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Nonprofit to For-Profit Hospital Conversions: The Effect on Charitable Care

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INTRODUCTION

Capitalism serves as the driving force of the United States economy, where for-profit firms dominate the market. However, it is a much different scenario in the healthcare industry, because not-for-profits account for a large share of the market. Additionally, healthcare is the largest nonprofit service sector, accounting for 60 percent of all nonprofit revenue and more than 25 percent of all private charitable contributions.¹ Healthcare continues to represent a large portion of the nonprofit service sector and the spending on healthcare in the United States continues to increase at a rapid rate. From 1965 to 1996 healthcare spending increased from \$230.3 (In billions of 1996 dollars) to \$1,035, which is an increase of 349 percent; this increase nearly doubles the nation's gross domestic national product.

Hospitals are the single largest component of the healthcare sector, receiving 35 percent of the \$1.035 trillion (1996 dollars) in health care spending, or roughly \$362.3 billion, making hospitals considerably prominent in the nonprofit arena. There are three classifications of the ownership of hospitals: (1) Nonprofits, which account for 50 percent of all hospitals (2) Government, which accounts for 31 percent of all hospitals and (3) For-profits, which only account for 19 percent of all hospitals. (Based off of 1996 spending)²

Advocates of not-for-profits believe that the non-distribution constraint allows the mission of the nonprofits to focus on serving the community, with excess revenue being pumped back into the community, resulting in a higher societal benefit due to increased uncompensated

¹ Salamon, Lester. "America's Nonprofit Sector: A Primer" 2nd Edition. The Foundation Center (1999). Pgs. 77-80

² Salamon, Lester. "America's Nonprofit Sector: A Primer" 2nd Edition. The Foundation Center (1999). Pgs 80-81

care rates, and programs designed to educate the community. Also, the theory behind not-for-profits is that they focus on output maximization rather than profit maximization.³ Therefore not-for-profits receive tax exemption.

If the healthcare sector has been significantly influenced by nonprofits for years, then the issue at hand would be asking why the conversions of hospitals from nonprofit into for-profit status are being criticized so significantly. As discussed by Thorpe, Florence, and Seiber (2000), the level of uncompensated care decreases when converting a nonprofit to a for-profit. Advocates such as Young and Desai (1999) suggest that “non-profit conversions do not, on average, reduce community benefit relative to uncompensated care, prices, or unprofitable/nonreimbursable services”. Community benefit is defined as any program and service “designed to improve health in communities and increase access to health care.”⁴

This paper attempts to determine whether the conversion of not-for-profit into for-profit hospitals negatively affects the output of community benefits or if it is actually beneficial. One reason there may not be a negative impact is that for-profit hospitals are significantly more operationally efficient, consistently containing lower operating costs. Also, for-profits provide community benefit in the form of property taxes, where the revenue from these taxes is dispersed into the surrounding community. In addition, many researchers have found that for-profits often times produce levels of uncompensated care that are similar to the non-profits. An explanation for this is due to the relatively low variable costs of patients. The largest expenses in hospitals

³ Harrison, Teresa and Lybecker, Kristina. “The Effect of the Nonprofit Motive on Hospital Competitive Behavior” Contributions to Economic Analysis & Policy. Volume 4, Issue 1. 2005.

⁴ The Healing Ministry of Catholic Health Care . <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/> (2007). Accessed on 12/15/07.

are their fixed costs, meaning an additional patient has a relatively small impact on the cost. Not only will this paper focus primarily on the output of health care services in the two ownership structures, but it will also introduce a new tax incentive that may encourage participation of charitable care, which in turn would benefit the community.

LITERATURE REVIEW

Three distinct differences distinguish a nonprofit firm from a for-profit firm. First, nonprofits must obtain start-up capital from donations because they do not have the power to borrow capital on the premise that the firm will pay it back with future profits. Secondly, due to the non-distribution constraint, nonprofits are not allowed to pay out cash dividends from any profit the company may earn, rather they must reinvest back into the company. Lastly, if a nonprofit firm is sold, the proceeds cannot be paid to a set of owners.⁵ Essentially, these three major characteristics of nonprofits affect the overall operations of the hospital. The differences in the structural organization also affect the vision of a company.

The missions of not-for-profits and for-profits differ significantly. Due to the non-distribution constraint, all not-for-profit missions are primarily similar around the idea of output maximization, where the firm attempts to maximize the amount of services that it can provide to the community. For-profits firms are created around the premise of profit maximization, producing at a level that yields the maximum profit. Upon first glance, it may appear that not-for-profits should provide the most community benefit, at the lowest cost; however, studies have both proven and disproven this conjecture.

⁵ Pauly, Mark. Nonprofit Firms in Medical Markets. *The American Economic Review*, 1987 – JSTOR. Pg 257

The idea that the structure of not-for-profits increases community benefits is one of the significant reasons why they receive tax exemptions. Since the tax exemption status of not-for-profits cut a significant amount of their costs, they should be able to provide more community benefits. Ultimately, hospitals' services can yield three types of community benefits; uncompensated care, net prices, and unprofitable/nonreimbursable services. In short, uncompensated care is defined as any charitable care that is provided to individuals who cannot afford the services. Net prices are looked at because the lower the price of services, then the more people can afford it. The unprofitable/nonreimbursable services include the programs that are developed to increase community knowledge and raise awareness about various problems. Together, all three of these outputs help create some benefit for the community.

Kurt (1997) attempts to define the social responsibility of hospitals and compares how for-profit and not-for-profit institutions adhere to his definition. He believes that the social responsibility of hospitals is two-dimensional, the first dimension is meant "to protect and enhance organization assets while maximizing community benefit."⁶ He argues that this can most effectively be accomplished by controlling costs and improving efficiency.

In his research, Kurt conducts a comparison of a for-profit endoscopy physician's clinic and a not-for profit hospital. Evidently, the for-profit clinic was owned by the physicians who have an interest in the financial health of their company. This translated into them constantly finding ways to use supplies more effectively and reduce the cost of the procedure, which ended up being 35% lower than it cost the nonprofit. The nonprofit company he examined was a larger, wealthier company that had issues using its money for the community. Consequently,

⁶ Darr, Kurt. "The Social Responsibility of Hospitals" Hospital Topics; Winter97, Vol. 75 Issue 1.

disagreements arose between members of the board and hospital managers regarding where monies should be allocated and what new programs should start, leading to little to no production of community benefit. As a result, the lack of management structure and bottom line decisions prevented the hospital from following its mission. Furthermore, the second dimension is described as “the organizations objective to protect the commonwealth.” The author introduces an interesting argument, claiming that non-profits lack the economic incentive and instead focus on feeling good about themselves rather than concentrating on performing well and efficiently.⁷

Young and Desai (1999) focus on three specific outputs that yield community benefit; uncompensated care, net prices, and unprofitable/nonreimbursable services. The first output, uncompensated care, is one of the most widely controversial concerns with nonprofit conversions. The belief is that once a company converts into for-profit ownership status, the level of uncompensated care will be reduced. The next output, price, was determined by looking at the net revenue per patient. Lastly, the study looked at the unprofitable/nonreimbursable services provided by the converted hospitals. These services include but are not limited to emergency/trauma care, neonatal care, and substance abuse programs. In general, these services are directed at the general public to increase knowledge and raise awareness. The researchers concluded, “conversions in the short term did not have an effect on uncompensated care, prices, or availability of unprofitable/nonreimbursable services”⁸. This study also looked at the long-term results to reject the claim that for-profit firms are comparable in the short term due to government imposed regulations. The analysis found that the long-term rates were similar to the

⁷ Darr, Kurt. “The Social Responsibility of Hospitals” Hospital Topics; Winter97, Vol. 75 Issue 1.

⁸ Young and Desai. Nonprofit Hospital Conversions and Community Benefits: New Evidence From Three States. Health Affairs. Vol. 18 Num. 5

results of the short term leading to the conclusion that both the short-term and long-term conversions did not negatively impact community benefits.

A study conducted by Thorpe, Florence, and Seiber (2000) analyzed 127 hospital conversions from 1991 – 1997 to disprove the study by Young and Desai (1999). The researchers' argument is based on the conjecture that, "for-profit hospitals and systems have a fiduciary obligation to maximize shareholders' wealth. This obligation may run counter to the provision of community benefits, such as care for the uninsured."⁹ Within this study, the researchers conducted an analysis on data that they collected from the AHA Annual Survey of Hospitals for 1990-1997 and found differing results from Young and Desai (1999). By the end of the study, the researchers were able to conclude that conversions of not-for-profit to for-profit hospitals had a negative effect on the provision of charitable care.

One of the explanations they provide for their contradictory results centers around the idea that previous studies have focused on limited, single state (Florida) or three states (Texas, Florida, and California), sample sizes. So, their study was modified to be more comprehensive and focuses on nationwide data, 60 percent of the not-for-profit conversions since 1990 have occurred outside of Texas, Florida, and California. Furthermore, this study includes more measures of output such as: hospital operating margins, revenues, expenses, and total adjusted admissions.¹⁰

⁹ Thorpe, Florence, and Seiber. "Hospital Conversions, Margins, and the Provision of Uncompensated Care" Health Affairs. November/December 2000. Volume 19, Number 6.

¹⁰ Thorpe, Florence, and Seiber. "Hospital Conversions, Margins, and the Provision of Uncompensated Care" Health Affairs. November/December 2000. Volume 19, Number 6.

Due to the complexity of finding the exact dollar of charitable services provided, uncompensated care is a total of charity care and bad debt. Thus, the result of the study shows that the uncompensated care rates of not-for-profit to for-profit conversions are lower than hospitals that have always been not-for-profit. They have found that 4.7% of converted hospitals total expenses are uncompensated care, whereas uncompensated care for not-for profits, accounts for 5.3% of the total expenses. Furthermore, the profit margins for converted hospitals are 8.7% compared to the 4.7% margin of not-for-profit hospitals. The increased profit margins represent how much for-profits mark up the price of their services, in order to pay shareholders' and higher wage differentials. Also, it is interesting to note that the price of services for not-for-profits and for-profits are very similar, the for-profits receive higher margins because of their cost efficiency in production.

The official ruling position of the IRS on not-for-profit hospitals, "required any hospital seeking exemption under Code 501(c)(3) to be 'operated to the extent of its financial ability for those not able to pay for services rendered'".¹¹ The stance of the IRS was that any activity which was intended to provide relief of the poor that constituted a charitable purpose. Initially, the IRS did not specify the quantity of charity care that was adequate; however, if a not-for-profit hospital was to be audited, and the hospital lacked community programs, auditing agents would recommend removal of the tax exemption status.

Thirty-five years ago, the Internal Revenue Service adopted the community benefit standard, Revenue Ruling 69-545, for tax exemption of hospitals.¹² The standard was developed as a means to ensure that not-for-profits were engaging in community activities that warranted

¹¹ Colombo, John. "The Failure of Community Benefit". Health Matrix. Vol 15:29. 2005

¹² Colombo, John. "The Failure of Community Benefit". Health Matrix. Vol 15:29. 2005

them to receive tax exemption status. However, this amendment was riddled with issues. In particular, the amendment lost focus of providing charitable care to the needy and expanded its exemption qualification activities to any conduct that promoted health in general. This broadening of the exemption standards negatively impacted the level of charitable care. The quantitative requirements outlined by the Revenue Ruling 69-545 were that a not-for-profit hospital must have: a community board, operational acute-care facilities with an open emergency room, and participate in Medicare/Medicaid reimbursement programs.

One factor not accounted for in many of the analyses is lost tax revenue due to the tax exemptions. Does the increase in uncompensated care from nonprofits outweigh the lost revenue because of their tax exemption status? While tax revenue is not an intended output of community benefit for a hospital, it does put revenue directly into the surrounding community, increasing the benefits produced by for-profit hospitals.

Bramer (2005) used the results of previous studies to argue that not-for-profits are not producing community benefits at the level they should. His paper looked at the community benefit of the nonprofits and if they were meeting the requirements outlined by the IRS. He found that in 2002, the nonprofit industry only spent 5.4% of its overall expenses on uncompensated care, the lowest percentage in a decade. This low percentage came even though the profit margins were up from 4.2% to 4.4%. If this hospitals truly acted in the manner not-for-profits are supposed to, spending all of the profits on the community, then why are they operating with higher margins? Similarly, another study revealed gaps ranging from \$5.8 million to \$9.9 million between the expected community benefit and their actual spending.

On the other hand, for-profit hospitals were \$1.2 billion over their expected contribution. For-profit hospitals are not expected to provide any charitable care to the community, the only community benefit they are expected to produce is a result of the taxes imposed on them. Any additional services they provide for community benefit is considered additional to what is expected. The author also presented another authors interesting solution to the problem, which yields benefits from both ownership structures. All hospitals should be made into for-profit status and a “Receivable from Society” account could be established. The hospitals could then book all healthcare rendered to the uninsured in this account. Any money collected from the uninsured or government taxes could then be subtracted from the account. Any money left in the account, the uncompensated care, could then be used as a tax credit.¹³ This proposition would help to capture the efficiency of for-profit hospitals, while promoting the incentive for charity care provision of not-for-profit hospitals.

¹³ Owens, Bramer. “The Plight of the Not-for-Profit” Journal of Healthcare Management; July/August 2005. pgs 237-250.

THEORY AND DISCUSSION

According to Santerre and Neun (2007) not-for-profits are especially prevalent in health care because of market failures that occur when for-profits control the market for hospital services. Market failure occurs as a result of three factors: (1) “The private market works best when all market participants are perfectly informed”¹⁴. Due to the complexity of health care services and the difficulty of determining exactly what type of services are needed, consumers usually possess imperfect and incomplete information. (2) The resource allocation of for-profits is based on the most profitable expenditure. Individuals that cannot afford the services often do not receive the care needed. (3) The presence of positive externalities also contributes to market failure. Resources are not being allocated efficiently when externalities are present.¹⁵ More people demand health care than what is actually provided due to the expensive cost of medical services. The poor especially suffer because they rely mostly on inadequate government programs to pay or subsidize the cost of health care. Medicaid is a government program, targeted

¹⁴Santerre, Rexford and Neun, Stephen (2007). Health Economics: Theories, Insights, and Industry Studies. 4th edition. Pg 82-83

¹⁵ Santerre, Rexford and Neun, Stephen (2007). Health Economics: Theories, Insights, and Industry Studies. 4th edition. Pg 82-83

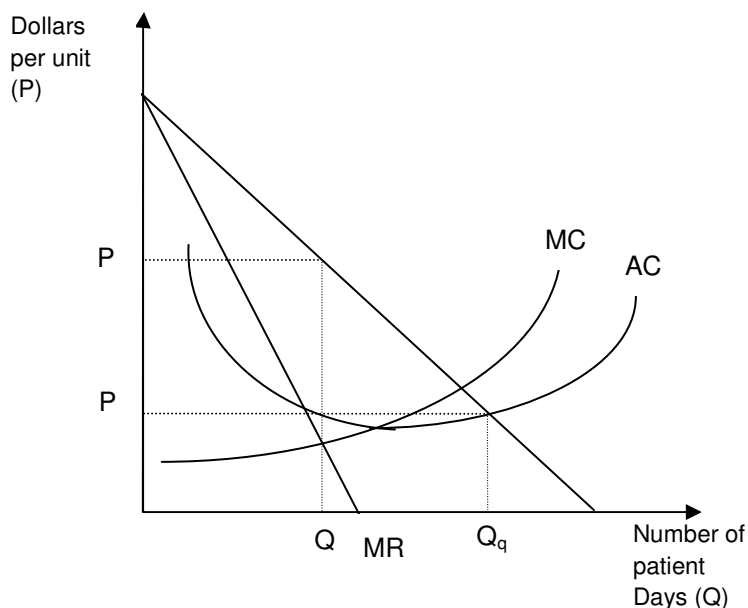
at individuals and families with low income, which aid in the costs of health care. Funding for this \$213 billion (2002 dollars) program comes from both the state and federal governments¹⁶. The impact of increasing Medicaid spending indicates a shortage of care provided. Baker and Royalty (2000) found that a 10% increase in Medicaid fees, increases physician office visits of the poor by 2.4%.¹⁷

Not-for-profit hospitals serve to satisfy market demand, where positive externalities might exist and lead to an underproduction of health care. The ownership structure of not-for-profits induces quantity maximization rather than profit maximization. The focus on quantity maximization encourages not-for-profit hospitals to provide health care to the community at a lower cost or in some cases free, increasing the contribution to the community benefit of a hospital, correcting for externalities. Figure-1 displays an output maximization model, assuming a downward-sloping demand curve. The price and quantity outputs represent the equilibrium points of a for-profit firm and a not-for-profit firm. The not-for-profit firm assumes a break even decision and must produce where ($P = AC$), the quantity maximization equilibrium.

Figure-1: Output Maximization Model

¹⁶ Santerre, Rexford and Neun, Stephen (2007). Health Economics: Theories, Insights, and Industry Studies. 4th edition.

¹⁷ Santerre, Rexford and Neun, Stephen (2007). Health Economics: Theories, Insights, and Industry Studies. 4th edition. pg 270

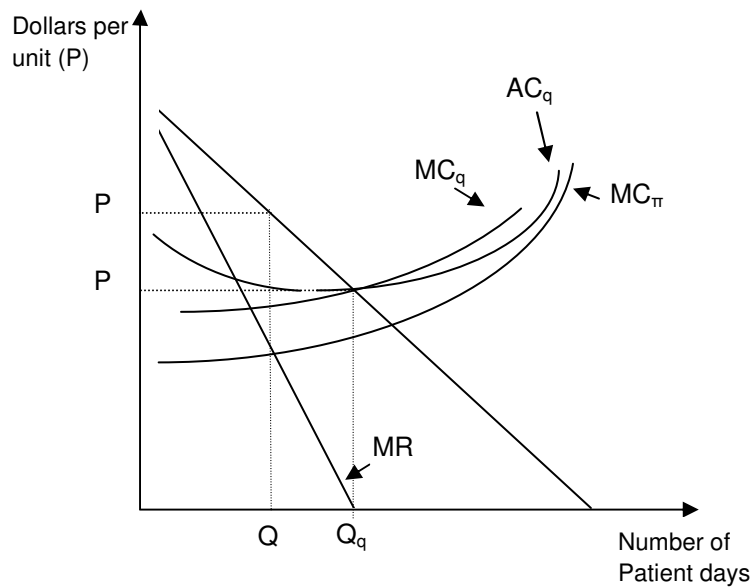


This output maximization model compares profit maximizing (for-profit) and output maximizing (not-for-profit) firms. The y-axis represents the dollar per unit of health care services, and the x-axis represents the quantity of health care services provided, which will equal the number of patient-days provided by the firm. The two ownership structures yield different equilibrium price and quantity outputs. Many market conditions exist which alter output and prices of health services in a real market. Furthermore, this graph assumes that the two firms offer perfectly substitutable goods.

The not-for-profit firm produces where average cost (AC) and the average revenue (AR) or demand, intersect. In this model the price and quantity of a quantity maximizing firm is represented by P_q and Q_q . Not-for-profit firms have an incentive to maximize their output due to the non-distribution constraint, which means that not-for profit firms cannot redistribute profit to the employees or executives of a firm.

Advocates of for-profit firms in the health care industry argue that firms that are driven by profit maximization produce nearly the same amount of community benefits as their not-for-profit counterparts for a variety of reasons. Firstly, in the short-run, for-profit firms are constantly looking for ways to reduce costs in order to increase its profit margin of services provided. Second, fixed costs account for a majority of expenses in a hospital. The cost of an additional patient contains a relatively low marginal cost, meaning for-profits could provide similar charity levels as not-for-profits for a lower cost to the tax payers. Figure-2 adjusts for this and provides new equilibrium points for the for-profit and not-for-profit hospitals.

Figure-2: Adjusted Output Maximization Model



This model includes two adjustments which advocates of for-profits have argued differentiate the two ownership structures. The first adjustment represents the increase in fixed

cost for both firms. The biggest expenses for hospitals include the acquisition and payments of costly medical equipment and facilities. The addition of patients does not have a large impact on the total cost, but it reduces the opportunity cost of providing charitable services. This graph assumes the notion that for-profit hospitals contain lower costs is true. The theory revolves around the idea that the owners and executives of for-profit companies are more invested in the company compared to executives in not-for-profit firms. This investment in the company motivates employees to seek cost saving techniques in order to maximize profit in the short run. However in the long run, firms enter the market when economic profit is present, which effectively lowers the price of services. As a result, the amount of services provided increases until the equilibrium price and quantity is reached.

The not-for-profit hospital still sets the equilibrium price and quantity where average cost intersects the demand curve. Additionally, the for-profit hospital produces where marginal cost intersects marginal revenue. However, new equilibrium points are derived due to adjustments of the fixed cost and average cost. The not-for-profit firm (P_q and Q_q) produces at a level in the short-run, where the price is lower and the quantity is larger relative to the for-profit firm (P_π and Q_π). However, the difference between the price and quantity levels is narrow.

The ownership structure of a not-for-profit requires the firm to produce at a level that provides zero economic profit. In order to do so, a firm may provide charitable care without expecting a patient to pay the hospital back for those services. This is to engage in Q_π charitable activities which increase the hospitals' contribution to community benefit. However, the tax exemptions that not-for-profits receive from the government also reduce not-for-profits contribution to community benefits. A for-profit firm must pay federal and state taxes. One tax in particular, property tax, goes back into the community from where the taxes are drawn from.

This may be in the form of income to schools, parks, roads, etc. Not-for-profits benefit the community only if the amount of benefit they provide from charitable care and lower prices, outweighs the community benefit that is lost due to tax exemption. For-profit firms are required to pay the taxes which increase their contribution to community benefit. The taxes serve as a form of government intervention to correct for the externalities that would occur if the market were left alone.

The not-for-profit firms have the incentive to increase community benefit and for-profit firms are driven by profit maximization, which constantly pushes them to be operated more efficient through allocation and production decisions. The motive of not-for-profits is on track to maximize community benefit; however, due to the lack of financial investment of the board of trustees and executives, often times they run at increased levels of fixed costs and variable costs, relative to for-profit hospitals. “Improving efficiency in the organization and delivery of services is the greatest contribution hospital managers can make; the result will be increased access and affordability of care to all segments”¹⁸. The question one asks is- how can the government capture the efficiency of for-profits, while encouraging the community focus of not-for-profits? The answer would be a tax incentive system that is not delivered until charitable care is provided. This would address the problem of nonprofits free-riding the tax exemption status, while promoting for-profits to provide services that would increase the community benefit.

Critics of converting not-for-profit hospitals into for-profit ownership status believe that removing the incentive for quantity maximization contains a negative effect on the poor. With profit margins driving the operation of for-profits, the poor suffer. However, to address this

¹⁸ Darr, Kurt. “The Social Responsibility of Hospitals”. Hospital Topics. Winter 97. Vol. 75 Issue 1.

issue, state governments are beginning to pass legislation to correct for the problem of underproduction. For instance, California passed legislation which set up a “system of mandatory Attorney General consent for sale of non-profit hospitals to for-profit and non-profit entities”¹⁹. The increased regulation and oversight by the Attorney general, increases public disclosures and enforces guidelines that the for-profit owners must follow. Conditions that follow a transfer include: (1) continuation of levels of charity care (2) continuation of the most important hospital programs (ER, Intensive Care Units, etc.) and (3) continuation of major community benefit programs (Outpatient Services, Diabetes Programs, etc.). In conjunction with these conditions, hospitals must also contain a local governing advisory board that reflects the community. Furthermore, the hospitals must use its proceeds in a way that is consistent with the previous hospital services. The for-profit hospitals are expected to contribute at equal levels of the preexisting not-for-profit hospital, without substantial donations or tax breaks.²⁰

“Tax treatment of nonprofit hospitals is based on the anachronistic policies that have lead to inefficiency and waste in the health-care system. Moreover, the federal tax treatment of nonprofit hospitals has lead to the counter-intuitive result that nonprofit hospitals provide less charity care than for-profit hospitals.”²¹

The issue with the current tax exemption standards is they are not adequately enforced or regulated. Once a company obtains not-for-profit status, it is easy to remain exempt without adhering to the standards laid out by the IRS. As a result, many not-for-profit hospitals are taking tax revenue from the community without fulfilling their community requirements. Consequently, this inefficiency leads to underproduction of charitable care provided.

¹⁹ Fremont-Smith, Marion R.; Urban, Mark; Praeger, Sandy. The Challenge of For-Profit Health Care Conversions. *Journal of Law, Medicine & Ethics*, Winter2003 Supplement, Vol. 31 Issue 4, p49-50

²⁰ Fremont-Smith, Marion R.; Urban, Mark; Praeger, Sandy. The Challenge of For-Profit Health Care Conversions. *Journal of Law, Medicine & Ethics*, Winter2003 Supplement, Vol. 31 Issue 4, p49-50

²¹ Gilbert, Charles. “Health-Care Reform and the Nonprofit Hospital: Is Tax-exempt Status Still Warranted”. *Urb. Law*. 1994

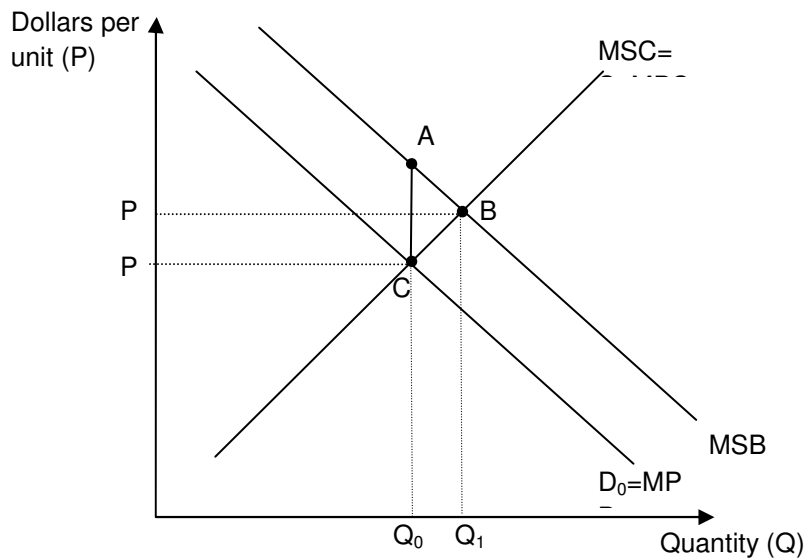
In 1994, it was estimated that the aggregate value of capital tax exemptions for not-for-profit hospitals was \$6.3 billion from income taxes and property taxes²². Bellandi (1998) looked at conversions from a different perspective than most studies of turning for-profit hospitals into not-for-profit status. She found that “uncompensated care increased in most cases, but those increases rarely offset the loss of property taxes in a community”²³. Discrepancies exist between many of the tests, whether uncompensated care rates increase or decrease; however, all of the analyses agree that not-for-profits are not providing enough charitable care.

Furthermore, converting the ownership structure of not-for-profit hospitals is an appropriate step in the right direction in order to maximize the benefit to the community by minimizing the positive externalities. Figure-3 represents the current state of the hospital market, and illustrates the effect of the positive externalities created by the underproduction of health care services to the poor and uninsured. It shows that the quantity being produced is not the socially optimal level.

Figure-3: Current Market of Charitable Care

²² Nesvisky, Matt. “The Value of Tax-breaks for Not-For-Profits”. National Bureau of Economic Research. Accessed on December 5, 2007.

²³ Bellandi, Deanna. “Reversing Conversions”. Modern Healthcare; 10/05/98, Vol 28 Issue 40

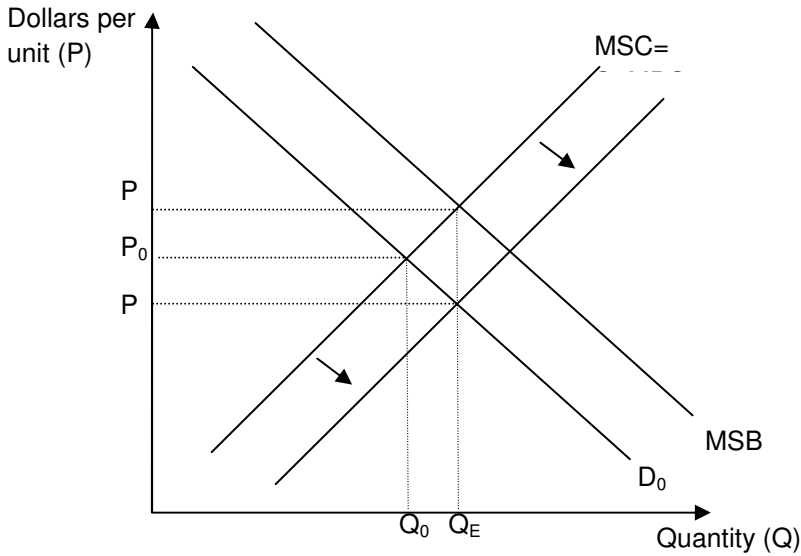


This model highlights the positive externalities that are present with the current hospital market structure, large concentration of not-for-profit hospitals. In this graph, consumers purchasing decision is driven by maximizing utility; whereas, producers supply at a quantity where they are maximizing profits, which results in an equilibrium point where the marginal private benefit (MPB) equals marginal private cost (MPC). The equilibrium point produces at P_0 and Q_0 . However, this is an inefficient market outcome because marginal social benefit (MSB) exceeds the marginal social cost because of the external benefits of having a community full of healthy individuals. The socially optimal equilibrium occurs where $MSB=MSC$, at P_1 and Q_1 . If left alone, the hospital market may have a tendency to under produce charitable care. Triangle ABC represents the amount of charitable care that needs to be provided in order to correct for the positive externality.

With more than 70 million uninsured or underinsured people in the US²⁴ and funding of government programs is questionable, new techniques need to be developed to encourage the most output for the lowest cost. As previously mentioned, for-profits could produce the same amount of charitable care as not-for-profits, at a lower cost. Additionally, if there is truly an underproduction of charitable services, then for-profits could provide more services for the same cost. The approach that would encourage charitable production while utilizing efficiency would be converting all hospitals' to for-profit ownership status. Monies that originally were not recognized as tax revenue for the government, for instance property tax of not-for-profit institutions, could be placed into an account designated for tax subsidies to the for-profit hospitals for providing charitable care. The cost would be no greater for the government. By utilizing the efficiency of for-profit hospitals, more care could be provided to the poor, increasing the benefit to the community. This subsidy program would effectively lower the cost of providing charitable care, which would assist in the pursuit for producing at the socially optimal level.

Figure-4: Subsidies as a Corrective Instrument

²⁴ Wood, Kevin. "Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make any Difference". Summer 2001. Volume 20:3



This graph captures the impact of the hospital market when a subsidy program is instituted. P_1 represents the price that would be present if the hospital market provided optimal amount of charitable care. The actual price, prior to a subsidization, is shown at the equilibrium P_0 . This is the point in which the current market is producing charitable care. If a subsidization program was put into effect, the marginal MSC line would shift rightward, as a result of the reduction of the cost to the hospital in providing charitable care. Because of the per-unit subsidization of hospital services, the market price of the services decreases from P_0 to P_E . This reduction in cost, results in the quantity of services provided increasing from Q_0 to Q_E and the production efficiency exists at the point where $MSB=MSC$. Subsidies can be a useful way to promote socially beneficial activities that might otherwise be undervalued in the hospital market. This subsidy, due to its price reduction incentive, would work to encourage for-profits hospitals to engage in charitable care, increasing the quantity of health care provided to the socially optimal level represented at Q_E .

Using government subsidies to correct for positive externalities is not a new approach. In fact, the government subsidizes many industries today. One example of subsidization

implemented by the government is the Small Business Innovation Research Program (SBIR), which has supplied more than \$7 billion to small high technology firms between 1983 and 1997²⁵. Government supported subsidy programs may also be an effective and necessary method to correct for the externalities in the health care market.

CONCLUSION

²⁵ Lerner, J. "[The Government as Venture Capitalist: The Long-Run Impact of the SBIR Program](#)" Journal of Business- UChicago Press. 1999.

Not-for-profit hospitals were primarily used as an instrument to correct market failures that existed when only for-profit hospitals were in control of the market, which resulted in a shortage of health care services being provided. However, times have changed and the need of not-for-profit hospitals is now being challenged. Regarding scope and numbers, both government and nonprofit hospitals have been steadily declining the past 15 years. For-profits, on the other hand, have been growing substantially.²⁶ This is partly due to the acquisition of not-for-profits by for-profits. The conversions of the ownership structure for the hospitals have come under increasing criticism by advocates of not-for-profit hospitals.

The models in this literature developed the idea of why not-for-profit hospitals were created. However, with the ever increasing production efficiency and cost reduction strategies of for-profits, for-profits are now positioned to provide more care to the community for the same, if not lower, cost per unit of service provided. Not-for-profit hospitals simply have lost the focus to produce charitable care for a variety of reasons. One of those reasons is the broad definition of community benefits, outlined by the IRS. With the broad definition, many times the poor suffer at the expense of the executives and board of trustees of the not-for-profit hospitals.

Socially speaking, it is important to ensure that an adequate amount of charitable care is being provided to the community. Prehistoric methods for providing charitable care and a less prosperous economy have resulted in a deficiency of charitable care being provided. In order to counter this deficiency in provision of care, new methods, like the tax subsidization program, need to be implemented by the government. The subsidization program that was introduced in

²⁶ Salamon, Lester. "America's Nonprofit Sector: A Primer" 2nd Edition. The Foundation Center (1999)

this paper, reduces the cost of providing charitable care, shifting the marginal social to the right. The shift in the MSC curve increases quantity closer to the equilibrium output.

The conversion of not-for-profit to for-profit hospitals is the first step in implementing this program. If all hospitals were transitioned into for-profit status, the same amount of charitable care could be provided for a lower cost to the government. Any additional funds, created by the increased tax revenue from the previous not-for-profit hospitals, could be reinvested into the tax subsidy program. This paper is only to be used as an introduction for the policy. Before implementing the subsidization program further studies need to be completed. It would be beneficial to look at the exact cost of health care services and how large of a government subsidization would be needed to increase the quantity of health care services provided to reach the optimal level.

Currently, the conversion of not-for-profit into for-profit hospitals has little to no affect on the provision of charitable care provided. The tax subsidy program, if implemented, would increase the output of charitable services the hospital industry could provide. It may not be enough to completely correct for the positive externalities due to under production but it should help to minimize them at the least. Therefore, the conversion of not-for-profit hospitals into for-profit hospitals could benefit the provision of charitable care in the long-run.

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