THE EFFECT OF SYSTEM INTEGRATION, OWNERSHIP CONTROL AND DIVESTITURE DECISIONS ON HOSPITAL FINANCIAL PERFORMANCE

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ABSTRACT

Recent research has been devoted to examining the types of organizational change associated with hospital closures, conversions, mergers, and the introduction of new organizational forms. The increased acceptance of divestiture as a strategy may reflect recent patterns of consolidation in the health care field that require hospital systems to cut back certain subsidiaries by removing assets that do not contribute to the core business and organizational mission of the system. Hospital divestitures enhance a health system's performance by improving internal focus and integration among member hospitals. To gain an understanding of hospital system divestiture, factors that enhance a hospital's value to the system, and its likelihood of being retained, are identified. This study examines the association of hospital integration strategies and ownership control with divestiture decisions among health systems as well as to observe the effect of divestiture decisions on hospital financial performance.

INTRODUCTION

The introduction of the Medicare prospective payment system (PPS), and the resulting increase in competition among health care providers during the early to mid 1990s, compelled United States hospitals to engage in more affiliation and consolidation behavior in healthcare organizations (Shortell, 1999). The emerging inter-organizational relationships that developed represented a strategic response to the rise of capitated or fixed-fee payments required under the PPS. Furthermore, there existed the perception that frequent consolidation and merger activities would improve efficiencies, reduce duplication of services, and increase survival chances in an environment of managed competition (Conklin, 1994).

With the rise in managed care, a number of major external conditions have impacted hospital systems, making the need for change important. Pressures from managed care organizations regarding the means to finance hospital systems with which they are affiliated, combined with concern over quality medical care delivery to the community, have left hospitals and physicians in a quandary over costs, compensation and the appropriate clinical procedures to use (Burns et al., 2000).

Partly to account for this concern about hospital performance has been the need for managers of hospital systems to satisfy their stakeholders. Much of the difficulty in structuring integration efforts originates from the inherent conflict between physicians' motivation to work in their own self-interest and any unselfish motivations to work in the hospital's interest (Ginn & Young, 1992). Thus, hospital managers have had a strong incentive to develop administrative mechanisms that improve the fit between the goals and actions of physicians and health care administrators.

Fundamentally, four options have existed for hospital systems to improve the fit between the goals and actions of physicians, hospitals, and administrators (Gaynor & Haas-Wilson, 1999; Rich, 2000). Although they are presented here as distinct choices, they may also be taken in combination in establishing a course to improve a hospital's financial performance and its contribution to the health care system. The choices are: (1) Improve and find processes for management to reduce costs, maximize revenue, and selectively consolidate hospitals and practices; (2) Transform or close hospitals with significant economic problems and then restructure the remaining hospitals within new entities which are strategically aligned with the health system; (3) Privatize or sell hospital assets and physician contracts to a commercial physician practice management company (PPM) which then establishes a strategic relationship with the parent hospital or health system; and (4) Divest or sell/transfer hospital assets to another hospital system.

Despite the theoretical appeal of divestiture as a strategy for effecting change in the operating practices of hospital systems, and the increasing frequency of divestiture among hospitals over the past decade, few studies have examined how divestitures affect health system financial performance (Lee & Alexander, 1999). The increased acceptance of divestiture as a strategy may reflect recent patterns of consolidation in the health care field that require health systems to cut back certain subsidiaries by removing assets that do not contribute to the core business and organizational mission of the system (Zuckerman, 2000).

BACKGROUND AND IMPLICATIONS OF THE STUDY

Even though studies have shown that stakeholders gain from divestitures, and that the gains are consistent with increased efficiency in organizations, few studies have analyzed long-term operating performance following divestitures (John & Ofek, 1995). Mitchell and Mulherin (1996), in their study of declining organizations, demonstrated that financial performance might not necessarily improve following a period of divestiture, especially in organizations characterized by much diversification. Thus, divestitures in health systems are likely to impact a broad set of factors beyond the financial performance of member hospitals.

Focusing on divestiture alone as a factor affecting financial performance is challenging for two reasons. First, divestiture decisions among health systems can be volatile and influenced by the uncertainty of financial accounting under a complex third-party payment system (Kane, 1991). Second, an affiliated hospital's value to the system may be multidimensional; divestiture is but one aspect affecting value.

This study examines empirically the effects of hospital divestitures in health systems. It draws on two bodies of organizational literature-contingency theory and interorganizational relations theory-in identifying the specific effects of divestitures. These theories are considered important because of the complexity of hospital behavior compared with that of non-health care organizations (Shortell, 1999). To test our hypotheses, a national sample of community hospitals from health systems is compared in 1997 and 2003.

Several potential implications can be drawn from this analysis. Results of the study are expected to inform managers of health systems regarding the likely short-term effects of hospital divestiture efforts on financial performance, thus serving as a basis for an evaluation to reduce their own operations. Second, this analysis may alert managers of health systems to a wider

range of factors that can be of relevance to their decisions to retain or divest a particular member hospital. Finally, the factors examined in this study may help system managers identify member hospitals at potential risk of divestiture.

CONCEPTUAL FRAMEWORK AND HYPOTHESES

Divestiture occurs when a business unit loses its value to the parent firm (Kaplan & Weisbach, 1992). A decrease in financial performance is a strong indicator of a decline in the value of a business unit. In the hospital industry, factors other than divestiture may affect financial performance. To identify such factors, we draw from the literature on contingency theory and interorganizational relations theory. These theories provide balancing viewpoints on factors that may enhance a hospital's value to the system and thus its likelihood of being retained. Based on these theories, two factors-the hospital's capacity to adapt to its environment and its ability to integrate into the system-are examined to see if they affect the hospital unit's financial performance over and beyond the impact of the risk of divestiture.

Impact of hospital ownership control on divestiture

Contingency theory illustrates that an affiliated hospital's value to its health system is determined by its ability to adapt to the uncertainty and instability of the environment. It is a systems model based upon a framework of factors that have a generally important influence on strategic choice and also have performance implications.

Contingency theory emphasizes the importance of ownership control in determining the fate of organizations (Ginsberg & Venkatraman, 1985). Hospitals possessing assets that are valuable and not easily accessible by other hospital organizations achieve advantages over others in the system. A major reason that hospitals join systems is to help secure needed resources and gain greater bargaining power with purchasers and health plans. Through these actions, an individual hospital's dependence on its environment is reduced, and thereby its prospects for survival and growth increase (Lin & Wan, 1999). Thus, the control of critical resources relative to nearby hospitals may support a system's competitive position and thus reduce an affiliated hospital's chance of divestiture.

From a structural perspective, organizations that are more centralized have an advantage in making decisions more quickly and with a more unified purpose. Centralized organizations also can leverage their size in negotiation with external parties by having a single corporate agent acting on behalf of the individual hospitals (Burns et al., 1997). Dranove, Durkac and Shanley (1996) found that centralization can result in greater concentration of productive assets and reductions in administrative overhead by generating economies of scale. Accordingly, one might expect that hospitals belonging to more centralized systems enjoy greater financial performance than those associated with less centralized health systems. On the basis of these assumptions, it is hypothesized as follows:

Hypothesis 1: System-affiliated hospitals that possess more ownership control over assets by their management are less likely to be divested by their parent health system.

Impact of hospital integration on divestiture

Inter-organizational theory suggests that firms integrate to compensate for an incomplete market for resources, such as management expertise and referrals. In the case of hospital integration, both acquirers and targets may hold critical resources for which markets are incomplete. Through integration, the acquirer might gain access to the target's resource of a close attachment to local patients and physicians; the target might gain access to specialized technology, the quality reputation of the acquirer, and potentially valuable contracts with managed care payers (Reitan, 1998; Lee & Alexander, 1999).

Functional integration determines the long-term allocation of existing resources and the development of new ones essential to assure the success of health systems (Oliver, 1990). To guarantee the efficient use of resources in meeting their own objectives and to add value, health systems need to achieve functional integration (Shortell et al., 1996). Simply grouping a collection of hospitals under a corporate umbrella is unlikely to produce benefits in a volatile health care environment.

To the extent that integration is a valued objective in health systems, the degree to which a hospital is integrated into the system is likely to affect the risk of the hospital being divested. First, integration increases the interdependence between the system and the hospital. The operation and performance of the health system depends on the hospital as much as the hospital counts on the support of the health system for its continuous operation and survival. Second, integrated hospitals enhance the core business of the health system. They contribute to the exchange of services and resources and the reduction of service duplication. Thus, the following hypothesis is postulated:

Hypothesis 2: System-affiliated hospitals that are more integrated with their parent health system are less likely to be divested by their parent health system.

Effects of hospital divestiture on financial performance

The literature on divestiture in non-health care industries has highlighted the importance of poor financial performance as a determinant of divestiture (Duhaime & Grant, 1984; Alexander & Scott, 1984). Health systems may consider divestiture of poor-performing hospitals as a way to avoid further financial losses. An alternative view suggests that health systems may consider divestiture when divestiture gains become so large as to provide an incentive to invest the proceeds in ways that can increase stakeholder value (Weston, 1989; Lang et al., 1995). A testable hypothesis can be stated as follows:

Hypothesis 3: Hospitals that are less likely to be divested by the system are more likely to enhance a health system's financial performance.

METHODS

Study design and data sources

This study utilized a correlation and longitudinal design using archival data sources (American Hospital Association, Health Care Financing Administration). The model used discrete-time

probit regression, a method appropriate for analyzing longitudinal data with a continuous dependent variable but with both dichotomous and continuous independent variables.

The sample consisted of 402 community hospitals that were affiliated with a health system between 1997 and 2003 with the exception of sole community providers and contract-managed hospitals. The resulting number of hospital observations was 362. Sole providers, or the only hospitals operating in a county, were not included in the study since comparison with those hospitals with other hospitals in the same geographical area could not be made. Contract-managed hospitals, or hospitals managed by a health system through formal contracting, were eliminated because the managing health system had no legal ownership control over the hospitals' assets.

Three sources of 1997 and 2003 data were employed: (1) the American Hospital Association (AHA) Hospital Guide, Part B, (2) AHA Annual Surveys of Hospitals files, and (3) the Health Care Financing Administration (HCFA) data files which includes the Cost Reports. The AHA Hospital Guide, Part B and Annual Surveys of Hospitals files contain characteristics such as ownership, services, and bed size. HCFA cost reports include hospital financial records and case-mix data.

Measurement of variables

The variables in this study were divided into four categories. The first category has two exogenous constructs consisting of ownership control and integration strategies. The second category is the endogenous construct, divestiture. The third group of variables, also endogenous constructs, represents financial performance. The last group is a set of control variables representing the common but significant hospital characteristics of size and nonprofit ownership.

Ownership control was measured based on two independent variables: profit status and system type. Profit status includes two dummy variables used to differentiate for-profit and non-profit organization. System type consists of two dummy variables used to distinguish centralized and decentralized type of operations.

Integration strategies were determined by six independent variables representing three different dimensions of integration including (1) service type, (2) physician participation in the management of the hospital, and (3) managed care contracts. Integration based on service type was measured by the number of inpatient beds used, number of outpatient visits made, and the number of physicians associated with the hospital. Included with integration based on service type was the variable case-mix index. Case-mix index is an estimate of the average complexity of the medical and surgical treatments provided by a hospital to its inpatients. In its most simple form, the case mix index identifies and can group patients based on the various types of medical conditions on a very broad basis (such as medical, surgical, and obstetric patients). On a more detailed basis, case mix index can be measured by categorizing patients into various diagnosis related groups (DRG) and assigning a case weight based on the average resources among many hospitals required to treat patients in that DRG. Integration based on physician participation in the management of the hospital includes two dummy variables used to differentiate open physician hospital organization and closed physician hospital organization. Although other forms of physician participation in the management of the hospital are available, open and closed physician hospital arrangements represent the most direct means of physician integration in a hospital system and, thus, indicate the more significant choice used in the model (Goes & Zahn,

1995). Integration, based on managed care contracts, was represented by the number of managed care contracts provided in the system. Managed care contracts include health maintenance organizations and preferred provider organizations.

Hospital Divestiture is the dependent variable defined as the transfer or sale of the assets of an associated hospital from one system to another or as the termination of the hospital relationship with the system whereby the hospital is converted to independent (freestanding) status. In this study, a hospital was considered divested if the hospital name was removed from the member list of one health system and appeared on the list of another health system (AHA Hospital Guide). A hospital was also considered divested if the hospital assumed freestanding status. In the event where the hospital name was removed from the membership list, the health system must have remained on the annual directory to eliminate situations where an entire health system was closed.

Financial Performance was measured by cash flow from operations or the ratio of changes in working capital and depreciation to total assets. This measure is a more effective and timely indicator of both profits earned based on a hospital's cash-based activities than financial measures based on profits only (Kane, 1991). Profitability as financial indicator can be misleading because accounting rules might allow organizations to alter the state of the two measures of revenues and expenses so that reported profits might be subject to significant managerial discretion.

RESULTS

Sixty-four system hospitals of the sample were divested during the study period. There were significant differences between the for-profit and non-profit groups across integration strategies and centralized ownership control. Non-profit hospitals were more likely to utilize system integration strategies and centralized control, but for-profit hospitals were more likely to divest, as indicated in Table I. As non-profit hospitals clearly behaved differently, the study analysis controls for the effects of non-profit ownership and hospital size.

TABLE I.
HOSPITAL INTEGRATION STRATEGIES AND OWNERSHIP CONTROL BY PROFIT STATUS, 2003

Profit Status (*N*=362)	Non-profit (*N*=179)		For-profit (*N*=183)	
	Frequency	%	Frequency	%
Physician management integration	23	13%	13	7%
Managed care integration	122	68%	87	48%
Centralized ownership control	136	76%	17	9%
Divestiture	22	12%	42	23%
Hospital staff physician integration	105	59%	90	49%

Descriptive statistics and correlations for study variables are presented in Table II. None of the correlations between independent variables are over .50, suggesting that there is little potential concern of multicollinearity. Results indicate a high negative association between the hospital

service integration variables (inpatient and outpatient services) and divestiture, and a high positive association between the hospital management integration variables (physician management and managed care) and divestiture. However, results indicate a high negative association between for-profit ownership control and divestiture, and a high positive association between centralized ownership control and divestiture.

TABLE II
DESCRIPTIVE STATISTICS AND PEARSON CORRELATION MATRIX OF VARIABLES, 2003

Variables	Mean	S.D.	2	3	4	5	6	7	8	9
Dependent Variable										
1. Financial performance	7611.99	2764.64	0.36	0.34	0.11	0.39	0.09	0.17	-0.31	0.40
Predictor Variables										
2. Inpatient beds used/day	214.86	293.68	-							
3. Outpatient visits/day	144.15	195.51	0.45	-						
4. Physician mgmt. integration	68.48	24.18	0.18	0.34	-					
5. Managed care integration	9.93	12.38	0.20	0.01	-0.03	-				
6. For profit ownership	0.23	0.26	0.01	0.07	-0.02	-0.01	-			
7. Centralized ownership	0.48	0.14	-0.10	-0.26	-0.10	0.03	-0.06	-		
8. Divestiture	0.17	0.33	-0.39	-0.28	0.19	0.14	-0.21	0.13	-	
9. Hospital staff MDs	7.65	20.84	-0.12	-0.10	-0.07	-0.09	0.12	-0.02	-0.07	-
Control Variables										
10. NFP ownership	0.58	0.09	0.19	0.35	0.17	-0.03	0.15	-0.27	-0.10	0.07
11. Hospital size	342.17	0.03	-0.07	0.26	-0.13	0.16	-0.18	0.07	0.16	-0.17

Table III presents the results of the profit regression model used for testing the hypotheses.

The results of the study show a significantly negative relationship between divestiture and hospital financial performance. The three models (A, B and C) include control variables and determinants of divestiture and hospital financial performance. None of the control variables was significantly related to divestiture or to hospital financial performance. Thus, nonprofit ownership and hospital size were not significantly related to the risk of divestiture or to hospital financial performance.

Hypothesis 1: predicted that system-affiliated hospitals that possess more ownership control over assets by their management were less likely to be divested by their parent health system. This hypothesis was partially supported. For-profit health systems are less likely to divest hospitals from the system but only when they maintain less centralized control over their assets.

Hypothesis 2: predicted that system-affiliated hospitals that are more integrated with their parent health system were less likely to be divested by their parent health system. This hypothesis was partially supported. For-profit health systems are less likely to divest hospitals that provide more inpatient services, managed care products, physician participation in management and when they provide less complex (riskier) medical and surgical treatments. However, providing more outpatient services and maintaining more staff physician affiliation has had no effect on divestiture decisions that the hospital system has made.

TABLE III.
RESULTS FROM PROBIT REGRESSION MODELING: ANALYSIS OF EFFECTS OF DIVESTITURE ON CHANGES IN HOSPITAL FINANCIAL PERFORMANCE 1997-2003

	Hospital Financial Performance					
	Model A		Model B		Model C	
	ß	S.E.	ß	S.E.	ß	S.E
Hospital Ownership Control						
1. For-profit ownership	.118	0.22	.245	0.44 *	. 345	0.34 **
2. Centralized ownership	-.157	0.13	-.142	0.18	- .122	0.16 *
Hospital System Integration						
3. Inpatient services			.352	0.10 **	.345	0.09 **
4. Outpatient services			.314	0.01 *	.116	0.01
5. Physician management			.149	0.08 *	-.146	0.07 *
6. Managed care integration			.108	0.15	.113	0.11 *
7. Hospital MDs			-.011	0.09	-.008	0.07
8. Casemix			-.032	0.11	-.075	0.12 *
9. Divestiture					.059	0.51 **
Control Variables						
10. Nonprofit ownership	-.163	0.12	-.427	0.55	-.264	0.38
11. Hospital size	.260	0.53	.355	0.77	.273	0.71
Model F	1.734		5.462 *		10.146 **	
R^2	0.017		0.285		0.389	
N	362		362		362	

* $p < .10$
** $p < .05$

Hypothesis 3: predicted that hospitals that are less likely to be divested by the system are more likely to enhance a health system's financial performance. This hypothesis was supported.

DISCUSSION

According to the literature on divestitures in non-health care industries, a key predictor of increased financial performance is firm divestiture (Capron et al., 2001). Divestitures can resolve stakeholder problems by reducing overinvestment, but aggravate stakeholder problems by providing managers cash to pursue their own objectives, or even be unrelated to stakeholder problems if the sale or transfer of assets is in response to economic declines. This study investigated the financial performance of system hospitals that divested assets in order to produce gains. Results of this study can be used to determine whether ownership control and integration can explain some of these gains. Hospitals that sell or transfer assets that cause negative synergies should experience improved financial performance, but hospitals that divest assets to raise capital or in response to economic declines may not see improved financial gains. In this study, results supported the notion that hospital divestitures improve the health system's operations, perhaps by removing non-performing assets and improving services. Further analysis suggests that the poor performance preceding the divestiture is unrelated to managerial ownership, but that the post-divestiture performance is strongly related to the effectiveness of integration strategies employed by the hospital system. Overall, results lend support to the argument that divestitures eliminate negative synergies, that these negative synergies are not

solely the consequence of stakeholder problems, and that managerial ownership provides strong incentives to improve operations following the divestiture.

However, making divestiture decisions to enhance a health system's value may be difficult given that divestiture decisions are but one aspect that influences hospital financial performance, and that financial performance may provide incomplete information about a hospital's value to the system. One can argue that a health system's measurement of a hospital's value may take into consideration other factors such as ownership control and integration. Results from this study support such expectations. While the findings confirm previous studies that divestiture decisions indeed influence financial performance, ownership control and integration factors also play a significant role in determining hospital financial performance, independent of divestiture decisions.

Several specific findings merit discussion. First, health systems are less likely to divest member hospitals that are more integrated with the system in terms of their inpatient services and managed care products. Health systems may prefer to retain such hospitals because of the value generated from coordination of managed care products and synergy of services, particularly if the hospital system intends to develop or maintain a dominant position in its geographic area. The number of less riskier services that an affiliated hospital accesses from the health system also may indicate the amount of investment that the health system has made in the referral and exchange relationships between the hospital and its member hospitals in the system. Other things being equal, these costs are likely to be a deterrent to divestiture.

Second, contrary to expectations, integration based on physician participation in system-based management is positively related to divestiture of the central hospital. One explanation is that health systems have generally experienced limited success in the integration of physician arrangements. Investments in this area have achieved few improvements in medical staff relationships or risk contracting ability and may even lead to considerable financial losses (Thrall, 2001). The integration of physician arrangements has, for the most part, failed to enhance a hospital systems' financial performance or value (Holm & Schroeder, 2000). Our finding may be an indication that health systems have begun to back away from the strategy of fully integrated physician management arrangements and view physician participation in management as too difficult or too expensive to realize. Alternatively, physician integration may be a fundamentally local phenomenon and attempts to create system-wide physician integration may violate this basic orientation toward the local provider organization.

Third, health systems are more likely to divest poor-performing member hospitals than high-performing hospitals. This is a source of concern given that health systems often acquire financially distressed hospitals, considered not performing up to their potential, in anticipation of "turning around" these poor performers (Coddington, Fischer, & Moore, 2000). Failure to turn the financial performance of these member hospitals around places such hospitals at risk for consecutive divestitures. To the extent this is true, health systems should be cautious about the acquisition of poor-performing hospitals and articulate clear expectations about performance improvement.

Finally, it is worth noting that the ownership of the system does not appear to play a major role in divestiture. However, for-profit systems are more likely than non-profit systems to divest their hospitals. In addition, a centralized ownership structure appears to affect the divestiture decisions of systems regardless of integration strategies employed. This suggests that despite the

importance of financial viability and the priority placed on profit by some types of health systems, a decision as important as divestiture demands that systems consider the ownership structure and control of the hospital in its system. These factors collectively reflect the complex strategic, ownership, and community-based nature of health care delivery that must figure into the calculation of a system when it assigns value to a member hospital.

These research findings have several important implications for management. At the most basic level, managers of hospital systems and hospitals should recognize that divestiture has become increasingly common in the health care field. Such information should motivate managers of health systems and affiliated hospitals to develop practices designed to assist member hospitals manage the divestiture process or in some cases to prevent it.

CONCLUSION

The research results suggest that in addition to improvement in financial performance, there are ways for hospitals to improve their ties with their hospital system and improve strategic focus and operational effectiveness. This might be accomplished through the reconfiguration of services and the decentralization of management based decisions. These findings also may make managers of hospital systems aware of criteria for potential acquisition targets to reduce future risk of divestiture of these acquisitions.

Two limitations of the study are worth mentioning. First, this study assumes independence among hospitals in similar health systems. While diagnostic tests indicated no problems with associated error terms based on system effects, additional adjustments for system properties (e.g., multiple regression modeling with additional system-level characteristics) may be needed to eliminate the possibility of bias due to system-level consolidation of variables. Second, research was limited to a comparison of two years over a 7-year period. Analyses comparing more than two years and covering a longer period of time may provide a more complete understanding of the underlying relationship between the factors associated with a hospital's divestiture decisions and its value to a system.

Results of this study raise two important issues worthy of future research: First, what is the fate of hospitals that are divested? Research is needed to examine whether divestiture represents an opportunity for a hospital to affiliate with a more compatible system or whether the disruptive effects associated with a divestiture will lead the divested hospital one step closer to closure or back to freestanding status. Second, what is the influence of divestitures on the global environment and on communities? Answers to these questions would provide information for system and hospital managers to make sound decisions regarding affiliation strategies and for policy-makers to monitor the impact of system and hospital relationships on communities.

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