Study examines effect of hospital switch to for-profit status

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Hospital conversion from nonprofit to for-profit status in the 2000s was associated with better subsequent financial health but had no relationship to the quality of care delivered, mortality rates, or the proportion of poor or minority patients receiving care, according to a study in the October 22/29 issue of *JAMA*.

During the past decade, there has been increasing attention to the growing number of nonprofit or public hospitals that have become for-profit. These conversions are controversial. Advocates argue that for-profit organizations bring needed resources and experienced management to struggling institutions, improving the quality an d efficiency of the care that these hospitals provide. Critics are concerned that once hospitals become "for-profit" they will focus on financial metrics such as improving payer mix and increasing volume, shunning disadvantaged patients and providing less attention to the provision of high-quality care. There is little contemporary empirical evidence on what happens to patient care or to patient mix when hospitals convert, according to background information in the article.

Karen E. Joynt, M.D., M.P.H., of the Harvard School of Public Health, Boston, and colleagues examined characteristics of U.S. acute care hospitals associated with conversion to for-profit status and changes following conversion. The study included 237 converting hospitals and 631 matched control hospitals. Participants were 1,843,764 Medicare fee-for-service beneficiaries at converting hospitals and 4,828,138 patients at control hospitals.

The researchers found that converting hospitals improved their total margins (ratio of net income to net revenue plus other income) more than controls (2.2 percent vs 0.4 percent improvement). Hospitals that converted had similar performance on process quality indicators for heart attack, congestive heart failure, and pneumonia compared with controls at baseline (84.3 percent vs 85.5 percent). Both groups improved their process quality metrics (6.0 percent vs 5.6 percent).

Mortality rates did not change at converting hospitals relative to controls for Medicare patients overall or for dual-eligible (Medicare and Medicaid eligible) or disabled patients. There was also no change in converting hospitals relative to controls in annual Medicare volume, the proportion of patients with Medicaid, or the proportion of patients who were black or Hispanic.

"We found no evidence that conversion was associated with worsening care, as measured by processes of care, nurse staffing, or outcomes. On the other hand, for-profit hospitals have often argued that conversion will provide resources that will lead to better care, and our study failed to find any evidence to support this notion, either. In fact, our findings suggest that as regulators and policy makers consider for-profit conversions, the likely changes that could be anticipated will primarily be in the financial health of the institution, with little relationship, either positive or negative, to the quality of care provided or the institution's mortality rates. Although there may be individual instances in which quality or outcomes improve or decline after a conversion, we did not find any consistent pattern during the past decade," the authors write.

In an accompanying editorial, David M. Cutler, Ph.D., of Harvard University, Cambridge, Mass., comments on the three studies in this issue of *JAMA* that examine the effect of hospital conversions, physician competition, and physician practice ownership.

"The data from the 3 studies reported in this issue of *JAMA* are all from the period when payments were largely on a fee-for-service basis and patient cost sharing was relatively low. These findings may not necessarily translate to the current rapidly changing environment, in which payments are increasingly rewarded on a value basis, not a volume basis, and in which patients have significant cost sharing for services received. Such a payment system could lead to more systematic cost savings."

"The experience so far is that consolidation has been good for many health care organizations and entities and for many clinicians and practitioner groups, with little clarity on how it has affected patients. Understanding how consolidation is related to resource use and quality of care, and how consolidated institutions will change in a changing health care system, will be fundamental in measuring the winners and losers in the new organization of care."

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