2008

Florida's Community Hospitals: Service Delivery Choices and Policy Implications

Elsie Bradwell Crowell

FLORIDA STATE UNIVERSITY

COLLEGE OF SOCIAL SCIENCES

FLORIDA'S COMMUNITY HOSPITALS: SERVICE DELIVERY CHOICES AND POLICY IMPLICATIONS

By

ELSIE BRADWELL CROWELL

A Dissertation submitted to the
Askew School of Public Administration & Policy
In partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

Degree Awarded:
Summer Semester, 2008

The members of the Committee approve the dissertation of Elsie B. Crowell defended on June 23, 2008.

_____
Mary E. Guy
Professor Directing Dissertation

_____
Marie Cowart
Outside Committee Member

_____
Robert Bradley
Committee Member

_____
Lance deHaven-Smith
Committee Member

The Office of Graduate Studies has verified and approved the above named committee members.

This dissertation is dedicated to the memory of my parents, Willie and Carrie Bradwell. Their early and untimely death was a testament that each moment in time must be seized and cherished - for the future is but an unpredictable Crystal Ball.

ACKNOWLEDGEMENTS

Without the Supreme Being and the joint effort of family friends, professionals, and my academic community, the achievement of this goal would not have been possible. A special thanks to my dissertation committee. Drs. Mary E. Guy, major professor, Marie Cowart, Lance deHaven-Smith, and Robert Bradley. I am most grateful to my major professor, Dr. Mary E. Guy for guiding me through this process. Her wisdom, encouragement and expertise was an invaluable asset. She gave of her time unselfishly to help me frame a topic that was compatible with my interest in an established program environment. Despite her heavy academic responsibilities, she graciously shared her expertise and time in helping me produce two publications during my tenure as an atypical doctoral student. A special thanks to Dr. Marie Cowart who was instrumental in encouraging me to enter the PhD program. She has followed my progress from start to finish, always offering an encouraging word and reminding me that "you start school to finish not to drop out" an option that seemed rather attractive at times. She has that "quite force" about her that makes you feel guilty if you disappoint her by not completing your educational pursuits. Dr. Lance deHaven-Smith was also generous with his time, offering his expertise, ideas, and resources each time I stopped by his office. He is a storehouse of knowledge on Florida issues and always willing to share with others. Appreciation is also extended to Dr. Robert Bradley. His knowledge, insight and expertise helped to fine-tune the topical issues and offer a platform for future research.

Words are inadequate in expressing my appreciation to those professionals who assisted me in data collection and interpretation: Betty Brown, statistical consultant, Ryan Fitch, financial analyst, Agency for Health Care Administration (AHCA), Joe Sharp, hospital consultant, Alan Pierce, director of planning and county hospital liaison, Robert Winkler, CEO, and other health care professionals who provided input for data collection purposes.

Finally, but certainly not least, thanks to my husband, James and other family members who endured a life without my full attention. Your support and encouragement helped me to keep going when I questioned this journey. Brian, my son, the "high-tech" guy who tried to teach his mom "high-tech" skills with limited success. Thank You Buddy! To a special friend Laura Brock: although we started this journey together and later changed paths, we remain a source of support and encouragement for each other and will continue to do so until you, too, have accomplished your goals. To each of my supportive friends, sorors, church members, and former co-workers who kept me in your prayers and made those periodic telephone calls, offering words of encouragement, and informing me that I had no option but to complete this assignment. THANK YOU!

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

During the past quarter century, efforts have been made to control rising hospital costs, which are the largest component of U.S. health care expenditures. The purpose of this research is to examine the relationship among five community characteristics and hospital ownership types; determine whether there are differences in operational performance (cost and efficiency) between private nonprofit and private for-profit hospitals; and propose an answer to the question – Why do local governments contract-manage their hospital operation? Using a mixed-method research design, the findings are: (1) there are mixed results in the relationship between community characteristics and hospital ownership types; (2) there are no significant differences in operational performance of private nonprofit and private for-profit hospitals; and (3) hospitals pursue contract management services to gain hospital management expertise, financial management, medical and information technology, and human resource management and recruitment. The implications of this study calls for a broader examination of operational performance among hospital ownership types and policy direction on the goals and mission of a public private venture such as contract management.

CHAPTER 1

FLORIDA'S COMMUNITY HOSPITALS: A RESEARCH OVERVIEW

This chapter provides a brief background on the state of health care costs in the U. S. and in the State of Florida, along with an historical perspective and report on the current status of community hospitals. This chapter also poses research questions, addresses the significance of their answers, emphasizing their relevance to Florida health care and provides an overview of the remaining chapters.

Statement of the Problem

Since the 1940s, per capita growth in U.S. healthcare expenditures has increased at a faster rate than has the gross domestic product (GDP). This pattern is expected to continue for the foreseeable future. Healthcare expenditures are projected by some observers to reach 20 percent of the GDP by 2015 (Borger, et al., 2006). Over the past two decades, the U.S. has experienced the fastest annual growth rate of healthcare spending per capita among the Organization for Economic Cooperation and Development (OECD) countries. In 2003 alone, the U.S. spent almost $1.7 trillion on health care services, nearly two and a half times the $696 billion in 1990. This amount represents 15.3 percent of the gross domestic product (GDP) compared to 8.4 percent, the median for OECD countries (Centers for Medicare and Medicaid, 2003). In 2006, U.S. health care spending increased 6.7 percent to $2.1 trillion. The health care portion of the gross domestic product (GDP) was 16 percent (Catlin, Cowan, Hartman, & Heffler, 2008). U.S. per capita spending for healthcare consistently outpaces that of other industrialized nations by 2 ½ times their comparable median (Frogner & Anderson, 2006). The most recent OECD data show that the U.S. health spending per capita is 24 percent higher than the next highest spending country and 90 percent higher than countries considered to be its global competitors (OECD Health Data, 2006).

Although the U.S. spends more than twice the amount per person on health care ($4,270 vs. $2000 annually) than the median amount spent by OECD countries, it does not achieve health outcomes that reflect comparable improvements in health over other developed countries. More than 47 million people in America lacked health insurance in 2006. The greatest influence on

access to health care appears to be the availability and affordability of health insurance (Anderson & Hussey, 2001; DeNavas-Walt, Proctor, & Smith, 2007).

Florida is no exception in its rising health care costs. From 1992-2002, personal health care expenditures for the state grew by 85.1 percent; in 2002, they reached a total of $83.4 billion, up from $77.3 billion in 2001 (Agency for Health Care Administration [ACHA], 2005). Although Florida's hospital costs were a lower percentage of all health care expenditures than the nation's in 2002 (33.3%, - $27,757, compared to 36.6%, - $486,511 billion, respectively), hospital expenditures remain the highest cost per service category. Florida's total health care expenditures as a percentage of Gross State Product (GSP) were 15.6 in 2004, compared with the national average of 13.3 percent (Kaiser Family Foundation [KFF], 2005; National Health Expenditures [NHE], 2005).

Given that health care expenditures comprise the largest single component of the U.S. gross domestic product (GDP), cost is a primary factor affecting access. This holds true for hospitals. Growth in hospital spending has been substantial since 1960, accounting for 34 percent of the rise in health care spending in 2004 (Smith, Cowan, Hefler, & Catlin, 2006).

Policymakers are under intense pressure to curb spending growth in government. Economic recessions, growing deficits, and dissatisfied taxpayers have created a sense of urgency in seeking long-term solutions to health care costs. Since hospitals represent the largest share of these expenditures, one approach to tackling overall health care costs has been to explore alternatives in delivering hospital services.

The purpose of this research is to answer three key questions associated with such alternatives: (1) What are the relationships of five select community characteristics with hospital ownership types (public, private nonprofit and private for-profit)? (2) Does the operational performance (average length of stay (ALOS), operating margin percentage, Medicaid and charity and case mix) of private nonprofit hospitals differ from that of private for-profit hospitals? and (3) Why do some local governments contract-manage their hospital operation?

Historical Perspective

Over the past 200 years, hospitals evolved from institutions that provided healthcare for the poor and homeless to delivery of a modern standard for specialized healthcare services and comprehensive coverage, including teaching and research for an expanded cohort of users.

According to Starr (1982, p. 145), "few institutions have undergone as radical metamorphosis as have hospitals in their modern history."

Hospitals have been an American institution since the first one opened in Philadelphia in 1872. Before the 1880s, there was no widespread development of hospitals in the U.S. Those that existed served mainly as charitable entities to assist the poor and those without family support. However, between 1880 and 1920, US hospitals experienced a major transition, as affluent patients observed that hospitals provided better care than could be obtained at home.

The number of hospital increased from 178 in 1872 to more than 4,000 in 1910. This was due in part to the growth in hospitalization. These hospital systems emerged in three phases (Starr, p. 169-170; Jonas & Kovner, 1999, p. 159-160).

- 1751 – formation of voluntary hospitals operated by charitable lay boards and public hospitals emanating from almshouses and operated by municipalities, counties or the federal government.

- 1850s – more specific types of hospitals evolved, primarily religious, ethnic and specialized hospitals catering to certain types of diseases. Denominational hospitals after the 1850s reflected the arrival of large numbers of Catholic immigrants.

- 1890-1920 – profit-making hospitals began to increase. They were mainly operated by physicians, individually, or in partnership, and by corporation. The growth of proprietary hospitals after 1890 reflected the new potential for profit due to the progress of surgery.

There was a decline in the number of hospitals between 1920 and 1945. However, a second major growth period occurred between 1945 and 1980. This was due to the rapid increase in hospital services, that could not be obtained elsewhere, growth of technology and availability of health insurance. The creation of Medicare and Medicaid provided hospital and medical insurance for the elderly and poor (Jonas & Kovner, 1999).

The Hospital Survey and Construction Act of 1946, also referred to as the Hill-Burton Act, provided generous funding to expand the number of hospitals and to provide new equipment for them. This program accounted for nearly 40 percent of all U.S. government owned hospital beds during the 1950s and 1960s. Federal construction grants based on bed to population ratios allowed for even small communities to have their own hospitals (Jonas & Kovner, 1999; Shi & Singh, 1998).

However, the growth trend in public government-owned hospitals declined during the 1980s. Investor-owned (for profit) hospitals increased by 72 percent between 1980 and 1985 (Haglund & Dowling, 1993). Florida became a preferred state of location for investor-owned hospitals during the early 1980s. It experienced a 60 percent increase in this type of hospital ownership between 1979 and 1982 (Brow & Klosterman, 1986). The state continues to be dominated by investor-owned hospitals as it had the highest percentage of for-profit hospitals in 2006 (46.8%) in the nation (Kaiser Family Foundation, 2008; AHA 2006 Annual Survey, 2008).

One of the greatest influences on evolutionary changes in hospitals occurred with the enactment of Medicare and Medicaid in 1965, when the federal government became a key purchaser of health care services. As federal spending began to rise and the financing of health care escalated, hospital costs also rose significantly. The factors contributing to increased costs were the passage of the Health Maintenance Organization (HMO) Act in 1973, changing Medicare reimbursement to the Prospective Payment System (PPS) in 1983, new technologies, and the number of regulations imposed by federal, state, and local governments. In turn, each of these elements contributed to the present types and organizational structures of hospitals (Shi & Singh, 1998). Hospitals in the U.S. are unique institutions. They are required to provide services to anyone without regard to ability to pay. Historically, they tackled rising costs by being able to cross-subsidize services by charging higher prices to insured patients to compensate for losses in treating the uninsured. However, changes in price transparency, influenced largely by the PPS and the HMO Act, have prevented hospitals from building losses into their prices (Altman, Shactman, & Eilat, 2006).

The 1980s were challenging times for hospitals. Many of them experienced a number of organizational changes that were influenced by three key periods: (1) professional dominance with local control, 1945-1965, (2) entrance of Medicare and Medicaid, which increased federal involvement funding and regulation, (1966-1982), and (3) reliance on market mechanisms or managed competition (1983-present) (Ruef & Scott, 1998). During these transitional periods, some scholars posited that a shift occurred from providing high quality health for the collective good in the 1960s to a period of maximization of profit, which influenced managerial legitimacy of hospitals with different ownership characteristics (Fishman, 1997; Ruef & Scott, 1998).

Since the 1980s, hospital discharge rates and average length of stays have decreased. Discharged rates declined from 159 per 1,000 in 1980 to 109 per 1,000 population (National

Center for Health Statistics, [NCHS] 1996). Rising costs help reverse the growth of community hospitals and undercut their financial viability. Similarly, the American Hospital Association (AHA) identified the appearance of "cracks in the foundation" that extend beyond costs. These include worker shortages, rising demand and constrained capacity, regulatory burden, growing number of uninsured, and decreased access to capital and payment reductions for Medicare and Medicaid (AHA, 2002).

Community Hospitals

As typically understood, the term "community hospital" has two components. First, it entails the type of service provided and second, the extent to which those services are available to the general public. Community hospitals, also referred to as acute care hospitals, provide short-term medical/surgical care to the general public for an average period of 30 days. They may be public (government-owned), or private nonprofit or private for-profit hospitals (AHA, 2006; National Association of Public Hospitals and Health Systems [NAPA], 2004). In the context of this research, the terms community and acute care hospitals are used synonymously.

This research is restricted to community hospitals in Florida. They represented 82 percent of all hospitals in the state in 2000 (Florida Hospital Association [FHA], 2001). This study population specifically excludes long term care, teaching, state specialty, psychiatric, rehabilitation, and military hospitals.

The service delivery choices of community hospitals are defined by their type of ownership and financial structure. There are three types: public (government owned and funded, including both public and quasi-public owners), private nonprofit (tax-exempt), or private for-profit (non tax-exempt). In this study, special attention will also be given to a less common type, namely, contract-managed hospitals which are public-private partnerships between local government and the private sector. Table 1 provides a detailed explanation of these ownership types. While hospital organizational changes and cost factors have been the subject of extensive research as they relate to the role of nonprofit, for-profit or investor-owned status (e.g., Burgess & Wilson, 1996; Gaynor & Has-Wilson, 1999; Shortell, Gillies, Anderson, Erickson, & Mitchell, 1996), there is limited research on the practice of contracting with outside organizations to provide full service management for the daily operation of a hospital, despite the fact that this arrangement can be traced back to the late 1970s (U.S. General Accounting Office [GAO], 1980).

Table 1

Types of Hospitals by Ownership and Financial Structures

Public	Public hospitals are owned and funded by the government. Sources of funding may come from all levels of government, as public hospitals are responsible for serving the needs of those without adequate sources of income or health insurance.
Quasi-Public	Hospital Authority – a public body or agency of a governmental unit created by a state statute to administer a portion of the powers of the government delegated to it.
	Hospital Taxing District – a quasi-municipal independent corporation covering a defined geographic area that is established under state legislation. A hospital taxing district has taxing authority and operates a district hospital.
Private	Private Non-Profit – a tax exemption corporation created under a state's non-profit corporation law to serve a charitable purpose. Any profits from its operation are reinvested in the corporation.
	Private For-Profit – a corporation that is not tax-exempt, the profits of which are distributed in a systematic manner to the corporation's owners.
Public/Private Partnerships	Affiliations, consolidations and joint ventures. Entity may maintain its own board and/or ownership status.
	Contract Management – general day- to- day management of an entire hospital by another organization, under a formal contract. Managing organization reports directly to the governing board or owners of the managed hospital.

Sources: The Henry J. Kaiser Family Foundation (January 1999). *Summary of Findings: Privatization of Public Hospitals. #1450;* Alexander, A. & Fennell, M. (1986). *Journal of Health and Social Behavior,* 27(1) 14-77.

Community Hospital Status

Although community hospitals currently represent 82 percent of Florida's hospitals, nationwide, their numbers show a steady decline in both urban and rural areas. In the U.S., there were 4,936 such hospitals in 2005, compared with 5,813 in 1981. During this same period, urban hospitals declined from 3,048 to 2,927 and rural hospitals from 2,765 to 2,009 (FHA, 2001; AHA Data Chart, 2004). In Florida, a larger percentage of nonprofit and public acute care hospitals are located in rural areas than for-profits (see Table 2 for distribution).

The U.S. Census Bureau (2006) classifies "urban" as all territory, population, and housing units located within an urbanized area or an urban cluster. These boundaries are distinguished by (urban area) population density with a population of at least 1,000 people per

square mile and (urban cluster) surrounding areas with at least 500 people per square mile. "Rural" consists of all territory, population, and housing units outside of these urban areas or clusters. Six of Florida's 67 counties are rural: Gilchrist, Jefferson, Lafayette, Levy, Liberty, and Walton. The remaining counties share a population base of both rural and urban distinctions (Florida Legislature, Economic and Demographic Research, 2007).

Table 2

2006 Snapshot of Florida's Acute Care Hospitals-Sector, Rural, and Urban Distribution

Sector	**Rural**	**Urban**
Not for Profit	16 (55.20%)	80 (40.80%)
Public	7 (24.10%)	19 (9.70%)
Investor-owned/for profit	6 (20.70%)	97 (49.50%)
TOTAL	**100.00 %**	**100.00%**

Source: Data Adapted from *Eye on the Market. Florida Hospital Association*, 2006.

These declines in community hospitals are largely influenced by the entrance of freestanding facilities, physician and specialty clinics, health maintenance organizations, and a number of other joint ventures, mergers, acquisitions, and network service providers. These facilities are now providing many of the services traditionally offered by community hospitals, thanks to the growth in outpatient surgeries and increase in freestanding ambulatory care surgery centers. The number of specialty hospitals tripled between January 1990 and March 2003, while the number of ambulatory surgery centers doubled between 1991 and 2001 (Shactman, 2005). More recently, these centers increased from 2,864 in 2000, to 5,197 in 2006 (AHA Trend Chartbook, 2004).

Advocates of both community and specialty hospitals offer compelling views about the significance of each in the health care industry. The specialty groups believe they can offer greater efficiency, higher quality and lower cost than general hospitals. Community hospitals respond that specialty groups limit their services to only the most profitable procedures and patients, leaving them to care for the uninsured and to provide less profitable services. From a

public policy perspective and in response to these differing views, the federal government has discontinued the building of new specialty hospitals in which physicians have an ownership and frozen reimbursement rates for ambulatory care centers until 2009 (Shactman, 2005).

At the same time, community hospitals have moved to change their service portfolio and survive a changing market by offering what are known as non-hospital services: home health care, skilled nursing facilities, long-term care, assisted living facilities, meals on wheels and hospice care (AHA, 2004). These strategies can be interpreted using the arguments advanced by institutional theorists that organizations will respond to their respective environments by seeking methods to ensure their survival. They resonate with the propositions advanced by the theoretical models of resource dependency, population ecology, and contingency theories (Baum & Oliver, 1991).

Ownership by Sector and Conversion

Hospital ownership is not always synonymous with the building of a new facility but also occurs through conversion of existing facilities from previous owners, mostly by for-profit entities. In examining the trends in hospital ownership and conversions, much of the research activity has been focused on costs, organizational structure, service comparisons, access to care and quality of care (e. g., Lee, 1971; Madison, 2004; Vladeck, 2006; Wheeler & Zuckerman, 1984). To an extent, this misses a major public concern: a significant decline in the number of public (government owned) hospitals, which are generally charged with providing care for the medically needy, uninsured, under-insured and with being more responsive to the unique needs of a community. They are often referred to as "safety nets' and are generally in worse financial condition than other ownership types (NAPH, 2004; Fishman, 1997; Vladeck, 2006)

Hospital ownership types, and conversion trends are particularly relevant to the field of public administration and public policy for several reasons: (1) a historical mission of hospitals – charitable entities to provide health care to needy populations – is key toward health policy; (2) the lingering question of whether government regulating policy is necessary to address the spiraling cost of health care or if the market forces provide a better alternative; (3) policy issues surrounding access to care for the poor, underinsured and uninsured; (4) competitive policy implementing antitrust laws; (5) performance accountability and quality of care; and (6) policy regarding social equity consequences. Since Florida has a large number of uninsured individuals, the types of hospital ownership and where they choose to locate, may have

significant public policy implications. Public hospitals have served as a safety net for the poor and uninsured and typically have shown a significant commitment to uncompensated care. This concern often diminishes with ownership conversion (Fishman, 1997; Needleman, Cholett, & Lamphere, 1997; Collins, Gray, & Hadley, 2001; NAPH, 2004).

These are issues that increase concern among policymakers about the potential effect on health care access and costs in communities. Public hospitals pursue conversion opportunities to achieve both short and long term financial stability. They also respond to decreased public subsidies and the reduction in Medicare and Medicaid reimbursement rates. Between 1985 and 1995, the number of American public hospitals declined from 1607 to 1387, or 14 percent (Kaiser, Family Foundation, 1999). During this same period, 293 public hospitals converted to private ownership or management, and 165 closed; an additional 20 formerly- public hospitals closed after converting to non-public status. A small number of public hospitals that converted to non-public status converted back to public status in subsequent years. In sum, for every 100 public hospital conversions, one closes and two convert to private ownership or management annually (Kaiser Family Foundation, 1999, p. 5).

Public hospitals have been found to be more likely to convert than either private non-profit or for-profit hospitals. Between 1990 and 1993, public hospitals accounted for almost 32 percent of all conversions with three percent changing control. Some findings suggest that the intent behind converting public hospitals was to relieve them of civil service and government procurement rules. However, the most important reason is generally viewed as the desire of local governments and communities to reduce tax support. Three-quarters of public hospitals that converted to nonprofit status did so between 1980 and 1990. The role of public hospitals has been much greater in providing care for the uninsured and those publicly insured than either the nonprofit or for-profit hospitals (Needleman, et al., 1997; Collins, Gray & Hadley, 2001). Consequently, these trends raise significant public policy issues.

In the U.S., private, nonprofits, the second largest category after public hospitals, have also been converted at significant rates. In 1995, nearly sixty nonprofit hospitals converted to for-profit status, double the number in 1994. A cross sectional study found that nonprofit hospitals provided significantly more uncompensated care and other community benefits than did their for-profit counterparts (Gray, 1991; Claxton, Feder, Shactman, & Altman, 1997).

Private for-profit conversions represent a relatively smaller percentage of conversions. The majority of these changes shifted to nonprofit control. Between 1990 and 1993, 25 percent of these conversions became publicly controlled. This suggests an increase in community concern about the commitment of for-profit providers to maintaining long-term community access to health care as well as to the decision to maintain local influence on hospital policy (Claxton, et al., 1997).

Nationally, hospital conversions were concentrated in a limited number of states. More than half of all conversions, 55%, occurred in five states – Alabama, California, Georgia, Florida, and Texas. Between 1980 and 1990, Florida experienced 21 conversions, 14 from nonprofit and seven from the public sector hospitals, whereas between 1990-1993, there were only five conversions, four among the nonprofits and one from among public Florida hospitals (Needleman, et al. 1997).

Critics of private for-profit hospitals have raised concerns about access ("creaming" profitable patients), and cost (offering services that are more profitable), along with consistency and stability in providing health care to communities (Fishman, 1997). These concerns have been reinforced by the acceleration of hospital conversions across the country during the 1990s when Columbia/ Hospital Corporation of America (HCA) aggressively acquired hospitals through mergers and acquisitions. The speed of these conversions only slowed when they became the subject of a round of fraud investigations. Criminal prosecution of fraud in the health care sector increased three-fold between 1993 and 1997. Consequently, public policymakers in 19 states passed laws resulting from these actions to address the conversion of nonprofit hospitals (Freemont-Smith & Lerner, 2000; Defino, 1999).

The consequences of changing ownership may significantly impact Florida due to the size and distribution of its Medicare population. Silverman (1999) found that per capita Medicare spending and increases in spending rates are higher in geographic areas served by for-profit hospitals than nonprofit hospitals. Decisions to establish post-acute care facilities provide evidence that for-profit hospitals generate higher Medicare costs than do the other types of hospitals (Horwitz, 2004). There is also a significant difference between hospital ownership in Florida than in the nation at large. Florida has a smaller percentage of public hospitals, 11 percent, compared to the national rate at 26 percent. Florida also has more investor-owned hospitals, 43 percent. Nationally, 15 percent of hospitals are investor-owned (FHA, 2001).

Table 3 provides a ten-year overview of Florida's hospital ownership distribution. It shows that for the past ten years ownership distribution has remained fairly stable since the significant changes during the late 1970s and 1980s (AHCA, 2006).

Table 3

Florida's Acute Care Hospital Distribution by Ownership: 1995-2005

ACUTE CARE HOSPITALS REPORTING FINANCIAL DATA BY OWNERSHIP TYPE BY YEAR							
Year	Voluntary Not for Profit		Proprietary (for Profit)		Local Government		All Acute Care
	Number	Percent	Number	Percent	Number	Percent	Total
2005	73	40.78%	85	47.49%	21	11.73%	179
2004	74	41.34%	84	46.93%	21	11.73%	179
2003	73	41.01%	85	47.75%	20	11.24%	178
2002	69	39.88%	84	48.55%	20	11.56%	173
2001	73	41.48%	84	47.73%	19	10.80%	176
1999	75	42.61%	81	46.02%	20	11.36%	176
1998	76	41.76%	87	47.80%	19	10.44%	182
1997	78	42.62%	86	46.99%	19	10.38%	183
1996	77	41.40%	89	47.85%	20	10.75%	186
1995	81	42.63%	87	45.79%	22	11.58%	190

Source: Adapted format. *Florida Agency for Health Care Administration, 2006.*

These changes reflect the shifting circumstances of hospitals in the state. Changes in market share, patient mix, government regulations, and the health care delivery system have forced hospitals to compete with ambulatory surgery centers, specialty hospitals, and emerging health care practitioner demands. Hospitals also have to deal with other factors, some self-imposed, such as excess hospital capacity (declining inpatient utilization), duplication of competitive services, discounts, uncompensated services, unnecessary and inappropriate care, medical interventions that are not cost effective, expensive technologies, and overall rising health care costs (McComb, 1992). Given these developments, the question is whether and, if so, how can community hospitals survive as an institution in a constant environment of cost containment measures imposed by the government – to say nothing of competing with other medical providers that may not share their missions and restrictions. How will local governments

respond to these challenges and what policy decisions will they make to ensure quality hospital services?

Purpose of the Research

The purpose of this research is three-fold: (1) to specify the factors that may predict service delivery choices as a function of ownership and location; (2) to examine differences in operational performance of private nonprofit and private for-profit hospitals; and (3) to propose an answer to the question - why local governments choose to contract-manage their hospital operation.

In the health care system, local government has four organizational options for delivering hospital services: internal (self production) or external (private nonprofit, for-profit or outsourcing to a different governmental body) (Ferris & Graddy, 1994). The option that is sparingly addressed in the research is known as contract-management. This option is defined as a public-private partnership and a form of outsourcing to a private organization. It also may be a special type of multi-hospital arrangement (AHA, 2006). In an environment where policymakers must be concerned with cost, this option has drawn interest in several jurisdictions.

To answer the research questions in this study, I used a mixed-method research approach. This two-phase study was done by conducting a quantitative study that examined the relationships among select community characteristics and hospital ownership, and compared operational performance of private nonprofit and for-profit ownership types. The qualitative component is applied to propose an answer the question, "Why do some local governments choose to contract-manage their hospital operation?" This part will be accomplished by conducting structured in-depth interviews with selected subjects.

Since hospitals are both economic and social institutions, they are expected to balance the objectives of both systems with respect to transaction cost and institutional theories that are applied to generate testable hypotheses. Analysis of transaction costs is one way to examine both internal and external delivery of services. It provides a rationale as to why an organization may choose to purchase services rather than produce them internally. Transaction cost theory is concerned with the uncertainties and risks of doing business in an unstable environment. By focusing on transaction costs, organizational study shifts its attention from an exclusive concern for technical production to governance structure (Coase, 1937; Williamson, 1981).

Institutional theory seeks to explain variation among organizations during their early formation, and subsequently, their homogeneity once they become mature (DiMaggio & Powell, 1983). These latter scholars argue that organizations experience pressure to conform to their institutional environments as a result of the demands of political, occupational or professional constituencies and mimic pressures from entities with which they compare themselves. Also, institutional theory elucidates our understanding of public-private partnerships, privatization and contracting, and describes networks and linkages between public and private jurisdictions.

These theoretical perspectives provide the framework within which the three purposes of the research will be examined.

Research Questions

Given the statement of the problem and the purpose of the study, the following questions have been formulated**.**

1. What are the relationships of five select community characteristics with hospital ownership type?
2. Does operational performance for private nonprofit differ from private for-profit ownership type?
3. Why do some local governments contract-manage their hospital operation?

Significance of the Study

The research aims to address several issues raised in the reviewed literature. Stein (1990) posits that while the general rationale for external contracting assumes that this alternative is more efficient than governmental service production and delivery, the consensus is that the experiences with service contracting suggests the collective influence of multiple factors. This research hopes to contribute to finding a clearer answer to this question with particular emphasis on health care delivery.

Existing studies on government outsourcing are more likely to focus on refuse collection, transportation, fire services, and other public services that are more visible and better understood by the public than health services (e.g., Abraham & Taylor, 1996; Brown & Potoski, 2003; Hirsch & Osborne, 2000). Findings by Ferris and Graddy (1994) suggest that predicting production choices (internal and external) for human services programs, including the management/operation of hospitals, is more difficult. This is due to the lack of precise measures of service quality and the possibility of eliminating local control and interruption of service continuity to constituents. There is limited research (e.g. Ferris & Graddy, 1987; Brown &

Potoski, 2003; Wheeler & Zuckerman, 1984) that uses transaction cost and institutional theories to examine the service delivery choices for hospitals by focusing on ownership types.

Because of the complex nature and structure of hospitals and their service role in the community, a contrasting view in terms of the health sector delivery services will be offered as a supplement to the traditional public services that lend themselves to more quantifiable and measurable outcomes. Numerous studies (e.g. Brown & Potoski, 2003; Clingermayer & Feiock, 1997; Feiock, 2001; Ferris & Graddy, 1986, 1987, 1988, 1994; Siegel, 1999), used to predict service delivery alternatives have made use of surveys generated by the International City/County Management Association (ICCMA). These studies requested information on a broad range of services (Brown & Potoski, 2003). Other studies used survey data completed in 1982, 1988, and 1997. This research provides a current assessment of this rapidly changing policy environment.

Furthermore, most research is concerned with national or regional developments. Research that limits findings to national comparisons or to specific states may mask concerns within a state such as Florida because of its large number of low-populated counties that have district institutional arrangements. This research has provided the opportunity to learn more about the contract-management alternative, which is more likely to be found in smaller communities (Florida Legislature, Economic and Demographic Research, 2007). Also, survey data from the ICCMA indicates that three-fourths of the responses are provided by city officials. This suggests a gap in information since county governments are more likely to be accountable to constituents for hospital services in Florida. Southern states are underrepresented in the survey data (Greene, 2002). By limiting this research to hospitals, a better understanding of the challenges they face and often conflicting objectives as economic and social organizations, can be recognized.

The Florida Focus

Florida was selected as the subject of this research because it offers a venue in which a number of the most pressing issues bearing on health policy are prominent: (1) its high growth rate that forces accommodation to a rapidly changing health delivery system, (2) its large percentage of the population that is elderly (over 65 years of age), with a significant increase in Floridians who are 85 years and older, places unusual demands on health care - this age group requires the majority of health care expenditures due to an overall decline in physical condition

and the increases in prescription drug use, (3) its increasing number of non-citizens, which strains the demands on the health care system, (4) its uninsured population that is larger than the national average, which also strains hospital finances, and (5) its health system has complexities compounded by federally mandated changes in Medicaid and Medicare programs that provide more than half of the revenue earnings for hospitals in Florida (Florida Legislature, Economic & Demographic Research, 2007; Kaiser Family Foundation (KFF), 2005; Florida Hospital Association (FHA), 2001).

Demographics

Florida's growth rate has slowed, based on the 2005 census data, but it remains one of the fastest-growing states in the U.S. The state experienced a 23.5 percent population increase in the past decade, whereas the U.S. population grew only 13.2 percent during the same period. Florida is expected to become home to 19,920,348 people by April 2010. It is currently the fourth largest state (18 + million) after California (36.1 million), Texas (22.9 million), and New York (19.3 million) (Florida Legislature, Economic and Demographic Research, March 2007). This level of growth in population is largely due to net migration which accounted for 88.7 percent. Between April 2000 and 2005, the U.S. Census Bureau estimates that 34 percent of the increase in Florida's population is due to international migration (U.S. Bureau of the Census, 2005). This level of growth calls for continuous focus on the health care demands in the state's health care delivery system.

Aging Population

The aging of Florida's population is significant in terms of health care. The growth of Floridians aged 65 and older increased by 70 percent between 1970 and 1980; by 39.6 percent between 1980 and 1990; and by 19.2 percent between 1990 and 2000. This segment of the population is expected to grow by an additional 24.5 percent by 2010. Those aged 85 and older make up one of the fastest-growing groups. Their numbers increased by 75.1 percent in the 1980s and 61.2 percent in the 1990s. This pattern represents more than twice the growth rate for the state and is projected to increase an additional 61.9 percent by 2010. In sum, Florida has the largest population 65 years of age and older in the U.S. (KFF, 2005-2006; US. Census Bureau, 2004-2005). This group experiences higher incidence of chronic diseases and is hospitalized more often than all of the other age groups (Commonwealth Fund, 2006).

Race and Ethnicity

The state's population has become increasingly nonwhite. From 1990-2000, Hispanic residents increased by 70.4 percent. It is projected that this group will constitute 19.8 percent of Florida's total population by 2010. Non-citizens or undocumented immigrants make up 11 percent of the state's population. Florida ranks second after California in the percentage of non-citizens. It is tied with four other states (Arizona, New Jersey, Nevada, and Texas) at 11 percent (Florida Legislature, Economic and Demographic Research, 2007; KFF, 2006). Such a population profile provides a continuing challenge to the health care delivery system.

Uninsured

The largest racial/ethnicity component of the uninsured people in the U.S. and Florida is Hispanics. As these numbers increase, funding for health care costs become increasingly challenging, particularly for hospitals where emergency rooms have become the primary source of their health care. Health disparity rates are more pervasive among Blacks, Hispanics, low-income and uninsured patients than white, high-income and insured patients. These groups are less likely to receive recommended care and are more likely to be admitted to a hospital for preventable conditions (Commonwealth Fund, 2006).

Florida ranks number three after Texas and New Mexico with the highest uninsured rate at 20.3 percent. One in five or 3.6 million Floridians were uninsured in 2006 (DeNavas-Walt, Proctor, & Smith, 2007). Anthony Escobio, director of patient financial services at Tampa General Hospital, told the *St Petersburg Times* that his institution had experienced a 39 percent increase in uninsured patients between 2004 and 2006. The St Petersburg Free Clinic indicated that there had been a steady increase of patients who had no other options for health care (Huntley, & Nohlgren, 2007).

Income Level

Blended with these health care dynamics just mentioned and further complicating access to care is poverty. Florida has a higher percentage of people at or below the poverty line than does the U.S. as a whole, (ranking, 37th among all states). Its median income level is $42,079, compared with the U.S. average of $46,037 in 2003-2005 (KFF statehealthfacts.org, 2005; US. Census Bureau, 2006).

Florida has a two-tiered health care system (private/public) which is challenged by an increasing number of uninsured individuals. Approximately 60 percent of its poor citizens are not covered by Medicaid and nearly half of Florida's minority population has no health insurance at all (Needleman, Lamphere, Cholett, 1999; Klein, 2000).

Table 4 highlights Florida's population by race/ethnicity, poverty and uninsured rates in comparison with the nation. Florida ranks third after Texas and New Mexico in the uninsured category at 20 percent; the U.S. rate is 15.8 percent (KFF, 2006; De-Navas-Walt, et al., 2007).

Table 4

Florida Population Comparisons: Ethnicity/Race and Uninsured Percentages
Florida - 2004-2005/U.S. - 2005

Race Ethnicity	**Population Percentage**		**Poverty Rates**		**Uninsured** (non elderly)	
	Florida	US	**Florida**	US	**Florida**	US
White	**62**	67	**11**	12	**45**	47
Black	**15**	12	**32**	33	**18**	15
Hispanic	**20**	15	**23**	29	**33**	31
Other	**3**	6	**nsd***	nsd*	**3**	7
Non citizen	**11**	7				

Sources: Data Adapted from Kaiser Family Foundation, Urban Institute and Kaiser Commission on Medicaid and the Uninsured Statehealthfactas.org (Uninsured rates reflect updated changes released by U.S. Census Bureau released in March 2007) *denotes not sufficient data

Health Insurance Coverage

For the most part, hospitals receive their revenue from the federal government, private pay insurance, patients' out-of-pocket expenditures, and state and local government reimbursements. Medicare and private pay are the major components, while Medicaid and other sources are less predictable (AHA, 2006). In 2005, Florida ranked second in the country, after California in the number of Medicare beneficiaries, 3,008,193 (16 percent of the population). This group also represents the largest category of hospital patients (KFF StateHealth facts.org 2005). Although Medicare reimbursements have been reduced, they are still seen as a steady source of income for hospitals.

In sharp contrast, Medicaid reimbursement rates do not cover the full cost of health care, forcing hospitals to cover ever-increasing uncompensated care. Florida ranked fourth in Medicaid enrollment in 2004, after California, New York, and Texas. It boasts an enrollment of 2,867,200 individuals or 11 percent of the population (KFF statehealthfacts.org, 2005). Florida continues to experiment with Medicaid reform, attempting to reduce cost through a market model now being tested in select counties. The remaining coverage availability among Floridians is 47 percent via employers, five percent individual and two percent other. By the same token, Florida's health care spending ranked fourth behind California, New York and Texas in 2004, at $95,136 million. Its uninsured rate rose to 20 percent in 2005 (KFF statehealthfacts.org 2005).

Florida's hospitals face unique challenges because of the state's demographic profile, poverty rate and uninsured residents which exceed the U.S. average. These factors are further complicated by the overall health care dynamics and rising cost of health care nationally.

Florida represents a plethora of health care challenges. The findings of this study are expected to provide a broader perspective that will assist other states both large and small to effectively address their unique health care policy issues. Nationally, Florida is often viewed as a state that represents the collective ideology of the country. It has the fourth largest number of electoral votes. These findings should be helpful to health care policymakers and public administrators at all levels of governments.

Overview of the Remaining Chapters

The second chapter presents the theoretical framework of the study. It focuses primarily on transaction cost and institutional theories. It discusses the concept of governance and further examines the role of recent reforms that influence production choices. The third chapter describes the research design; it covers the research methodology, procedures and data collection technique and sources, sampling strategy and data analysis techniques. Chapter four presents results of hypotheses testing and findings from the qualitative study. The fifth chapter offers a discussion of the findings, theoretical and policy implications, and conclusion.

CHAPTER 2
THEORETICAL FRAMEWORK

Two theoretical perspectives – transaction cost and institutional theory have been used to form testable hypotheses for this research. Hospitals are both economic and social institutions and survive based on their success in balancing these different approaches to their activities. This chapter discusses: (1) the argument about the role of government in the health delivery systems (regulation, Certificate of Need, financial viability), 2) the concepts and propositions that comprise the traditional components of the transaction cost theory, (3) role of hospitals in the community and how they are understood by institutional theory, (5) the role of multihospital systems, and (6) a summary of hypotheses.

Overview

One of the foremost debates in the realm of health care economics and the U. S. health care market system emanates from the work of Nobel Laureate Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care." Two years before the passage of Medicare and Medicaid, Arrow (1963) identified key market failures in health care, specifically, "the existence of uncertainty in the incidence of disease and in the efficacy of treatment." His presumption was that health care markets could not reach a competitive equilibrium without certain nonmarket interventions. Even though many of Arrow's peers have investigated these issues at length, the debate and suggestions about alternative solutions to control health costs have remained controversial and unresolved.

The theoretical framework used in the discussion of health care cost and service delivery choices is influenced largely by whether government intervention is necessary to address flaws in the health care market or whether an open competitive market strategy is adequate. Those opposed to government intervention believe that the distribution of health care is based on "the egalitarian principle of need," an approach that fails to allocate health care resources efficiently. This premise has been advanced by the Libertarians believing that the market is the most efficient mechanism for allocating resources. Reducing the role of government, which advocates health care for all, would make it possible for the market to separate allocation and distributional policies (Berki, 1983).

These debates are not new; they date back to the early nineteenth century when the U.S. economic institutions began to emerge. Alexander Hamilton argued at that time that government was necessary to guarantee property rights and enforce contracts, while the Jeffersonians argued against government intervention in favor of self-reliance (Sellers, 1991). These linkages between economic and political theory continue to be a part of the debate about the appropriate regulatory oversight of the health care delivery systems.

The American health care system has long been a mix of public, private, nonprofit, and for-profit approaches. However, over the last several decades, the impact of private organizations has increased significantly, particularly among for-profit providers. This may be attributed to the broader efforts to reduce the role of government and to outsource services to private organizations (Scott, Mendell, & Caronna, 2000). Superseding the debates just mentioned are the realities of hospital survivorship regardless of ownership type. Three key issues that need to be addressed are regulation, Certificate of Need, and financial viability.

Regulation of Hospitals

In Florida, hospitals are monitored and reviewed by some 28 federal agencies, 12 state agencies, and multiple city, county and volunteer entities, which together regulate such factors as accreditation and quality compliance standards, food service, fire safety, building codes, and incinerators (Florida Hospital Association, 2001). Rising health care costs are linked to some of these regulations.

According to Sloan (1982), regulatory approaches fall within three categories: (1) rate and revenue regulation, which dictates private and public pay to hospitals; (2) facility and service regulation, which controls the entry of hospitals in the market, investment in beds, major equipments and expansion of special services; and (3) utilization review, which focuses on quantity and quality of care. Administration of and compliance with regulation among these diverse requirements are seen as costly and problematic, particularly in terms of protecting the community's health and safety. Furthermore, government regulation is found to be more pervasive in the hospital system than in other, traditionally regulated industries. As a function of their basic social mission, hospitals are linked to government and have been since their development in the United States (Drake, 1980).

Bernd (2003, pp.1-3), in a presentation at the National Health Policy Conference, stated that the burden of increased processes and regulations of hospitals must be further examined in

terms of patients versus paperwork. The larger question that looms and has been problematic for many years, he said, is whether health care is "a competitive commodity or… a public good." He further states that hospitals must "navigate thousands and thousands of pages of rules that govern Medicare and Medicaid programs. In fact, Medicare and Medicaid rules and instructions are contained in more than 130,000 pages. That is three times the size of the Internal Revenue Service Code and its accompanying regulations.

Enactment of the Medicare and Medicaid programs significantly altered the hospital and health care markets. In addition to increasing the role of the federal government with hospitals and state governments, these programs resulted in substantially higher expenditure rates by hospitals. According to Drake (1980), increased costs were perpetuated by the federal government because they reflected higher rates of institutional utilization for a significant number of newly created beneficiaries. In addition to his recognition of the need for economic regulation, Drake also argued that these regulations must be appropriate for meeting the challenges and opportunities of specific market places. "Such policies, programs, and regulations must be formulated with the realization that change in health care is ultimately a local phenomenon. Not recognizing this reality will continue to create unbearable (sic) high regulatory costs" (p. 59).

Certificate of Need (CON) Program

Florida's Certificate of Need program began in 1973 as a federal health planning system initiative. Its original intent was to regulate the entrance of hospitals, nursing homes, and hospices into the Florida health care market and to prevent unnecessary duplication of services in a specific region or community.

In 2004, Florida passed the Certificate of Need (CON) Reform Bill. The purpose of this legislation was to improve the process and reduce the lengthy litigation that had created delays in access to services. It permitted the addition of acute beds in high growth areas without CON review. Escambia County and counties defined as "low growth areas" were excluded from this prescription. Requests for new or replacement facilities must still receive CON review and approval with one exception: rural counties are allowed to construct replacement facilities without CON review in accordance with Section 395.6025, Florida Statutes. This exemption is restricted to nonprofit hospitals located in a county with 15,000 to 18,000 residents. Twice a

year, the CON program projects needs for new hospitals, looking at service utilization rates and predicted population growth (AHA, 2002; CON Reform Act, 2004)

Financial Viability

Factors such as level of regulation, population demographics, uninsured status, and poverty rates, and health care workforce shortages affect hospitals' viability and ultimate capacity to survive. These factors have significantly influenced the operating margins for Florida's acute care hospitals. During the years 1998-2004, with one exception in 2002, Florida's hospital operating margins were lower than the U.S. average. Hospital operating margins have experienced a steady decline. In 2004 alone, these operating margins declined by 53 percent. Net revenues barely exceeded expenses associated with patient care (FHA, 2006).

New Public Management (NPM)

The regulatory and financial factors discussed in the previous two sections affect both government owned and private hospitals. Unfortunately their linkage to the concepts deployed in the New Public Management (NPM) is tenuous at best because of its emphasis on competition in the private sector as a method to solve many of the financial and accountability challenges facing public managers. Contracting out, decentralization, and the adoption of private sector management practices draw heavily on a privatization model (Hood, 1990), complicating any use where regulation play a large role. This approach in turn relies on elements of public choice, agency, transaction costs, and property rights theory. All have their own unique features. Ultimately, of course, governance must be factored in as a component of any framework used to understand hospitals. An overview of these relevant theories follows.

Public Choice Theory

Advocates of public choice believe that the role of government should be limited; that production and delivery of services should be performed separately and that the most desirable method for implementing economic and social activities is through networks of private, for-profit arrangements. Public sector bureaucrats are viewed as self-interested, motivated by salary, power, and public reputation, while politicians and interest groups are influenced by rent seeking, power and perks respectively (Batley & Larbi, 2004; Self, 1994). Downs (1967, p.257) argues that "we can intuitively postulate that the total amount of waste and inefficiency in society is likely to rise as bureaucracy becomes more prominent." In sum, public choice

theorists advocate reliance on the private market that is projected to increase competition and improve efficiency.

Principal Agent Theory

Bearing a similarity to transaction cost theory, principal agent theory had its beginnings in the 1960s and 1970s, when economists Arrow and Williamson used it as a framework to examine risk sharing among individuals and groups. Since principals who deal with agents encounter both moral hazard and adverse relationships, the goal in these transactions is to resolve problems that may occur when the objectives of the parties are contradictory. Therefore, the principal-agent relationship should reflect efficient organization and appropriate risk bearing costs. The Principal-Agent Theory emphasizes the self-interest of all stakeholders in both the public and private sectors (Batley & Larbi, 2004; Eisenhardt, 1989).

Property Rights Theory

Property rights theory examines property rights as an economic concept (Milgrom & Roberts, 1992). According to Grossman and Hart, 1986, Hart, 1995, Hart, Shlfeifer and Vishny, 1997, economists examine ownership debates to better understand mixed ownership markets, particularly in the health services sector. Private for-profit providers establish well-defined control rights. The incentive to invest in innovations is strong, which may result in too much focus on cost control and not enough on quality. On the other hand, government-owned providers may not have the control rights to make innovative changes. The property rights model suggest that private owners achieve lower costs but that quality may be higher or lower ((Shen, Eggleston, Lau, & Schmid, 2007).

Theoretical advances that examine the changing role of the state have contributed to recent perspectives on the organization of service delivery. Organizational reforms in health care are often grouped under the heading of "economics of organizations" which emphasize elements of transaction cost, principal-agent, property rights and public choice theories (Perker & Harding, 2003). Each plays a role in advancing our understanding of production choices.

The research presented here is intended to focus specifically on transaction cost and institutional theories because these are complementary and relevant in reflecting a broader framework and understanding of government production choices. Granovetter (1985) posits that transaction cost theory provides an undersocialized perspective on organizational phenomena while institutional theory offers an oversocialized viewpoint. Economic approaches to the study

of organization generally focus on efficiency, whereas institutional theorists place emphasis on legitimization processes, regardless of their efficiency implications (Oliver, 1992; Williamson, 1981).

Transaction Cost Theory (TCT)

Economists John Commons and Ronald Coase introduced the concept of transaction cost theory. Commons (1934) posited that transactions are the central unit of analysis in transaction cost theory. Coase as a young student at the London School of Economics first posed the question of "Why do organizations exist?" A response to this question was published in his 1937 article, *The Nature of the Firm*. The reason that organizations exist is that sometimes the cost of managing economic exchanges across markets is greater than the cost of managing economic exchanges within the boundaries of an organization. The enduring contribution of Coases's article was that it placed transaction cost at the center of the analysis as to why firms exist and suggested that markets and organizations are alternatives for managing the same transactions (Barney & Hesterly, 1996).

Theorists later addressed perceived deficiencies in Coase's model -- which transactions would be left to the market versus which would remain within the firm -- by developing a more complete model of the cost to manage economic exchanges. This work became known as transaction cost theory.

Williamson (1981, p. 573), revitalized the theory in the 1970s, and defined "transaction cost economics as an interdisciplinary approach to the study of organizations that joins economics, organization theory, and aspects of contract law." He argued that organizations not only develop to reduce transaction costs but that organizational forms may be different based on the type of exchanges they expect to govern. Given the significant number of research publications with their broad array of findings, transaction cost theory has become increasingly influential in explaining the governance of economic activity (e.g. Williamson, 1973, 1979, 1981, 1985, 1991; Perrow, 1981; Richman & Macher, 2006)

Complimentary to the long held views pioneered by Williamson is the more recent concept advanced by Lajili and Mahoney (2006). These investigators argue that while transaction cost economics principles are durable, electronic integration using information technology stimulates lower transaction costs for markets over hierarchies. It results in more efficient management strategies and increases advantages in contracting and outsourcing not

previously available. According to Lijili and Mohoney, electronic information exchange is an emerging form of business organization that has received little if any attention in the academic literature.

Transaction cost theory (TCT) is underpinned by two main behavioral assumptions: First, individuals are limited in their ability to predict the future and are therefore subject to bounded rationality. Second, actors are prone to opportunistic behavior due to difficulty in reaching common agreement through contracting (Simon, 1945; Williamson, 1981). These two assumptions present exchange hazards for the transacting parties. Exchange hazards occur when one party to the transaction is in a position to take advantage of a partner with the intent to achieve a more favorable rent distribution. Rents are returns deemed to be in excess of the minimum necessary to attract resources to a given activity (Perker & Harding, 2003). Therefore, two approaches may be taken to address these hazards, resort to administrative controls or hierarchies or contract law that protects each parties' long term interest (Crook, 2005; Richman & Macher, 2006; Williamson, 1991).

There are certain cognitive limitations economic actors have to face, along with their self-interest, and unpredictable changes in the environment. As a result, the most definitive and well-crafted contract may not be complete. Consequently, TCT scholars argue that internal organizations are to be relied upon when exchange hazards are too complicated to contract. Integrating activities within a single organization offers a better response and resolution for unforeseen circumstances and problems. Although "vertical organizations are characterized by some theorists as weak principally because of the substitution for low-powered incentives of profit and loss, transaction cost sees vertical integration as the governance of last resort" (Perker & Harding, 2003, p. 32).

Williamson (1985) coined the phrase "high-powered incentives and low-powered incentives" to make distinctions between organizations when neither receives much in benefits by exploiting the other. He does not clearly delineate these distinctions; his argument is simply that one is less powerful than the other. However, Frant (1996) argues that adjustments must be made to TCT to better explain its application to the public sector. High-powered incentives are linked to market transactions where efficiency gains directly benefit the transacting parties. On the other hand, low-powered incentives in hierarchies are not extended to specific individuals or groups, except perhaps for occasional pay increases or promotions.

Hospital ownership and organizational structure may be reflective of these incentive distinctions. Sloan, et al. (2001) posited that nonprofit hospitals may earn profits; however, they are precluded from distributing these profits to those in control of the firm. A second organizational difference between nonprofit and for-profit hospitals has to do with the relationships among physicians. The incentive systems are different for for-profit hospitals, since in some cases, the hospital may be owned by the physicians. According to Sloan, et al. (2001, p. 4), some hospital corporations have extended to some local doctors an explicit share of residual hospital income.

Cost savings are a higher priority and act to encourage greater incentives for direct benefits when services are delivered efficiently. Consequently, market economics is considered advantageous over planned economics where incentives are low-powered. However, Williamson (1985) emphasized that there are disadvantages to powerful incentives as they may not only encourage efficiency but also dishonesty.

Frant (1996, pp. 370-372) posits that placing public organizations in the same category designed for private organizations blurs the understanding of the application of high-powered and low-powered incentives. He suggests that public organizations should be viewed as having both high-powered and low-powered incentives since politics is the basic institution for allocating resources. Accordingly, politicians' desire for reelection is the public's version of high-powered incentives. In an effort to respond to opportunism created by high-powered incentives, the private sector "demarketize" and the public sector "depoliticize."

Since these strategies just mentioned affect efficiency costs, one alternative for the public sector is to create independent authorities, special districts (hospitals are but one example), or boards with limited functions. Hansmann (1980) proposes that we view these arrangements as non-profits of the public sector. He argues that nonprofits are valuable alternatives when it is difficult to monitor quality.

This is particularly true in the case of hospitals where for-profit providers have information advantage over cost and quality. The argument is further supported by Feiock's (2001) findings that when services are difficult to measure, particularly in a heterogeneous community, services are delegated to nonprofit organizations.

On the other hand, the private sector creates nonprofit organizations with different organizational characteristics than do for-profit firms to minimize risk and opportunism. These approaches substitute low-powered for high-powered incentives.

Moe (1987) presented an argument somewhat similar to Frant's (1996) that the concept of transaction costs and its application tend to treat the public and private sectors alike by subjecting them to the same set of economic incentives and disincentives. He emphasized that the most important characteristic that set them apart is sovereignty. It is important to keep in mind that public administration lies mostly in public law, not in economics or the social sciences.

Transactions are governed by three organizational forms: markets, hierarchies, and hybrids. In TCT, markets are described as transactions between buyers and sellers from different firms. In hierarchies, transactions occur within the same firm. Hybrids assume the characteristics of both markets and hierarchies. Their mode of governance may include alliances, franchises, or joint ventures (Williamson, 1985; 1991). Since each of these modes is unique in its ability to reduce transaction costs and adapt to environmental changes, Williamson (1981) argued that pairing transactions with the appropriate governance mode would lead to improved performance through lower costs and enhanced adaptability.

Williamson (1979) identified three key transaction attributes: (1) asset specificity, the degree of investment required or the transferability of assets to support a given transaction; (2) uncertainty, unpredictability or inability to measure outcomes; and (3) frequency, how often a transaction occurs. These attributes influence whether a transaction will be governed by one of these three organizational forms; "market (buy decision), hierarchy/firm (make decision), or hybrid (joint venture)" (Crook, 2005, p.2) As asset specificity and uncertainty increase, exchange hazards are created resulting in higher transaction costs. "TCT predicts that asset specificity and uncertainty are positively related to hierarchical governance (Crook, 2005; Williamson, 1985).

A governmental decision to purchase from external sources or to produce within is largely influenced by these attributes. Since private firms are viewed as having greater flexibility to adjust their governance structure to market changes than are public organizations, the private arrangements are thought to result in more efficient practices (Perker & Harding, 2003).

The hospital industry, somewhat unique in the organizational environment, exists because hospitals compete as both public and private firms. This suggests that public hospitals may be

less sensitive to efficiency measures than are their private counterparts. Therefore, public institutions respond differently to asset-specificity and uncertainty in make or buy decisions (Coles & Hesterly, 1998; Scott, 1992).

Asset specificity is the most important (TCT) property of the three (asset-specificity, uncertainty, frequency). It is the degree of investment required to support or produce a service (Williamson, 1985). Generally, when service is highly specialized and calls for extensive upfront costs, a monopoly is created resulting in government's decision to internalize. However, in the case of hospitals where a high level of asset specificity is necessary to secure investments, potentially beyond the scope of the government's resources, they are likely to seek external suppliers. As asset specificity increases, governments prefer complete contracting rather than joint and/or internal production (Brown & Potoski, 2003). Because hospital services require a long-term capital investment, it is more difficult for governments to change their commitment over a short time frame. Substantial changes in response to fiscal pressure may not be known for several years (Ferris & Graddy, 1988).

Uncertainty, the second attribute of transaction cost, is unpredictability or inability to measure outcomes. It can take two forms: the first implies that the rate of occurrence of uncertain events is high for a transaction; the second concerns the magnitude of these events rather than the numbers. Uncertainty seems to increase the cost of market governance to a level higher than the cost of internal governance (Williamson, 1985; 1991). Uncertainty not only takes into account service measurability but the difficulty in monitoring the activities necessary to deliver the services (Brown & Potoski, 2003). Since product production is a more precise activity, it is easier to monitor than in-service quality which may significantly increase costs. Health care services are considered soft services as they are difficult to measure and monitor. Under these circumstances, government is exposed to risk of vendor performance or has to deal with negligence (Prager, 1994). Service disruption of health care can lead to substantial down side consequences. Under these circumstances, governments are more likely to maintain service production in-house (Brown & Potoski, 2003).

However, governments may also rely on a joint contracting arrangement (contract-management), other governments (special districts), or establish a relationship with a more trusting partner to mitigate risks. In this case, nonprofits are viewed as more trustworthy partners (Brown & Potoski, 2003; Feiock, 2001).

Coles and Hesterly (1998, p. 384), argued that integrating asset specificity with uncertainty, rather than isolating them, is a more useful approach when evaluating a make or buy decision. Their findings suggest that a more uncertain environment interacting with asset specificity drives an organization toward integration. Much of the literature reviewed in this area focuses on physical assets. The Coles-Hesterly model includes dimensions of both physical and human assets that play crucial roles in the production process, particularly in the case of hospital services. Human capital represents a significant cost of doing business in hospitals. Labor costs include salaries for physicians, nurses, lab technicians, pharmacists and many other health care professionals and support staff. In sum, the high cost of hospital services, fiscal pressure to cut costs, asset specificity, service measurability and the difficulty in contract monitoring are all predictors of how organizations make service delivery choices.

The third attribute of TCT influencing costs is frequency of transaction. Williamson (1985, p. 60), asserts that higher levels of frequency provide incentive for internal organization because "the cost of governance structures will be easier to recover for large transactions of recurring kind." Transaction frequency has not received the same level of attention in the literature as has asset specificity or uncertainty. The proposed advantage of internal organization in realizing scale economies related to frequency has not been confirmed through hypotheses. Several empirical studies failed to show a positive association between transactional frequency and organizational mode (Richman & Macher, 2006). Furthermore, frequency in this aspect may be less relevant to hospital operational management.

Because of the escalating cost of hospital care, it is no surprise that economics is critical and is one of the most frequent reasons given by local government officials in seeking alternative approaches to public service delivery. They choose to reduce costs through outsourcing and/or privatization. In examining a profile of alternative delivery service approaches, it was found that fiscal factors were the most important in determining choices to contract out services (Clingermayer & Feiock, 1997; Ferris & Graddy, 1986; 1987).

More specifically, 74 percent of respondents in a 1987 survey indicated that outsourcing was more advantageous than internal production (Greene, 2002). When similar questions were asked in a 1992 survey about why local governments were interested in privatization, 90 percent of the respondents indicated that they thought the reason was efforts to cut costs and 53 percent mentioned external fiscal pressures (Savas, 2000).

Health care services have generally been thought to be a significant responsibility of local government. Because hospital services are categorized as "soft services," they are more unique, more complex and less profitable activities for for-profit firms. Thus, health services are most likely to be contracted out to nonprofit entities. Their escalating costs and complexity have contributed to the decline in the number of public hospitals. Several hospitals have been sold to private companies or established as private nonprofit organizations. Another alternative to managing hospital operations is to form special hospital districts to run them. This approach may be attributed to public sector accountability and citizens' opposition (Greene, 2002).

Florida Hospital Authorities and Districts

During the early 1920s, Florida counties began to seek legislative authority to raise money through bond issues and through the passage of ad valorem taxes to establish county hospitals. Broward, Polk, and Levy counties were leaders in obtaining special legislative approval in 1923. These hospitals were created to provide free care for indigent county residents. For the most part, special legislation was not specifically enacted to create hospital districts. It simply sought to issue bonds to pay for the establishment of county hospitals. Later statutes contained language to the effect that their purpose was to establish county hospitals for the benefit of the district or for county residents. All hospitals that were created exclusively for the purpose of providing indigent care are now closed. Polk County Hospital was the last to shut down, on September 30, 1995. Near the end of the 1970s, counties began to dissolve these hospital districts. Confronted with increasing costs, competition, and difficulty in maintaining rural facilities, many hospitals were sold, or leased to be managed by corporations (Florida House Committee on Health, 1996).

Presently, there are 17 hospital districts and three authorities that actively manage hospital facilities in 13 counties. The majority is concentrated in Broward County. These districts have remained relatively unchanged for the past two decades with one exception. The North Florida Sumpter Hospital District was created in 2000 (AHCA, 2006). Several local governments have also turned over the operation of their hospitals to nonprofit organizations. Cost savings, though crucial, is not the only factor considered in predicting service delivery choices. Several notable scholars (Brooks, 2004; 1988; Brown & Potoski, 2003; Clingermayer & Feiock, 1997; Feiock, 2001; Ferris & Graddy, 1988; Siegel, 1999) have found that scale

economies, availability of suppliers or market competition were strong positive factors that favored contracting out health care services.

Notwithstanding these findings, the TCT model fails to capture many of the most significant political and social aspects of a community hospital. Hospitals stimulate economic growth and provide employment opportunities for local residents. Therefore, institutional factors and the value to and roles of citizens in them are also influential in the decision-making process.

Role of Hospitals in the Community

Hospitals contribute significantly to the community. They impact local economies in terms of employment, commercial services, outreach programs and uncompensated care. Hospital care remains the largest segment of health services, affecting national, state and local economies. In 2004, it represented about 15 percent of the Gross Domestic Product (GDP) of the country. Of the $1.8 trillion dollars, in national expenditures for health services and supplies, hospitals accounted for $571 billion of the total or 33 percent (National Health Expenditures, 2005).

Employment/Commercial Services

Hospitals are the second largest private employer in the country and in many communities, especially rural ones, the largest. In 2004, American hospitals paid approximately $249 billion in employee wages. Nationally, they provided roughly one out of every 10 jobs. During this same year, community hospitals employed almost five million people (AHA, 2004). Hospitals, which have needs for both higher- and lower-skilled jobs, employ across the workforce spectrum from physicians and nurses to cafeteria and laundry workers, increasing their economic impact. These numbers do not begin to reflect the multiplicative effect of salaries and their impact on businesses within a community. Hotels, florists, food and telephone services, electricity and other commercial entities all benefit from the presence of a hospital. During 2005, Florida's hospitals filled 265,913 full and part time jobs with payroll and benefits at $13,802 million (AHA, 2007). These multipliers of income are essentially statewidewide since hospitals are located in 58 of the 67 Florida counties (Bureau of Economic and Business Research, 2005; AHCA, 2005). This is also key to real estate development decisions in the growth of the state.

Community Outreach Services

Hospitals provide many extramural outreach services: health screenings, health fairs, support groups, information centers, and meals on wheels programs are a few examples (AHA, 2004). One of the most important roles of hospitals is their value in providing uncompensated care. To comply with the mandates of the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals offer emergency screening and treatment to those who need it regardless of their ability to pay (FHA, 2001). Since this requirement does not include funding, hospitals incur costs for services provided for which they are frequently uncompensated.

Uncompensated Care

Uncompensated care is a combination of charity care to various services provided to eligible patients, in which reimbursement is unexpected. It also includes the assumption of incurred debt for which payment was expected but was not received (FHA, 2001; AHA, 2002). The precise cost of all community hospital service is not specifically known, but some national estimates indicate that it may be as high as $80 to 95 billion yearly. An estimated $30 billion of this is uncompensated. This represents about 15 percent of the total economic activity of the $500 billion health care industry (Vladeck, 2006).

As reflected in Table 5, for each year during the period 1998-2004, Florida reported a higher percentage of uncompensated care than did hospitals nationwide.

Table 5

Florida's Hospitals: Uncompensated Care as a Percent of Total Cost 1998-2004

	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Florida	7.3%	7.4%	7.6%	7.5%	6.8%	7.3%	7.7%
US	6.0%	6.2%	6.0%	5.4%	5.5%	5.5%	5.6%

Source: Data Adapted from Florida Hospital Association, FHA Data Brief: *Financial Health of Florida Hospitals, 2004.*

Medicare traditionally subsidizes uncompensated care related to some non- reimbursable costs; however, the enactment of the Prospective Payment System (PPS) in 1983 and the

growing number of uninsured individuals make this alternative untenable in the long term. State trends of uncompensated care show that Florida and New Jersey provided the highest levels of uncompensated care in the U.S. in the late 1980s, when levels represented 11-12 percent of the total hospital charges. These rates began to decline in the 1990s as women and children gained coverage under Medicaid. Identifying these costs more precisely is complicated by the rising number of uninsured individuals, particularly in Florida, which has one of the highest uninsured rates in the country (Atkinson, Helms, & Needleman, 1997; Kaiser Family Foundation, 2005).

According to the Florida Hospital Association (2003), Florida's hospitals incurred more than $40 million in unpaid medical bills in one year from treating undocumented immigrants. The FHA concluded that this amount represented only a fraction of the annual costs of medical care for this group. Florida receives less than $2 million a year from the federal government to pay for undocumented immigrant care.

All of these services (community outreach, employment, and uncompensated care), highlight the significance of hospitals to society not just in terms of economics or costs as implied in the transaction cost theory. Hospitals are a deeply embedded component of the political and social fabric of the community. This feature of hospitals reinforces the applicability context of the institutional theory approach.

Scale economies, market competition, and the role of hospitals in the community are all significant in predicting service delivery choices (Ferris & Graddy, 1987). However, transaction cost theory would suggest that these factors are also influenced by the size and type of jurisdictional area. Heavily populated areas draw more service providers, which results in greater market competition while less densely populated areas may experience a limited number of external health care suppliers. For instance, smaller jurisdictions (those with fewer than 25,000 people) in metropolitan areas may seek contracts to achieve economies of scale that can most likely be gained through opportunities with nonprofits, private firms and other governments. Smaller jurisdictional units tend to have fewer resources such as medical technology equipment, human resources (physicians, nurses, and other health care workers), and other specialized treatment services than do their larger counterparts. On the other hand, smaller governments in non-metropolitan areas tend to produce their services internally because of an absence of competitive markets (Brown & Potoski, 2003; Ferris & Graddy, 1986; 1987).

As population increases in very large cities or in metropolitan areas, governments may choose to produce the majority of their services to take advantage of their existing economies of scale. Larger more urban jurisdictions in non-metropolitan areas may have greater availability of external producers and alternative suppliers and are thus more likely to outsource services (Ferris & Graddy, 1994:138, 1988; Brown & Potoski, 2003).

Research supports the principle that constituency demands play a role in production choices about how health care is provided. Opposition to higher taxes resulting in limits on taxing authority or demands for higher quality services are also indicators of constituent actions that impact production choices (Ferris & Graddy, 1994:138, 1986). Low-income communities may have concerns such as costs, specific service needs and the availability of suppliers. Wealthy jurisdictions may prefer outsourcing due to limitations mentioned above.

If there is consensus within a community over the constraints and need for care, it is more likely that negotiation for service needs will be less difficult. Costs increase in heterogeneous communities due to diverse preferences and difficulty in measuring expectations. Such communities may prefer nonprofits or reliable partners to provide health care services. Social demographics such as race, age, the uninsured and unemployment rates may also be factors in service delivery choices. This is particularly true in rural hospitals where the overall influence of such factors is likely larger but may also be the case in inner cities despite the greater range of alternatives (Feiock, 2001; Ferris & Graddy, 1987; Weisgrau, 1995).

Institutional Theory

Transaction Cost Theory (TCT) was designed to address and explain governance choices. As a result, TCT fails to adequately address production choices. One of the main deficiencies of TCT is its inability to account for the evolution of organizational structure as it responds to changes in the organizational environment. Therefore, it is important to examine the role of the institutional context to complement the theoretical framework of TCT and to integrate components of both theories to gain a better understanding of health care production choices.

Earlier theoretical models of administration (Taylor, Simon, Weber, Follett, and Fayol), embraced scientific management, decision-making, human relations, bureaucratic and administrative theories (Shafritz, Hyde & Parks, 1990). These theories, termed the classics, reflected a closed system view of organizations. Methodologies typically based on these

approaches were used to devise the "one best way" and were increasingly applied to bureaucratic situations. During two decades (1930s to the 1950s) application of these earlier perspectives were tested repeatedly and in response, researchers began to shift emphasis to the human relations perspective by authors such as Barnard and Mayo. Consequently, a more scholarly depiction of the organizations emerged after the 1950s (Scott, 2003).

Institutional theory, the result of this remarkable influence, has enjoyed a lengthy history and remains relevant today largely because it embraces many ideas drawn from the social sciences. It emphasizes that organizations are open systems strongly influenced by their environments (Perrow, 1981; Scott, 1995; Selznick, 1949). Selznick, the founder of institutional theory, noted that the most important thing about organizations is that each has a life of its own. His study of the Tennessee Valley Authority (TVA) is a classic example of institution that developed as a result of normative forces. "The more valued the organization is to culture and society in which it is embedded, the more likely the organization is to persist" (Selznick, p. 10). Organizational legitimacy is significant to such persistence.

The concept of organizational legitimacy was first emphasized by Max Weber in 1922. He focused on forms of actions that were molded by the existence of a legitimate order. Weber extended this ideology of legitimization to both private and public power structures (Ruef & Scott, 1998). Examples of organizations that extend"legitimacy" to hospitals are the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Hospital Association (AHA), and the Hospital Quality Alliance (HQA).

In the years following Weber and Selznick, organization theory was developed more fully Thompson (1967), March and Simon (1963), and Lawrence and Lorsch (1967). During the 1980s, inter-disciplinary organization theory was described as institutional theory. This change was largely influenced by March and Olsen's *Rediscovering Institutions* (1989). They emphasized the distinction between organization and institutional theory. Their premise was that institutional theory is not limited to the study of government bureaucracies. Based on the framework set by Cohen, March and Olsen (1972) institutionalists subscribed to the "big tent theory of institutions" embracing a number of conceptual frameworks. Nonetheless for the most, part institutional theory is still based on the most common characteristics found in public institutions. Central to this reasoning are such concepts as "bounded rationality, incremental

adaptation, loose coupling, resource scarcity, political intervention, and other measures of performance" (Kettl, 2002, p. 68-69).

Scott (1995) in *Institutions and Organizations*, defines institutions as cognitive, normative, and regulatory structures and activities that provide stability and meaning to social behavior. He contends that there are three pillars of institutions – regulative, normative, and cognitive - that they are analytically independent and separate. (Scott**,** p. 33-62)

Scott's Three Pillars of Institutional Theory

- Regulative: Rules, governance system, constitution
- Normative: Logic of appropriateness, accreditation, certification, conformity
- Cognitive: Adaptation, isomorphism

However, there are scholars who question Scott's definitive lines and distinctive pillars. Baum (1998) and Hirsch (1997, p. 1720) argue that these pillars are not distinct as Scott suggests and that organizations emerge on different fronts. Scott's critics question whether his ideas are different only by degree or whether they are conceptually different. Do they "constitute barriers that may not be crossed," asked Hirsch.

DiMaggio and Powell (1983) argued from a sociological perspective that organizations experience pressure to conform to their institutional environments because of political, occupational or professional constituencies or mimetic pressures from other organizations with which they compare themselves. Drawing on concepts similar to Scott's three pillars of institutional theory, these scholars describe three types of isomorphism: coercive (political and cultural influence, legitimacy), mimetic (faced with uncertainty, they imitate each other), and normative (they seek legitimacy from professional groups). Therefore, strong ties with other organizations create the path and resulting changes to certain practices. The creation, transformation, and diffusion of institutions require legitimacy, a condition whereby other alternatives are seen as less appropriate or useful.

Many of these patterns of organizational conformance have been noted by other institutional theorists (e.g., Meyer & Rowan, 1983; Meyer, Scott & Deal, 1983). The thrust of their research has reinforced the image of structure, legitimacy, culture, training and the external forces of accreditation and regulation. Goodrick and Salanick (1996) suggest that the common elements in this approach may be responsible for the present neglect in explaining organizational response to institutional pressures. They contend that these explanations were based on long-

standing rules and myths with little understanding of the role actors play in influencing organizational behavior. Conformity is also reinforced by external forces - the state and society – structures that perpetuate their legitimacy (Goodrick & Salanick, 1996; Powell, 1991).

Zucker (1987) contends that the most significant consequence institutional theorists attributes to institutionalization is permanency. Once organizational activities become institutionalized, they are assumed to be stable, enduring and sustainable over long periods of time without continuing rejustification.

Goodrick & Salanick (1996) argue that uncertainty initiates discretion and that organizational influence on practice will increase as institutional standards become more uncertain. Thus the institutional perspective is not sufficient for constraining practice in an uncertain environment. Consequently, practices can become indeterminant and additional constraints are necessary for guidance. Because discretion is created by the resulting uncertainty, actors may use their own unique interests to give further definition of appropriate action (Pfeffer & Salanick, 1978).

The context of this argument is found in Goodrick and Salanick's research on hospitals' decisions on Cesarean births. Hospitals with different types of ownership, teaching status, and patient contracts were influential in determining the use of Cesareans, only when the level of institutional uncertainty was high. That is, the patient risk was at an *intermediate* rather than a high or low level. However, this discretion is bounded by the institutions that gave rise to such choice of delivery based on their own organizational interests (nonprofit, for-profit, public) For instance, a public hospitals may take a different position than would a for-profit because it receives public assistance for serving a larger percentage of indigent uninsured mothers and thus have some incentives to keep cost down because of its limited revenue stream. Conversely, for-profit hospitals expect to generate a profit for their owners and have a greater economic incentive to perform Cesareans since the reimbursement rate for this procedure is higher and hospital stays tend to be longer (Keebler & Brodie, 1993).

According to Kettl (2002, p. 77), Thompson (1967) made a similar argument that "uncertainty appears to be the fundamental problem for complex organizations, and coping with uncertainty is the essence of the administrative process." To protect itself, an organization will insulate itself and gain protection by standardizing work processes.

Oliver (1992, p. 564) emphasized that while institutional theory has contributed a significant body of work to legitimization processes and to organizational conformity, it has "precluded inquiry into factors that cause organizations to challenge, discard, or abandon legitimated organizational practices. Institutional environments are not always monolithic nor are they always passive. They may respond to institutional pressures according to their resource dependencies." Oliver identified three major sources of pressure on institutionalized norms: (1) function, pressures that arrive from perceived problems in performance levels; (2) political, shifts in societal interests; and (3) power distribution and social pressures associated with differentiation of groups. These factors are deemed to be strong predictors of institutional change. Because of such criticisms due to the lack of attention to the political processes as well as other non-institutional factors, Oliver's study suggested that the cultural persistence of an institutionalized activity may be much more fragile than institutional theory suggests (1991).

In the specific case of hospitals, several threats to the persistence of an institutionalized practice complement Oliver's work. These include a decline in (a) the functional necessity for the practice, (movement from inpatient to outpatient services) (b) the political interests and agendas that support the institution's maintenance, (c) the degree of cultural consensus among actors that perpetuate the institution, or (d) the structural integrity of proximity and interaction patterns that are necessary to sustain institutional coherence (Pfeffer & Salancik, 1978; Weick, 1979). These factors push beyond motivational forces

DiMaggio and Powell (1983) and Tolbert and Zucker (1983) recognized that institutional forces are not always primary, noting that the tendency for novel adoptions are driven by technical, as opposed to legitimacy considerations. Therefore, the various institutionalisms (Scott, 1995) may be grouped into two broad categories of institutional effects: preconscious and postconscious. Preconscious institutionalization – organizations operate and make choices in environments where much is taken for granted. Preconscious institutionalization corresponds to DiMaggio's (1988, pp. 4-5) factors "that make actors unlikely to recognize or act on their interests." According to postconscious institutionalization, tangible forces in an organization's environment directly or indirectly divert design adoption away from the proposed dynamic in transaction cost economics and toward the dynamic of legitimacy.

Roberts and Greenwood (1997) support Granovetter's (1985) position that TCT provides an undersocialized account while institutional theory offers an oversocilaized perspective of

organizational theory. These scholars contend that TCT and institutional theories are not in conflict but provide complementary elements of constrained efficiency framework that is confronted with bounded rationality and institutional limitations. Powell (1991), p. 194) suggested, "much of the institutional theory portrays organizations as overly passive and depicts environments as overly constraining

Given these theoretical arguments, local government officials and researchers alike would be best served if they understood the implications of both transaction cost and institutional theories for hospitals. Since hospitals are not limited to one type of governance, public policy makers must be keenly aware of the dynamics of hospital operations and organizational demands at the local, state, and federal levels. Community hospitals may be owned and operated by both public and private sectors.

While TCT and institutional theory can be reconciled to tackle such concerns, it is important to recognize that they may conflict over current market practices. Hospitals are strong models of the isomorphic process at work in many organizational settings because they operate according to a social legitimization that can conflict with market considerations of efficiency.

In its health care provider role, a hospital must increase its range of services not only because of need but because it is defined based on services offered by other hospitals in their area. Lee (1971, p. 51) maintains that this is the reason "why hospital administrators are less concerned with efficient use of resources and more concerned with status competition and parity in prestige."

Lee's description of a conspicuous production theory of hospital behavior is unique in that it postulates defensive behavior under independent conditions while other theories are based on sales-maximization, output and prestige maximization, short run net revenue and profit maximization. His view of hospital's organization offers a logical and consistent explanation of why hospitals acquire resources without justification of actual need. This perspective helps to explain why there is an overage of specialization, equipment, capacity, and extensive duplication, all of which result in continuous inflation in the hospital sector. Consequently, hospital organizational structure has become much more homogeneous. An example of this homogeneity is evident in trends reflected in the rapid acceleration of system affiliations in Florida's hospitals. Independent hospitals are becoming fewer each year.

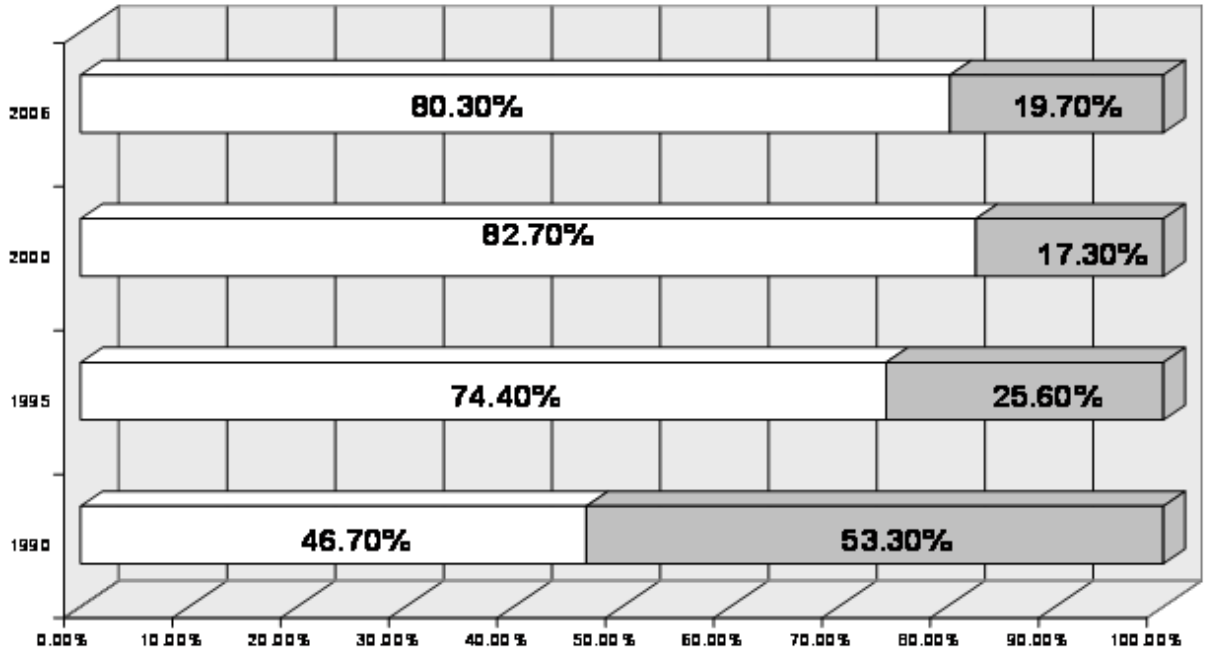
Multihospital Systems

A multihospital system is defined as two or more hospitals owned, leased, sponsored or contract-managed by a central organization (AHA, 2006). Concerns have been expressed by policy makers, health care workers, and by members of the general public about the potential effect of such affiliations and their control over hospitals and health care policy (Snail & Robinson, 1998).

The literature on the overall effect of these affiliations is in a developing stage. Most studies in this area have found the challenge of refining and acquiring the necessary data daunting. We are therefore left with a void in our understanding of how these organizational structures affect health outcomes, policy and financial performance. The decision to affiliate has become more common over the past two decades (Harris, Ozgen, & Ozcan, 2000; Shortell, Gillies, & Devers, 1995).

In Florida, the rapid growth of multihospital systems occurred between 1990 and 2006. Figure 1 illustrates this escalation of growth in multihospital. This change, in turn, had an effect on services. Independent hospitals decreased with a corresponding reduction in bed count comparable to the emerging multihospital structure. But the situation is not as clear cut as the data suggest. It is important to note that some of the "independent hospitals have affiliation arrangements with other hospitals for either group purchasing or managed care contracting" (FHA, 2006; FHA, 2001, p. 127).

Ermann and Gabel (1984) identified three key advantages of a multihospital system (MHS): (1) economics, increased efficiency and economies of scale, ability to diversify; (2) personnel and management benefits, improved recruiting and ability to develop high caliber staff; and (3) planning, program and organizational benefits. However, Madison (2004) posits that system affiliation may dictate the services that are offered, which in turn either replicate the services in other areas or choose to concentrate them in a limited number of locations to exploit economies of scale.



	1990	1995	2000	2006
Systems	**46.70%**	**74.40%**	**82.70%**	**80.30%**
Independent	**53.30%**	**25.60%**	**17.30%**	**19.70%**

Figure 1 Multihospital and Independent Systems in Florida: 1990-2006
Source: Adapted format. Florida Hospital Association, 2006.

As a result of such complexity, Fennell and Alexander (1993, p. 505) posited that hospitals do not constitute a good market system because patients do not possess the necessary knowledge of potential exchange in terms of partners and prices. The physicians and hospital administrators are the actual consumers. Competition among hospitals is based on "attracting physicians, who in turn, bring their patients to the hospitals."

Since hospitals are but one of many players in the health care market, they must compete with other entities to survive. Some of these include physicians, traditional insurers, managed care organizations, specialty clinics and advocacy groups. These challenges have created

uncertainties that not only contributed to Lee's homogeneity but they have also led to closures, mergers, consolidation, and conversions to for-profit status in ownership.

Overall, these trends in the structure of U.S. hospitals reveal a transformation in medical care organizations. Fennell and Alexander (1993) found that no one factor influenced the structure of hospitals. The introduction of Medicare and Medicaid, the Hill-Burton Act in 1946, federal and state statues pertaining to reimbursement rates, multihospital system, and contract-managed arrangements, and specialty hospitals are but a few factors that influence hospital organizational structure. The trends can be viewed using the perspectives developed in TCT in market economics.

Brown and Potoski (2003) combined a transaction cost framework with institutional and market theories to examine how governments choose to produce services. They posited that governments may be more influenced by institutional forces which promote uniform production choices and professional associations. These affiliations may serve as a network to alert members of potential vendor opportunism when contracting with private firms. Their work suggests TCT, institutional theory, and economic theory are fertile sources of hypotheses regarding hospital ownership. The foregoing theoretical arguments suggest the following hypotheses.

Summary of Hypotheses

Hypothesis 1: Private for-profit hospitals will have a positive association with Jurisdictions where population is 100,000 or more.

Hypothesis 2: Private for-profit hospitals will have a positive association with jurisdictions where density exceeds the state's average.

Hypothesis 3: Private for-profit hospitals will have a positive association with jurisdictions where tax millage rates exceed the state's average.

Hypothesis 4: Private nonprofit and public hospitals will have a positive association with jurisdictions where the minority population exceeds the state's average.

Hypothesis 5: Private nonprofit and public hospitals will have a positive association with jurisdictions where unemployment rates exceed the state's average.

Hypothesis 6: Operational performance for private nonprofit hospitals will not be significantly different for private for-profit hospitals.

Summary

Two theoretical frameworks have been drawn upon to generate testable hypotheses about production choices: transaction cost and institutional theories. Transaction cost examines both internal and external delivery of services. It provides a rationale as to why an organization may choose to purchase some inputs rather than produce them internally. Focusing on transaction costs reinforce the trend that organizational study has shifted its attention from technical production to governance structure (Coase, 1937; Williams, 1981).

Institutional theory seeks to explain variation among organizations during early formation and subsequently, their homogeneity once they become well established (DiMaggio & Powell, 1983). These scholars argued that organizations experience pressure to conform to their institutional environment due to political, occupational, or professional constituencies and mimic pressures from organizations with which they compare themselves. However, there are theorists who challenge this perspective and suggest that internal and external pressures may differ and that organizations will adapt in accordance with their respective environments.

Chapter Two describes these two theoretical perspectives as they bear on issues related to community hospitals – transaction cost and institutional theories. Once these two theories were thought to be incompatible. However, the weaknesses and strengths of each as outlined in this chapter present the rationale for integrating them into a single framework that offers a more comprehensive explanation of production choices. Granovetter (1985) argues that transaction cost theory provides an undersocialized perspective of organizational phenomena while institutional theory offers an oversocialized viewpoint. Not only does it help to better understand their make or buy decisions but also to whom they will enter into a contract arrangement. We learn from this review that while governments are keenly concerned of costs, it is not the only factor that influences service delivery choices. The philosophical perspective on government intervention, the role of hospitals in the community and survival as organizations are all factors that enter into such choices.

CHAPTER 3
RESEARCH METHODOLOGY

This research design is a cross-sectional study of Florida's community hospitals. The format uses a mixed-method design that includes both quantitative and qualitative methodological techniques. Its purpose is three-fold: (1) identify factors that may predict service delivery choices as a function of ownership and location; (2) examine differences in operational performance of private nonprofit and private for-profit hospitals; and (3) propose an answer to the question, "why do local governments choose the contract-management alternative"?

This chapter is divided into two parts: Part one includes the following sections: (1) study variables and operational definitions, (2) research hypotheses, (3) study population sample, (4) data collection and sources of data, (5) sampling strategy, and (6) data analysis techniques. Part two is qualitative and is designed to develop an answer to research question number three. Also, included in this part is (1) an overview of the literature on contract-management, (2) sampling strategy, (3) data collection techniques, (4) data analysis procedures, and (5) method of verification. The quantitative method tested the transaction cost and institutional theories that predict the applicable hypotheses. The qualitative method explored reasons why contract management is an alternative service delivery choice.

Since contract-managed hospitals are public-private partnerships, they offer unique characteristics that can enhance our understanding of hospital operations through qualitative inquiry in a way that cannot be achieved through quantitative research alone. The features of partnerships are not easily understood in quantitative data because data systems are not set up to focus on such factors. Partnerships have both advantages and disadvantages. Combining analytical strategies may be useful in improving our understanding of the types of exchanges between sectors in the governance of these kinds of hospitals. For example, the private sector is noted for its emphasis on short-term savings at the least cost. It may be, however, that savings may lead to later increased cost to the public sector over the long term. That is, reduced access to health care in the private sector may eventually result in increased public sector costs.

The qualitative findings were expected to provide: (1) information about the success of these public/private relationships, (2) how governance, ownership and policymaking processes proceed under local government authority, (3) information about the role of a community

hospital, (4) useful measures for the evaluation of financial and operational performance, (5) challenges in contractual negotiations and agreements, and (6) lessons learned that can be shared with a larger constituency. Qualitative findings may also prove helpful to smaller communities in the State as they represent almost half of the jurisdictions in Florida (Florida Legislature, Economic and Demographic Research, 2007).

Part I – Quantitative (Cross-Sectional Study)

Study Variables and Operational Definitions

Using data from all 67 Florida counties, the study variables included five community characteristics. The data represent a snapshot of county characteristics. Examining these relationships over a broader period of time is outside of the scope of this study. All U.S. Census data is based on population estimates, effective July 1, 2006. Other state data is the effective date listed in the citation.

1. *Size of jurisdiction* - defined based on population as small (fewer than 100,000 people - 34 counties) and large (100,000 people or more – 33 counties). (U.S. Bureau of the Census, 2006).

2. *Density* - population divided by land area. Based on 2006 census data, Florida's average density is 340 persons per square mile. The density of a particular county is defined as low or high in comparison to the state's average population density.

3. *Tax millage rates* - the cumulative of all taxes levied against property authorized by a governmental body. Tax rates are based on mills. One mill produce one dollar for each $1,000 of taxable property. The average tax millage rate for all counties is 17.6 mills (Florida Department of Revenue, 2006). Tax millage rates are defined as lower or higher than the state's average millage rate.

4. *Minority population* in this research is defined as all persons who are nonwhite. The states average minority population is 37.7 percent (U.S. Census, 2006). Minority population is categorized as less than or greater than the state's average minority population.

5. *Unemployment rate* is defined in terms of all civilians 16 years of age or older who do not work, who actively seek employment and who are available to work, except for temporary illness during a given week. The state's average unemployment rate was 3.3 percent in 2006 (Florida Agency for Workforce Innovation, Labor Market Statistical Center, 2006). Therefore, unemployment rate is categorized as lower or higher than the state's average value.

Each of the identified community characteristics is a predictor variable that may influence the type of ownership of hospitals. Hospital service delivery choices are referred to in terms of the type of ownership and include: private nonprofit, private for-profit, and public.

6. *Hospital operational performance* is defined using the following key components: (a) Average Length of Stay (ALOS); (b) Operating Margin Percentage; (c) Medicaid and Charity; and (d) Case Mix (Florida Agency for Health Care Administration, 2005).[1]

(a) *Average Length of Stay* (ALOS) is the average number of days a patient stays in the hospital. Average Length of Stay has been standardized to control for different types of diagnosis.
(b) *Average Operating Margin Percentage* – is a measure of the hospitals profitability from patient services (payer sources, net revenues per adjusted admission, operating expenses per adjusted admission, proportion of charity care, uncompensated care and bad debts.
(c) *Average Medicaid and Charity*. Medicaid covers the difference between the reimbursement level and the cost to provide the hospital service. Charity refers to medical service provided to patients who have no resources or assets to pay for their medical care. Medicaid and Charity may have a significant impact on a hospital's operating margin percentage.
(d) *Average Case Mix* is an index which reflects the type and severity of patient compared to a national mix of patients. Standardized values are used in this data to compare hospital revenues and costs which reflect both case mix and geographic index. This is accomplished by dividing cost per adjusted patient day and cost per adjusted admission by the case mix (AHCA).

Research Hypotheses

Consistent with transaction cost and institutional theories, research hypotheses were tested as outlined in Table 6. The general research question is, "does the provision of hospital services to Florida's communities vary according to ownership type"? The community characteristics and hospital data represent a snapshot of county data as cited in the study variables and operational definitions in Part I – Quantitative section.

[1] Hospital data is based on reports covering the 12 months preceding the hospital fiscal year 2005 ending date.

Table 6

Florida Community Hospitals: Research Questions and Hypotheses

Questions/Community Characteristics	Hypotheses
Question #1 What is the relationship of select community characteristics with hospital ownership type?	
1. Size of Jurisdiction	H_1 Private for-profit hospitals will have a positive association with jurisdictions where population is 100,000 or more.
2. Population Density	H_2 Private for-profit hospitals will have a positive association with high-density jurisdictions.
3. Tax Millage Rate	H_3 Private for-profit hospitals will have a positive association with jurisdictions where millage rates are higher than the state's average.
4. Minority Population	H_4 Private nonprofit and public hospitals will have a positive association with jurisdictions where the percentage of the minority population exceeds the state's average.
5. Unemployment Rate	H_5 Private nonprofit and public hospitals will have a positive association with jurisdictions where unemployment rates are higher than the state's average.
Question #2 Does operational performance for private nonprofit differ from private for-profit hospital ownership types?	H_6 Operational performance for private nonprofit hospitals will not be significantly different from private for-profit hospitals.

Study Population Sample

The study population included all 169 community hospitals in the State of Florida that provided acute care services in 2005. (See Appendix A). This study population specifically excluded long term care, major teaching, state, specialty, psychiatric, rehabilitation, and military hospitals. Also excluded were six hospitals with insufficient reporting data.

Data Collection and Sources of Data

The data included in this study is secondary data collected by state agencies and the Florida Legislature. Hospitals submit annual financial filings and other administrative data to the Agency for Health Care Administration. The Agency for Health Care Administration is created

in Chapter 20, Florida Statutes. It is the chief health policy and planning entity for the State of Florida. The agency is responsible for health facility licensure, inspection, and regulatory enforcement. Hospitals are regulated under the Bureau of Health Facility Regulation which also includes the Certificate of Need Program (CON) and hospital financial analysis programs (AHCA, 2008 ahca.myflorida.com). The Florida Statistical Abstract is a compilation of data on services, resources and economic trends of counties in Florida. These hospital filings in addition to county level data on economic and population demographics were the primary sources of data for this study.

Quantitative data were obtained from the Agency for Health Care Administration (AHCA), Bureau of Economic and Business Research, Florida Statistical Abstract (2006), University of Florida, Florida Legislature, Office of Economic and Demographic Research, and the U.S. Census Bureau. All data used in this research are aggregate hospital level data and available to the public. Furthermore, it is not the intent of this study to identify any specific hospital, but rather to examine relationships based on the focused questions in this study.

Sampling Strategy

This study included all 169 acute care community hospitals that provided medical services during 2005 in Florida. The exclusions have been identified in the Study Population Sample section.

Data Analysis Techniques

The purpose of these analyses was to test whether significant relationships exist as a function of hospital ownership type based on five select community characteristics and to determine whether there is a difference between operational performance of private nonprofit and private for-profit hospitals.

The Chi-square statistic[2] was used to test hypotheses about population size, density, tax millage rates, minority population, and unemployment rate. The independent samples t-test[3] was used to examine differences in operational performance of private nonprofit and private for-profit ownership types.

[2] Chi-square calculates variances of observations between dichotomous variables. It tests whether two variables are independent from each other.

[3] Independent samples t-test, a form of Analysis of Variances, (ANOVA), is used to determine the extent to which two groups differ from each other based on established parameters. Laverne's Test for Equality of Variance is used to determine if the variables in the two populations are equal.

Part II – Qualitative (Exploratory)

Contract Management

A qualitative study was conducted of contract-managed hospitals. This component of the research was exploratory in nature and designed to learn more about why local governments choose to contract-manage the operation of their hospitals. In addition, a comparison group (CEOs of non-contract-managed hospitals) was interviewed to determine why they did not choose the contract-management alternative.

Over the years, some governmental bodies have entered into joint arrangements to deliver hospital services through contract-management. Contract management is an arrangement where the hospital board of trustees hires a management firm to provide full service management of the hospital and to assume responsibility for the day-to-day operation of the hospital (U.S. GAO, 1980). This raises a number of issues but one key concern is how to ensure the maintenance of accountability and independence of such a critical community service under such a system, wherein the day-to-day operation of the hospital is under the control of an outside organization. Health care costs, economies of scale, uncertainty of resources, and competition may compel organizations to consider contract-management as a survival option. Alexander and Morrisey (1989, p. 262) offered four determinants that may pressure governments to enter into contract management: (1) general market characteristics of the hospital, (2) environmental regulatory structures, (3) hospital management characteristics, and (4) enabling factors related to the hospital's willingness to compromise its independence. Dor (1994) posited that contract-managed hospitals are smaller facilities, often located in rural areas. In addition to financial constraints, research findings (Carey & Dor, 2004; Dor, Duffy, & Wong, 1997, p. 543) revealed that prior to adopting contract-management arrangements, hospitals tended to be in poor financial shape and showed persistent negative revenue returns.

These findings suggest that boards of trustees may see contract management as a better alternative than merger, which requires giving up control of their local health services (Lutz, 1994). Contract-management was one of several adaptive strategies used to avoid closure and/or survival in challenging environments. In the past, management organizations took on small hospitals with severe financial difficulty partly to establish a track record and to gain expertise in management contracting (Wheeler & Zuckerman, 1984). Some theorists suggested that

government decisions to engage in contract management are complex and not reflective of a dichotomous choice (Ferris & Graddy, 1994). Given this diversity of views and the paucity of insight offered by transaction cost theory and institutional theory, the question of why some governments choose to contract-manage their hospital operation was addressed through interviews.

Sampling Strategy

Purposive sampling was used to select the most knowledgeable and experienced subjects familiar with contract management. The intent was to obtain the most comprehensive information to answer the research question and expand on lessons learned. Therefore, the selection was based on interviewing subjects reflecting the following criteria.

- Hospitals under current contract management arrangements.
- Hospitals that reverted (reverse their decision) from contract management to public management.
- Hospital(s) closed after contract management arrangements failed.
- Traditionally managed hospitals of similar comparison that chose not to contract-manage their hospital operation.

Data Collection Techniques

In accordance with the sampling strategy, data collection was accomplished by conducting in-depth structured interviews with selected research respondents. These included hospital administrators, a hospital consultant, a director of planning and liaison to local government and the hospital trustee board. A questionnaire guide was used to conduct the interview process (see Appendix B).

The list of participants was drawn from a dataset provided by the Florida Agency for Health Care Administration. Additionally, a list of hospitals and their CEOs was compiled that was congruent with the definition set for the study sample. All of the chosen institutions had experienced a contract management arrangement with an external organization. Because there were difficulties in determining the accuracy of the list, telephone calls were made to each hospital to obtain the name of the appropriate person to contact for the study. Letters were mailed to hospital CEOs, Board Chairs of County Commissioners, during the months of December, 2007, January, 2008, and February, 2008.

Follow up calls were made approximately one week after the letter was sent to request an interview appointment. A complicating issue was the turnover in hospital CEO positions. I was given alternative names of other individuals who might bring an equal or better experience level

to the study process. In some cases, the county government was no longer in the hospital business and correspondence letters was transmitted to a different entity.

The research respondents consisted of nine individuals, five in-person interviews were conducted, three telephone interviews, and one respondent provided written comments plus a follow up e-mail and telephone interview. Interviews were conducted at the respondents' hospital in most cases. One location was chosen by the researcher.

In each case, respondents were provided a written transcript of the interview to confirm its accuracy. In some cases, follow up questions or points of clarification were asked of respondents.

Data Analysis Procedures

The steps taken to conduct this component of the research followed the inductive model. This procedure is based on the emergence of themes or strands that are generic and are in accordance with the six steps advanced by Creswell (2003, p. 191) and implemented with the assistance of QRS qualitative software, Nvivo. The steps are as follows: (1) organize and prepare the data for analysis, (2) review the data to determine its overall meaning, (3) conduct detailed analysis with a coding process, (4) analyze data to generate descriptions, categories, themes, (5) advance the description and themes in a qualitative narrative, and (6) interpret the data, meaning, lessons learned.

Data from interviews and documents were classified and coded using as many categories as deemed necessary. From these classifications, patterns and themes articulated by the respondents emerged. Although the themes are interrelated, the categories were first identified through initial coding and later consolidated into sub-topics to better define and outline the broader relevant topic.

Method of Verification

To corroborate the emerging themes, interviews were also conducted with the Executive Director of Big Bend Rural Health Network, the Florida Agency for Health Care Administration Bureau Chief of Health Care Regulation and License, and a hospital CEO whose responsibility includes pursuing invitations for contract management services. Other documents reviewed included the Florida Agency for Health Care Administration Annual Report (2005), various county commission minutes, newspaper articles about hospitals in the local area, Department of Health, Office of Rural Health Report, an online document, written by Kelli Peacock, news

editor, county record, from Florida Representative Marti Coley's web page (http://www.myfloridahouse.gov), and articles from *Florida Trend Business Journal*, (2001 & 2006) and *Mississippi Business Journal* (Whitehead) (2002).

CHAPTER 4

RESULTS

This chapter presents the results of the research findings and is organized in two parts. Part I describes the findings related to hypotheses one through six of the quantitative section. Part II provides results of responses to the research question related to contract management services.

The sample (unit of analysis) in Part I of the study includes data from 169 acute care community hospitals as defined in the population sample described in Chapter Three. It includes all private nonprofit, for-profit, and public hospitals that provided acute care services in Florida during 2005. See Appendix A for a distribution included in the dataset. The study population specifically excludes long term care, major teaching, state, specialty, psychiatric, rehabilitation, and military hospitals. Also excluded were six acute care community hospitals that did not provide annual financial data to the Florida Agency for Health Care Administration (AHCA).

Part I – Quantitative Section

The independent variable "hospital ownership" (for-profit, nonprofit, and public) was analyzed to determine whether there is a relationship between ownership type and community characteristics (size of jurisdiction, population density, tax millage rate, minority population percentage and unemployment rate). These results are presented to test the predictive power of hypotheses one through five.

The alpha level for all hypothesis testing was set at a 95 percent confidence level. The Chi-square statistic was used to test hypotheses one through five to determine whether they are supported by research findings. The Chi-square test calculates the variance of the observations and the comparability of distributions between dichotomous variables. Contingency tables were constructed to determine whether there is a relationship between the row and column variables.

Hospital operational performance was tested to confirm the predictive power of hypothesis six. Independent samples t-test was used to determine the extent to which the two groups, private for-profit and private nonprofit hospitals differed.

A summary of the hypothesis testing results of part one is provided in Table 7, followed by a more detailed discussion.

Table 7

Summary of Hypotheses Testing Results

Hypotheses	**Prediction**	**Results**
H1 Private for-profit hospitals will have a positive association with jurisdictions where population is 100,000 or more.	Positive association	Significant P=.051
H2 Private for-profit hospitals will have a positive association with high-density jurisdictions.	Positive association	Not significant P=.078
H3 Private for-profit hospitals will have a positive association with jurisdictions where millage rates are higher than the state's average.	Positive association	Not significant P=.102
H4 Private nonprofit and public hospitals will have a positive association with jurisdictions where the percentage of the minority population exceeds the state's average.	Positive association	Not significant P=.412
H5 Private nonprofit and public hospitals will have a positive association with jurisdictions where unemployment rates are higher than the state's average.	Positive association	Significant P=.031
H6 Operational performance for private nonprofit hospitals will not be significantly different from private for-profit hospitals.	No sig. Difference – ALOS Op. margin%, Medicaid/charity & case mix	Not Significant P=.145, .809, .477, & .369 Respectively

Community Characteristics

Hypothesis 1: Private for-profit hospitals will have a positive association with jurisdictions where population is 100,000 or more.

> *Size of jurisdiction* – defined based on population as small (fewer than 100,000 people - 34 counties) and large (100,000 people or more – 33 counties). U.S. Bureau of the Census, 2006).

Chi-square was performed to determine whether there is a relationship between hospital ownership type and size of jurisdiction. For this research, the size of the counties was categorized based on population with small being less than 100,000 and large being 100,000 or more. The contingency table shows the distribution of hospital ownership and jurisdiction size. Based on these findings, the Chi-square value (p=.051) is deemed statistically close enough to

p=.050 to confirm that there is a relationship between jurisdiction size and type of hospital ownership. The cell frequencies are not distributed equally. Among the 169 acute care hospitals, 71 or 42 percent are private for-profit hospitals and are in large jurisdictions; 52 or 31 percent, are private nonprofit hospitals and are in large jurisdictions; and 17 or 10 percent, are public hospitals and are in large jurisdictions. Chi-square results: $\chi^2 = 5.93$, *df*=2, p=.051 (See Table C-1, Appendix C).

Hypothesis 2: Private for-profit hospitals will have a positive association with high- density jurisdictions.

> *Density*- population divided by land area; the number of individuals per square mile. Based on 2006 census data, Florida's average density is 340 persons per square mile. The density of a particular county is defined as low or high in comparison to the state's average population density.

Chi-square was performed to determine whether there is a relationship between hospital ownership type and population density. For this research, density is categorized as low (below 150) and high (150 and higher). The contingency table shows the distribution of hospital ownership type in low and high density levels. Among the 169 hospitals where density exceeds the state average, 70 or 41 percent are private for-profit and are in high density jurisdictions; 53 or 31 percent are nonprofit and are in high density jurisdictions; and 17 or 10 percent are public and are in high density jurisdictions. Based on these findings, the Chi-square value (p=.078) shows that there is not a significant relationship between population density and hospital ownership type. Chi-square results: χ^2=5.095, *df*=2, p=.078. (See Table C-2, Appendix C). Although this value is not significant at the 95 percent confidence level, a pattern is observed in the table that shows a greater concentration of private for-profit hospitals in high density jurisdictions. In comparing Tables C-1 and C-2, a shift of only one hospital from private for-profit to private nonprofit accounts for the results.

Hypothesis 3: Tax Millage Rate – Private for-profit hospitals will have a positive association with jurisdictions where tax millage rates are higher than the state's average.

> *Tax millage rates* – the cumulative of all taxes levied against property authorized by a governmental body. Tax rates are based on mills. One mill produce one dollar for each $1,000 of taxable property. The average tax millage rate for all counties is 17.6 mills (Florida Department of Revenue, 2006). Tax millage rates are defined as lower or higher than the state's average millage rate.

Chi-square was performed to determine whether a relationship exists between tax millage rates and hospital ownership types. For definition, two categories were formulated: counties that had millage rates below and above the state's average millage rate. The contingency table shows the distribution of hospital ownership type and tax millage rates. Among the 169 hospitals where tax millage rates are above average, 42 or 25 percent are private for-profit hospitals and are located in above average jurisdictions; 44 or 26 percent are private nonprofit hospitals and are located in above average jurisdictions; and 17 or 10 percent are public hospitals and are located in above average jurisdictions. Based on these findings, the Chi-square value (p=.102) is not significant. Chi-square results: χ^2=4.558, *df*=2, p-.102. (See Table C-3, Appendix C).

Hypothesis 4: Private nonprofit and public hospitals will have a positive association in jurisdictions where the minority population exceeds the state's average.

Minority population - defined as all persons who are nonwhite. The state's average minority population is 37.7 percent (U.S. Census, 2006). Minority population is categorized as less than or greater than the state's average minority population.

Chi-square was performed to determine if a relationship exists between hospital ownership type and minority population. Two categories were created: below and above the state's average. The contingency table shows the distribution of hospital ownership type and minority population as below and above average. Of the 169 hospitals, 24 or 14 percent are private for-profit hospitals and are located in above average jurisdictions; 32 or 19 percent are private nonprofit and public hospitals and are located in above average jurisdictions. Based on these findings, the Chi-square value (p=.412) is not significant. Chi-square results: χ^2=.674. *df*=1, p=.412. (See Table C-4, Appendix C)

Hypothesis 5: Private nonprofit and public hospitals will have a positive association with jurisdictions where unemployment rates exceed the state's average.

Unemployment rate - defined as all civilians 16 years of age or older who do not work, who actively seek employment and who are available to work, except for temporary illness during a given week. The state's average unemployment rate was 3.3 percent in 2006 (Florida Agency for Workforce Innovation, Labor Market Statistical Center, 2006).

Chi-square was performed to determine whether a relationship exists between hospital ownership type and unemployment. Unemployment rates were categorized as below and above the state's average of 3.3 percent. The contingency table shows the distribution of hospital ownership type and unemployment rates of above and below average. Of the 169 hospitals, 41 or 24 percent are private for-profit hospitals and are located in above average unemployment jurisdictions, and 31 or 18 percent are private nonprofit and public hospitals and are located in above average jurisdictions. Based on these findings, the Chi- square value (p=.031) is significant. Private nonprofit and public hospitals have a positive association with jurisdictions where unemployment rates are below the state's average. Chi-square results: χ^2=4.644, *df*=1, p=.031. (See Table C-5, Appendix C). This result is the opposite of the predicted hypothesis.

Hypothesis 6: Operational performance for private nonprofit hospitals will not be significantly different from private for-profit hospitals.

Operational performance is measured using four components.

(1) *Average Length of Stay* (ALOS) is the average number of days a patient stays in the hospital. Average Length of Stay has been standardized to control for different types of diagnosis.

(2) *Average Operating Margin Percentage* is a measure of the hospital's profitability from patient services. This includes payer sources, net revenues, per adjusted admissions, operating expenses per adjusted admission, proportion of charity care, uncompensated care and bad debts.

(3) *Average Medicaid and Charity* - Medicaid covers the difference between the reimbursement level and the cost to provide the hospital service. Charity refers to medical service provided to patients who have no resources or assets to pay for their medical care. Medicaid and Charity may have a significant impact on a hospital's operating margin percentage.

(4) *Average case mix* is an index which reflects the type and severity of patient compared to a national mix of patients. Standardized values are used in this data to compare hospital revenue and costs, which reflect both case mix and geographic index. This is accomplished by dividing cost per adjusted patient day and cost per adjusted admission by the case mix index. (AHCA)

For each of the above four components, a t-test was used to assess for comparison of means. The two-tailed tests of significance at the 95% confidence level do not indicate statistical significant differences in the operational performance between private for-profit and private nonprofit hospitals. In looking at the significant column, all numbers are greater than .05, which indicate that the difference between for-profit and nonprofit is statistically insignificant. There is

a high variability in Medicaid/charity due to the high standard deviation for both for-profit (9.423) and nonprofit (7.689) compared to others. There may be operational reasons for this high variability. However, the results indicate that for-profits show a greater contribution to Medicaid/charity than nonprofits. For-profits also show a larger variation for ALOS than nonprofits. There is very little variation between case mix and operating margin percentage. (See Table C-6, Appendix C).

Part II – Qualitative Section

Research Question

This component of the research is guided by a single question – "Why do local governments pursue the contract management alternative?" A comparison group, known as "traditionally managed" will also provide perspectives as to why hospitals *do not* choose the contract-managed option. The response to this question unveiled a number of broader issues which are discussed in this section.

Historical Context and Community Characteristics

The exploratory study represents participants from eight Florida counties, all rural, and nine hospital officers. A description of these respondents' hospitals and communities is appropriate to give us a better understanding of their challenges and perspectives. Ninety percent of the hospitals in this study had experienced at least three organizational changes during the past 25 years. Three of the hospitals are products of the Hill-Burton Act and two predate the Hill-Burton Act (summary of Hill-Burton Act, also known as the Hospital Survey and Construction Act of 1946, is presented in Chapter One). The 1980s were difficult times for many hospitals influenced largely by: 1) the entrance of for-profit hospitals into the market, 2) introduction of the Prospective Payment System (PPS), 3) Health Maintenance Organizations (HMOs), and 4) rapid increases in health care costs.

Prior to the 1980s, most hospitals in Florida were owned and operated by county governments. These counties are diverse in some ways in their population diversity and growth and are located in south central and north Florida. However, the majority are located in north Florida and the panhandle. The growth rate is slow for some, yet fast for others.

The Florida Department of Health (FDOH), Office of Rural Health (n.d.), pointed out a number of significant rural health issues. Some are: (1) higher mortality rates for certain diseases, (2) a larger population of uninsured/underinsured individuals, (3) recruitment –

retention problems for Emergency Medical Services (EMS) personnel, (4) a shortage of health personnel (health providers are not evenly distributed throughout the state – there are surpluses in urban areas and shortages in rural areas), and (5) hospitals in small counties often experience financial hardships. This in part is due to clients' lack of health insurance, lower incomes among the population served, aging or obsolete facilities, and less access to technological innovations. Table 8 highlights selected characteristics of the counties.

Table 8

Characteristics of Counties Where Interviews were Conducted

Characteristics*	**State Average**	**County Average Range**
Uninsured Rates, percent (2004)	19.2	20.4 – 36.2
Unemployment Rate, percent (2006)	3.3	2.9 - 6.2
Population Change, percent (4/2000-7/2006)	13.2	2.5-11.7
Median Household Income (2004)	$40,900	$27,521 – 32,197
Persons Below Poverty, percent 2004	11.9	13.5- 17.7

Note. Data sources: Florida Agency for Health Care Administration (2005 August). *Florida Health Insurance Study 2004: County Estimates of People without Health Insurance;* Florida Department of Health, Office of Planning and Data Analysis (2006). Retrieved March 20, 2008, from http://www.floridacharts.com; U.S. Census Bureau, *State and County Quick Facts.* Retrieved March 22, 2008, from http://quickfacts.census.gov/qfd/states; Bureau of Economic and Business Research, *Florida Statistical Abstract, 2006.*
*Years listed under characteristics are the effective time frames of the data.

It is relevant to note that in October 2005, three of the hospitals in this study, managed by the same firm, experienced major disruptions of service. This resulted in the closure of one hospital and the temporary loss of business and support service for the other two (FL Department of Health, Office of Rural Health (n.d.; Crane, 2006). In addition, turnover in key positions and in trustee board members for these hospitals may have affected current participant views and limited the past and transitional experiences with the contract management firm and a different

organizational status. These experiences are reflected in the research participants' perspectives on contract management services.

Definitions

Respondents frequently used words or phrases during the interviews that described the types of hospitals they served. These descriptions are as follows:

(1) CAH – Critical Access Hospital. The Balanced Budget Act of 1997 created the Rural Hospital Flexibility Program, sometimes referred to as FLEX Program. It allowed for small rural hospitals (25 beds or fewer) to apply for and receive this status. Under this program Medicare pays CAHs on a cost-based reimbursement schedule for inpatient, outpatient and swing-bed services (101 percent of allowable and reasonable costs). CAHs are exempt from the Prospective Payment System but must comply with other limitations such as average length of stay, distance from a second hospital, and 24-hour emergency service (Centers for Medicare and Medicaid, (CM&M) Fact sheet, March 2007).

(2) Swing-beds– beds in rural hospitals that can be used for either acute care or skilled nursing care (rural hospitals usually allocate up to ten).

(3) Three-Strikes Malpractice Law– an amendment to the Florida Constitution (approved in 2004) that automatically revokes the medical license of any doctor with three malpractice judgments.

(4) Joint Commission – often referred to as "JCAHO", Joint Commission on Accreditation of Health Care Organizations is a national private not-for profit accrediting organization that establishes standards for the operation of health facilities and services and awards certification to facilities that meet its criteria.

(5) Payer-Mix – the ratio of admissions or patient days for each payer category (Medicare, Medicaid, commercial, HMO, PPO to total admission or patient days).

(6) Medicare – Title XVIII of the Social Security Act provide medical care to Americans age 65 or older, disabled, and individuals with end-stage renal disease.

(7) Medicaid – Title XIX of the Social Security Act provides medical care to the poor through a combination of state and federal funding.

Method

Using a general outline of questions (see Appendix B), emerging themes were generated from participants. Their oral responses were recorded and analyzed using the six steps outlined in the research methodology chapter (Creswell, 2003). The distribution of the research participants and hospital status are shown in Table 9.

Table 9

Current and Historic Hospital Status

Hospital Status	**# of participants**
Presently contract-managed (public)	2
Previously contract-managed, now private nonprofit	2
Previously contract-managed (public)	1
Previously contract-managed (public) now closed	1
	Comparison Group
Traditionally Managed public	3

Broad Themes – Contract Management

Five broad themes emerged from participant interviews: (1) rationale for contract-management, (2) effects of or issues with contract management, (3) perspectives of participants in traditionally managed (non contract) settings, (4) lessons learned, (5) strategies employed by CEO's of both contract and traditionally managed hospitals, and (6) challenges in the hospital industry. A detailed review of each theme is discussed below.

The summary of reasons (rationale) for contract-managing hospital operations based on priority rankings (see Table 10) by participants is as follows: (1) hospital management expertise, (2) financial management, (3) information and medical technology, and (4) human resource management and recruitment.

Hospital Management Expertise

Participants believed that managing a hospital in a rural community required a different level of expertise than did management in a larger metropolitan area. It is thought to be more challenging to find an administrator with the appropriate skill set to manage a small rural hospital. According to respondents, it is more advantageous to recruit a Chief Executive Officer (CEO) who had experience running a hospital in a small rural area. Factors such as the health regulatory environment (complex rules and regulations), marketing skills, managing and understanding the role of board members (expertise and training), and strategic planning are important responsibilities of a hospital administrator.

Some of respondents offered the following perspectives relative to hospital management.

"The skill set for a rural hospital is different, it's broader, and the administrator may have to be a recruiter as well as a financial and market expert. Human resources are an important component – a small rural hospital manager must not let health care decline."

"Small and rural counties failed to recognize the economic changes associated with the rising cost of health care, HMO's, the change in PPS reimbursement rates and that a different skill set was necessary to run a small rural hospital."

"Lack of human resources to run a hospital – not informed of the way a hospital really works, it's complicated."

"Board of Trustees is a volunteer board. They may be weary of the time and resources necessary to operate hospital business."

"Hospital board is the official oversight of the contract management company. The management company will report to the hospital board, providing reports and dealings on all policy matters. Training for board members must be provided: specifying what reports they need, their format, content and software. Quality assurance is a key priority."

"In addition to education specialization, hospital administrators must be qualified to meet the needs of that particular area as there may be different kinds of hospitals and healthcare entities and their missions are probably different. The hospital industry is one of the most regulated industries. Like other kinds of hospitals, rural hospitals are adversely affected by many things and by relationships that are not aligned together."

Financial Management

Financial issues and/or management were ranked second in importance by the majority of the respondents. All participants believed that adequate financing was key to seeking contract-management alternatives. Since hospitals are both social and economic institutions, they experience conflicting missions unlike other private organizations. Hospitals must remain financially solvent to stay in business, yet, they are required by law to serve the health care needs of anyone seeking their services regardless of the client's ability to pay. Therefore, financial stability must be a top priority. According to these respondents, hospitals are confronted with varied financial issues in their operation: reimbursement rates, rate structure, cost shifting, risk avoidance, payer mix, vendor services (fees, contracts, & service delivery), debt collection and compliance audits. The opportunity to participate in bulk purchasing, and the effect of economies of scale are also reasons for engaging in contract-management organizations with hospital operational expertise.

Some participants had this to say in response to the question of "why contract-manage"?

"They have access to more resources and provide good national information, and are quick to respond to trends in the industry."

"Finance is the main reason, reimbursement rates, financing, uninsured rates and charity contributions and payer mix. Many small employers do not offer health insurance."

"Contract management offers buying through group purchases – lower prices for goods, insurance collection – how to improve procedures, compliance audits. Training on Medicare and Medicaid rules and how to comply with them."

"A Contract management company offers accounting services and provides consultant services based on its experience with 200 hospitals in 42 states."

"Contract management provides a mock audit. Preparing for the Joint Commission review," which is a pre-inspection prior to the formal audit. (JCAHO)

"Contract management can offer rate structure expertise, how an institution charges, purchases supplies, handles risk avoidance (keeping Medicare from coming back and asking for reimbursements), assisting with maximizing critical access designation."

Medical and Information Technology

Medical and information technology were viewed as important components in seeking the contractual services of an outside organization. However, the two must be contrasted in this theme. Information technology is viewed from the perspective of financial services, accounting, tracking revenues, reimbursements, human resources payroll, and other administrative-related functions. By engaging the services of an outside organization that is already established, hospitals can gain their service benefits such as (back up information system), becoming a part of a larger operation, thus gaining access to what is needed at a reduced cost through economies of scale. This will permit them to have access to professional expertise and technology that cannot be achieved independently. On the other hand, medical technology services can be promptly provided by having equipment available on site or readily accessible for immediate test results and diagnosis. Participants made these comments relative to technology benefits.

"Very hot topic and they can provide information without trial and error."

"Training at College of Medicine must consider technology or lack thereof in rural hospitals – physicians may not find this in real practice."

"There are three things that physicians want: (1) money – expectation of a given amount, (2) culture – higher level of respect for where they work, and (3) technical resources – equipment, technology, convenience and recording of data."

Human Resource Management & Recruitment

Respondents experienced a variety of recruitment and retention issues based largely on location, accessible resources, and salary dollars to pay competitive rates for health care professionals. Contract management firms are a source of recruitment assistance for physicians, particularly high-end specialists who can provide more specialized services to the hospital. Examples from one respondent included orthopedics, otolaryngology, neurology, and cardiology. According to another respondent, the three key positions for the hospital are the chief executive officer (CEO), the chief financial officer (CFO), and the Director of Nursing. Some participants experienced difficulty in securing and maintaining the services of other health care professionals such as therapists, nurses, and department managers in other organizational units of the hospital.

The issue of medical malpractice (three strikes and you are out) and liability for physicians and hospitals is common for all hospitals whether contract-managed or not. It is a major financial consideration to secure adequate insurance coverage for a hospital. It is also a consideration and a challenge to recruit physicians not only to small rural areas but also to the entire State of Florida.

> "It is very difficult to recruit the full range of healthcare workers to a small rural area. Recently, we have been fortunate to acquire the services of two physicians through the National Health Care Service Corporation. I am hoping to find some more physicians in the future through the same program. The NHCSC is a great resource for primary care providers."

> "There is still a challenge for small hospitals that must hire employees who require a salary greater than the mean. To hire MD's, they must live within 30 minutes of the ER (you have issues such as schools, shopping, and social ills in the community) that you must "sell" to the physicians' families).

> "We use ARNP's to provide coverage. We have had some success attracting physicians in a shared-arrangement with other hospitals but continue to work toward physician recruitment and to retain those that are dedicated full time to our hospital."

> "Recruitment and retention of doctors is at the top of the wish list. How does a small hospital pay the demanded salary rates? We have taken the MDs out of the ER and are using nurses or nurse practitioners. This is further complicated by the shortage of doctors. A new study predicts a 20,000-doctor shortage in Florida. Doctors may be listed in the area but that does not mean they are working at the hospital."

> "Disparity in wages for certain skills in a small county is a big issue. The CEO makes more than anyone else in the county, including the judge. This creates problems with other workers."

From a contract provider's perspective, "what value do contract management services offer"? According to an interview with one nonprofit hospital CEO that responds to invitational bids to offer contract management services, the larger hospital can offer the following services to small rural hospitals: (a) provision of access to high end specialists, who may not live in the community or cannot be supported by the community on a regular basis, (b) on-site clinic services, (c) education and training programs for health care workers, (d) trustee board member training – strong boards are important and key to responding to the health care needs of the community, (e) strategic planning and managerial support and expertise to the CEO, (f) conduct focus groups meeting with constituents and policymakers and assistance with articulating the needs of the community, (g) consultative advice for improvement of claim processing, clinical training, and medical record keeping. In summary, the contract provider can offer many of the services participants believe are sound reasons to adopt the contract management model for health service delivery.

Table 10

Rationale for Contract Management Services

Themes	**# of Participants**	**Rankings**
Hospital Management Expertise	4 of 6 ranked it	#1
Financial Management	4 of 6 ranked it	#2
Information & Medical Technology	4 of 6 ranked it	#3
Human Resource Management & Recruitment	4 of 6 ranked it	#4

Effects of Contract-Management

The second emergent theme is the effect of or issues with contract management services. Respondents' views were directly linked to current and historical hospital status. The perspectives of three respondents who are no longer engaged in contract management services are in sharp contrast with those of clients who presently benefit from such services. The differences revolve around: (1) Lack of community hospital control and independent authority, (2) poor management, (3) fiscal mismanagement, (4) ethics/integrity, and (5) quality service.

These themes were not ranked since they were evenly distributed among respondents (three for each effect). Table 11 provides a summary of these contract management effects.

Lack of community control and independent authority.

The qualitative theme viewed as the most critical theme due to its impact on the quality of medical care, the accountability entity for providing health care and the outcomes of hospital closure. In contract negotiation, some participants turn over their hospital license to the management firm and leased the building requiring monthly rent payments. In such cases, the Florida Agency for Health Care Administration and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, holds the licensee accountable for the quality of medical service and for the appropriate administration and compliance with all applicable state and federal regulations.

This licensure arrangement caused three hospitals to be subjected to the whims of the private company to regain their license and subsequent (CAH) critical access designation. In the case of two of these hospitals, their licenses were voluntarily returned. However, it took one hospital (Gadsden Community) two years to regain its licenses. This hospital has still not been successful, even through court appeal, in regaining its critical access designation (Spires, 2008), which is crucial for a small rural hospital. The Gadsden Community Hospital was closed by the Agency for Health Care Administration due to inferior medical care provided by the private company (Agency for Health Care Administration, November 2005; L. MacLafferty (personal communication, April 25, 2008).

> "Quality medical care is the highest priority for a hospital and represents the largest medical expense. The respondent who gave this comment indicated that inferior medical care resulted in the closing of this institution which was under contract management."
>
> Effect of closure: "Emergency medical transport system is strained; 50% more trips outside the county (the longer trips); expenses increased by 25% to the county, unacceptable strains on people and equipment operated at the limits of capacity for extended periods of time; significant increases in DOA's (Dead on Arrival) at the Leon County Emergency Room, payments required to be made to Leon County for uninsured residents increased by 50%."

A further complication of the lack of control effect is the potential for change of ownership. Centennial Healthcare Corporation of Atlanta, the original owner, spun off its hospital business and a newly formed company, DasSee Community Health Systems and its

affiliate, Ashford Community Health Care, assumed ownership of the three hospitals (Florida Trend, 2001).

Poor Management. The level of dissatisfaction among some participants was revealed in comments below. Many clients felt betrayed by the actions taken by the hospital management firm. Yet, they were willing to acknowledge some responsibility for the outcome due to their own lack of expertise and inability to properly monitor and hold the contract manager accountable. Lack of timely and periodic reporting to the hospital board; inaccurate financial reports, and decision-making that were not in the best interest of the hospital are all characteristics of poor management practices. Some of the comments from respondents reflect the level of intensity related to shoddy management practices of the contract management company.

> "During the company's tenure, it "raped the hospital and left it for dead." "Rent was not paid, payroll was not met during the last month, and employees did not receive any type of benefits. There was no attention paid to upkeeps. Repairs were not made to the hospital. The reputation of the hospital in the community was not good at this time."
>
> "ML was an employee of Centennial and the company had the lease on the hospital but were about to give it up so ML, with no experience in hospital administration formed his own company, DasSee, and took over the hospital from Centennial. They wanted to get out of the nursing home business and keep the hospitals. He (ML) got into a lot of trouble with financing the company and was cross-collateralizing the revenue stream to support the debts of other hospitals. We did not know this."
>
> "The management company knew it was going down. The hospital was caring for an unusually high number of uninsureds. The management company wanted the county to pay directly the cost of serving the uninsured. The Board thought the problem was poor management and was taking steps to regain control of the hospital."
>
> "The county did not really know what was going on with the finances. The county and the private company agreed to support the ambulance service, $5,000 each. The private company did not keep its part of the bargain. They stopped paying rent on the lease and stopped paying the ambulance fee."

According to the Agency for Health Care Administration, (AHCA), DasSee Community Health Services did not file required financial reports for hospitals it managed in 2005. The company was fined but those fines have not been collected. ACHA's priority is quality of care. "We would not necessarily review and monitor financial reporting. Some management contracts

do not allow for transfer of licenses." (L. MacLafferty, (personal communication), April 25, 2008).

Financial Mismanagement.

Financial mismanagement is a major component of poor management: payments for services rendered and negotiated contracts for rents and lease payments were not made. Other decisions left some local governments in a serious financial bind can best be articulated through the words of these respondents.

> "In December 2006, we were notified by the private management team that they could not make the next payroll and the County had to step in. We had $1 million in reserve and had to use it to make the payroll."
>
> "The management company was attempting to cope with these expenses by cutting back on people, which resulted in inferior medical care. Another big reason was that the medical profession was the first to recognize the decline in the quality of care and they started to leave. Some even stopped admitting patients to the hospital."

Medicare reimbursements were also issues linked to overpayments resulting in potential liability for the hospitals, which are reimbursed through the Centers for Medicare and Medicaid. These overpayments become the responsibility of the present license holder even if the previous license holder has failed to resolve them.

Florida's small rural hospitals were not the only ones adversely affected by Medicare overpayments. There has been disruption of medical services and related financial issues with the same firm in the case of Choctaw County Hospital in Mississippi, which suspended inpatient and emergency room services due to financial difficulties after a Medicare audit. According to a board attorney, a Medicare audit showed that Choctaw County Hospital had received Medicare overpayments totaling $407,000. In January 1999, the hospital was leased to another hospital management company called Centennial Health Services, then subleased to DasSee Health Services of Quincy, Florida in 2001. DasSee began to fall behind on monthly lease payments of $17, 2000 according to the County Clerk. The board attorney stated that with the hospital under a board of trustees during the fiscal year the overpayments occurred, "the county had no day-to-day role in running the facility at that time" (Whitehead, 2002, p. 3).

Ethics/Integrity

Some respondents expressed disappointment at the actions of the contract management company and believed that the company CEO was not forthcoming about the financial and

management issues of the hospitals. The belief existed that this was intentional and purposely designed to take unfair advantage of local policymakers and their respective communities. Comments from participants suggest that indeed there were problems but that a lack of timely intervention and accountability provided the opportunity for problems to escalate resulting in substandard medical care and subsequent closure of one hospital. Some examples of these comments follow.

> "They (the administrator) alluded to problems but were never specific about what they were." "…We were not aware of the financial circumstances of the private company."
>
> "We later learned that "cost reports were falsified."
>
> "Infrequent communication – the county really did not know what was going on with the finances. County officials took the word of the administrator that "they were just experiencing a small problem and things would be worked out."
>
> "Hospital administrator made an *annual* [italics added**]** report to the board."
>
> "There were plenty of signs that there were problems but we felt that it was acceptable as long as they could keep the hospital open and pay the employees."
>
> **"**The Contract company left the county in debt for Medicare reimbursement overpayments."

"The private company *did* relinquish the hospital license back to the county."

Quality Services. Despite the challenges and disappointments experienced by some participants, others saw the benefits of a contract management firm. Some respondents expressed satisfaction with the services of the private company and believed that it as an overall asset to the successful operation of the hospital. One of these hospitals has been served by a contract management company for 25 years, another for 12 years, and one just under three years. However, one institution later engaged in a quasi-contractual arrangement where the CEO and the CFO became employees of the hospital instead of the usual arrangement where these positions are employees of the private company. Furthermore, two of the respondents who experienced past unsatisfactory services with a contract management firm are willing to try again, given the "lessons learned."

These respondents believe that there are numerous benefits in engaging a management company to operate a small rural hospital. Among these are training, strategic planning, and assistance with complex rules and regulations.

> "Provide training on new Medicare and Medicaid rules; physicians offer lectures to medical staff on these rules and how to apply them."
>
> "Provide board member training is provided through seminars, the management company, the CEO, and other external organizations."
>
> "Offers resources and expertise in a variety of areas on an as needed basis or ongoing: include discussion of rate structure – how does the institution charge for services, how does it handle risk avoidance (keeping Medicare from coming back and asking for reimbursements), getting help with maximizing critical access designation, board member training."
>
> "Make resources available through consultant services in accounting, information technology, board member training, recruitment of CEO and CFO, economies of scale."
>
> "Board of County Commissioners has a fiduciary responsibility."

Table 11

Effects of Contract Management

▪ Lack of community hospital control and independent authority\
▪ Poor management
▪ Fiscal mismanagement
▪ Ethics/integrity
▪ Quality services

Traditionally Managed Hospitals (Non-contract-managed)

A comparison group of respondents was interviewed to gain insight into their strategies to maintain a successful operation and to explore their views about contract-management services. From these interviews, it was determined that three key reasons influenced their decision not to engage in contract management. These include (1) Lack of vested community interest/loss of independence, (2) financial issues, and (3) ethics/integrity.

Lack of Vested Community Interest/Loss of Independence. Respondents preferred to let the community control the local hospital and believed that having managers and board members who lived in the community would better reflect the interest of the local community. Contract

management companies recruit the CEO and CFO, and sometimes the nursing director for the contract-managed hospital. However, from the researcher's perspective, there was no indication that a local hospital board could not reject recommendations or hiring for these critical positions.

Financial Issues. Respondents were particularly concerned about the financial impact of hiring a contract-management company. They perceived that excessive outside management fees would prevent the hospital from efficiently maximizing its financial resources in the most effective way. Coupled with the former concern is the fear of excess debt. Some of their comments are as follows.

"Left other counties in debt."

"Contract management company did not want to take us over unless the board approved the maximum millage rate."

"Saw other hospitals sign on and the company took the Medicare reimbursements out of the hospital."

"Skim the profits, probably would not put them back into the hospitals."

"Line the pockets of the company stockholders."

Ethics/Integrity. Important issues for managers of traditionally managed hospitals were the trustworthiness and integrity of contract management companies, particularly because the managers were keenly aware of the experiences of other counties that had selected the contract management alternative. Counties/hospitals were not given enough time to engage in an orderly transition to pursue alternative organizational changes that would not jeopardize the health and safety of the patients and the community. In the conversations of both groups, the challenges of the uninsured were mentioned as a key concern within the community. In the case of three hospitals in this study, the contract management company appeared to pursue separate negotiated fees to service the uninsured in the counties they served.

Many "traditionally managed" hospitals have operated successfully without benefits of a contract management firm. For example, one of the hospitals in this study was ranked by Thomson Healthcare among the top 25 hospitals in the nation as the most profitable critical access hospital. This was the only CAH in Florida to receive such designation (Thomson Healthcare, 2007). It must be noted that their operating margin were based on 2005 Medicare cost data reports. This may be influenced by payer-mix for a hospital in a specific locale with a

certain percentage of individuals covered by Medicare insurance. The administrator of the ranked hospital believes that its success is centered around one term: "ACTION" Management. He defines action management as utilization of several techniques such as (a) controlling costs, (b) communication – both inter-and intra institutional, (c) supervision oversight and ongoing examination of departmental activities and production, and (d) planning. Operational performance is monitored based on monthly financial reports, statistical trends, and comparisons. Departmental units meet weekly to discuss staffing, departmental services and utilization of customary hospital operation budgets. This traditionally managed hospital was successful, in collaboration with the Office of Rural Health, to build a new replacement facility and completed its relocation in April 2008.

Given the perspectives of respondents who experienced unsatisfactory service with contract management, a summary of "lessons learned" is provided in Table 12.

Table 12

Contract Management - Lessons Learned

- Never lose your hospital license.
- Never lose your critical access designation (this is particularly true now as the federal laws changed effective January 2006 regarding eligibility to become a CAH).
- Never allow your hospital to close
- Business processes must be formalized
- Accountability and performance measures must be outlined and documented.
- Transparency, appropriate processing procedures and financial reports that are subject to auditing and financial accountability must be outlined.
- A formal process is essential to solicit invitations to bid, negotiating a contract and effectively monitoring the standards set forth in the contract.

The top three lessons to be learned, particularly by those participants who experienced a major disruption in health care services for their community, were repeatedly echoed: (1) never lose your license, (2) never lose your critical access designation, and (3) never allow your hospital to close. These three key lessons may be reframed in summary, never turn over your hospital license to another organization unless you are engaging in a sale of the facility and relinquishing any role in its operational services.

The terms of a contract management agreement is negotiated by the policymaking board and advisers who must understand the consequences – both legal and the disruption or loss of a

health care delivery system. I learned in the interviews that respondents from both traditional and contract-managed hospitals used similar strategies to maintain the viability and successful operation of their hospitals. They share their views in Table 13.

Table 13

Strategies Employed by Contract and Traditional Hospital CEOs

- Pass a sales tax to raise revenue for upgraded services or new hospitals.
- Increase tax millage rates.
- Employ the use of Hospitalists. (Physicians who provide medical care for hospitalized patients)
- Increase the volume of out-patient services, do health screenings, clinical diagnosis, laboratory tests, etc
- Formalize relationships with academic organizations (community colleges, universities - Colleges of Medicine) to enhance recruitment and retention of health care workers.
- Maximize and encourage the use of the "swing bed" program.
- Establish partnerships with the community – marketing and increasing the community awareness of the hospitals' economic value to the community.
- Networking and becoming actively involved in the community.
- Become more aggressive in collecting debts. Build a strong financial staff; implement aggressive collection policies–make sure that the hospital gets every dollar due either through reimbursement plans or bad debts.
- Look at other types of businesses as models – follow up on every opportunity to secure payment for services rendered.
- Building community support and trust - encouraging local residents to have confidence in the service provided by the local hospital and to seek local health care rather than driving to another county or state to seek medical care.
- Initiate or expand telemedicine capacity

For the most part, representatives of health care affiliations (AHCA, Big Bend Rural Network, Hospital CEO (not a part of the study), DOH, and American College of Health Care Executives) confirm many of the challenges facing small rural hospitals in this study. Some of them include the recruitment and retention of hospital CEOs and other health care professionals, particularly high-end specialists; restrictions on hospitals with CAH's designations; difficulty in competing with larger, urban nearby hospitals; board member training and expertise; and lack of technology and economies of scale. Each of these, though not all inclusive, may affect the financial viability and survivability of small rural hospitals.

Finally, each respondent was afforded the opportunity to express their views on the circumstances or opportunities in the hospital industry. All shared somewhat similar perspectives and were focused on the challenges of the uninsured, uncompensated care and the state of the health care delivery system in Florida and in the nation. These three were mentioned first and most often. Table 14 summarizes their views.

Table 14

Challenges in the Hospital Industry (Reflections of all Participants)

- Control Costs (hospital operations are very expensive, salaries, etc.)
- Be competitive with respect to patient services (new medical treatments—hospitals have to acquire them to remain competitive
- Increase understanding of the health care delivery system, its complexity, ways in which it has become fragmented, its service demands, and its payment system,
- Understand the political factors influencing health care
- Find creative ways to serve the uninsured population
- Find a way to value uncompensated care.
- Seek ways to address Medical malpractice laws
- Look for balance between services provided and escalating costs.
- Upgrading and investing in new facilities.
- Hospitals' survival in small rural communities
- Convincing community residents that they can receive quality medical care at their local hospital.

The findings in this chapter were presented in two parts. The first part examined the relationship of hospital ownership types with certain community characteristics. Mixed results were found for hypotheses one through five. However, hypothesis six, related to the operational performance of private for-profit and private nonprofit hospitals was found to be not significant as predicted.

The second part provided insight from research respondents on contract management services. These individuals offered four reasons why community hospitals engage in contract management: (1) hospital management expertise, (2) financial management, (3) information and medical technology, and (4) human resource management and recruitment. Respondents commented on issues that might require examination that extends beyond the research question.

CHAPTER 5
DISCUSSION AND CONCLUSION

Three types of hospital ownerships were investigated: private nonprofit, private for-profit, and public. In addition, through qualitative inquiry, the decision to contract-manage hospital operations was explored. This research (1) examined the relationship between five select community characteristics and hospital ownership types; (2) determined whether there were differences in operational performance between private nonprofit and private for-profit hospitals; and (3) proposed an answer to the question–why do some local governments choose to contract manage their hospital operation. This chapter provides the following discussion: 1) overview of the findings, 2) theoretical implications, 3) policy implications, and 4) conclusion.

Transaction cost and institutional theories informed the theoretical framework of this study. Transaction cost theory suggests that three constructs govern organizational transactions: markets, hierarchies and hybrids. In this research, markets are deemed to be the private sector, hierarchies, the public sector, and hybrids - public private partnerships, such as contract management services. Institutional theory elucidates our understanding of public private partnerships, privatization and contracting and while also describing linkages between public and private jurisdictions.

To some extent the literature in this study advances the view that local governments are in a position to make decisions regarding service delivery choices. It is important to note that in Florida decisions regarding ownership types are limited for these reasons: (1) most local governments have sold or converted their hospital organization to a private entity or a quasi-public organization as in an authority or district, and (2) the State renders a decision on hospital location and ownership type through its Certificate of Need (CON) program authority. Consequently, it becomes the prerogative of the hospital board to make decisions regarding existing hospital operations, whether it chooses to sell, merge or explore other alternatives.

Five predictor variables, referred to as community characteristics, were used to answer research question one. They were: size of jurisdiction, density, tax millage rates, minority population, and unemployment rate. To answer research question two, differences in operational performance (cost and efficiency) of private nonprofit and private for-profit hospitals were examined using four components: average length of stay (ALOS), operating margin percentage, Medicaid/charity care, and case mix. An additional goal of this research was to find why some

local governments choose to contract-manage their hospital operation. This answer is based on the interviews of research participants.

The first community characteristic and predictor variable explored was size of jurisdiction. Research findings provided some evidence for the prediction that for-profit hospitals would be more dominant in large jurisdictions. In comparing size of population and density level, research findings did not support the prediction that for-profit hospitals would have a positive association with higher levels of density. However, a pattern was observed that showed a significant concentration of for-profit hospitals in high-density areas. This pattern of location relative to for-profit ownership types was also supported by research findings of other scholars (Brown & Potoski, 2003; Ferris & Grady, 1986, 1987).

The diversity of Florida's land area and county population density may also influence the outcome of these findings. On the one hand, Pinellas County is ranked number one in the state in population density with 3,383 persons per square mile (in 280.2 sq.mi). On the other hand, Levy County is ranked number 55 with 34 persons per sq. mi. (in 1,118.4 sq. mi.). Several other counties, for example, Taylor (20 persons per sq. mi. in 1,042 sq. mi.), Hendry (33 persons per sq. mi. in 1,152 sq.mi.), and Calhoun (25 persons per sq. mi. in 567.4 sq. mi.), twice the land area of Pinellas County (Bureau of Economic & Business Research, 2006). All of these examples reflect the breadth of variation in population density levels and prediction of hospital ownership type and location.

The prediction that for-profit hospitals would have a positive association with jurisdictions where tax millage rates are higher than the state's average was not supported in research findings. In reviewing transaction cost theory, this lack of significance may be influenced by the fact that privatization includes both private for-profit and nonprofit hospitals. Transaction cost theory does not necessarily delineate these distinctions, largely because most private sector organizations within a given industry are generally for-profit entities rather than a combination of both for-profit and nonprofit such as the case with hospitals.

According to transaction cost theory, communities that are limited with respect to taxing authority and that experience public opposition to higher taxes are more likely to have private hospital services. The hypothesis, as stated, limits the analysis to private for-profit ownership, a circumstance that does not capture the full range of private hospital services in counties that have higher tax millage rates. If both private for-profit and private nonprofit hospitals were included

in the analysis in Table C-3, at least 86 hospitals would have been included in the above average millage rate category compared with 17 public hospitals.

The prediction that private nonprofit and public hospitals would have a positive association in jurisdictions where the minority population was higher was not supported in research findings. This prediction was largely based on the premise that social demographics and diverse preferences are expected to be in heterogeneous communities**.** In an effort to be more responsive to these varied service demands, these communities tend to prefer more trustworthy partners such as nonprofits or public entities, particularly in rural communities (Feiock, 2001; Ferris & Graddy, 1987; Weisgrau, 1995).

Although the latter findings were not shown to be significant, a few observations are offered. First, two hospitals, located in counties with large minority populations, 65 and 46 percent respectively, were excluded. Second, 9 of 67 counties, all rural, have no hospitals at all and were not included in this research. For example, one of these, Jefferson County, has a 40 percent minority population. Third, major teaching hospitals, one located in a county with a significant minority population, are excluded from this study. These findings may also be influenced by the linkage of hospital ownership types and minority percentage rate to county level data.

The prediction of hypothesis five, which posits a relationship between ownership type and high unemployment rates revealed a statistical significance. This prediction was advanced based on the concept that health insurance is largely available through employers and that unemployment rates may have a relationship with the number of uninsured persons. This effect is generally not favorable for investor-owned hospitals. However, the findings demonstrate that there is an equal distribution of for-profit hospitals in jurisdictions above and below Florida's average unemployment rate. This broad construct (that may have national implications) that employment is linked to the availability of health insurance suggests that, in Florida, some function of the states' high concentration of small businesses may explain these findings. Small employers (those with fewer than 50 workers), are less likely to offer health insurance than are employers with a larger workforce. According to the Florida Hospital Association (2008), 69% of the uninsured workers are employed with companies that offer no health coverage.

The nonprofit and public hospitals show a significant concentration in jurisdictions that exhibit lower unemployment rates. These results might also be linked to previous mergers or

consolidations and competition among for-profit and nonprofits hospitals. This phenomenon was in contrast with the prediction of TCT that asserts that nonprofit and public hospitals may dominate jurisdictions with higher unemployment rates.

Finally, the prediction that operational performance for private nonprofit hospitals is not significantly different than private for-profit hospitals was supported by research findings in each of the four components tested (average length of stay (ALOS), operating margin percentage, Medicaid/charity care, and case mix. The research design captures the strength of operating costs and efficiency by testing each of these components independently. These data were standardized to reflect cost of living, geographic variation and formulated to ensure uniformity and consistency among hospitals in each county area. These findings do not reveal a significant difference in operating performance.

A vast body of literature exists on the operational performance of hospitals and their respective ownership types (e.g. Becker & Sloan, 1985; Ermann & Gabel, 1986; Burgess & Wilson, 1996; Fishman, 1997; Duggan, 2000; Shen, Eggleston, Lau, & Schmid, 2007). However, significant variations exist in the definition of operational performance, the threshold for measuring performance, payer mix (numerous studies limited to Medicare) and geographic variation. Additionally, the inaccuracy of reported ownership types gives cause for concerns because of the large number of mergers, acquisitions, and consolidations among hospitals over time. This cause for concern is reinforced because the American Hospital Association (AHA) provides a major database source for a large number of studies. This organization relies on multi-hospital groups and affiliated organizations to supply annual survey information. Mitchell, Spetz & Seago (2001), suggest that these inaccuracies may affect the outcomes of such studies in terms of service mix, costs and access to care.

The contribution of charity and community benefits of for-profit and nonprofit hospitals continue to be debated among scholars and hospitals as well (Norton & Staiger, 1994; Horwitz, 2005; Schneider, 2007). At the heart of this issue are the favorable tax benefits for nonprofits. Are nonprofit hospitals providing enough charity care to justify their tax-exempt status? Does this give them a competitive edge? Are the questions asked by Schneider (2007 and Hundley (2008). Since the U.S. does not provide health coverage for all Americans, the strong ideological basis for extending tax preferences to nonprofits is that they provide more charity care and community benefits than do for-profit hospitals. As the number of uninsured persons

grows, particularly in the current economy where the number of job losses is on the rise, this policy and economic debate has escalated.

For the most part, scholars agree that public hospitals, often referred to as "safety nets," are the largest providers of Medicaid/charity care in practically every American community (Fishman, 1997; Needleman, Chollet & Lamphere, 1997; NAPH, 2004). Florida is no exception. Compared to other ownership types, public hospitals in the state are the largest provider of Medicaid/charity care (ACHA Hospital Financial Data, 2006). Since the private hospital market provides so much more care in Florida (approximately 89%) than does the public market, comparing operational performance of the two types of private markets, nonprofit (40.78%) and for-profit (47.49%) offers more useful insight in terms of cost and efficiency.

Many scholars have postulated that the significance in examining hospital ownership types is that for-profit (investor-owned) types of hospitals drive up the cost of health care (Fishman, 1997; Silverman, 1999; Horwitz, 2004). These for-profit ownerships types increased after the passage of Medicare and Medicaid in 1965. The passage of these laws made more federal dollars available in the form of third-party payments (Gray, 1986). Other health care advocates argue that for-profit hospitals have an allegiance to shareholders and they must look to favorable characteristics for profit-making, i.e., per capita income, population growth, insurance coverage and other positive conditions to advance profit making (Sloan & Vraciu, 1983; Sloan, Picone, Taylor, & Chou, 2001; Gold, 2004; Horwitz, 2005).

Unlike previous cross sectional studies that found nonprofits provided significantly more uncompensated care than did their for-profit counterparts (Gray, 1991; Claxton, Feder, Shactman, & Altman, 1997), findings in this study did not show similar results. It confirms an earlier Florida study conducted by Sloan and Vraciu (1983, p. 34) to get a better understanding of the impact on hospital cost due to the large numbers of for-profit hospitals. These authors compared financial performance and community benefits of both ownership types and found no real differences. They also eliminated teaching hospitals because of the latter's high percentage of charitable compensation and contribution to medical education. The findings of these researchers suggest, "Ownership type (private nonprofit and private for-profit) is a poor predictor of a hospital willingness to treat low-income patients, costs to the community, and profitability." The results of operational performance in the current study are compatible with these findings.

Contract Management

An additional purpose of the current research was to find out why local governments choose the contract management alternative to operate their hospitals. The first important finding from this study is that one of the research questions should be reframed to ask, "Why do *local hospitals* [emphasis added] choose the contract management alternative." This is because the majority of local governments (counties) that previously owned and operated hospitals no longer do so. Only one of the hospitals in this study is currently owned and operated by a county governing body. This specific ownership is reflective of a reversed decision due to the failure of a contract management arrangement.

These research findings are, in part, based on interviews with hospital administrators and suggest that hospitals engage in contract management for four basic reasons: (1) hospital management expertise, (2) financial management, (3) information and medical technology, and (4) human resource management and recruitment.

In qualitative studies, the theory emerges inductively. However, in the case of contract management, a significant challenge exists to advancing a theoretical framework largely because of the absence of consistent and comprehensive studies of this kind. A systematic method is not available to assess the impact of this alternative service within the contract management framework. Rundall (1984) suggested that contract management is quite complex and may have effects that are in conflict with a variety of dimensions related to hospital performance. Different types of arrangements may be negotiated through complex crafted contracts.

The literature related to this subject brings a set of mixed results and varied methodological approaches for investigators to rely on (Shonick & Roemer, 1982; Wheeler & Zuckman, 1984; Rundall, 1984; Alexander & Rundall, 1985; Dor, 1994; Dor, Duffy & Wong, 1997; Cary & Dor, 2004). Another contributing factor may be the lack of performance measures or standards for evaluation or a lack of consensus among parties about what constitutes success or failure in hospital operation. The results in this current study are consistent with this observation. Most scholars of this phenomenon agree that more time and attention need to be devoted to the conduct of studies that can yield useful results. The contractual time period is also a factor in obtaining comparative data. The majority of the contract tenure in this study was three to five years.

During the late 1970s and early 1980s, citizens were not willing to support tax increases to fund public hospitals and political interference served to weaken the hospital's ability to adapt to a rapidly changing health care environment. These factors created difficulty in the recruitment of physicians and other health care workers who remained the core assets for increased revenue sources (Alexander & Rundall, 1985).

Confronted with increasing health costs and varied local, state, and federal regulations, local governments sold their hospitals to private nonprofit or to private for-profit organizations or converted them to hospital authorities or districts. These conversions allowed hospitals to operate independently of local government. They employed strategies to seek additional revenues in a number of ways: (1) establishment of nonprofit foundations, (2) passage of sales tax increases for medical services, and (3) passage of a hospital tax, all of which increased the county's tax millage rate (these tax increases must be approved by the voters in their respective districts or counties)**.** Only one interview respondent indicated that the county commission had a fiduciary responsibility to the hospital operation. Other respondents indicated that there was no relationship, accountability or financial support to the hospital unless there was "pass through money" from the State.

A second finding in the current study supports Dor's (1994) contention that contract-managed hospitals are generally smaller hospitals often located in rural areas. The core of these changes in how hospitals were funded in Florida embraced the opportunity for local communities to maintain some level of control over their hospitals while, at the same time seeking alternatives not only to respond to the financial conditions of the hospital but also to assure survival in a competitive market. For the most part, these public hospitals were built in the 1930s, 1940s and 1950s. They represented an infrastructure that was at the end of its design life, had outdated equipment and technology, and that lacked financial resources. Some of these hospitals have been successful in the past few years in raising funds and building new modern facilities.

One may argue that the governance of these rural hospitals deviates from some of the institutional norms associated with their urban counterparts. As a unique service provider within their boundaries, they share common concerns such as size, case mix, demographics, and health challenges commonly found in rural communities. However, they are in conformance with such mimetic pressures posited by DiMaggio and Powell (1983) and Scott (1995), because such

pressures are inherent in a hospital environment. Regulation, normative and cognitive factors are evident in rural hospitals given their highly regulated environment.

Because contract management is a hybrid among the service delivery choices and represents a subset of the relatively small number of hospitals in this study, exploratory research was conducted to further examine the expectations and challenges of contract management. This arrangement introduces a dual line of authority and responsibilities of hospitals as organizational entities (Rundall, 1984). The contract management company and the hospital board of trustees are equal partners in the mission of delivering quality health care to the community.

In most contract management arrangements, the hospital CEO, CFO, and nursing director are employees of the management company. The hospital boards of trustees are generally members of the community who provided policy direction for hospital operations. This was the case in this study with one exception where a quasi-arrangement existed to provide for the hospital board to appoint its own CEO and CFO with other selected consultant services provided by the management company.

The research findings of several scholars (Shonick & Roemer, 1982, Wheeler & Zuckerman, 1984) support the themes that emerged in the qualitative part of this study that hospitals pursued contract management to bring to bear the necessary administrative skills to manage hospital operations, enhance financial status, increase production efficiency, and recruitment of health care professionals. Rundall's (1984) findings suggest that the primary benefits expected from contract management were increased management expertise, administrative services, and access to joint purchasing and capital. Shonick and Roemer (1982) findings in a California study support some of the views expressed by Florida CEOs of traditionally managed (non-contract) hospitals. The main concerns were excessive management fees, expenses increased at a much more rapid rate, though it is possible that this may have been linked to technology acquisitions and other capital improvements. Payroll savings were reduced, raising another important question: is there a reduction in nursing personnel from full-time to hiring more temporary workers? The final question, "did the introduction of a more rigorous billing and collection system discouraged people from seeking certain kinds of outpatient care?" These findings did suggest that smaller hospitals benefited more than did larger hospitals from the expertise of a management firm.

Ironically, in the current study, local government or hospitals sought certain contract management services to overcome barriers related to hospital management expertise and financial management. Yet, these issues were listed as top concerns (effects) with contract management.

Theoretical Implications

The overview of the relevant theories discussed in Chapter two embraces varied theoretical implications and relationships to transaction cost and institutional theories. Ferris and Grady (1986) findings suggested that limited research exists using transaction cost and institutional theories to examine service delivery choices of hospitals, due in large part, to the potential of eliminating local control and service continuity to constituents. Williamson (1981) posited that pairing transaction cost with the appropriate governance model would lead to improved performance through lower costs and enhanced adaptability. He emphasizes that there are two types of transaction cost: governance and measurement. Governance costs emanate from the role of governance structure on conflicts between two parties to a contract, and measurement costs come from difficulties related to ambiguities associated with the service production (Williamson, 1985). The outcomes and uncertainty of health care are difficult to assess and are therefore more challenging to frame in one theoretical model.

Although it has been widely recognized and accepted by scholars that TCT has broad implications in the social sciences and several other disciplines (Richman & Macher, 2006), the findings in this research reinforce the argument that TCT leaves a void in explaining the governance of economic activity, particularly in the health care sector. Therefore, the appropriate governance model and theory implication may bear certain restrictions and limitations given the complexity and role of hospitals in their respective communities.

Agent/Agency Theory

The exploratory investigation of contract management services provided insight into the relationship of the principal agent and transaction cost theories. In considering whether to contract-manage or maintain hospital service in a traditional setting, the high costs of auditing, monitoring, disruption of services, and taking legal action, if necessary, must be taken into account. Williamson (1985) emphasized the disadvantages in powerful incentives as they not only encouraged efficiency but also dishonesty.

The principal agent or agency theory, a cost element of TCT, is first intended to address problems when the objectives of the principal and agents are contradictory, and second when it is expensive or difficult to confirm whether the agent is behaving appropriately. Agency theorists apply this framework to formalize rules and monitoring scope to gain the most cost effective organizational system (Eisenhardt, 1989). Since agency problems are a form of transaction costs that are built into contractual relationships, this theory is particularly relevant in the qualitative study because of the adverse effects of contract management.

In the example of contract management services, several transaction costs are incurred to negotiate service: 1) preparing specifications to determine if there are available providers, 2) determining whether responding bidders can produce the service in accordance with the contract specifications, 3) writing a succinct contract that clearly defines and measures performance outcomes, and (4) monitoring the agent to determine compliance with quantity and quality standards (Ferris & Graddy, 1994). Another transaction cost is dealing with policy implications such as those arising from this study.

The weakness of the agency theory has to do with its limitation in explaining how the parties decide to engage in a contractual agreement. Kim and Mahoney (2005) posit that neither TCT nor agency theory is expansive enough to handle circumstances when transaction parties do not conclude a contractual agreement. The focus of the agency theory comes only after an agreement is effectuated, i.e., monitoring and measuring progress, (*ex post)*. In addition, its framework does not adequately address the complexities of joint partnerships nor does it examine why the relationship should not be formed. So while the principal agent theory provides the foundation to design and implement external controls (Acar, Guo, & Yang, 2008), the lack of accountability on the part of the principal may still result in contract failure and disruption of service.

Property Rights Theory

Although property rights is not used in this study to test hypothesis, it is viewed as a useful theory to examine ownership debates and to better understand mixed ownership markets in the private sector (Grossman & Hart, 1986; Hart, 1995). Kim and Mahoney (2005) posit that property rights theory more fully accounts for business cases where inefficient economic outcomes (contractual imperfections) persist, while TCT and agency theories take a more optimistic approach. They further suggest that resources are put to their most productive use and

thereby the market arrives at an optimal output level (a Pareto optimal outcome). Property rights emphasize two important elements for understanding ownership: 1) residual value rights and 2) residual rights to income. Both residual control and residual claim (ex ante and ex post contractual issues) are at the core definition of ownership. The main concern with the property rights theory in a health care environment is that its model suggest that private owners achieve lower costs but that quality may be higher or lower (Shen, et al., 2007). Quality is an important component of health care services. The delivery of these services is critical and may have serious consequences when a service environment is unpredictable. The lack of consistency in providing an acceptable level of health care resulted in the closing of one hospital in this study.

Public Choice Theory

The public choice theory as discussed in Chapter Two emphasized that early public choice theorists believed that the role of government should be limited and that the most desirable method for implementing economics and social activities is through networks of private for-profit markets. Private markets are expected to increase competition and improve efficiency. Florida leads the nation in the percentage of private for-profit hospitals. (AHA, 2008; Kaiser Foundation, 2008). Public hospitals represent approximately 10 percent of the community hospitals and most of them are quasi-public such as authorities and districts. Although public choice theory emphasizes for-profit market networks as the superior organizational forms, the results in these findings do not show a significant difference between the operational performance (cost and efficiency) of private for-profit and private nonprofit hospitals.

Institutional and Transaction Cost Theories

Roberts and Greenwood (1997) contends that transaction cost and institutional theories are not in conflict but provide complementary elements of a constrained efficiency framework that is confronted with bounded rationality and institutional limitations. The high cost of hospital service, fiscal pressure to cut costs, asset specificity, service measurability, and the difficulty in contract monitoring are all predictors of how organizations make service delivery choices.

The integration of these theories is limited in view of prevailing market competitions. Since hospitals are strong models of isomorphism and operate according to social legitimation, it is likely that conflict will exist with market considerations of efficiency. Another aspect of

hospital governance that is not often mentioned is its lack of an integrated organizational structure. Unlike other organizations, hospitals are organized as a system of three separate centers of authority: trustees, physicians, and administrators (Haglund & Dowling, 1993). Starr (1982) postulated that sociologists wanted to know why hospitals depart from a standard model of bureaucracy in lacking a clear line of hierarchical authority and economists wanted to know what does the hospital maximize if it does not maximize profit. The absence of integrated management led to more competition among hospitals, more business function, and more administration. All of which left, instead of a single governing power, three centers of authority held together in loose alliance. Hospitals are strongly influenced by their local environment.

Institutional theory offers an explanation of these organization forms, notwithstanding the issue of cost. Based on TCT, one might predict that some of the hospitals that chose to engage in contract management would likely have chosen to maintain such services within their own boundaries. However, this perspective is influenced by the limited approach espoused by transaction cost theory in responding to uncertainty as strictly an economic problem. Transaction cost theory does not accommodate the varied cultural environments and shared values that apply to local hospitals. Institutional theory is more expansive and accommodates a wider range of methodological approaches given the social and economic mission as well as the organizational form of the hospital. Yet, both theories bring complementary elements to the study of service delivery choices.

North (2005, p.1) argues that a comprehensive theory of economic change would blend theories of demographics, stock of knowledge and institutional change. He further posits that the key to improving economic performance is the effort of human beings to control their environment and that priority is given to institutional change.

Public Policy Implications

In Chapter One, public policy issues were raised in terms of hospital ownership and relevancy to public administration. The role of local governmental bodies in health policy was discussed in Chapter Two. The issue that remains constant in the health care debate is whether government or the markets can best resolve the issues of costs, inefficiencies, and the uninsured. The question may best be answered by asking if the health care system is a well-functioning market. These issues are key factors in the successful and efficient operation of all hospitals. Based on the current research, a summary of relevant policy implications are provided below.

1. *Social Mission of Hospitals*. There has always been an historic social mission for hospitals to act as charitable entities to provide health care to needy populations. Though not shown to be significant, for-profit hospitals contributed slightly more of these services than did nonprofits. The contract management company tended to view the uninsured as an anomaly and attempted to pursue separate contracts with hospitals to serve needy populations.

The U.S. Congress conducted hearings on nonprofit hospitals in 2006 focusing on two main areas: community benefit and health care for the uninsured. Senator Thomas Grassley emphasized policies that would permit medical care to be discounted or free to low-income and uninsured persons in the community (U.S. Senate Committee on Finance, 2007). Recent news articles (Boehne & Carreyrou, 2008; Hundley, 2008) highlighted data provided by the American Hospital Directory that nonprofits were faring much better than their for-profit counterparts. While 77 percent of the U.S, nonprofits are in the black, only 61 percent of the for-profits are profitable. The Congressional Budget Office estimated that nonprofit hospitals received $12.6 billion in annual tax exemptions in addition to the $32 billion in federal, state and local subsidies (Hundley, 2008). According to Horwitz (2005), more than fifty lawsuits were filed in federal district courts in 2004 alleging that nonprofit hospitals had violated their charitable commitment. The historic role of the nonprofit hospital appears to be at a defining stage in its purpose and organizational mission. Policymakers will be expected to provide guidance and future direction on this issue because findings in this research indicate that there is no significant difference in Medicaid/charity services between private for-profit and nonprofit hospitals.

2. *Charity Care and Community Benefits*. As evidenced by the federal hearings, as well as a report issued by the Missouri Foundation for Health (2005), there are many definitions of charity care and community benefits. Several states have laws that are intended to apply to all hospital ownership types. However, these rules are defined and interpreted differently among hospital ownership types. Florida's legislation requires that charity care and community benefit be provided by hospitals, but does not clarify its definition and/or intent. This is a debatable issue among hospitals that are related to tax subsidies and location preferences.

For-profit hospitals argue that they operate more efficiently, pay taxes, and provide charity care. Schneider (2007) suggests that if community benefits are the same for both ownership types, the for-profits are competing at a disadvantage with nonprofits. According to Norton and Staiger (1994), there are findings that show similar results for Medicaid and charity

care between for-profits and nonprofits. However, for-profit institutions look for growth patterns that permit them to "skim off the cream" by locating in affluent and well-insured areas. If nonprofits are located in less-insured areas, tax subsidies may be justified to increase access to care to those without health insurance. Charity and uncompensated care is a top concern for CEOs in this study, and is confirmed by the survey conducted by the American College of Healthcare Executives (Khaliq & Thompson, 2006).

3. Role of Local Government. Although most of the hospitals are not county-owned and operated, hospital ownership type may not necessarily remove local government from responsibility associated with the consequences and disruption of health care delivery services. The adverse effects cited by respondents in this study support this viewpoint. Several respondents indicated that local government had no direct role in their hospital operation. Yet, operations are an area of concern because local government officials represent the constituency in the county. In each cases where health care services were disrupted or discontinued, local elected officials became involved in restoring these services either through assumption of the responsibilities or working with state officials to minimize the loss of service. According to the Executive Director of the Rural Health network (B. Lombardo, personal communication, May 1, 2008), in cases where bonds have been sold to finance a new hospital, a strong consideration for approval of those sales was the county's financial rating capacity. Health care is also a quality of life issue and is one of many indexes by which the growth and viability of a county is measured. This, in turn, is a considerable area of interest to firms thinking about relocating their businesses.

In rural counties, the hospital is generally the largest economic engine in that community. Factors such as job opportunities, education, and health care affect economic and population growth. The loss of these assets will most likely cause a decline in revenue sources through the purchase of goods and services and a declining tax base. It is therefore unlikely that privatizing or contract-managing hospital services will completely remove local government officials from accountability for a failed health care delivery system.

4. Hospital Board of Trustees is the policymaking body of the hospital. From this research, several pertinent issues emerge for policy consideration: (a) Does the lack of a service fee for board members adversely affect oversight? (b) Does the recruitment and retention of qualified CEO's present an insurmountable obstacle for part-time boards? (c) Does the demands of public accountability and oversight overburden part-time boards? (d) Does the requirements

for establishing and monitoring performance standards prove to be time-consuming for a part-time board? (e) Does the steps to ensure due diligence in all contractual matters require an unreasonable investment of time for a part-time board?

a) Nonprofit and public board members are expected to volunteer their time without remuneration. Private for-profit hospital board members are paid a service fee for their time spent in board and committee meetings. The consideration for policymakers may be whether this difference affects the commitment and quality of service provided by board members. One respondent suggested that board members may be wary of the time and expertise necessary to serve effectively. This is particularly the case with those who are business owners or hold other occupations. This perspective may also be reinforced by the lack of due diligence in some aspects of the contract management contracting. Additionally public boards require appointments by political leaders. This may suggest that a board may not necessarily be comprised of members with the necessary skills, expertise, or time to serve the interest of the community.

Some nonprofit boards are required to appoint individuals within the districts they serve. Does this limit the potential for selecting the best board members or does the influence of local politics and long-standing family traditions in the community dictate appointments? These are questions that serve to critique the composition of the board and to ensure that board appointees possess the necessary skills and expertise to advance effective policy.

b) Hospital CEOs. The CEO is one of the most important and challenging positions in the operation of a hospital. Based on interviews with the respondents, most of whom were CEOs, the complexity of hospital operation calls for a well-trained individual that is qualified to meet the needs of the hospital in a given community. Based on respondent rankings, hospital management and expertise was the number one reason for engaging in contract management. CEOs of small rural hospitals must be knowledgeable in a broader range of areas than one managing a larger hospital with specialty units headed by other managers. They must fill the role of several positions: finance, human resources, public relations and marketing. Rural hospitals with a critical access designation require a knowledgeable CEO who understands the rules and regulations of a CAH. The views of these respondents are supported by a survey

conducted by the American College of Healthcare Executives (Khaliq & Thompson, 2006). The research findings in this survey indicated that small rural hospitals are more dependent on the CEO for day-to-day operational and organizational tasks. Furthermore, the hospital is more likely to suffer from sudden or frequent CEO turnover. The average tenure for CEOs in this study was two years.

c) Public Accountability and Oversight. Since the hospital board of trustees is the policy making body for the hospital, accountability and oversight in the selection process for contract services is an important responsibility In most cases, at least two to three individuals were involved in crafting a contract for services (local attorney for the board or the county, designated county administrator, and senior manager of the management company). According to research respondents, the selection process for securing the services of the contract management company appeared to have been by word-of-mouth. This approach negates the process of due diligence and establishing performance standards for the service to be provided. In addition, there is no indication that the hospital board conducted periodic monitoring and oversight of the management company. Respondents acknowledged that in some cases they received an *annual* report or simply took the word of the management company's CEO on the status of financial matters and other hospital services. They also acknowledged that the company violated certain provisions in the contract that required shared payments for ambulance services and other obligations. In sum, it is unclear whether the hospital board understood its role in this public-private partnership.

d). Performance Standards. As mentioned in some of the earlier studies, it is difficult to monitor progress and evaluate the cost and efficiency value of a contract agreement if performance measures and standards are not carefully crafted in advance. The respondents in this study suggest perhaps that both parties to the contract were unclear about their respective roles and responsibilities. Suggestions for changes in the contract to handle uninsured persons, ambulance services, lack of upkeep of the facilities and other changes in contract provisions appeared to be moving targets and warning signs of a failed partnership.

e) Due Diligence. In an effort to better understand the operation of this same company that provided services to three hospitals, the question of due diligence becomes

evident. The following series of questions come to mind: What kind of background check is necessary? What is the position of the hospital board on company ownership transfers? Who assumes liability for failed partnerships and resulting costs? What legal action is appropriate? What steps must the hospital board take to ensure that they do not conduct business with organizations that show a pattern of shady practices, fraudulent activities, frequent turnover of ownerships, and bankruptcy filings?

Finally, who is responsible, if anyone, to notify other (states') hospitals of patterns of failure with a given management firm. Answers to these questions may prove beneficial to all hospitals in an effort to avoid the adverse circumstances found in this study. As discovered during this study, the State of Mississippi experienced a major disruption of health services at one of its hospitals. This occurred as a result of similar practices from the same firm. One respondent stated that this same company is currently pursuing business in other states.

In 2003, the U.S. Department of Justice publicized the potential liability in contracting the services of a management firm. Two firms that ran the Edgewater Medical Center in Illinois during a six-year period were charged with fraud that included "doctors lying to patients about their need for hospitalization, admitting patients unnecessarily and performing medically unnecessary procedures." Each pled guilty to criminal fraud charges and was sentenced with an agreement to pay $2.9 million to resolve related criminal and civil health care fraud. The detailed actions of health care providers in these companies should be a "lesson learned" for any medical facility considering partnership ventures.

5. Mission and goals of public-private partnerships need to be clarified. The role of the policy making body is unclear under this arrangement. Precise directives that delineate clarity on this point are essential. Long range, what is the future of local government control over access to health care and who influences local hospital policy?

a). Licensure Status. This study found that some hospitals leased their facility to the management company and turned over their licenses to the same company, with the intent of removing themselves from fiduciary responsibility, liability, risks management decisions in the hospital operation. Overall, this process is designed to improve the operational aspects of the hospital in terms of efficiency, effectiveness, and financial and finally survivability. However, leasing and turning over a license is different from any found in existing literature previously identified. The bottom line is that the contract management firm becomes the direct source of

contact and negotiations for all local, state, and federal regulatory bodies. According to Agency for Health Care Administration, MacLafferty (personal communication, April 25, 2008), not all hospitals take this approach. They may use the services of a contract management firm but retain their hospital license. The resulting effect of this is that the loss of health care services in a given community eventually becomes the responsibility of local government even when it chooses to rid itself of the challenges in hospital operation by outsourcing such services.

6. Regionalization. This term is being heard more often as rural hospitals struggle to adapt to a changing and competitive market and at the same time maintain a hospital in their respective communities. This concept must be advanced to secure many of the advantages sought in a contract management arrangement or those achieved in multihospital or system structures. Some hospitals in this study are pursuing agreements with other tertiary hospitals, looking at transferring patients from one level of care to another; rural to urban. Technology is a key factor in a hospital's ability to increase revenue and profitability. Public officials (e.g. Representative Coley, Senator Peaden, former AHCA Secretary Levine, who suggested that they organize and report to their respective County Commissions) have warned small rural hospitals that they can no longer operate independently and expect to survive in this competitive health care environment. North Dakota, a largely rural state with geographically dispersed communities, has recently received attention from other policymakers because of its innovative approach to providing health care to its community despite the challenges normally attributed to serving small rural communities (McCarthy, et al., 2008).

7. Reimbursement Policies. There are numerous variations of payment policies embedded in a plethora of health insurance contracts with different providers. Should this practice be reexamined? Hospitals in Florida and across the nation lament that it is the type of medical procedure that dictates, (i.e. heart surgery) the best payments that increases profitability and survival. Small rural hospitals such as the one in this qualitative study do not have such medical technology. This topic embraces many of the discussions on duplication of services, rising cost of technology, variable amounts for elective surgery, and other specialty group services. The major concern is whether these types of practices drive up the cost of health care and in what way must it be resolved.

8. Public versus private ownership. Should the larger public policy issue in Florida be a dichotomous question of public control versus private control rather than nonprofit versus for-

profit? With fewer hospitals bearing the greater share of serving underserved populations – could this potentially drive medical cost up as poor patients seek medical care at the emergency rooms of other hospitals. At what point should health policy be left to the markets and when or if, should government intervene?

Conclusion

The main purpose of this research was to examine the hospital service delivery choices in Florida. These choices are commonly referred to as ownership types. A by-product of this research was to advance public policy suggestions that may serve to improve the health care delivery system. As policymakers continue to grapple with the challenges of controlling healthcare costs, the health economics debate has recently focused on these ownership types and the purpose they serve.

The primary thrust was to determine if there are significant differences in these delivery choices from the perspective of select community characteristics and operational performance (cost and efficiency). Since this research included a public private partnership structure, its findings represent an expansion of traditional studies that focus specifically on private nonprofit, private for-profit and public hospitals. The results of this study showed mixed results in the relationship of select community characteristics with ownership types and no significant differences in operational performance. The rationale for contract management included: hospital management and expertise, financial expertise, information and medical technology, and human resources and recruitment.

This research contributes to the literature by: 1) filling a void in the contract management literature in a broader context, 2) focusing on the implications for governance in a hospital public-private partnership, and 3) confirming the mutual characteristics of hospital ownership types in Florida.

The limitations of this study are that it is restricted to Florida's acute care community hospitals which may limit its generalizability; its data and community characteristics are linked to Florida's counties; and it is a small sample (169 hospitals) with certain exclusions. The qualitative component is subject to perceptual biases of the participants who were majority hospital CEOs.

Given the diversity of views and the paucity of insight offered by transaction cost and institutional theories, the findings in the exploratory component of contract management services

afford the expanded opportunity for further research in an area that may have significant policy implications for governance and accountability. For example, Table 11 identifies several adverse effects of contract management; one of which is lack of community hospital control and independent authority. While several scholars believed that this was one of the main reasons why hospitals engage in contract management, this same reason was identified as a negative effect of contract management by respondents in this study. What is the appropriate structure and accountability design for a public private partnership? One inherent issue that is evident may be the difference between "loss of control" versus "control" in conventional thinking. Other themes identified in the effects of contract management are poor management, fiscal mismanagement, and ethics and integrity. Each of these themes suggests a level of applicability to transaction cost and institutional theories. Therefore, these themes may be advanced as variables and hypothesized in a quantitative study to further refine, broaden and fill the literature gap in contract management services.

In addition, part of the argument evolving from this study questioned the historic mission of nonprofit hospitals and their charitable service in exchange for certain tax benefits. These issues will no doubt continue to be a part of future dialogues as policymakers search for resolutions to create a health care delivery system that is cost effective and inclusive of all who require basic health care.

Finally, in order to successfully tackle the ongoing thorny issue of healthcare costs, we must search beyond the boundaries of acute care community hospitals and look at all providers, who are not subject to all of the same rules and regulations as the hospitals in this study. Examples include specialty hospitals, ambulatory centers and other facilities that perform services traditionally offered by acute care hospitals and in some cases under different reimbursement policies. Parsons (1960) believed that in order for organizations to have legitimate claims on scarce resources, the goals they pursue should be congruent with wider societal values. Examining hospital ownership among the same types may limit our knowledge base and delay the intervention necessary to solve many of the outstanding problems. Without a comprehensive policy approach on varied providers, reimbursement policies, covering the uninsured, and the intervention of a myriad of participants in the healthcare sector, reigning in cost will remain an unachievable goal.

APPENDIX A

SAMPLE DISTRIBUTION OF FLORIDA'S COMMUNITY HOSPITALS

Hosp #	Hospital Name	Ownership Type
100009	Cedars Medical Center	For profit
100010	St. Mary's	For profit
100024	Fishermen's Hospital	For profit
100029	North Shore Medical Center	For profit
100035	Manatee Memorial	For profit
100047	Charlotte Regional Med. Ctr.	For profit
100049	Highlands RMC	For profit
100050	Palm Springs General	For profit
100053	Hialeah Hospital	For profit
100054	Twin Cities Hospital	For profit
100070	Venice RMC	For profit
100071	Brooksville Regional Hospital	For profit
100077	Peace River RMC	For profit
100080	JFK Medical Center	For profit
100081	Walton Regional	For profit
100099	Lake Wales Medical Center	For profit
100107	Lehigh Regional Medical Center	For profit
100110	Osceola Regional Hospital	For profit
100121	Bartow Memorial	For profit
100122	North Okaloosa Med. Ctr.	For profit
100124	Santa Rosa Medical Ctr.	For profit
100126	Palms of Pasadena	For profit
100131	Aventura Hospital and Medical Center	For profit
100137	Heart of Florida Regional Medical Center	For profit
100139	Nature Coast Med. Ctr.	For profit
100150	Lower Florida Keys	For profit
100156	Lake City Medical Center	For profit
100161	Central Florida Regional	For profit
100165	Westchester General	For profit
100166	Columbia Doctors Hospital of Sarasota	For profit
100167	Plantation General	For profit
100176	Palm Beach Gardens Medical Center	For profit
100179	Memorial Hospital Jacksonville	For profit
100180	St. Petersburg Gen. Hosp.	For profit
100181	Larkin Community Hospital	For profit
100183	Coral Gables Hospital	For profit
100187	Palmetto General Hospital	For profit
100189	Northwest Medical Center	For profit
100191	Community Hospital of New Port Richey	For profit

100204	North Florida RMC	For profit
100206	Memorial Hospital of Tampa	For profit
100209	Columbia Kendall Medical Center	For profit
100210	Florida Medical Center	For profit
100211	Pasco Community Hospital	For profit
100212	Ocala Regional Medical Center	For profit
100213	Blake Medical Center	For profit
100217	Sebastian River Medical Center	For profit
100220	Southwest FL RMC	For profit
100223	Ft. Walton Beach Med. Ctr.	For profit
100224	University Hospital and Medical Center	For profit
100226	Orange Park Medical Center	For profit
100228	Westside Regional Med. Ctr.	For profit
100231	West Florida Regional Medical Center	For profit
100232	Putnam Community Medical Center	For profit
100234	Columbia Hospital	For profit
100236	Fawcett Memorial	For profit
100237	North Ridge Medical Center	For profit
100238	Northside Hospital	For profit
100239	Edward White Memorial	For profit
100241	Lake Butler Hospital Hand Surgery Center	For profit
100242	Gulf Coast Medical Center	For profit
100243	Brandon Regional Hospital	For profit
100246	Lawnwood Regional MC	For profit
100248	Largo Medical Center	For profit
100249	Seven Rivers Regional Medical Center	For profit
100252	Columbia Raulerson Hospital	For profit
100254	Capital Regional Medical Center	For profit
100255	Town & Country Hospital	For profit
100256	Columbia Regional Medical Center at Bayonet Point	For profit
100258	Delray Medical Center	For profit
100259	Columbia South Bay Hospital	For profit
100260	Columbia Medical Center-Port St. Lucie	For profit
100264	Oak Hill Hospital	For profit
110004	Englewood Community	For profit
110006	Palms West Hospital	For profit
110008	West Boca Medical Center	For profit
110403	Good Samaritan Med. Ctr.	For profit
111522	Gulf Coast Hospital	For profit
23960046	Lakewood Ranch Medical Center	For profit
100002	Bethesda Memorial	Non profit
100004	Madison County	Non profit
100007	Florida Hospital	Non profit
100008	Baptist - Miami	Non profit
100012	Lee Memorial Hospital-Cleveland	Non profit

100015	Sun Coast	Non profit
100018	Naples Community	Non profit
100019	Holmes Regional	Non profit
100020	Doctors Hospital	Non profit
100023	Citrus Memorial Hospital	Non profit
100025	Sacred Heart - Pensacola	Non profit
100032	Bayfront Medical Ctr.	Non profit
100040	St. Vincent's	Non profit
100043	Mease Hospital-Dunedin	Non profit
100044	Martin Memorial Medical Center	Non profit
100045	Memorial Hospital-West Volusia	Non profit
100046	East Pasco Medical Center	Non profit
100048	Jay Hospital	Non profit
100051	South Lake Memorial	Non profit
100052	Winter Haven Hospital	Non profit
100055	Helen Ellis Memorial	Non profit
100056	Cleveland Clinic Hospital	Non profit
100057	Florida Hospital Waterman	Non profit
100061	Mercy Hospital, Inc.	Non profit
100062	Munroe Regional Medical Center	Non profit
100063	North Bay	Non profit
100068	Memorial Hosp. Ormond/Peninsula	Non profit
100069	University Community Hospital-Carrollwood	Non profit
100072	Florida Hospital-Fish Memorial	Non profit
100073	Holy Cross Hospital	Non profit
100075	St. Joseph's Hospital	Non profit
100076	Pan American Hospital	Non profit
100084	Leesburg Regional MC	Non profit
100088	Baptist Medical Center and Wolfson Children's Hospital	Non profit
100092	Wuesthoff Memorial	Non profit
100093	Baptist Hospital-Pensacola	Non profit
100102	Shands at Lake Shore	Non profit
100103	Shands at Starke	Non profit
100105	Indian River Memorial	Non profit
100106	Doctors' Memorial - Perry	Non profit
100109	Florida Hospital -Heartland	Non profit
100117	Baptist MC - Beaches	Non profit
100118	Memorial - Flagler	Non profit
100125	Homestead Hospital	Non profit
100127	Morton F. Plant	Non profit
100132	South Florida Baptist	Non profit
100135	Tallahassee Memorial Hospital	Non profit
100140	Baptist Med. Ctr. - Nassau	Non profit
100146	Shands at Live Oak	Non profit
100151	Saint Luke's Hospital	Non profit

100154	South Miami Hospital	Non profit
100157	Lakeland Regional Med. Ctr.	Non profit
100160	Mariners Hospital	Non profit
100168	Boca Raton Community	Non profit
100173	University Community Hospital	Non profit
100175	Desoto Memorial	Non profit
100177	Cape Canaveral	Non profit
100219	Flagler Hospital	Non profit
100244	Cape Coral Hospital	Non profit
100253	Jupiter Medical Center	Non profit
100282	Florida Hospital - Wauchula	Non profit
23960025	Cleveland Clinic Florida Hospital Naples	Non profit
23960032	The Villages Regional Hospital	Non profit
23960034	Wuesthoff Medical Center Melbourne	Non profit
23960041	Sacred Heart Hospital on the Emerald Coast	Non profit
100014	Bert Fish Medical Center	Public
100017	Halifax Medical Center	Public
100026	Bay Medical Center	Public
100028	Parrish Medical Center	Public
100030	Health Central	Public
100038	Memorial Regional Hospital	Public
100039	Broward General Med. Ctr.	Public
100078	Doctor's Memorial-Bonifay	Public
100086	North Broward Med. Ctr.	Public
100087	Sarasota Memorial	Public
100098	Hendry General	Public
100112	Calhoun - Liberty Hosp.	Public
100114	Parkway Regional	Public
100130	Glades General	Public
100134	Ed Fraser Memorial	Public
100138	Campbellton - Graceville	Public
100142	Jackson Hospital	Public
100147	Northwest Florida Community	Public
100153	George E. Weems Memorial Hospital	Public
100200	Imperial Point Medical Center	Public
100225	Hollywood Med. Ctr.	Public
100230	Memorial Hospital Pembroke	Public
110019	Coral Springs Med. Ctr.	Public
111527	Memorial Hospital West	Public
23960050	Memorial Hospital Miramar	Public
		169

APPENDIX B

CONTRACT-MANAGED HOSPITALS: PROPOSED QUESTIONNAIRE GUIDE FOR INTERVIEWS

Respondents: Hospital Administrator, County Administrator, Trustee Board Chair
Hospitals: (1) Currently contract-managed (2) Reverted Back to Public Status (3) Closed

General Questions (All three categories of Hospitals)

1. Why did you enter into a contract-management agreement?
2. How long have you (did you) operate under this agreement?
3. What is (was) the term period of your contract?
4. Who participated in the negotiations and final contractual agreement?
5. Why did you select this company to manage your hospital operation? Is (was) it nonprofit or for-profit?
6. What is (was) the relationship between your board of trustees and the managing company? A) How are decisions made, b) How do you monitor financial and operational performance?
7. What is the status of your population base: employment, income, race, and health?
8. How has this arrangement affected the residents in the community?
9. What lessons can you share about the contract-management arrangement?
10. Are you satisfied with your present arrangements? Why/why not?
11. Are there other challenges/opportunities you would like to share not previously discussed?

Specific Questions for these categories

Currently Contract-Managed (CCM)

- What contractual revisions would you make upon renewal and/or expiration of the existing contract? Why?

Reverted Back to Public Status (RBPS)

- Why did you revert back to self-managed status?
- Will you consider contract-management in the future? Why/why not?

Closed (C)

- Do you have plans to reopen your hospital? If yes, how will you do it? If no, what arrangements do you make for delivering hospital services to your community?

APPENDIX C

HYPOTHESES TESTING TABLES

Table C-1

Hospital Ownership Type and Size of Jurisdiction

	Ownership Type			
	For-Profit	Nonprofit	Public	Total
Jurisdiction Size				
Small	9 (5.3%)	12 (7.1%)	8 (4.7%)	29 (17.2%)
Large	71 (42%)	52 (30.8%)	17 (10.1%)	140 (82.8%)
Total Hospital %	80 (47%)	64 (38%)	25 (15%)	169 (100%)

Chi-square results: χ^2 =5.93, df=2, p=.051

Table C-2

Hospital Ownership Type and Population Density

	Ownership Type			
	For-Profit	Nonprofit	Public	Total
Density Level				
Low	10 (5.9%)	11 (6.5%)	8 (4.7%)	29 (17.2%)
High	70 (41.4%)	53 (31.4%)	17 (10.1%)	140 (82.8%)
Total Hospital %	80 (47%)	64 (38%)	25 (15%)	169 (100%)

Chi-square results: χ^2 =5.095, df=2, p=.078

Table C-3

Average Tax Millage Rate and Hospital Ownership Type

	Ownership Type			
	For-Profit	Nonprofit	Public	Total
Tax Millage Rate				
Below Average	38 (22.5%)	20 (11.8%)	8 (4.7%)	66 (39.1%)
Above Average	42 (24.9%)	44 (26%)	17 (10.1%)	103 (60.9%)
Total Hospitals %	80 (47%)	64 (38%)	25 (15%)	169 (100%)

Chi-square results: $\chi 2=4.558$, *df*=2, p=.102

Table C-4

Hospital Ownership Type and Minority Population

	Ownership Type		
	For-Profit	Nonprofit/Public*	Total
Minority Percentage			
Below Average	56 (33.1%)	57 (33.7%)	113 (66.9%)
Above Average	24 (14.2%)	32 (18.9 %)	56 (33.1%)
Total Hospitals %	80 (47%)	89 (53%)	169 (100%)

Chi-square results: $\chi 2=.674$, *df*=1, p=.412

*Nonprofit and Public are combined based on hypothesis prediction.

Table C-5

Hospital Ownership Type and Unemployment Rate

	Ownership Type		
	For-Profit	Nonprofit/Public*	Total
Unemployment Rate			
Below Average	39 (23.1%)	58 (34.3%)	97 (57.4%)
Above Average	41 (24.3%)	31 (18.3%)	72 (42.6 %)
Total Hospitals	80 (47%)	89 (53%)	169 (100%)

Chi-square results: $\chi 2=4.644$, *df*=1, p=.031

*Nonprofit and public are combined based on hypothesis prediction.

Table C-6

Operational Performance: Private For-profit and Nonprofit Hospitals

	Private-for-Profit		**Private Nonprofit**		**T-Test Results**		
Operational Performance	Mean	Standard Deviation	Mean	Standard Deviation	T-value	*df*	Sig.
ALOS**	3.904	1.003	3.676	.835	1.464	142	.145
Operational Margin %	.034	.092	.030	.080	.242	142	.809
Medicaid/Charity	14.655	9.423	13.619	7.689	.712	142	.477
Casemix	1.250	.223	1.282	.202	-.900	143	.369

**ALOS – Average Length of Stay

APPENDIX D

UNIVERSITY CONSENT AGREEMENT FORM

From: Human Subjects <humansubjects@magnet.fsu.edu>
Date: Tuesday, November 6, 2007 10:23 am
Subject: Use of Human Subjects in Research - Approval Memorandum
To: ebc7904@fsu.edu
Cc: mguy@mailer.fsu.edu

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673. FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 11/6/2007

To: Elsie Crowell

Address: 2250
Dept.: PUBLIC ADMINISTRATION AND POLICY

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
Florida's Community Hospitals: Service Delivery Choices and Policy Implications

The application that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human
Subjects Committee. Your project is determined to be Expedited per 45 CFR § 46.110(7) and has been approved by an expedited review process. The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required. If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 11/3/2008 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chair of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is IRB00000446.

Cc: Mary Guy, Advisor
HSC No. 2007.752

Florida State University
Askew School of Public Administration & Policy

Florida's Community Hospitals: Service Delivery Choices and Policy Implications

Hello, my name is Elsie Crowell and I am involved in a research study called Florida's Community Hospitals: Service Delivery Choices and Policy Implications at Florida State University. We received your name from public documents (Agency for Health Care Administration, telephone directory, local government web page). You are eligible to participate in this research because you have been identified as a hospital administrator, county administrator, or board of trustee chair for your county in the State of Florida.

We are asking you to take part in a research study because we are trying to learn more about why local governments choose to contract-manage their hospital operation. You will be asked to participate in a one-time interview estimated to last less than one hour at a place of your choice. Examples of some of the questions you will be asked are as follows: (1) Why did you enter into a contract-management arrangement? (2) How long have you operated under this agreement? (3) What lessons can you share about the contract-management arrangement? and (4) What is the status of your population base in terms of employment, income, race, and health? In order to ensure accuracy, we prefer to have your permission to audio-tape the interview. However, if you do not wish to be audio-taped, you are still eligible to participate. Your participation is voluntary and you can stop the interview at any time. The information gathered from these interviews will first be coded according to themes or key subjects then summarized based on the responses to the questions. Your identity will be confidential and utilized only to the extent that we need to seek further clarification or follow up information directly with you. A coded system will be used to protect the identity of each participant. Only the Principal Investigator will have access to information that links the subject to interview data. Therefore, summary data will not be identified with any particular individual or hospital. You may request the opportunity to review the tapes and/or transcripts as well as provide follow up clarification as necessary.

You may find this research beneficial to improve your hospital operation. The findings in these interviews will be available to you upon completion. You will not be paid for participating in this research study. However, this work will enable you to become more aware of the challenges facing hospitals similar to your county and you may also discover improved ways of contract negotiations or how to better monitor operational performance of the contract company. Specific examples of benefits to you as a leader and your community include but are not limited to successful contract negotiation, effective board member training, sensitivity to the unique health service needs of your community, and increasing hospital operational efficiency.

FSU Human Subjects Committee Approved on 11/5/2007. Void After 11/3/2008. HSC# 2007.752

Tapes and other notes will be stored in a locked cabinet and will be accessible to me and my major professor, Dr. Mary E. Guy. These materials and tapes will be destroyed after three years. Confidentiality can be protected only to the extent permitted by law.

Do you have approximately 45 minutes to participate in this research study? If so, let's schedule a convenient date, time, and place to conduct the interview. I will follow up with a telephone call within five days to confirm your participation.

Answering the interview questions that I will ask means that you consent to participate in this research project. Please sign and date this document below if you consent to the interview.

_____
Research Participant (Print Name)

_____ _____
Research Participant (Signature) (Date)

Appendix A Contract-Managed Hospitals: Proposed Questionnaire Guide for Interviews

Respondents: Hospital Administrator, County Administrator, Trustee Board Chair
Hospitals: (1) Currently contract-managed, (2) Reverted Back to Public Status, (3) Closed

General Questions (All three categories of Hospitals)

1. Why did you enter into a contract-management agreement?
2. How long have you (did you) operate under this agreement?
3. What is (was) the term period of your contract?
4. Who participated in the negotiations and final contractual agreement?
5. Why did you select this company to manage your hospital operation? Is (was) it Nonprofit or for-profit?
6. What is (was) the relationship between your board of trustees and the managing company? a) How are decisions made? b) How do you monitor financial and operational performance?
7. What is the status of your population base: employment, income, race, and health?
8. How has this arrangement affected the residents in the community?
9. What lessons can you share about the contract-management arrangement?
10. Are you satisfied with your present arrangements? Why/why not?
11. Are there other challenges/opportunities you would like to share not previously discussed?

1. Currently Contract-Managed (CCM)

- What contractual revisions would you make upon renewal and/or expiration of the existing contract? Why?

2. Reverted Back to Public Status (RBPS)

FSU Human Subjects Committee Approved on 11/5/2007. Void After 11/3/2008. HSC# 2007.752

- Why did you revert back to self-managed status?
- Will you consider contract-management in the future? Why or Why not?

3. Closed (C)

- Do you have plans to reopen your hospital? If yes, how will you do it? If no, what arrangements do you make for delivering hospital services to your community?

If you have any questions or concerns about the research, please feel free to contact Elsie B. Crowell, Principal Investigator at 850-644-3525 or e-mail: ebc7904@fsu.edu or my Faculty Advisor at 850-644-9170, e-mail: myguy@mailer.fsu.edu

If you have questions regarding your rights as a research subject, contact the FSU IRB at 850-644-8633 or Ms. Julie Cooper at jjcooper@admin.fsu.edu.

Revised: October 31, 2007

REFERENCES

Abraham, K., & Taylor, S. (1996). Firms' use of outside contractors: Theory and evidence. *Journal of Labor Economics. 14*(3), 394-424.

Acar, M., Guo, C., & Yang, K. (2008). Accountability when hierarchical authority is absent: Views from public-private partnership practitioners. *The American Review of Public Administration*, 38(1), 3-23.

Agency for Health Care Administration, Certificate of Need WorkGroup. (2002). Retrieved June 25, 2007 from http://ahca.myflorida.com/MCHQ/CON

Agency for Health Care Administration, State Center for Health Statistics (2005). *Florida Health Care Expenditures, 2002.* Tallahassee, FL: Author.

Agency for Health Care Administration (August 2005). *Florida Health Insurance Study: County Estimates of People without Health Insurance.* Retrieved December 23, 2007, from http://ahca.myflorida.com/Medicaid/quality_Management/mrp/ Projects/fhis2004/index.shtm

Agency for Health Care Administration (August 2005). *Comparative Findings from 1999 and 2004:Florida Health Insurance Studies.* Retrieved December 23, 2007, from http://ahca. myflorida.com/Medicaid/quality_Management/mrp/Projects/fhis2004/index.shtm

Agency for Health Care Administration, Financial Analysis Unit (2006). *2005 Hospital Financial Data.* Tallahassee, FL: Author.

Agency for Health Care Administration (2008) *Statement of agency organization and operation.* Retrieved June 23, 2008, from http://ahca.myflorida.com

Aldrich, H., & Fiol, C. (1994). Fools rush in? The institutional context of industry creation. *Academy of Management Review, 19*, 645-670.

Alexander, A. & Fennell, M. (1986). Patterns of decision-making in multihospital systems. *Journal of Health and Social Behavior, 27*(1), 14-77.

Alexander, J. & Morrisey, M. (1989). A resource-dependence model of hospital contract management. *Health Services Research, 24*(2), 259-84

Alexander, J. & Rundall, T. (1985). Public hospitals under contract management: An assessment of operating performance. *Medical Care, 23*(3), 209-219.

Altman, S., Shactman, D., & Eilat, E. (2006). Could U.S. hospitals go the way of U.S. airlines? *Health Affairs*, *25*(1), 11-21.

American Hospital Association. (2002). *Cracks in the foundation: Averting a crisis in*

America's hospitals. Chicago, IL: Author.

American Hospital Association (2003, April). *From crisis to opportunity: What the future holds for the American hospital*, Conference Highlights. Retrieved October 15, 2006, from http://www.aha.org.

American Hospital Association. (2004). *Trendwatch, Chartbook 2007: Trends affecting hospitals and health systems.* Chicago, IL: Author.

American Hospital Association (2004). *Beyond Health care: The economic contribution of hospitals.* Chicago, IL: Author.

American Hospital Association (2004). The Lewin Group analysis of AHA Annual Survey Data, 1993-2004 – Community Hospitals. Chicago, IL: Author.

American Hospital Association (2006). *Fast Facts on U.S. Hospitals from AHA Hospital Statistics.* Retrieved June 16, 2007, from http://www.aha.org/aha/resource_center

American Hospital Association (2007). TrendWatch Chartbook 2007: Trends affecting hospitals and health systems. Chicago, IL: Author

American Hospital Association (2008). *2006 Annual Survey.* Available at http://www.ahaonlinestores.com

Anderson, G.F. & Hussey, P.S. (2001). Comparing health system performance in OECD countries. *Health Affairs, 20*(5), 219-232.

Arrow, K.J. (1963). Uncertainty and the welfare economics of medical care. *American Economic Review, 55*(3), 941-973. Reprinted in the *Journal of Health Politics, Policy and Law* (2001). "Kenneth Arrow and the changing economics of health care." *26*(5), 851-883.

Atkinson, G., Helms, W.D., & Needleman, J. (1997). State trends in hospital uncompensated care. *Health Affairs*, *16*(4), 233-241.

Barney, J. & Hesterly, W. (1996). Organizational economics: Understanding the relationship between organizations and economic analysis. In S. Clegg and C, Hardy (Eds.), *Handbook of Organizational Studies* (pp. 115-148). London: Sage.

Batley, R. & Larbi, G. (2004). *The changing role of government: The reform of public services in developing countries.* Basingstoke, UK: Palgrave Macmillan.

Baum, J. (1998). Review of institutions and organizations by W. Richard Scott. *Contemporary Sociology, 27*(2), 161-162.

Baum, J. & Oliver, C. (1991). Institutional linkages and organizational mortality.

Administrative Science Quarterly, 36, 187-218.

Becker, E., & Sloan, F. (1985). Hospital ownership and performance. *Economic Inquiry. 23*, 21-36.

Berki, S.E. (1983). Health care policy: Lessons from the past and issues of the future. *Annals of the American Academy of Political and Social Science, 486*(2), 31-46.

Bernd, D. (2003, January). *Hospitals and the unintended effects of regulation*. Presentation at the National Academy for Health Policy Conference. Washington, D.C.

Boehne, B. & Carreyrou, J. (2008 April 4). Nonprofit hospitals, once for the poor, strike it rich. *Wallstreet Journal.* Retrieved April 8, 2008, from http://www.wsbt.com/news/consumer/17296354.html

Borger, C., Smith, S., Truffer, C., Keehan, S., Sisko, A., Poisal, J., & Clemens, M.K. (2006). Health spending projections through 2015: Changes on the horizon. *Health Affairs Web Exclusive, 24*(2), 61-73.

Brooks, R. (2004). Privatization of government services: An overview and review of the literature. *Journal of Public Budgeting, Accounting & Financial Management, 16*(4), 467-491.

Brow, K. & Klosterman, R. (1986). Hospital acquisitions and their effects: Florida, 1979-1982. In B. H. Gray, ed., *For-Profit Enterprise in Health Care*. Washington, DC: National Academy Press.

Brown, T., & Potoski, M., (2003). Transaction costs and institutional explanations for government service production decisions. *Journal of Public Administration Research and Theory, 13*(4), 441-468.

Bureau of Economic and Business Research. (2005) *Florida Statistical Abstract 2005.* University of Florida. Gainesville, FL.

Bureau of Economic and Business Research (2006) *Florida Statistical Abstract 2006.* University of Florida. Gainesville, FL.

Burgess, J & Wilson, P. (1996). Hospital ownership and technical inefficiency. *Management Science*, *42*(1), 110-123.

Carey, K. & Dor, A. (2004). Trends in contract management: The hidden evolution in hospital organization. *Health Affairs*, *23*(6), 192-199.

Catlin, A. Cowan, C., Hartman, M. & Heffler, S. (2008). National health spending in 2006: A year of change for prescription drugs. *Health Affairs,* 27 (1), 14-29.

Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics (2003). National Health Care Expenditures. Retrieved May 16, 2006, from http://www.cms.gov/statistics/nhe/default.asp

Centers for Medicare and Medicaid Services. (2007 March). *Critical Access Hospital Fact Sheet.* Retrieved April 4, 2008, from www.cms.gov/center/cah.asp

Certificate of Need Reform Act [CON] (2004). Section 395. 625, Florida Statues.

Claxton, G., Feder, J., Shactman, D., Altman, S. (1997). Public policy issues in nonprofit conversions: An overview. *Health Affairs, 16*(2), 9-28.

Clingermayer, J. & Feiock, R. (1997). Leadership turnover, transaction costs, and external city service delivery. *Public Administration Review*, *57*(3), 231-239.

Coase, R. (1937). The nature of the firm. *Economica, 4*, 386-405.

Cohen, M., March, J., & Olsen, J. (1972). A garbage can model of organizational choice. *Administrative Science Quarterly, 17*, 1-25.

Coles, J. & Hesterly, W. (1998). The impact of firm-specific assets and the interaction of uncertainty: An examination of make or buy decisions in public and private hospitals. *Journal of Economic Behavior and Organization, 36*(3), 383-409.

Collins, S., Gray, B., & Hadley, J. (2001, May). *The for-profit conversion of non profit hospitals in the U.S. health care system: Eight case studies.* The Commonwealth Fund (Publication Number 455) New York, NY.

Commons, J. (1934). *Institutional Economics.* Madison, WI: University of Wisconsin Press.

Commonwealth Fund (2006, September). *U.S. health system performance: A national scorecard.*(Commonwealth Fund Publication No. 956). New York, NY: Author.

Crane, C. (2006, March 1). Financial woes at Quincy-based DasSee Community Health Systems and its affiliate, Ashford Community Health Care are causing trauma at three regional hospitals. *Florida Trend* online services. Retrieved January 22, 2008, from http://goliath.ecnext.com/coms2

Creswell, J.W. (2003). *Qualitative, quantitative and mixed methods approaches,* 2nd edition Thousand Oaks, CA: Sage.

Crook, R. (2005). *Transaction attributes and governance choice: A meta-analytic examination of key transaction cost theory predictions.* (Doctoral dissertation, Florida State University, 2005). URN: etd-06242005-171552.

DeFino, T. (1999). Mediscare. *Healthcare Business*, *2*(3), 60-70.

DeNavas-Walt, C., Proctor, B., & Smith, J. (2007). U.S. Census Bureau, Current Population Reports, P60-233, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Washington, DC: U.S. Government Printing Office.

DiMaggio, P. & Powell, W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, *48*(2), 147-160.

DiMaggio, P. (1988). Interest and agency in institutional theory. In L. Zucker (Ed.)., *Institutional patterns and organizations* (pp. 3-21). Cambridge, MA: Ballinger.

Dor, A. (1994). *Are contract-managed hospitals more efficient?* (AHCPR Publication No. 94-0004, Provider Studies Research Note 21). Agency for Health Care Policy and Research, Public Health Service. Rockville, MD: U.S. Government Printing Office.

Dor, A., Duffy, S, & Wong, H. (1997). Expense preference behavior and contract-management: Evidence from U.S. hospitals. *Southern Economic Journal, 64*(2), 542-554.

Downs, A. (1967). *Inside bureaucracy.* Boston: Little Brown.

Drake, D. (1981). The struggle over health care continues. *Hospitals,* 55(7), 159-164.

Duggan, M. (2000). *Hospital ownership and public medical spending.* Working Paper 7789. National Bureau of Economic Research. Cambridege, MA. Retrieved November 15, 2007, from http://www.nber.org/papers/w7789

Eisenhardt, K. (1989). Agency theory: An assessment and review. *The Academy of Management Review, 14*(1), 57-74.

Ermann, D., & Gabel. J. (1984). Multi-hospital systems: Issues and empirical findings. *Health Affairs, 3*(1), 50-64.

Ermann, D. & Gabel, J. (1986). Investor-owned multihospital systems: A synthesis of research findings. In B.H. Gray, ed., *For-Profit Enterprise in Health Care.* Washington, DC: National Academy Press.

Feiock, R. (2001). Service contracting and alternative service delivery: Theory and practice. In K. Liou, (Ed.), *Handbook of public management practice and reform* (pp. 561-572). NY: Marcel Deker.

Fennell, M & Alexander, J. (1993). Perspectives on organizational change in the US medical care sector. *Annual Review of Sociology*, *19*, 89-112.

Ferris, J. & Graddy, E. (1986). Contracting out: For what? With whom? *Public Administration Review, 46*(4), 332-344.

Ferris, J. & Graddy, E. (1987). What governs the decision to contract out for local hospital services? *Inquiry*, *24*, 285-294.

Ferris, J. & Graddy, E. (1988). Production choices for local governments services. *Journal of Urban Affairs, 10*(3), 273-289.

Ferris, J. & Graddy, E. (1994). Organizational choices for public service supply. *Journal of Law, Economics, & Organization, 10*(1), 126-141.

Ferris, J. & Graddy, E. (1999). Structural changes in the hospital industry, charity care, and the nonprofit role in health care. *Nonprofit and Volunteer Sector Quarterly, 28*(1), 18-31.

Fishman, L. (1997). What types of hospitals form the safety net? *Health Affairs, 16*(4), 215-222.

Florida Agency for Workforce Innovation and Labor Market Statistics Center, Local Area Unemployment Statistics Program in cooperation with the U.S. Department of Labor Statistics 2006 Annual Report. Retrieved October 19, 2007, from http://www.florida.jobs.org/

Florida Department of Health, Office of Rural Health. (n.d) *Rural hospitals struggle to survive.* Retrieved October 15, 2007, from www.doh.state.fl.us

Florida Department of Health, Office of Planning, Evaluation and Data Analysis (2006). Retrieved April 22, 2008, from http://www.floridacharts.com

Florida Department of Revenue (2006). *Florida property valuations and tax data book.* Retrieved November 15, 2007, from http://dor.myflorida.com/dor/property/databk.html

Florida Hospital Association (2001). *FHA Eye on the Market*: *Health Care in the Sunshine State.* 14th Edition, Orlando, FL: Author.

Florida Hospital Association. (2003). *Care for uninsured non-citizens: A growing burden on Florida's Hospitals.* Retrieved June 17, 2007, from http://www.fha.org/non-citizensreport.pdf

Florida Hospital Association (2004). *FHA Data Brief: Financial health of Florida's hospital*. Orlando, FL: Author.

Florida Hospital Association. (2006). *FHA Eye on the Market: Multi-systems in Florida.* Orlando, FL: Author.

Florida Hospital Association (2008). *FHA data brief: Uninsured and the impact on Florida's*

hospitals:2000-2006. Orlando, FL: Author.

Florida House of Representatives, Committee on Health. (1996, February). *A Study of hospital districts.* (Document HC-002.0296). Tallahassee, FL: Author.

Florida Legislature, Office of Economic & Demographic Research. (2007, March). Retrieved May 13, 2007, http://edr.state.fl.us

Florida Trend (2001) DasSee Community Health Systems to take over three hospitals from Centennial Healthcare Corporation. *Florida Trend, 44*(2). Retrieved January 18, 2008, from http://goliath.ecnext.com/coms2

Frant, H. (1996). High-powered and low-powered incentives in the public sector. *Journal of Public Administration Research and Theory*, *6*(3), 365-381.

Freemont-Smith, M. & Lever, J. (2000). State regulation of health care conversions and conversion foundations. *Bureau of National Affairs Law Reporter, 9*(19), 714-720.

Frogner, B & Anderson, G. (April 2006). *Multinational comparisons of health systems data, 2005*. The Commonwealth Fund: New York.

Gaynor, M. & Haas-Wilson, D. (1999). Change, consolidation, and competition in health care markets. *The Journal of Economic Perspectives*, *13*(1), 141-164.

Gold, M. (2004). *Geographic variation in Medicare per capita spending: Should policymakers be concerned?* Research Synthesis Report No. 6. The Robert Wood Foundation: Princeton, NJ.

Goodrick, E. & Salancik, G. (1996). Organizational discretion in responding to institutional practices: Hospitals and cesarean births. *Administrative Science Quarterly*, *41*, 1-28.

Granovetter, M., (1985). Economic action and social structure: The problem of embeddedness. *American Journal of Sociology, 91*(3), 481-510.

Gray, B.H., ed. (1986). *For-profit Enterprise in Health Care.* Institute of Medicine. Washington, DC: National Academy Press.

Gray, B. (1991). *The Profit Motive and Patient Care.* Cambridge, MA: Harvard University Press,

Greene, J. (2002). *Cities and privatization: Prospects for the new century.* Upper Saddle River, NJ: Prentice-Hall.

Grossman, S. & Hart, O. (1986). The costs and benefits of ownership: A theory of vertical and lateral integration. *Journal of Political Economy, 94*(4), 1119-1158.

Hansmann, H. B. (1980). The role of nonprofit enterprise. *Yale Law Review, 89*, 835-899.

Haglund, C. & Dowling, W. (1993). The hospital. In *Introduction to health sciences.* 4th ed., S.J. Williams and P. R. Torrens(Eds.), (pp. 135-176) Albany, NY: Delmar Publishers.

Harris, J., Ozgen, H., & Ozcan, Y. (2000). Do mergers enhance the performance of hospital efficiency? *The Journal of Operational Research Society, 51*(7), 801-811.

Hart, O. (1995). *Firms, contracts, and financial structures.* Oxford: Clarendon Press.

Hart, O., Shleifer, A & Vishny, R. (1997). The proper scope of government: Theory and an application to prisons. *Quarterly Journal of Economics, 112*(4), 1127-1161.

Hirsch, P. (1997). Sociology without social structure: Neoinstitutional theory meets brave new world. *American Journal of Sociology*, *102*, 1702-1723.

Hirsch, W., & Osborne, E. (2000). Privatization of government services: Pressure-group resistance and service transparency. *Journal of Labor Research, 21*(2), 315-326.

Hood, C. (1990). A public management for all seasons. J. Shafritz, A. Hyde. & S. Parkes (Eds.), *Classics of public administration* (pp. 502-516), Thomson Wadsworth.

Horwitz, J. (2004, January). *Why we need the independent sector: The behavior, law, and ethics of not-for-profit hospitals.* University of Michigan Legal Working paper Series. University of Michigan: John M. Olin Center of Law & Economics Working Paper Series #3.

Horwitz, J. (2005). Making profits and providing care: Comparing nonprofit, for-profit, and government hospitals. *Health Affairs, 24*(3), 790-901.

Hundley, K. (2008, April 7). Nonprofit hospitals can be money making operations. *St. Petersburg Times.* Retrieved April 18, 2008, from http://www.tampabay.com/news/Business/articles

Huntley, H. & Nohlgren, S. (2007, August 29). 1 in 5 Floridians uninsured. *St. Petersburg Times.* Retrieved August 29, 2007, from http://www.sptimes.com

Jonas, S. & Kovner, A. (Eds.). (1999). *Health care delivery in the United States,* NY: Springer.

Kaiser Family Foundation (1999). Summary of findings: Privatization of public hospitals (Document #1450). Prepared by the Economic and Social Research Institute. www.kff.org

Kaiser Family Foundation. (2005) Retrieved July 21, 2006, from http://www.statehealthfacts.org

Kaiser Family Foundation. (2006). Retrieved August 13, 2007, from http://www. kff.org

Kaiser Family Foundation (2008). Hospitals by ownership types, 2006. Retrieved March 3, 2008, from http://www.statehealthfacts.org

Keebler, E. & Brodie. M., (1993). Economic incentives in the choice between vaginal delivery and cesarean section. *Milbank Quarterly, 71*, 65-404.

Kettl, D. (2002). *The transformation of governance: Public administration for twenty-first century America.* Baltimore: John Hopkins University Press.

Khaliq, A. & Thompson, D. (2006, February). *The impact of hospital CEO turnover in U.S. hospitals.* The American College of Healthcare Executives (ACHE) Final Report. http://www.ache.org

Kim, J. & Mahoney, J. (2005). Property rights theory, transaction costs theory, and \ agency theory: An organizational economics approach to strategic management. *Managerial and Decision Economics,* 26, 223-242. Retrieved March 12, 2008, from www.interscience.wiley.com John Wiley & Sons, Ltd.

Klein, R. (2000). *Clouds over the sunshine state: Florida's working parents lose health coverage.* Families USA. Retrieved August 22, 2007, from http://www.familiesusa.org

Lajili, K. & Mahoney, J. (2006). Revisiting agency and transaction costs theory predictions on vertical financial ownership and contracting: Electronic integration as an organizational form choice. *Managerial and Decision Economics*, 27, 573-586. Retrieved June 5, 2007, from www.interscience.wiley.com John Wiley & Sons, Ltd.

Lawrence, P. & Lorsch, J. (1967). *Organization and environment.* Cambridge, MA: Harvard University Press.

Lee, M. (1971). A conspicuous production theory of hospital behavior. *Southern Economic Journal, 38*(1), 48-58.

Lutz, S. (1994). Managed hospitals improved over time. *Modern Healthcare,* 22 August p. 12.

Madison, K. (2004, August). Organizational issues: Multi-hospital system membership and patient treatments, expenditures, and outcomes. *Health Services Research* 39:4 Part I.

March, J. & Olsen, J. (1989). *Rediscovering institutions: The organizational basis of politics.* New York: The Free Press.

March, J. & Simon, H. (1963). *Organizations.* New York: John Wiley & Sons.

McCarthy, D., Nuzum, R., Mika, S., Wren, J. & Wakefield, M. (2008, May). *The North Dakota experience: Achieving high-performance health care through rural innovation and cooperation.* New York: The Commonwealth Fund. Retrieved May 15, 2008, from www.commonwealthfund.org

McComb, J. (1992). *Governing community hospitals: A primer for trustees and health care executives*. San Francisco: Jossey-Bass.

Meyer, J. & Rowan, B. (1983). The structure of educational organizations. In J. W. Meyer & W.R. Scott (Eds.), *Organizational environments: Ritual and rationality* (pp. 71-79). Beverly Hills, CA: Sage.

Meyer, J., Scott, W.R., & Deal. T. (1983). Institutional and technical sources of organizational structure: Explaining the structure of educational organizations. In J.W. Meyer and W.R. Scott (Eds.), *Organizational environments and rationality* (pp. 45-67). Beverly. Hills, CA: Sage.

Milgrom, P. & Roberts, J. (1992). *Economics of organization and management.* Englewood Cliffs, NJ: Prentice-Hall.

Missouri Foundation for Health (2005 Summer). *Issue overview: Hospital charity in the United States.* Retrieved April 16, 2008, from http://www.mffh.org/

Mitchell, S., Spetz, J., & Seago, J. (2001/2002). Errors in data on hospital ownership. *Inquiry, 38*, 432-439.

Moe, R. (1987). Exploring the limits of privatization. *Public Administration Review, 47*(6), 453-460.

National Association of Public Hospitals and Health Systems. (2004, September). *How are safety net hospitals financed? Who pays for free care?* Washington, DC: NAPH Issue Brief. Retrieved August 15, 2007, from http://www.naph.org

National Center for Health Statistics (1996). *Health United States: 1995.* Hyattsville, MD, Public Health Services.

National Health Expenditure Data. (2005). Health Expenditures by State, Centers for Medicare and Medicaid, Office of the Actuary. Retrieved February 28, 2007, from http://www.cms.hhs.gov/ NationalHealthExpendData/05

Needleman, J., Chollet, D., & Lamphere, J. (1997). Hospital conversion trends. *Health Affairs, 16*(2), 187-195.

Needleman, J., Lamphere, J., & Chollet, D. (1999). Uncompensated care and hospital conversions in Florida. *Health Affairs, 18*(4), 125-133.

North, D. (2005). *Understanding the process of economic change.* Princeton, NJ: Princeton University Press.

Norton, E. & Staiger, D. (1994). How hospital ownership affects access to care for the uninsured. *RAND Journal of Economics, 25*(1), 171-185.

Oliver, C. (1991). Strategic responses to institutional processes. *Academy of Management Review, 16*, 45-179.

Oliver, C. (1992). The antecedents of deinstitutionalization. *Organization Studies, 13*, 563-588.

Organisation for Economic Co-operation and Development. *OECD Health Data 2006,* from The OECD Internet subscription database, updated October 10, 2006. http://www.oecd.org/health/healthdata.

Parsons, T. (1960). *Structure and process in modern society.* Glencoe, IL. Free Press.

Perker. A.S. & Harding, A. (Eds.). (2003). *Innovations in health service delivery: The corporatization of public hospitals*. Washington, DC: The World Bank.

Perrow, C. (1981). Markets, hierarchies and hegemony. In A. Vandeven and Joyce (Eds.). Perspectives in organizational design and behavior (pp. 371-386). New York: Wiley.

Pfeffer, J. & Salanick, G. (1978). *The external control of organizations.* New York: Harper and Row.

Powell, W. (1991). Expanding the scope of institutional analysis. In W. Powell and P. DiMaggio (Eds.), *The new institutionalism in organization analysis* (pp. 183-203) Chicago: University of Chicago Press.

Prager, J. (1994). Contracting out government services: Lessons from the private sector. *Public Administration Review, 54*(2), 176-184.

Ruef, M. & Scott, W.R. (1998). A multidimensional model of organizational legitimacy: Hospital survival in changing institutional environments. *Administrative Science Quarterly, 43*(4), 877-904

Richman, B. & Macher, J. (2006, August). *Transaction cost economics: An assessment of empirical research in the social sciences.* (Paper No. 115). Duke Law School Legal Studies.

Roberts, P. & Greenwood, R. (1997). Integrating transaction cost and institutional theories: Toward a constrained-efficiency framework for understanding organizational design adoption. *The Academy of Management Review, 22*(2), 346-373.

Rundall, T. (1984). Hospital contract management: Organizational and public policy issues. *Health Services Research, 19*(4),456-460.

Savas, E.S. (2000). *Privatization and public private partnerships.* NY: Chatham House Publishers.

Schneider, H. (2007). Paying their way? Do nonprofit hospitals justify their favorable tax treatment? *Inquiry, 44*(2), 187-199.

Scott, W.R. (1995). *Institutions and organizations.* Thousand Oaks, CA: Sage.

Scott, W.R. (1992). *Organizations: Rational, Natural, and Open Systems* (3rd ed.) Upper Saddle River, NJ: Prentice-Hall.

Scott, W. R. (2003). *Organizations: Rational, Natural, and Open Systems* (5th ed). Upper Saddle River, NJ: Prentice-Hall.

Scott, W.R., Rue, F., Mendell, P., & Caronna, C. (2000). *Institutional change and health care organizations.* University of Chicago Press.

Self, P. (1994). *Public choice and public benefits: politics, public service and markets.* Presentation to the Annual RIPPA Conference, Melbourne.

Sellers, C. (1991). *The Market Revolution: Jacksonian America,* 1815-1846. NY: Oxford University Press.

Selznick, P. (1949). *TVA and the grassroots. A study in the sociology of formal organizations.* Berkeley: University of California Press.

Shactman, D. (2005). Update Conference Report. Specialty hospitals, ambulatory surgery centers, and general hospitals: Charting a wise public policy course. *Health Affairs, 24*(3), 868-873.

Shafritz, J. Hyde, A. & Parkes, S. (1990). *Classics of public administration* (5th ed.). Belmont, CA: Thomas Wadsworth.

Shen, Y., Eggleston, K., Lau, J., & Schmid, C. (2007). Hospital ownership and financial performance: What explains the different findings in the empirical literature? *Inquiry, 44*(1), 41-68.

Shi, L. & Singh, D. (1998). *Delivering health care in America: A systems approach.* Gaithersburg, MD: Aspen Publication.

Shonick, W. & Roemer, R. (1982). Private management of public hospitals: The California experience. *Journal of Public Health Policy, 3*(2), 182-204.

Siegel, G. (1999). Where are we on local government contracting? *Public Productivity & Management Review, 22*(3), 365-388.

Silverman, E. (1999). The association between for-profit hospital ownership and increased Medicare spending. *New England Journal Medicine. 341*, 420-424.

Simon, H. (1945). *Administrative Behavior.* New York: The Free Press.

Shortell, S., Gillies, R., Anderson, D., Erickson, K. & Mitchell, J. (1996). *Remaking health care in America: Building organized delivery systems.* San Francisco: Jossey-Bass.

Shortell, S., Gillies, R. & Devers, K. (1995). Reinventing the American Hospital. *The Milbank Quarterly, 73*(2), 131-160.

Sloan, F. (1982, May). *Government and the regulation of Hospital Care*. Papers and Proceedings Ninety-Fourth Annual Meeting of the American Economic Association. (pp. 196-201).

Sloan, F., Picone, G., Taylor, D., & Chou, S. (2001). Hospital ownership and cost and quality of care: Is there a dime's worth of difference? *Journal of Health Economics, 20,*1-21.

Sloan, F. & Vraciu, R. (1983). Investor-owned and not-for-profit hospitals: Addressing some issues. *Health Affairs, 2*(1), 25-37.

Smith, C., Cowan, C., Heffler, S. & Catlin, A. (2006). National health spending in 2004: Recent slowdown led by prescription drug spending. *Health Affairs*, *25*(1), 186-196.

Snail, T. & Robinson, J. (1998). Organizational diversification in the American hospital. *Annual Review Public Health, 19,*414-53.

Spires, B. (2008, April 3). Critical access appeal denied. *Havana Herald*, p. A1.

Starr, P. (1982). The reconstitution of the hospital. In *The social transformation of American medicine* (pp.145-179). NY: Basic Books.

Stein, R. (1990). The budgetary effects of municipal service contracting: A principal-agent explanation. *American Journal of Political Science, 34*(2), 471-502.

Thomson Healthcare. (2007, November 5). Most profitable critical-access hospitals. *Modern Healthcare*, p.28.

Thompson, J. (1967). *Organizations in action.* NY: McGraw-Hill.

Tolbert, P. & Zucker, L. (1983). Institutional sources of change in the formal structure of organizations: The diffusion of civil service reforms, 1880-1935.

Administrative Science Quarterly, 23, 22-39.

U.S. Census Bureau. (2004-2005). Retrieved July 20, 2007, from http://www.census.gov

U.S. Census Bureau. (2006). Retrieved August 13, 2007 from http://www.census.gov

U.S. Census Bureau. (2006). *State and county quick facts*. Retrieved March 22, 2008, from http://quickfacts.census.gov/qfd/states

U.S. Department of Justice. (2003, January 15). *Edgewater Medical Center management firms to pay $2.9 million in resolving related criminal and civil health care fraud cases.* United States Attorney Patrick Fitzgerald, Northern District of Illinois, Chicago, Ill.

U. S. General Accounting Office. (1980, June). *Hospitals' Use of Contract Management Services*. (Report No. 011232/112715). Washington, DC: U.S. Government Printing Office.

U.S. Senate Committee on Finance. (2007). *Taking the pulse of charitable care and community benefits at nonprofit hospitals.* Retrieved March 5, 2008, from http://finance.senate.gov

Vladeck, B. (2006). Paying for hospitals community service. *Health Affairs, 25*(1), 34-43.

Weick, K. E. (1979). *The Social Psychology of Organizing.* Reading, MA: Addison-Wesley.

Weisgrau, S. (1995). Rural hospitals. *Health Care Financing Review, 17*(1), 1-15.

Wheeler, J. & Zuckerman, H. (1984). Hospital management contracts: Institutional and community perspectives. *Health Services Research, 19*(4), 499-515.

Whitehead, J. (2002, February 25). Financial difficulty forces hospital to curb medical services. *Mississippi Business Journal* online services. Retrieved January 22, 2008, from http://goliath.ecnext.com/coms2/summary

Williamson, O. (1973). Markets and hierarchies: Some elementary considerations. *The American Economic Review, 63*(2), 316-325.

Williamson, O. (1979). Transaction cost economics: The governance of contractual relations. *Journal of Law and Economics, 22*, 233-261.

Williamson, O. (1981). The economics of organization: The transaction cost approach. *The American Journal of Sociology, 87*(3), 548-577.

Williamson, O. (1985). *The economic institutions of capitalism: Firms, markets, relational contracting.* New York: The Free Press.

Williamson, O. (1991). Comparative economic organization: The analysis of discrete structure alternatives. *Administrative Science Quarterly*, *36*, 269-296.

Zucker, L. (1987). Institutional theories of organizations. *Annual Review of Sociology, 13*, 443-464.

BIOGRAPHICAL SKETCH

Married to James R. Crowell, I have two children, Sylnovia and Brian, two grandchildren, Ciera and Bruce. I was a public servant for the State of Florida for nearly 35 years. During this time I enjoyed the wonderful opportunity to serve the citizens of Florida in a variety of capacities, holding key leadership positions. My tenure as Consumer Advocate afforded me the opportunity to serve on a number of public/ private boards and to effectively network and lobby public causes related to health care, insurance, complex insurance policy language, credit scoring, predatory lending and their effect on Florida's citizens.

I received the B.S. degree from Florida Agricultural and Mechanical University in Business and a Master of Public Administration degree from Florida State University, and earned numerous certification designations in leadership and training, the Academy of Health Care Management and the National Association of Insurance Commissioners (NAIC). I authored two publications: *Women in the Civil Rights Movement* (2001), Book Builders, Inc., and a Chapter entitled, Trends in Outsourcing Human Resources Benefits: Opportunities, Challenges and the Florida Example, In *Handbook of Employee Benefits and Administration* (2008); coauthored one pending publication: Crowell & Guy, Florida's HR Reforms: Service First, Service Worst or Something in Between*?* In *Public Personnel Management.*

Being a strong advocate for women issues, I served as Vice President of the Florida Women's Consortium, founding member of the women's political caucus, and chairwoman of the Florida Commission on the Status of Women. During this tenure, a permanent hall of fame display was erected in the Capitol to recognize and honor outstanding Florida women and the first Women Studies internship program was established with Dr. Jean Bryant, FSU. I also moderated an International Women Forum on social issues affecting women leaders representing 12 South American countries and the United States and participated in the Florida women conference in preparation of the Beijing, China women's conference.

Active in local and state communities: member of Bethel AME Church Health Ministry, past president of Tallahassee Alumnae Chapter-Delta Sigma Theta Sorority, Social Action Coordinator, Regional Leadership Team, Lobby Days Coordinator for the State of Florida Delta Sigma Theta Sorority, Golden Key International Honour Society, AAUW, and the LWVoters.