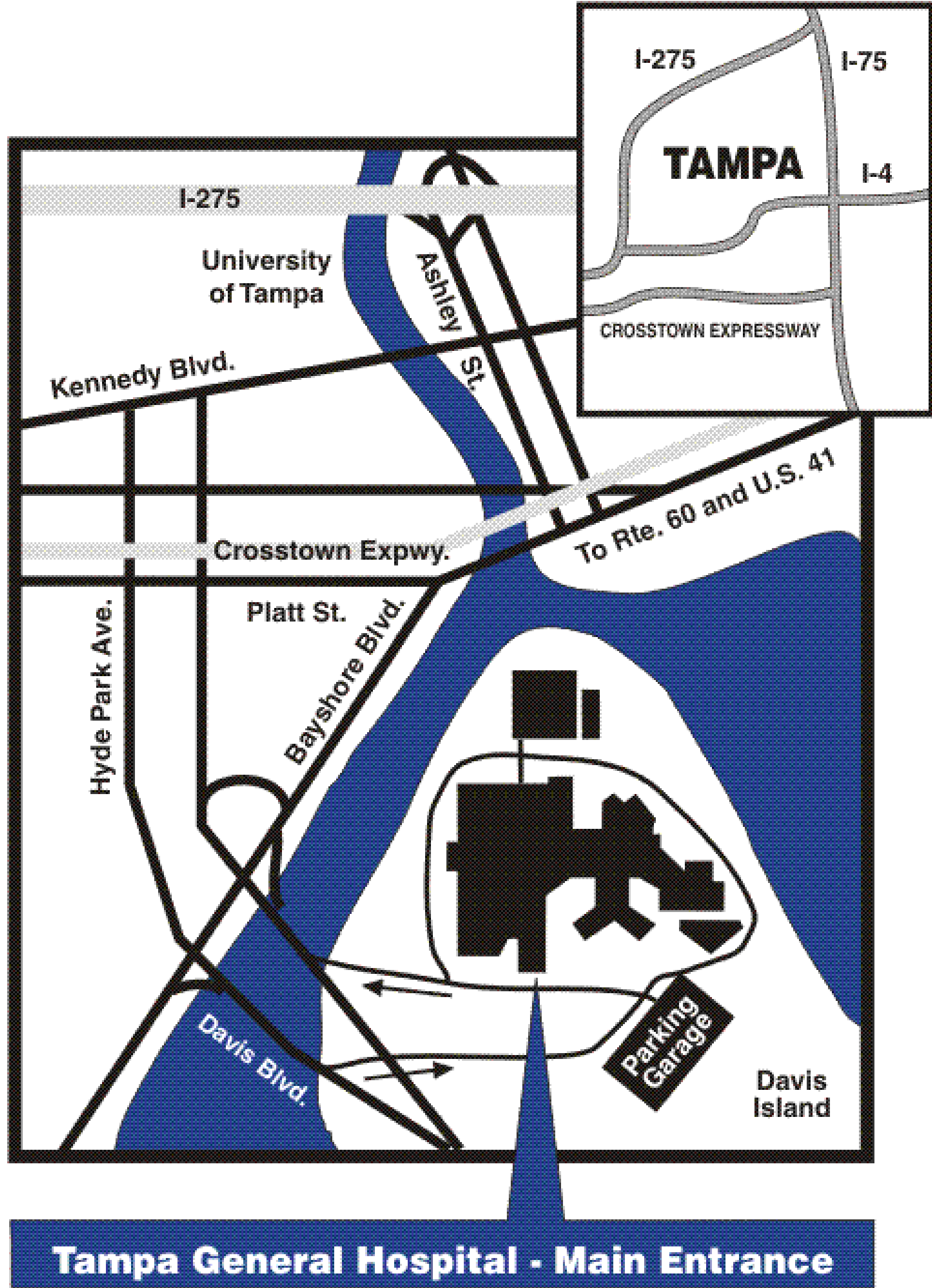
Appendix F: Tampa General Hospital Campus Map



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Appendix G: Key Hospital Performance Indicators

Table G.1 – TGH Financials 2001-2003

Tampa General Hospital Operating Indicators For the years ending September 30, 2003, 2002, 2001 ($'s in thousands)

	2003	2002	2001
Total Revenues	$566,065	$532,530	$411,706
Expenses			
Salaries & Benefits	$236,469	$206,336	$167,530
Medical Supplies	110,545	95,479	78,945
Provision for Bad Debts	40,418	50,819	38,816
Purchased Services	41,681	34,159	32,207
Depreciation, Amortization	17,590	16,927	17,173
Professional Fees	15,938	14,835	13,579
Utilities & Leases	14,401	12,742	12,863
Interest	8,628	7,715	8,001
Insurance	15,564	8,950	2,749
Other	33,200	28,366	29,066
Total Expenses	$534,434	$476,328	$400,929
Gain (Loss)	$31,631	$56,202	$10,777
Total Assets	$516,622	$381,466	$301,857
UTILIZATION			
Discharges (excludes newborns)	29,024	27,848	26,166
Patient Days (excludes newborns)	199,699	183,052	170,788
Deliveries	4,185	3,970	3,806
Surgeries	19,844	18,312	16,929
ER Visits	64,376	59,739	56,541

CARE PROVIDED TO INDIGENT PATIENTS

	2003	as a % of total	2002	as a % of total	2001	as a % of total
Charges Foregone						
Medicaid	$229,540	13.27%	$200,196	12.81%	$138,320	11.41%
HCHCP	63,017	3.64%	69,045	4.42%	60,933	5.02%
Charity	96,781	5.59%	65,130	4.17%	52,568	4.33%
Total Indigent	$389,338	22.50%	$334,371	21.40%	$251,821	20.76%
Hospital Gross Charges	$1,730,303		$1,563,280		$1,212,690	
Utilization of Services						
Discharges (includes newborns)						
Medicaid	10,495	30.88%	9,279	29.63%	7,522	25.43%
HCHCP	1,280	3.77%	1,171	3.74%	1,372	4.64%
Charity	2,768	8.15%	2,877	9.19%	3,813	12.89%
Total Indigent	14,543	42.80%	13,327	42.56%	12,707	42.96%
Total Discharges	33,981		31,313		29,574	

Source: Tampa General Hospital 2003 Annual Report

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Table G.2 – TGH Financials 1999-2000

Tampa General Hospital Operating Indicators
For the Years Ending September 30, 2000 & September 30, 1999
($'s in thousands)

	2000	1999
Total Revenues	**$363,086**	**$326,707**
Expenses		
Salaries & Benefits	$146,008	$131,960
Medical Supplies	69,666	62,655
Purchased Services	28,537	30,426
Depreciation, Amortization	17,166	18,111
Provision for Bad Debts	46,668	30,579
Professional Fees	14,522	18,331
Utilities & Leases	10,966	10,214
Interest	8,302	8,448
Insurance	2,019	2,119
Other	26,395	24,129
Total Expenses	**$370,249**	**$336,972**
Loss	**$(7,163)**	**$(10,265)**
Total Assets	**$284,873**	**$284,332**
UTILIZATION		
Discharges (excludes newborns)	23,700	22,734
Patient Days (excludes newborns)	155,703	154,789
Deliveries	3,477	3,215
Surgeries	15,978	16,059
ER visits	51,503	47,971

INDIGENT CARE	2000	As a % of Total	1999	As a % of Total
Charges Forgone for Indigent Patient Care($'s in thousands):				
Medicaid	$78,227	8.95%	$56,244	8.49%
HCHCP	33,387	3.82%	13,861	2.09%
Charity	57,510	6.58%	44,444	6.71%
Total Indigent	**$169,124**	**19.35%**	**$114,549**	**17.30%**
Hospital Gross Charges	**$874,151**		**$662,167**	
Utilization of Major Services by Indigent Patients:				
Discharges (includes newborns)				
Medicaid	7,765	29.02%	8,252	32.32%
HCHCP	1,409	5.27%	1,090	4.27%
Charity	2,233	8.34%	1,803	7.06%
Total Indigent	**11,407**	**42.63%**	**11,145**	**43.65%**
Total Discharges	**26,759**		**25,535**	

Source: Tampa General Hospital 2000 Annual Report

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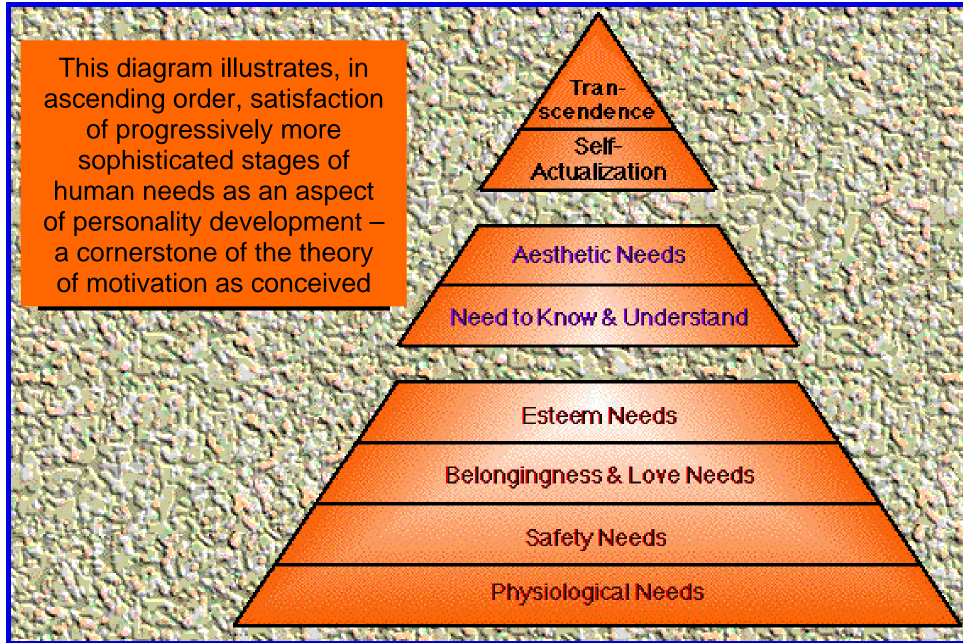
Appendix H: Theories of Human Personality Development & Motivation

Figure H.1 – Maslow's Hierarchy of Needs



Source: Huitt (2004)

Table H.1 – Alderfer's Hierarchy of Motivational Needs

Level of Need	Definition	Properties
Growth	Impel a person to make creative or productive effects on himself and his environment	Satisfied through using capabilities in engaging problems; creates a greater sense of wholeness and fullness as a human being
Relatedness	Involve relationships with significant others	Satisfied by mutually sharing thoughts and feelings; acceptance, confirmation, under-standing, and influence are elements
Existence	Includes all of the various forms of material and psychological desires	When divided among people one person's gain is another's loss if resources are limited
Source: Huitt (2004)		

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Table H.2 – A Reorganization of Maslow's and Alderfer's Hierarchies

Level	Introversion	Extroversion
Growth	Self-Actualization (development of competencies [knowledge, attitudes, and skills] and character)	Transcendence (assisting in the development of others' competencies and character; relationships to the unknown, unknowable)
Other (Relatedness)	Personal identification with group, significant others (Belongingness)	Value of person by group (Esteem)
Self (Existence)	Physiological, biological (including basic emotional needs)	Connectedness, security
Source: Huitt (2004)		

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