

# **A literature review on the structure and performance of not-for-profit health care organisations**

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***Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)***

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## Executive Summary

### **Aims, background and history**

1. The government's policy of contracting out public services to nonprofit (or 'third sector') bodies raises the crucial issue of government control, and in particular how public expenditure is accounted for and audited, and how services are regulated to ensure that the delivery conforms to their core values. A key question is whether nonprofits are public or private bodies, as this determines the nature and scope of the government's powers of intervention and regulation. The aims of the study were to review empirical of nonprofit performance and to examine how nonprofits are classified with respect to their regulation.
2. Nonprofits have had a role in English health care both before and after the creation of the NHS. Increased voluntary sector participation had been encouraged by successive governments at least since 1980. However, after 2000 exhortation was backed up by legal reforms abolishing the public sector's monopoly and thereby increasing opportunities for nonprofit participation. Policy towards nonprofits has focused principally on reducing or eliminating barriers preventing third sector bodies from being able to provide public services.

### **Approach and methods**

3. The conceptual framework for the review is based on definitions of nonprofits and on hypotheses generated by the theoretical frameworks used in nonprofit performance studies. Because of definitional problems and the sector's diversity, a range of theoretical frameworks has been adopted for its study and the associated hypotheses are consequently diverse.
4. It has proved extremely difficult to provide an analytic framework that encompasses this diversity. We have identified six main themes but there is inevitably substantial overlap. Our six analytic themes are as follows:
  - Funding and competition
  - Public purpose
  - Users and quality
  - Capital financing
  - Integration and planning
  - Governance and accountability
5. A number of systematic reviews of the performance of the nonprofit sector have already been conducted. These studies have noted methodological limitations, definitional problems and inconclusive findings in studies of nonprofit performance. They have also noted

that the literature is mainly drawn from the US health care system which means that it is of limited relevance to other health systems which are not market-based and are universal, as in the UK.

6. The literature reviewed in the present study was obtained from a variety of sources. Twenty-six core sources (14 literature databases and 12 websites) were searched, using 9 different search terms. The databases extended beyond the medical literature to include social science and economic literature. The initial search yielded over 14,000 hits including duplicates. The database was sifted three times for relevance and a final total of 163 studies was identified. Most (126) of the papers concerned the health sector. Only a small proportion concerned social services. The papers reviewed were mainly based on quantitative studies. Only 33 were based on qualitative research.

### **Review of the literature on nonprofit performance**

7. Most (77%) of the empirical literature finally reviewed relates to the USA, where the main focus of concern has been the relative merits of nonprofit and for-profit providers, as policy has increasingly turned from a system based heavily on the former to one relying more on the latter. The value of this literature for UK policy-making is reduced by its very different historical context (there being virtually no public sector in US health care) and the difficulty of abstracting, for the purpose of drawing lessons for the UK, from the specifically US elements that govern the way nonprofits are conceptualised there. These limitations are compounded by widespread limitations in the scope of the studies that have been done, noted by several previous reviewers, and by methodological weaknesses (not confined to the US literature), also noted by earlier reviewers.
8. Methodological problems limit the usefulness of much of the literature that might otherwise be of interest for UK policy-making. The literature relating to cost and quality is a particularly unfortunate case in point. Cost and quality definitions are often problematic. It is rarely possible to isolate the causal effects of the variables studied from those of other variables, and in too many cases no attempt is even made to do so. Data from company financial reports and accounts tend to be treated uncritically. In particular, the segmentation of the US health care market makes it impossible to generalise usefully about the relative efficiency or other aspects of alternative types of provider in the USA.
9. A limitation of the US studies overall, however, was their focus on providers. Reflecting the complexity of US system, the studies covered a range of fragments of the healthcare market, attempting to identify impacts of cost control and reimbursement methods on providers. This literature rarely relates the performance of nonprofit agencies to the achievement of universal health goals, such as equal access to care by geographically-defined populations, which

are a high priority for the UK government. In fact, few studies paid direct attention to the regulatory regimes within which nonprofits providers operate.

### **Nonprofit classification**

10. We reviewed the classification of nonprofits with respect to the regulatory regimes governing their operations in the UK. The classification systems in question are those of the system of national accounts and those of the European Union's economic constitution. The definitions used by these classification systems show the public or private character of nonprofit providers. The systems are subject to revision, through reviews by international standard-setters or through court judgements, precisely because of the growing importance of the use of 'third sector' bodies and the classificatory difficulties this creates.
11. The system of national accounts does not incorporate a nonprofit sector and nonprofit bodies can be classed to either public or private sectors. This system allows two interpretations of 'non-governmental' and the UK government's use of this term leaves open the question of whether it intends that third sector policy constitutes privatisation in the sense of the substantial transfer of government and public control over services and assets to the private sector.
12. While attempts are being made at the international level to harmonise the classification of nonprofits, the approach adopted stipulates that nonprofits are private bodies, a policy which is not reflected in UK practice. The approach does not clarify the government powers it is intended shall be retained when nonprofits take over public health care services.
13. A further classification problem being dealt with by international bodies concerns the question of how to determine whether public service contractors are part of the government sector. The decision depends crucially on whether payments include income guarantees from the public sector, in which case the contractor is deemed to be part of government. However it is often difficult to differentiate between payments that include income guarantees and those that do not. The classification of NHS trusts illustrates the problem. In 2003 these nonprofits were reclassified to the government sector on the basis of an Office of National Statistics reassessment of the income guarantees in their payments.
14. Our review of classification systems also draws attention to inconsistencies between the system of national accounts and government financial reporting with respect to the classification of nonprofit assets. The complexity of partnerships arrangements between nonprofit bodies and public agencies are such that is often difficult to judge where property ownership rests, as ownership is tied to the risks and rewards of providing a service, about which interpretations can differ.

15. Market bodies are subject to the European Union's competition law. We examine the classification system used to determine when this law applies to nonprofits delivering public services. Competition rules do not apply to those activities which constitute the 'exercise of official authority' or which are non-economic in nature. Derogations from competition law can apply in the case of bodies which are economic in character but nevertheless provide a public service. The nonprofit status of an agency providing health services is not of itself a guarantee against European jurisdiction. Furthermore, the fact that a service is contracted out may lead, irrespective of the sectoral classification of the contractor, to that service coming under EU jurisdiction. This finding is illustrated with a case study.

### ***Key lessons for the NHS***

1. There is no evidence to support the government policy in England of using nonprofits to switch from an integrated, publicly-owned and provided system to a provider- or firm-based system where market incentives and principles apply.
2. The overwhelming preponderance of American nonprofit studies in the literature makes it difficult, indeed dangerous, for the UK government in particular to draw inferences internationally; the US is a non-universal, private, voluntary insurance health care system in which almost 50 million people are uninsured.
3. The historical literature from the UK shows that the pre-NHS hospital system failed to achieve any correspondence between provision and health needs. Research into contemporary health systems reveals a preoccupation with internal performance detached from and unrelated to needs-based planning and equity of funding and provision.
4. Evaluations of non profit forms are problematic even within a single country because it is not possible to control for complex interactions between land and asset base values, regulatory regimes, patient entitlement, patient groups, system level resources, and levels of service provision both internal and external to the nonprofit firm.
5. There is no consistent evidence that nonprofits perform better than other ownership forms and there is little research of their impact on access to services. The evidence suggests that in a competitive environment nonprofit providers behave much like for-profit providers and this has a negative impact on quality of care and staffing levels.
6. The switch to commercial contracting with nonprofit providers will expose health service commissioners to European competition law, limiting their regulatory powers at national level. Under current case law, European competition law, from which nonprofit

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organisations are not exempt, can be triggered by commercial contracting.

7. The NHS should revisit the benefits of integrating the system from the perspective of planning, equity and efficiency in provision.



## ***The Report***

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# Introduction and approach to literature

The current policy of contracting-out state-run public services to non-governmental bodies such as nonprofits raises the crucial issue of government control, and in particular how public expenditure is accounted for and audited, and how services are regulated to ensure that the delivery conforms to the core values and goals of the services in question. In the case of the NHS this includes ensuring universal access and equity of access. These issues are of growing significance because government is increasingly using market mechanisms to vest responsibility for the provision of public services in a variety of new bodies outside direct ministerial control, including nonprofit organisations, for-profit commercial providers and hybrid public-private bodies.

When public money is paid to for-profit and nonprofit private sector bodies for operating a contracted out service, the locus of public accountability becomes unclear (Sharman, 2001, p14). The 2001 Sharman Report to the Treasury on audit and accountability arrangements in central government highlighted the weakening of public accountability where public money passes through chains of independent contractors.

Public expenditure controls have implications not just for audit and accountability but also for macroeconomic policy and the determination of balance sheet treatment, all government accounting, and net public sector debt and expenditure. However, the recent emergence of nonprofits is problematic because as Salamon and Anheier (1997) and Kendall and Knapp (1996) note, the sector occupies a space with indeterminate boundaries between the governmental and the private for-profit spheres, making it unclear what the mechanisms are for public control and government oversight. This problem is compounded by the lack of definition of this sector, and the fact that nonprofits are so diffuse in form and function. It is often unclear whether nonprofits are private market actors or public bodies.

The public-private divide is key, as it determines the nature and scope of the Government's powers of intervention and regulation, either through public (non-legal) or commercial (legal) contract forms at the level of both the UK and EU courts. How does the public law apply to bodies that are independent of government but have public service functions (Grace, 2003; OECD, 2002; Freedland and Auby, 2006)? As the Public Accounts Committee commented in 2001: 'There is no firm or clear theoretical framework for British public administration that dictates which functions should rest directly under the control of elected politicians or quasi-autonomous bodies' (Flinders, 2004).

The vexed question of political accountability and regulatory control is well illustrated in the case of health services, where the European economic constitution set out in the EC Treaty determines which health services come under EU competition law and which come under member state jurisdiction. The European Commission recognises that reliance on third sector providers raises fundamental questions about state control over redistributive welfare services because organisations that have some commercial characteristics, such as trading activity and competitive tendering, are regulated under European law. Increasingly, where services move into the sphere of private contract law, commercial rules apply and the jurisdiction may change from national to regional courts. Regional laws can reduce the sovereignty of the nation state by proscribing redistributive policies such as government subsidies and service monopolies, e.g. in postal services (European Economic and Social Committee, 2001).

Thus the switch from integrated state provision of services, to a market delivery system together with the introduction of nonprofits has implications for the systems of administration and law. The treatment of nonprofits raises constitutional issues because these bodies, despite providing government services, may under certain circumstances fall under the jurisdiction of the EU and its competition laws thus inhibiting the government's power to regulate public services to meet the core principles of the NHS.

For example, the NHS Plan in England contains in its preface a set of ten core principles:

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.
2. The NHS will provide a comprehensive range of services.
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.
4. The NHS will respond to different needs of different populations.
5. The NHS will work continuously to improve quality services and to minimise errors.
6. The NHS will support and value its staff.
7. Public funds for health care will be devoted solely to NHS patients.
8. The NHS will work together with others to ensure a seamless service for patients.
9. The NHS will help keep people healthy and work to reduce health inequalities.

10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance (NHS Plan, 2000).<sup>1</sup>

A key concern here is whether these principles are compromised as a result of current policy initiatives.

During the course of designing the literature review it became apparent that we were faced with some major conceptual challenges in trying to classify nonprofits and conduct a review of their performance. The first challenge was the need to take account of the policy context within which nonprofit forms are emerging, namely the switch from integrated publicly owned public services to a market based system of competing providers. The second was to examine the theoretical rationale and evidence base underpinning the switch to government's use of nonprofits in the NHS, and to consider this rationale in the context of the overarching goals of the NHS, namely universality, equity and public accountability. The third was the need to understand the regulatory and legal implications of bringing in nonprofits with respect to government controls over public expenditure and its right to regulate. This meant that we had to explore the literature and debates on how government itself classifies and treats nonprofits for public expenditure purposes, and how the European Union treats them for competition law purposes.

As a result our review of the literature is in four parts. The first section gives a brief overview of the policy development and highlights some of the regulatory and constitutional implications. The second examines the theoretical justifications for government policy of using nonprofits to substitute for public provision, and is used to provide a framework and rationale for our approach to the analysis of performance literature. Third, the substantive literature review, reviews the nature of the evidence underpinning the 'performance' of nonprofits in the context of theory and of government policy towards the NHS. In our original proposal, we stated that we would review the historical literature on the performance of nonprofits in the pre-NHS era. We have done this, but we have placed it in an appendix on the grounds that the historical literature on which we have drawn was derived from different sources to those used in the systematic literature review (though we believe it is comprehensive). Additionally, though this historical literature did not set out systematically to assess "performance" in the way that contemporary work does, we believe it sheds valuable light on current

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<sup>1</sup> As we went to press, the government published a revised set of principles in a new operating framework for the NHS in England. (NHS 2006) *The NHS in England: operating framework 2007/8*. London: NHS). The revised set of principles no longer require that public funds for health care will be devoted solely to NHS patients.

debates, not least because of the use by think tanks and government ministers of historical precedent.<sup>2</sup>

Finally, we examine how nonprofits are classified in national accounts from the perspective of government control and contrast this system with the way in which the EU assigns public control over nonprofits. We consider the policy implications of our findings for government control over public expenditure and their right to regulate and make recommendations for further research.

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<sup>2</sup> Peter Hain (2002) 'The past in new Labour's future', *Observer*, 27 October 2002; Blears, Hazel, MP, 'Mutualism and the development of the National Health Service', in Stephen Hogan ed. *Making health care mutual: a publicly funded, locally accountable NHS*, Mutuo, London, 2002, p.11; David Green (ed, 1996) *Reinventing civil society: the rediscovery of welfare without politics*, (London: IEA), p. 130.

## Section 1 Policy background

In this section we examine the history of nonprofit policy in England both before and after the creation of the NHS, with special reference to the emergence after 1991 of a contracting system for providers of NHS services, first in the form of a 'quasi' or internal market and, from 2003, in the form of a true commercial market.

### ***1.1 The history of nonprofit policy***

#### **1.1.1 Nonprofit providers pre-NHS**

Although a mixed (public-private) economy of health care existed in Britain for many years prior to 1948, this did not mean that there was an extensive network of contractual arrangements between the private and public sectors for the provision of health services. To the extent that this can be traced in hospital and local authority financial statistics, it seems that spending was concentrated on some specialist services (orthopaedic hospitals, tuberculosis sanatoria), which individual local authorities lacked the resources to provide (Mohan, 2006). However, once the wartime coalition government made its commitment to developing a national health service, with an announcement in 1941, the possibility that this might embody a purchaser-provider split was actively considered. Indeed, some have argued that the government's 1944 White Paper anticipated many of the subsequent features of the NHS reforms of 1989 (Powell, 1994).

However, those wartime proposals foundered for two reasons (Mohan, 2002, pp. 77-83). Firstly, it was known that the costs and efficiency of hospitals varied enormously, but no research had been done on the reasons for these variations, and there was considerable caution about embarking on a market-based reform of hospital services in those circumstances. The second and more fundamental reason was the reluctance of the nonprofit providers (the established voluntary hospitals, particularly the teaching hospitals) to accept that greater payment from public sources implied a greater degree of accountability for the use of public money. Various options for reimbursement were considered, and one of them was for centrally-determined standard payments for different levels of service; there was a clear implication that the ministry wished to avoid the transaction costs associated with what was termed a "network of separate bargains". However, it proved impossible to agree a solution because of the intransigence of the voluntary hospitals, which were determined to protect their independence from what they saw as unjustifiable state regulation (Mohan, 2002, pp. 80-1). The solution finally agreed upon was one in

which hospitals were integrated into a regionally administered health care system and paid on the basis of annual retrospective reimbursement not prospectively on the basis of contracts.

### **1.1.2 NHS policy towards nonprofits 1948-1991**

With the exception of long-term care, for which major divestiture to the private sector occurred throughout the 1980s, the post-1948 history of the NHS witnessed few efforts to revive the possibility of contractual arrangements between the public and private sectors, although such arrangements were developed in a small number of cases where hospitals had been “disclaimed”, that is, not nationalized when the NHS was established. The near-universal electoral popularity of the NHS meant that the Conservatives in the 1950s were disinclined to tinker with it, and the Labour governments of the 1960s and 1970s maintained a strong commitment to public provision. In terms of contestability it is also true to say that in these decades there were very few potential alternative providers of services: in the case of hospital provision there were no significant commercial providers and the existing nonprofit sector (a small number of rather undercapitalised institutions, such as those run by Nuffield hospitals and the religious sector) was not in a position to bid for contracts (see Griffith *et al*, 1987; Mohan, 1984, 1985; Rayner, 1986; 1987; for further details).

It was not until the return of the Conservative government in 1979 that initiatives were taken to reintroduce welfare pluralism. Health authorities were explicitly encouraged to take account of existing and likely future private provision of services when developing their plans for the future, and the concept of the NHS as a commissioner rather than a provider of care came on to the agenda (Davies, 1987). Health authorities were given more freedom in various respects: freedom to raise funds through charitable efforts, to expand private pay-bed provision, and to collaborate with the private and voluntary sectors.<sup>3</sup> However, for most of the 1980s, the Conservatives did not go so far as to create a contestable market in service provision. While there was much rhetorical support for the idea of public-private partnerships and a mixed economy of welfare, financial backing for developing new forms of service provision was not evident. Steps taken to expand choice were ill-considered and resulted in uneven growth of services, unrelated to needs, an obvious example being the mushroom growth of private nursing care for the elderly. GPs faced a more complicated structure of reimbursements and incentives but were not competing against other bidders for their practices (Moon and North, 2000, 26-8). There was some expansion of contracts with the private sector for the provision of

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<sup>3</sup> Teaching hospitals and special health authorities already enjoyed some freedoms in respect of their charitable endowments through the mechanism of special trustees: Mohan and Gorsky, 2001, 91-102.

acute surgery, although this was not systematically developed, since it depended largely on the existence of spare capacity in private hospitals.

### **1.1.3 The 1991 reforms create health care firms**

While divestiture of mainstream clinical care to other sectors had hardly progressed at all during the Conservative administration of 1979-1990, a structural change was made in 1991 that fundamentally changed opportunities for privatisation. The internal market reforms organised hospitals and community health services into more than 400 trusts legally obliged to break even by selling their services to NHS purchasers (at that stage, health authorities). This switch to a corporatised system of providers brought with it a new accounting regime and purchasing system that could in principle be extended to nonprofit and for-profit providers.

The New Labour government of 1997 abolished one aspect of the 1991 reforms, GP fundholding, but it held firmly to the market orientation of the Conservatives structural reforms by retaining the purchaser-provider split. However, until 2003 no administration had made an effort systematically to encourage nonprofits. Contracts were placed between the NHS and the private sector but they depended very much on ad hoc local circumstances, and the NHS Plan (2000) repeated exhortations first made in the early 1980s to use the nonprofit sector more widely.

## ***1.2 The evolution of nonprofit policy in England since 2000***

In 2000, the NHS Plan announced the government's intention to develop partnerships with the voluntary sector for the provision of NHS services:

'The NHS will develop partnerships and co-operation at all levels of care – between patients, their carers and families and NHS staff; between the health and social care sector; between different Government departments; between the public sector, voluntary organisations and private providers in the provision of NHS services – to ensure a patient-centred service' (NHS, 2000, p5).

Increased voluntary sector participation had been encouraged by successive governments at least for the previous twenty years, but on this occasion the announcement was backed up by subsequent initiatives designed to remove barriers to the entry of voluntary agencies and by legal reforms abolishing the public sector's monopoly. This was the first time that exhortation had been linked to statutory change.

Initiatives occurred at both government and NHS levels and will be discussed briefly in the following paragraphs.

### **1.2.1 Cross-government initiatives - reviews**

Following the NHS Plan, in 2002 the Treasury published an interdepartmental review of the role of the voluntary and community sector that recommended that policy-makers should give consideration to 'the full range of options for [voluntary and community sector] involvement', including service delivery (HM Treasury, 2002, p37). By 2004 the government's spending review included a report of an investigation into 'the potential for greater third sector involvement in public service delivery' (HM Treasury, 2004a). That investigation, led by chief secretary to the Treasury, Paul Boateng, reiterated calls for greater involvement of the sector in public service provision, including health and social care for older people. A further discussion was published in the same year by the UK Treasury that would 'help clarify what the third sector is, [...] describe the value which third sector organisations can bring to improving the quality and effectiveness of public services, and [identify] the challenges facing the Government and the sector in the years ahead if the full benefits of its involvement in public services are to be realised' (HM Treasury, 2004b).

High significance continued to be attached to the policy; in March 2006 a further review of the third sector was announced as part of the Treasury's comprehensive spending review and a minister of the third sector was appointed to the cabinet office.

### **1.2.2 Cross-government initiatives - legal reforms to allow diversion of NHS funds to nonprofit providers**

Meanwhile, new legal forms were introduced to facilitate commercial contracting with nonprofit bodies. First, the *Health and Social Care (Community Health and Standards) Act, 2003*, created the community benefit company as a legal basis for commercial contracting between foundation trusts and NHS commissioners of care. The Act included a new power permitting service commissioners to contract with any provider.

Second, in 2005 the Companies Act was amended to include a new corporate form called the 'community interest company'. This form was designed for use by 'social enterprises' wishing to contract for public services (social enterprise is a generic term which the Treasury views as synonymous with 'nonprofit').

### **1.2.3 New guidance**

In March 2006 the Treasury published guidance to funders choosing to purchase from the social enterprise sector. The guidance, which provided advice on 'best practice' and 'effective and efficient use of public funds in a way that is consistent with the principles of public accountability', called for a flexible approach to accounting rules so as to lower barriers to third sector involvement (HM Treasury, 2006, p10).



### **1.2.4 Other measures**

A "Third Sector Commissioning Task Force" was created in 2005 to lower barriers to entry and to place third sector organisations on a level playing field (third sector is another term the Treasury uses as a synonym for 'nonprofit'). A post of 'compact commissioner', responsible for compacts between the voluntary sector and public agencies, to be funded by the Home Office, was planned for September 2006, and a special body known as the Social Enterprise Unit was created in government to promote the policy ('compact' is a term the government uses to refer to a framework of principles underpinning relationships between the voluntary and community sector and the public sector).

## ***1.3 The evolution of nonprofit policy in the NHS since 2003***

### **1.3.1 Nonprofit opportunities in the new primary care market**

In 2003 the GPs' monopoly over the provision of primary care to the NHS was abolished with the enactment of the *Health and Social Care (Community Health and Standards) Act* of that year. This for the first time allowed PCTs to commission care from 'anyone who can secure a contract' (NHS Primary Care Contracting, 2006). Then in 2004 the GMS contract between GPs and the Secretary of State was replaced, resulting in contracts between practices and PCTs with very different provisions from its forerunner.

At the heart of the new system was a transformation in GPs' contractual relationships. The old GMS contract was backed by provisions of the Red Book, an extensive set of guidelines and regulations covering service range and quality, staffing and premises. The new system provides for four main categories of contract:

- revised nationally-negotiated GMS contracts for essential services only,
- primary care trust medical services contracts (PCTMS) which enable PCTs to employ GPs directly on salary,
- personal medical services (PMS) contracts, negotiated locally, which allow PCTs to contract with practices or with individual GPs to provide a variety of different mixes of primary care services,
- alternative provider of medical services (APMS) contracts which allow commercial firms to provide any combination of primary and secondary care services (Department of Health, 2003).

GPs can enter these various contractual relationships as sole practitioners; as part of a practice partnership; as employees, directors, or shareholders of commercial companies; as sub-contractors to

whatever entity holds the primary contract; or as salaried PCT employees. Nonprofits, including according to Treasury usage community interest companies, are included among the corporate bodies that can contract for primary care services on a commercial basis.

### ***1.3.2 The primary care White Paper and the NHS operating framework***

Third sector policy for the NHS is set out in the 2006 White Paper *Our health, our care, our say* (paragraph 7.93.). The White Paper followed the commitment in *Commissioning a Patient Led NHS* (DH 2005) to a 'competitive, contestable marketplace' for the supply of all NHS services, with the NHS as 'a commissioning-driven service'. The White Paper gave PCTs a central role in driving the policy and required them to become by 2008 'patient-led and community-led organisations' rather than providers of services. It included a set of policies 'to promote better use of health and social care "third-sector" providers' ('third sector providers' in this context follows Treasury definitions and includes 'organisations from the voluntary and community sector, as well as other forms of value-driven organisations such as co-operatives'). All providers that pre-qualify to quality standards during the tendering process will be put on an accredited list of primary care suppliers to ensure faster procurement of GP services in the future (pp 67-8). Furthermore, from April 2007 the Department of Health will establish a fund to provide advice to social entrepreneurs who want to develop new models to deliver health and social care services (pp 175-6).

The 2006 NHS operating framework identified capital investment as one of the key barriers to participation by nonprofits: 'Where a new service would require significant capital investment', it said, 'the PCT could seek to lower the barriers for new providers by considering a variety of different ownership and service delivery models which reflect the range of services provided and the different funding sources available' (Department of Health, 2006, p14).

In July 2006 a follow-up document, *Our Health, our care, our community: investing in the future of community hospitals and services*, built on its predecessor and the operating framework by including third sector providers as possible members of a new capital investment model known as 'community ventures' which allow for joint ventures between a PCT and a partner (potentially either a third sector or a private organisation). This joint venture company would be given capital. Then, in November 2006, a White Paper implementation plan, *Our health, our care, our say: making it happen*, proposed new funding arrangements, institutional arrangements and an independent regulator for social and community care, signalling the development of a system of care parallel to but separate from the NHS in which nonprofits are scheduled to play a role.

## *Structure and performance of not-for-profit health care organisations*

Nonprofit policy has therefore been an important element in the evolution of commercial contracting and the shift away from public provision of NHS services.

In the next section we set out the conceptual framework for the review of nonprofit performance.

## Section 2 The conceptual framework: definitions, hypotheses and theory

### **2.1 Definitions**

There is no agreement on the meaning of the term 'nonprofit'. What counts as a nonprofit organisation varies from country to country and here we examine briefly the efforts of various commentators and analysts to find a generally accepted definition. In this account it will become clear that the debate is fundamentally influenced by different perceptions of the relationship between nonprofits, the state and the market.

According to Kendall and Knapp the nonprofit sector "contains within it such a bewildering array of organisational forms, activities, personalities, ideologies, constraints, expectations and fears, that for many purposes of policy, research and discussion it would be a misrepresentation [of the sector] [...] and an unhelpful constraint" to base analysis on a single factor, such as ownership (Kendall and Knapp, 1996).

Salamon and Anheier (1997) illustrate the problem in their break down of the nonprofit sector into the charitable, independent, voluntary and tax-exempt sectors, non-governmental organisations, the *économie sociale*, and what the UK government refers to as 'value-driven' organisations or 'social enterprises'. Although each of these terms captures a different aspect of nonprofits, none on its own describes a distinctive sector or function. Not all nonprofits are charitable (in most countries charitable income is a small part of total revenues), and while the term 'independent sector' defines nonprofits in terms of autonomy from government, that autonomy varies from state to state and may be compromised by the receipt of funds from government contracts and by the terms on which such contracts are placed. Since all organisations are driven by values of one kind or another, the UK government's use of the term 'value driven' suggests a political rather than social purpose (HM Treasury 2006). Since 'social enterprises' generate most of their income from competing in markets, even if they are notionally 'non-market', they cannot avoid competitive behaviour. Indeed, according to UN's systems of national accounts, nonprofit organisations which receive the majority of their income from fees and commercial contracts will be classified as part of the market sector, regardless of their legal status, ethos, social purpose or function (see below, section 4).

Arriving at an agreed definition of nonprofits is therefore almost impossible. The situation is further complicated because nonprofits can also take several possible legal forms. Nevertheless, UK government policy and political rhetoric all too often employs a simple contrast between public, private, and voluntary sectors, even though the UK

Cabinet Office's own strategy unit has emphasised the diversity of the sector. Referring to social enterprises, for example, a study for the Cabinet Office stated that 'Social enterprises take an enormous number of different ownership and governance structures, and have a very wide range of objectives.' This study found 17 different types of social enterprise organisation but did not analyse the legal implications of this (Cabinet Office Strategy Unit, 2002).

We have adopted as a working definition for the literature review the definition of a nonprofit organisation used by the European System of Accounts (see section 4.1.1): 'a legal or social entity created for the purpose of producing goods and services whose status does not permit them to be a source of income, profit or other financial gains for the units that establish, control or finance them. In practice, their productive activities are bound to generate either surpluses or deficits but any surpluses they happen to make cannot be appropriated by other institutional units.' (ESA, 1996) (This qualification is known as the non-distribution constraint and will be discussed in more detail in section 2.2.5).

Government departments acknowledge that the plethora of nonprofit forms have implications for both structure and performance because of their potentially different effects on viability, social purpose, locus of control and interaction with the environment (Cabinet Office Strategy Unit, 2002; HM Treasury, 2002).

In the classification and regulation section we will examine whether and to what extent these definitional vagaries are resolved in official classification systems. We will identify where nongovernmental nonprofits fit into the institutional and sectoral classification system; discuss recent attempts to refine the basis of the public/private boundary; and describe certain conflicts in the way national and government accountants classify nonprofit organisations and assets. We will also examine the jurisdictional question of whether nonprofits are subject to European economic law or regulation. To examine this we will explore the scope of the European Union's economic constitution and the basis upon which nonprofit organisations are deemed to be providers of public or market services (see section 4.3.1).

## **2.2 Theories and hypotheses**

### **2.2.1 Competition hypotheses**

Nonprofit participation in the provision of public health services is facilitated by contracting-out. However, the economic literature supplies no theoretical accounts of nonprofits or their objectives under competitive conditions, nor any strong theoretical prediction that ownership dictates differences in cost performance in a market (Needleman, 2001; Shen *et al*, 2005). Instead market benefits are related at the theoretical level to the process of contracting-out rather than to nonprofits per se (Domberger and Jensen, 1997). According to economic theory, competition is the crucial determinant of performance (Shen *et al*, 2005). In comparisons of nonprofits with for-profits, any attempt to isolate the effect of ownership must take this into account. We will therefore examine, first, whether the performance literature includes controls for competitive pressures on nonprofits, and second what the literature has to say about the differential effects of contracting and reimbursement systems on nonprofit performance. We will then examine in the classification section the role played by competition in the designation of nonprofits as market actors.

### **2.2.2 Competition and contestability**

Theories of competitive bidding (the essence of contracting-out) predict a reduction in cost compared with the cost prevailing before competition, assuming more or less perfect competition, with a large number of bidders ensuring that none can individually affect the offered price. However, given that public service efficiency requires consumers and services to be bundled together, an alternative theory of 'contestability' has been employed for public service contracting-out. As currently used by the UK government for NHS policy (Reid, 2005; Department of Health, 2005), the theory involves claims about the significance of the costs of entry and exit. A contestable market is defined as one in which entry and exit costs are minimal and in which there are no legal restrictions on market entry or exit (Baumol *et al*, 1982). Barriers to entry can include differential costs of capital investment, and regulatory requirements, such as the requirement on US nonprofits to provide community benefits like uncompensated care that do not apply to all potential contractors.

Several studies look at the extent to which community benefits are actually provided by nonprofits and we examine these findings. We also scrutinize the findings of studies concerned to measure the effects of market entry and exit on patient access to care. In section 4 we consider whether the nonprofit sector is clearly defined with a determinate set of regulatory requirements distinct from other sectors.

Neither competitive bidding hypotheses, nor contestability theory predict that advantages will accrue from contracting with nonprofit rather than for-profit providers. On the contrary, contestability makes a case for treating nonprofits and for-profits equally. Nor does either theory provide an explanation of the different kinds of accounting entity among which competition takes place. However, competition can have implications for risk pools; competitive bidding may lower levels of funding aggregation at provider level, making funding recipients more vulnerable to random variations in patient needs and limiting the opportunities for risk-pooling (Heald, 2003). While appreciation of this has led to the inclusion of case mix adjustment techniques in empirical studies of relative cost performance in the USA, the question of the link between competition and the ability of hospitals to cross-subsidize free care for the poor remains under-theorised and is the focus of fierce debates over nonprofits' tax exempt status (Federal Trade Commission and Department of Justice, 2004). In the literature review we assess whether studies have included appropriate control variables, such as case mix adjustment, when they examined the responses of different ownership forms to the pressures of competition.

### **2.2.3 Property rights theory**

Property rights theory, an economic analysis of ownership, predicts efficiency benefits from private ownership of a trading body's surplus. But the main prediction, that private ownership of productive surpluses improves efficiency, provides an argument against nonprofits as well as against public ownership (Domberger and Jensen, 1997). We will examine findings about the relative cost efficiency of the nonprofit sector. However, a key consideration here is that cost results are uninterpretable without comparable data on the effects of cost efficiency on the quality of care.

Two economic frameworks predict differential effects on quality of nonprofit and for-profit organisation. The first is the theory of asymmetric information and the second is the principle of non-distribution.

### **2.2.4 Asymmetric information and incomplete contracts**

Attenuation of property rights through the establishment of nonprofits can solve some specific problems of market failure. The argument is that nonprofit organisations face in principle no financial incentive to compromise the quality of care they provide. In contrast, for-profits have a direct pecuniary incentive to do this.

Economists such as Kenneth Arrow (1963) and Burton Weisbrod (1975) argue that in certain circumstances producers of services will always have more information at their disposal than consumers. As a consequence, as in the case of health care, consumers are unable to evaluate fully the likely consequences of different courses of treatment

and so can never be certain that they have chosen the best provider of the service, or that the outcome of treatment is optimal. Unlike articles of individual consumption, the adequacy of services provided in such areas as health, childcare and nursing is hard to evaluate, particularly when the purchaser or his or her relative cannot be present. In this situation contracts are deemed to be 'incomplete', in the sense that not all possible eventualities can be written into a contract, and managers of for-profit organisations have an incentive, which experience shows is not always resisted, to exploit this situation and maximize profits by reducing service quality. This furnishes one theoretical reason to favour nonprofits for the provision of public services, where quality is at a premium.

### **2.2.5 The non-distribution constraint**

The nonprofit form of organisation, which limits property rights to earnings, is said to overcome such problems; in Hansmann's (1980) formulation, nonprofits have one key defining characteristic: the non-distribution constraint. While they may make surpluses, or profits, they cannot distribute them to shareholders, or to trustees, but are required to reinvest them and use them for the purposes for which the organisation has been established. The 'contract' between a nonprofit and a consumer therefore offers greater reassurance to potential users of a service where information is asymmetric. Thus when the consumer cannot measure output it makes sense to adopt incentive structures that reward behaviour that is less easily monitored by the user, that is, quality issues about which users can have little information. The nonprofit form is efficient to the extent that the increase in valuable behaviours offsets other responses which may be at the expense of social welfare. (Sloan *et al* 2001, 3). As a general rule, the larger the potential adverse effects of cost-cutting on service quality, the stronger the argument for direct public or nonprofit provision of services. Hence empirical studies frequently examine the cost/quality/access trade-off and test the prediction that it should have less influence among nonprofits. An important part of the literature review will involve examining whether studies motivated by these theoretical predictions have paid as much attention to variation in regulation by the public sector as they have paid to variation in market regulation.

It is argued that the non-distribution constraint influences behaviour in several ways, and we can infer from this that there ought to be identifiable differences of behaviour between nonprofits and for-profits. For example, Hansmann (1980, 1987) identifies potential effects on *goals* (e.g. nonprofits would be expected to be more concerned with maximising the quality or quantity of a service to be delivered, rather than purely maximising profits); on *efficiency* (the absence of ownership claims to residual earnings is said to imply that managers have little incentive to minimise costs, although on the other hand other aspects of the nonprofit form, such as greater support from volunteers, might affect the cost structure); on the *ability to respond flexibly to changes*



*in demand* (because they are constrained in terms of access to capital); and on *the extent to which they are able to cross-subsidise* 'unprofitable' services.

We will examine the findings of studies that combine assessment of cost efficiency with assessment of quality and also findings with respect to variation in nonprofit 'community benefit' performance. We will investigate findings with respect to nonprofit mergers, their conversion to for-profit status, and the protection of nonprofit assets. We will also examine findings with respect to public trust in nonprofits as well as staff commitment and satisfaction.

Notwithstanding the non-distribution constraint, the term 'nonprofit' does not mean that nonprofit organisations cannot make surpluses – they can and usually must, but surpluses may only be used for the purposes for which the organisation exists; they cannot be appropriated by staff or board members. From this perspective it is wrong to claim that nonprofits do not pursue surpluses in exactly the same way as for-profits (Thorpe *et al*, 2001). Surpluses have traditionally been used by for-profits and nonprofits alike to pursue social goals such as funding care for the uninsured. In this context, the question is whether, in the pursuit of surpluses, nonprofits are regulated sufficiently differently from for-profits to influence their operations, and in particular the scale and nature of the cost and quality trade-offs often associated with surplus generation. This question is explored in the section on classification and EU regulation (section 4.2).

### **2.2.6 Investment**

Since they cannot distribute profits, nonprofits may be unable to attract equity capital for investment. This suggests that their finance structure may differ from that of for-profit enterprises (United Nations, 2003). The significance of this prediction is that the government links third sector policy with privately financed public service infrastructure (see section 1). We explore the evidence from the literature about the implications of capital investment arrangements for the organisation and delivery of services by nonprofits.

### **2.2.7 Public administration**

Theoretical arguments drawn from the literature on the non-distribution constraint suggest reasons for thinking that nonprofits are a desirable form of organisation, particularly for the provision of welfare services, but James (1990) argues that there are three questions which remain unresolved and may cast some doubt on this conclusion. First, the theories are based on the American experience, and while they may provide reasons for having services provided by nonprofits rather than by government, several of the hypotheses derived from the same theories appear to give reasons to prefer direct public provision, such as exists in many countries, as much as nonprofit providers. Second, the theories do not explain why in many societies government and

nonprofits apparently compete, or at the very least operate to provide the same services. Finally, theories which highlight the social purposes which can be served by nonprofits do not explain the diversity of forms in the nonprofit sector (James, 1990, 22-3).

Theories of public administration can be contrasted with organisational economics in the emphasis given to system-level rather than firm-level analysis. At the system level public administration predicts that market fragmentation will impair mechanisms for ensuring integrated, equitable treatment for geographic populations. We will examine what the literature has to say about co-operation between nonprofits and other organisations, and about the role of geographic or locality planning in connection with nonprofit provision.

### **2.2.8 Social and political theories**

Other theorists argue in favour of nonprofit provision on the grounds that it can advance social or political goals, rather than for technical, economic reasons. And in practice nonprofits frequently appear as the only feasible option as a result of historical and political circumstances. But, as we shall see, in these accounts it is almost always assumed that nonprofits are private corporations not public sector bodies. The accuracy of this assumption is examined in the classification and regulation section.

Much contemporary writing on the desirability of nonprofits implicitly or explicitly seeks to create or re-create a sense of involvement and participation. Those who advocate the return of public services from public provision to control by voluntary organisations often rely on the proposition that this will enhance participation and community control, and will restore a better balance between the interests of consumers and producers. Paul Hirst (1994) and Brian Turner (2000) were impatient with defenders of the centralised Keynesian welfare state, arguing that consumer interests were repressed by its bureaucratic mode of service delivery, dominated by professionals. They felt that most people were competent enough to be given choice in the public services, and challenged critics to show that individuals would not be able to find and to evaluate appropriate guidance. Central to this argument is a conception of the role of nonprofits in providing vehicles for community control and participation. David Green (1996) sees nonprofits and volunteerism as ways of reinventing forms of collective social action which do not have a political dimension, and as an essential means of fostering civic virtues rather than relying on what he terms 'socialist materialism'. On his view they generate greater participation and 'active citizenship', which in turn promotes trust and perhaps, the formation of social capital.

A characteristic claim of conservative commentators such as David Green and Arthur Seldon (1980) is that state provision of welfare services stifled a huge wave of localist and voluntary effort, and therefore prevented the development of 'more spontaneous, organic, a

local, voluntary and sensitive services [...] [that would have] better reflected consumer preferences' (Seldon, 1980, p5) than what Whelan terms an 'overstuffed, underperforming state' (1993, p18). Responsiveness, they hold, will be promoted by welfare systems which give individuals, rather than governments, the greatest degree of choice of welfare providers. Similar arguments are advanced by writers such as Bosanquet (1999) who argue for 'managed pluralism' as a means of promoting access to services and increasing patient choice. Bosanquet believes the NHS would do better if it 'did less and encouraged substantial new sources of funding and supply' (ibid, p8). Ham (1995) has likewise argued for more flexible and participatory approaches to service delivery as being desirable in themselves. Not all are so sanguine about the benefits of nonprofits, however. Bruce (1995) implies that there are several structural reasons why nonprofits cannot automatically be presumed to 'value and respect their consumers', not least because of the numbers of stakeholders and the complexity of their governance arrangements, and we will seek to identify the ways in which responsiveness to consumers is assessed in the literature.

In the light of these contrasting predictions we will examine findings with regard to the adequacy of basic accountability mechanisms in the nonprofit sector, namely, boards of governance and financial reporting.

Predictions from these theories also generate hypotheses about the experience of patients and staff, for example, in respect of responsiveness to consumers and staffing policy. We examine measures in the literature of user satisfaction. In Section 4 we examine the definitions of public control over corporate policy that lie behind the assignment of nonprofits to government, public or private sectors.

### **2.3 Analytic framework**

It has proved extremely difficult to provide an analytic framework that encompasses this diversity. We have identified six main themes but there is inevitably substantial overlap and some of the concepts are found in studies with very different aims. For example, while there is a small number of studies that attempt to measure the effect on performance of the competitive situation of nonprofit organisations, competitive pressure is also frequently referred to in studies that do not directly examine it.

Our six analytic themes are as follows:

- Funding and competition
- Public purpose
- Users and quality
- Capital financing
- Integration and planning
- Governance and accountability

## Section 3 Systematic review of literature on nonprofit performance

In this section we give an account of the systematic literature review of nonprofit performance in health and social care. The section begins by describing the findings of previous reviews and their implications. We then describe the methodology we employed to identify relevant studies. This is followed by an outline of the key characteristics of the studies included, and a more detailed discussion relating to the six themes which guide this review. Finally, the main results are discussed.

### ***3.1 Findings of previous literature reviews***

A number of systematic reviews of the performance of the nonprofit sector have been conducted. While we cannot give a full account of all of them, we have sought to identify their main findings.

#### **3.1.1 Methodological limitations**

Previous reviewers have noted a number of methodological limitations in the studies evaluated. For example Sheaff *et al* (2003) criticised 'the weak methodologies underpinning many of the studies', 'uncertainty about the generalisability of the results', and 'the lack of clear conceptual and theoretical frameworks to guide the analysis and interpretation of the evidence' (Sheaff *et al*, 2003: 7)

Two systematic reviews comparing nonprofit and for-profit hospitals noted the absence of any randomised controlled trials and the potential for confounding variables as their two main problems. 'Ideally, studies would have adjusted for, or considered as explanatory factors, other variables for which data were not available' (Devereux *et al* 2002, 1404). And Eggleston *et al* (2006) pointed out that conventional methods of meta-analytic synthesis should be applied with great caution, given the fact that the same hospitals were frequently included in several different studies.

#### **3.1.2 Definitional and measurement problems relating to key variables**

A particularly serious shortcoming, closely related to the methodological limitations which previous reviews have highlighted, is the failure to define key terms and establish valid measures of key variables (Sheaff *et al*, 2003). This problem is particularly serious for empirical studies which attempt to detect effects of ownership type. As Currie *et al* (2003) pointed out, cost comparisons have been difficult to undertake on the basis of available data:

Empirical studies attempting to detect differences by ownership type are plagued with difficulties in ensuring comparability of financial data, and in accounting adequately for case-mix, diversity of services offered, degree of competition, regulatory factors and quality (Currie *et al*, 2003, 10).

Devereux *et al* (2002) complain that studies have done little to adjust for the proportion of Medicare patients versus privately insured patients in the various health institutions included in the analyses. In addition, large administrative databases afford limited ability to adjust for factors such as disease severity of patients admitted to different hospitals.

### **3.1.3 Inconclusiveness of studies and the impact on results of neglected contextual factors**

Previous literature reviews have shown that the for-profit versus nonprofit literature is far from conclusive on the issue of whether one ownership form is superior to another. There has so far been no good study design comparing nonprofits and for-profits. The New York Academy of Medicine, for example, reviewed studies comparing access, costs, quality of care, education and research in for-profit and nonprofit hospitals, managed care organisations, and nursing homes, and reached the general conclusion that the studies evaluated provided no clear indication as to the superiority of either hospital system regarding the quality of care and health outcomes (Division of Health and Science Policy, New York Academy of Medicine, 1999).

Similarly, Shen *et al* (2005) concluded in their meta-analysis of cost efficiency studies that there was little evidence of ownership differences. According to them this is little surprising since

*theory [does not] suggest that any ownership differences will swamp other factors strongly predicted to shape behaviour, such as market concentration or payment incentives. Rather, one of the strongest predictions of economic theory is that providers react to their market environment.* (Shen *et al*, 2005, 5).

The authors moreover found that the diversity of results in the literature on hospital ownership could be explained largely by differences in researchers' underlying theoretical frameworks, assumptions about the functional form of the dependent variables, and model specifications with weaker methods and functional forms tending to predict larger differences in financial performance between nonprofits and for-profits (Shen *et al*, 2005). Similarly, Eggleston *et al* (2006) claim that differences in results appear to arise predominantly from differences between studies' analytic methods.

Currie *et al* (2003) reviewed numerous studies which in their opinion show that the degree of competition in the marketplace significantly affects the responsiveness to financial incentives of nonprofits and for-profits; that the behaviour of the two sectors tends to converge as competitive pressures increase; and that the behaviour of for-profit and nonprofit providers is far more alike than different. On cost, the

majority of the 27 studies they analysed found no evidence that type of ownership made any difference to hospital costs or that for-profits were more expensive (Currie *et al* 2003: 4). However, they regarded this as difficult to interpret for two reasons: first, reimbursement mechanisms (e.g. cost-based reimbursement) influence the results – a rational response in such an environment would be to seek higher profits by charging more, rather than reducing costs, since the fact that all reasonable expenses were reimbursed meant that inter-hospital competition was based on quality, amenities, and availability of technology (what Currie *et al* called 'a medical arms race'). Secondly, information on cost differences cannot be meaningfully interpreted in the absence of information on service quality. For instance, the apparent low efficiency of nonprofits might indicate that they provide a high-quality service; conversely low administrative costs might indicate that less attention is actually given to monitoring service quality. Comparisons may also be difficult because of the problem of self-selection – on the face of it, nonprofits might appear less efficient than for-profits, but this could be because nonprofits were operating in less favourable locations, pursuing a goal of providing access to care, whereas for-profits were choosing to operate in areas most likely to generate a good return on investment.

Overall, the literature contains a few studies which favour for-profits hospitals, some which favour not-for-profits and a majority of studies which suggest that there is no significant difference (Currie *et al*, 2003, 13).

In their summary of the current state of public policy debate in the USA on the question of nonprofits versus for-profit organisation Schlesinger and Gray (2006) also emphasised the importance of the study context. Although – in contrast to a number of studies – Schlesinger and Gray claimed that there are consistent ownership-related differences, they also pointed out that ownership matters differently depending on the outcome under consideration and that the context under which nonprofits operate matters greatly. Some studies compare hospitals operating under relatively benign market conditions with others operating in rather harsher contexts. For example, comparisons of hospitals before and after conversion from nonprofit to for-profits status show few differences because the hospitals that converted were typically struggling and changed status in order to achieve certain strategic goals, while the underlying characteristics remained largely the same (Schlesinger and Gray, 2006).

### **3.1.4 The US dominance of the literature**

A final important point which previous literature reviews have made is that the empirical literature comparing for profit and nonprofit hospitals is mainly drawn from the US health care system which, as Currie *et al* (2003) pointed out, is of limited relevance to other health systems which are not market-based and are universal, as in the UK. In the US the comparison is between the nonprofit sector, which was historically

dominant in providing health and social care, and the increasingly important for-profit sector, whereas the move in the UK is one from a public health system to a mixed economy, including providers from the private for profit and the nonprofit sectors. In the US, the public sector only plays a minor role, though, and most studies exclude it from their analyses.

### **3.1.5 The pooling of studies within systematic reviews**

A problem of systematic reviews themselves is the fact that they seek to reach some overall evaluation by combining in a single review studies of very diverse character and quality. Sometimes this takes the form of simply counting studies purporting to show that one ownership form is superior to another (or, more likely, that no difference was detected between them); sometimes reviewers undertake more elaborate forms of statistical analysis, for example assigning a weight to each study according to the number of cases it covers.

But as we have already noted, studies vary greatly in terms of their purposes, methodological soundness, definitions of terms, measurement of variables, underlying theoretical frameworks, regard paid to context, etc; and as these factors all impact on the results it is questionable whether any synthesis of studies in pure numerical form is of any help.

### **3.1.6 Implications for our approach to the systematic literature review**

Given the heterogeneity of studies on the performance of the nonprofit sector and the problems revealed by previous systematic literature reviews, we do not consider it fruitful to analyse the studies by producing tables which purport to show how far, if at all, one ownership form is superior to another. Instead, we decided to pursue a more descriptive approach in which we give information about the background of the studies under evaluation. Appendix 2 gives a detailed overview of all the studies we reviewed. The information includes the studies' setting, the performance measures used, the methodology and the main results, and some other information, such as the limitations of the studies. In the main text itself we try to summarise the studies in tables according to country, setting, methodology and themes, in order to demonstrate the heterogeneity and complexity of the literature.

Before presenting the results in sub-section 3 we describe how the relevant literature on the performance of the not-for-profit sector was identified.

## **3.2 Search Methodology**

### **3.2.1. Sources**

The literature reviewed was obtained from a variety of sources. Online bibliographic databases were the primary sources. Also included were reviews of reference lists from papers obtained in the study, publications referred to by other researchers working in the area, and official reports and grey literature identified through internet searches. The applied search methodology was guided by our conceptual framework, with iterative refinements made as a result of taking expert advice.

Twenty-six core sources (14 literature databases and 12 websites) were searched between June and August 2006, using 9 different search terms (see next subsection). The databases included extended beyond the medical literature to include social science and economic literature. Structured internet searches were conducted, with the help of Google Scholar, of official websites of national departments of health, international organisations such as the WHO, and third sector institutions (see table 1). The search terms consisted of various synonyms of nonprofit forms.

### **3.2.2. Search terms**

Trial searches were conducted by combining a single not-for-profit form with outcomes or financial variables. Following initial searches, it was decided to search under not-for-profit forms only to maximise yield. The different synonyms of 'not for profit' were:

- Not for profit
- Non profit
- Social enterprise
- Co-operative
- Foundation trusts
- Community owned
- Independent sector
- Voluntary sector
- Third sector

Only studies of the health service sector (including long term care) and social care were of interest in this review. The first stage searches therefore combined the nine different terms for 'non profit' with 'health' and/or 'social care', or the nearest and most viable version possible within each database (i.e. 18 keyword searches). Where Booleans etc. vary this was recorded in the search histories. A tenth term, namely



'mutual', was dropped following five data base searches because it produced hundreds (and sometimes thousands) of results from each search. The vast majority of these related to other meanings of 'mutual' than nonprofit. Searches were limited to publications from 2001 to 2006, and to titles in English. See Appendix 1 for a detailed overview of the search algorithm.

### **3.2.3. Exclusion and inclusion criteria**

The initial search yielded over 14,000 hits including duplicates or rather 'multiplicates'. A first sift of this first comprehensive list eliminated all literature which was irrelevant at first sight, i.e. by title, subtitle or the first lines of the article. For internet searches, e.g. via Google Scholar, a degree of sifting took place during the initial search due to more information being available at the outset, and due to the large number of hits. A cut-off point was chosen once the hits were becoming repetitive of earlier hits or clearly non-relevant to the subject matter. This still left us with more than 1,800 articles to sift through (see Table 1).

A second sift eliminated all titles which did not fulfil any of the above inclusion criteria by studying the abstracts and, if in doubt, skim-reading the articles. This yielded 730 items (Table 1). Where full papers were not available, attempts were made to obtain as many as possible through interlibrary loans. The third and final sift eliminated all duplicates and those articles which provided only background information or proved not to be relevant when the full texts became available through interlibrary loans and were read in detail, yielding a final total of 163 items. Multiple reviewers independently decided whether to include a study according to our agreed criteria, but if in doubt, consulted with other colleagues.

Since this review is concerned with empirical findings, the main criterion for inclusion of a study was that it should be based on empirical data. Therefore we excluded short commentaries, editorials or similar formats of publications as well as all ungrounded policy studies which did not contain any empirical data. We also limited our literature review to original research, thus disregarded the number of previous literature reviews at this point of our systematic analysis. Although we attempted to include grey literature by searching various websites, in fact these did not yield any relevant material.

We included studies of organisations from both the public and private sector. This is necessary because national classification systems can involve different judgments about formally similar organisations. For example NHS hospital trusts were reclassified as government bodies in 2003 having been classified as public corporations in 1991. We initially used additional inclusion criteria for outcome studies. The inclusion criterion for clinical and cost effectiveness performance studies was the presence of a valid comparator. The inclusion criterion for impact on users and carers was the presence of qualitative data about the process

of care. In practice, these criteria were relaxed during the search and sifting processes, as they proved overly restrictive, given the studies available.

**Table 1: Database search hits**

<b>Database/source</b>	<b>Initial search</b>	<b>First sift</b>	<b>Section sift</b>	<b>THIRD SIFT*</b>
ABI/INFORM	203	93	32	-
ASSIA	106	29	10	-
BIOETHICSLINE	6	4	4	-
COCHRANE/NHS EED	66	13	3	-
EconLit	196	67	50	-
IBSS/GLOBAL HEALTH	278	47	9	-
INGENTA	77	25	8	-
JSTOR	405	72	36	-
MEDLINE/CINAHL/EMBASE	3151	269	158	-
PubMed	735	109	65	-
Science Direct	732	129	45	-
Social Services Abstracts	371	123	62	-
Web of Science	1006	201	70	-
Zetoc	314	69	45	-
EU Observatory on Health Systems	1209	25	0	-
EU	180	0	0	-
Google Scholar	1041	126	126	-
IMF	178	0	0	-
OECD	146	0	0	-
PSSRU	489	323	7	-
World Bank	229	0	0	-
DH Australia	156	22	0	-
Health Canada	1779	27	0	-
Ministry of Health New Zealand	9	9	0	-
DH UK	258	42	0	-
US Health & Human Services	13	0	0	-
Totals	14066	1824	730	163

\* Database source was not identifiable any more at this stage.

The search was complemented by looking at the citations within the relevant articles. This checking for cross-references by and large confirmed that most relevant studies had been identified by our systematic literature database search. However, if a study with a relevant title was cited that did not appear in our database search because it was published in a journal that was not included in any of the various databases it was added to our final list. Similarly, seminal works which were frequently referred to in the literature and had high relevance for the research topic but were excluded by our systematic search because they were published slightly before our inclusion year of 2001 were also included. The inclusion of such additional studies was always taken on the basis of the relevance of a study to our analytical themes and never on its empirical outcome. Once final exclusions had been made, the included studies were then systematically reviewed by the six authors of this report.

The following table gives an illustrative overview of our research strategy as just described:

**Table 2: Research Protocol and search strategy**

Task	Step 1	Step 2	Step 3	Step 4
Define research question and key themes	Review of theoretical literature on nonprofit performance	Arrival at six key themes for later analysis		
Identify search terms	Synonyms of "nonprofit" in different spellings (10 terms)	Trial search using five databases	Refinement of search terms: 9 search terms (combined with either health care or social care)	
Search	Initial search of 26 sources with specified search terms, confined to publications since 2001 in English language	first sifting by scanning of titles, subtitles	Second sifting by scanning of abstracts/ first paragraphs)	checking for cross-references to identify further relevant studies which were not captured by electronic search; third sifting for articles which were yielded by different sources (thus duplicated)

### **3.3 Results of the systematic literature review**

#### **3.3.1. Papers by country of origin**

This systematic review of the literature on nonprofits in health and social care identified 163 papers from the six years 2001-2006. The vast majority of these papers were from the United States, with 125 papers (see Table 3). The remaining 38 were from a variety of countries. The second largest number came from the UK, with 13 papers, followed by Canada with 9. The remaining 16 papers were distributed between 5 countries plus 4 international or cross-national studies.

**Table 3: Country of origin of papers**

<b>Country of origin</b>	<b>Number</b>
US	124
US (several states or national level)	82
US single state	42
UK	13
Canada	9
Israel	5
New Zealand	4
Switzerland	2
France	1
Germany	1
International	4
Total	163

#### **3.3.2. Characteristics of the health systems identified in the review**

Table 3 identifies two key characteristics of the health systems of each of the countries identified by the literature review which are fundamental in determining the way health care is organised and delivered. Universal health care is a system in which all residents of a geographic or political entity have their health care paid for, regardless of medical condition or financial status. Universal systems vary in the range of services covered, and the extent of coverage. For example, although the health service in the UK is universal, this does not include long-term care for older people. By contrast Israel is one of the few

countries in the world where long term care for older people is mandated by law (Schmid, 2005).

Health care systems can also be multi- or single-payer. Single-payer systems involve one body, typically a government-run organisation, acting as the administrator to collect health care fees, and pay health care costs. In multi-payer systems health care is financed by a variety of public and private contributions.

These two features have considerable influence on health care for national populations, and therefore should be taken into account in comparing health systems. The topics identified in the literature are influenced by them.

**Table 4: Health systems**

Health service	Universality	Payment system
US	Non universal	Multipayer
UK	Universal	Single payer
Canada	Universal	Single payer
New Zealand	Universal	Multipayer
Israel	Universal	Single payer
Switzerland	Non universal	Multipayer
Germany	Universal	Multipayer
France	Universal	Multipayer

### **3.3.3. Subjects and methodology of papers**

Most of the papers identified in our literature review concerned the health sector, with 126 of 163 papers. Only a small proportion concerned social services. It was notable that there were more papers on long term care of older people than on social services, (20 compared to 17). Of the six countries with more than one paper, all but New Zealand included at least one paper on long term care, reflecting international concerns about this topic. A further complicating factor relates to the organisation of the US health care system. As well as health provider organisations (i.e. hospitals and hospices), insurance providers (Health Maintenance Organisations, HMOs) can also be publicly or privately owned, which increases the complexity of a comparison between nonprofits and for-profits.

**Table 5: Subject of papers**

Subject	Number
Health	126
Social services	17
Long term care	20

The papers reviewed were mainly based on quantitative studies. Only 33 of 163 studies were based on qualitative research. It is notable that a greater proportion of the UK studies (11 out of 13) were based on qualitative research compared with the US.

**Table 6: Methodology of papers**

Methodology	Number
Qualitative	33
Quantitative	130

#### **3.3.4. Predominant themes in the literature**

Six key themes defined our concerns and were applied to the literature review, as outlined in Table 7. These themes, as outlined in our theoretical framework, were based on principles relevant to NHS policy objectives. In practice, in reviewing the literature, a number of sub-themes emerged, again reflecting the heterogeneity of the papers included, and the US dominance of the literature. For example, the emphasis of the papers on cost and quality (under themes 2 and 6), reflects key US concerns. Additionally, several of the sub-themes relating to public purpose of nonprofits relate to US papers, including community benefits, uncompensated care and conversions.

**Table 7: Themes in the performance literature**

<b>Key themes for the performance review (number of relevant papers)*</b>	<b>Sub-themes identified from the literature</b>
1. Funding sources and competition (29)	Access to capital/investment
2. Public purpose, organisational behaviour and asset protection (125)	Cost/efficiency Access to care/Service availability Community Benefits/Uncompensated care Conversions Public trust in/perceptions of NFP Staff commitment/satisfaction Impact of operational environment Asset protection
3. Users and quality (72)	Funding mechanisms Reimbursement
4. Capital financing (7)	Partnership/co-operation between agencies Locality or geographical planning
5. Integration and planning (11)	Boards of governance Financial reporting Cost, quality and public purpose
6. Governance and accountability (23)	Quality – outcomes/outputs/inputs User satisfaction User involvement Staff ratios

\* The total number of papers in listed in all the categories in the table exceeds the total number of papers included in the review, since many were relevant to more than one theme.

We next give a more detailed account of the content of the papers reviewed, according to the themes in Table 7. We will describe the emphases of the literature under each theme, and provide illustrative examples. Not all included studies are thus discussed in detail in the following summary. Please see Appendix 2 for information on all reviewed studies. Given the range and complexity of the literature, we propose to concentrate on the most predominant themes. The references given in square brackets are the reference IDs of the respective papers. These are unique specifiers by which each article can be located, generated automatically by Reference Manager software. These specifiers are not consecutively numbered, because once a specifier is allocated by the software, the numbers remain static

regardless of subsequent additions to or subtractions from the database.

#### **3.3.4. Funding sources and competition**

The revenues of providers of NHS-funded health care will come from contracts with NHS commissioners. Providers in this context are required to compete with one another, with organisational survival dependent on successful bids. The literature on funding sources from various countries in this review investigated how the contracting environment impacted on organisational behaviour. With regard to payment mechanisms, the new national tariff system in the UK, financial flows, requires providers to charge centrally-determined prices for individual episodes of care. The imposition in the UK of a payment-by-results system on independent organisations that are required to make cash surpluses has parallels in the USA, where much of the literature focuses on funding sources and reimbursement mechanisms, and how associated changes impact on both competition and the behaviour of providers.

Several studies were concerned with how contracting arrangements impacted on the functioning of providers. Literature on this topic came mainly from studies based in Canada, the UK and Israel, reflecting current changes in contractual frameworks in these countries. Some studies sought to identify whether ownership status conferred advantages on providers. One Canadian study [182] suggested that the contracting environment gives for-profits an advantage. Because they are already used to operating in a profit-motivated and competitive manner, rigorous contracting regimes will impact negatively on the ability of nonprofits to build community capacities. This may not always be the case, however; another Canadian paper [166] sought to establish to how best to promote relations between the government and not-for-profit sector so as to support the latter, focusing on the development of a shared mission rather than the government being simply a funder.

Contractual arrangements were the focus of two UK studies [346, 355] on the position and motivations of independent sector (nonprofit and for-profit) providers in the home care market. These papers viewed the voluntary sector as having some advantages over the private for-profit sector in that public purchasers in some cases were said to favour the voluntary sector. The voluntary sector was also found to charge higher price, although the authors noted that differences in clientele might have some bearing on this. Among organisations which were both registered charities and limited companies there was less variability.

Other papers argued that the real issue is isomorphism, promoted when both for-profits and nonprofits draw their funds primarily from one major source, i.e. the government. For example two Israeli studies [167, 283] argued that contractual arrangements with the public sector lead to conformist behaviour, with the focus on securing contracts.



Another Canadian study identified that contrasts between providers are illusory when the same level of government funding is offered to all operators [202]. Others contend that there are significant differences because for-profits seek opportunities to cut corners on cost and quality, particularly in the nursing home sector [12, 56]. Alternatively, a Canadian study suggested that apparent differences between sectors may reflect differences in payer mix between types of hospital. This might provide opportunities for hospitals to differentially exploit reimbursement disparities between payers [125].

Reimbursement was the focus of many studies from the US, with attention paid to how payments mechanisms impacted on cost, quality and access. Most of these studies focused on changes in the reimbursement system, with particular emphasis on the impact of managed care, and the more competitive environment engendered by a change from a retrospective to a prepayment system. These changes increased competition in the US health sector dramatically. Therefore, various studies looked at the effect of hospital competition (measured by the Herfindahl-Hirschman Index, HHI) or HMO penetration on uncompensated care [122, 295], quality of care [291], inefficiency [101, 305, 321] and in relation to mergers. These effects of competition will be discussed in the relevant subsections.

Some studies were concerned to identify ownership differences in relation to services for recipients of Medicaid and Medicare. One study [9] measured the impact of prospective payment by Medicare for nursing homes. This study found that mean inefficiency was highest for for-profit hospitals and lowest for nonprofit hospitals, with government hospitals falling in the middle. However, this study did not control for quality. Although another study of long term care [298] suggested a greater emphasis on quality of care by nonprofits, it also identified heterogeneity within the nonprofit sector, with reimbursement influencing quality of care.

In the long term care literature, three studies considering reimbursement identified that not for profits were not necessarily serving those with less access to services [71, 116, 298], as those with private funds tended to choose nonprofit nursing homes. Because Medicaid funding is low and NFP facilities heterogeneous, Medicaid residents are sorted into for-profit and lower quality NFP facilities. Choice of provider was therefore dependent on means to pay. One of these studies [116] concluded that public sector providers played an important role as a safety net in these circumstances.

Studies on the impact of capitation on performance also focused variously on cost, quality and access. Although one study found that capitation resulted in more cost-effective treatments, the outcomes for patients were not clear [100]. Other studies found that capitation led to reductions in services in hospices, which are largely funded by Medicare [306] and reduced numbers of psychiatric emergencies treated [299]. Other studies examining reimbursement trends paid more attention to

market shares in the health sector in question. These studies concluded that for-profits which cut costs affect reimbursement for the whole area, changing the behaviour of nonprofits too [78], and that nonprofits actively compete with for-profits when for-profits have a dominant market share [103]. A further study set out to test the competition hypothesis [344], finding that behavioural incentives are not greatly influenced by the level of concentration of the market. All in all this shows the complexity of the effect of reimbursement mechanisms.

Most notably, several studies were concerned to assess the impact of managed care on performance in the health sector [34, 81, 140, 154, 263, 280, 328]. Some of these [34, 81, 328] did not find significant differences according to ownership. While [140] identified differences between types of HMO, it concluded that capitated managed care was particularly unsatisfactory as a mechanism for delivering sexual health services. One study of the impact of managed care identified convergence in behaviour [280], while another, national, study [263] found that managed care had a leveling effect on performance. Overall, these studies tended to indicate that reimbursement methods, including managed care, may generate spillover effects by increasing competition in the marketplace, and influencing the behaviour of nonprofits by reducing the surplus available for community benefits.

### ***Public purpose, organisational behaviour and asset protection***

The issue of public purpose was one of the key themes of the review. Theoretical work on nonprofits has argued that the distinguishing feature of nonprofit organisations is that they operate under a 'non-distribution constraint', i.e. any surpluses may not be distributed to shareholders but must be applied to the activities for which the organisation is constituted.

We explore the evidence from the literature on the extent to which nonprofits meet public purposes and protect public assets. The theme of public purpose revealed the greatest diversity of papers in the literature, as indicated by the sub-themes in Table 7. This section will address each of these in turn.

### ***Cost/efficiency***

The cost and efficiency of health service provision are, as we have noted, key concerns of US health policy. Given the weight of US literature in our review, this issue was a very prevalent theme in papers comparing effects of ownership. One of the many difficulties, already noted, in interpreting research results on cost and profit differences is that the quality of care, the range of services, and access to care are so difficult to control for; limited efforts to control for case mix and simplistic attempts to control for quality signally fail to meet the case. But without adequate information on quality, range of services and access to health care, the information on cost differences cannot be meaningfully interpreted.

Similarly, while cost data are meaningless without controlling for variations in quality, any assumption of a direct relationship between cost and quality is misleading. Costs can increase because of a more severely-ill patient case mix and less selection of patients. Only a few studies of costs [1, 128, 130, 358] included variables to control for quality or for patient selection [78]. Studies variously covered reimbursement methods/payment mechanisms [17, 77, 95, 125, 235, 291, 299], regulation [89, 120, 235, 291], prevalence of social deprivation [235], size [256, 120, 265, 323], activity mix [125, 281], range of services, the extent of long term care (a major factor in rural hospitals which are usually nonprofit [125]), urban versus rural location [323], etc.. While most studies attempted to control for at least some of these factors, since none could control for them all (particularly when they employed large US country-wide samples), it is difficult if not impossible to know whether any observed differences in performance between ownership types is due to ownership status or other factors.

### ***Access to care***

A particular concern of this review, with regard to NHS policy priorities, was to identify whether and how, access to services was examined in the literature. The dominance of the US literature raises specific issues: in particular, the non-universality of the US health system leads to research being focused on providers not populations, which raises serious methodological problems in making adjustments for the different populations served by different providers. Further, when the focus is on providers, studies generally fail to take into account the level of provision for the whole population of an area. We reviewed the literature with the objective of determining how access to services was measured, and whether attempts were made to account for access at the geographical population level. It should be noted that the comparability of studies from the US is further compromised by the paucity of socioeconomic data in US public health surveillance systems. Although efforts have been made to use geo-coding and area-based socioeconomic measures to overcome these shortcomings, no consensus exists as to which measures should be used or at which geographic level (Kreiger *et al*, 2002).

The ease with which providers can enter and exit the health care market has implications for population access. Studies found that for-profits have higher exit and entry rates and are more sensitive to demand shifts than nonprofit and public hospitals [90; 359]. Less efficient hospitals were more likely to exit when ownership was for-profit or nonprofit as opposed to public, while community need also had a significant effect on exit – nonprofits were less likely to exit if community need was a significant factor [358].

One of the concerns of the US literature relevant to the question of access is whether patient selection is affected by ownership, with various conclusions drawn. One national study [315] found that nonprofits were more likely to serve more severely disabled people,

while another [1] found no significant differences. Some studies of access took market forces into consideration in assessing how ownership impacted on patient selection, usually finding that external pressures were at least as important as ownership differences in determining whether patient selection was evident [103, 306, 283]. A study comparing the three sectors [329] found that publicly-owned hospitals were most likely to admit poorer transfer patients.

Studies by Crampton and colleagues in New Zealand [46, 49, 268, 330] focused on questions of access to primary care. The community-controlled services included in this research were formed to fill gaps in primary care provision in rural areas, particularly following the introduction of a fee-for-service system. As a consequence these organisations serve poorer and sicker populations compared with the patients served by for-profits they also reduce financial and cultural barriers to access, since they charge lower fees and serve larger numbers of the Maori population.

Although there were a few exceptions, the literature usually does not, and in most cases cannot, account for variations in access under the different provider schemes and different entitlements of populations.

### ***Community benefits/uncompensated care***

Due to their tax-exempt status nonprofits have to satisfy the regulatory authorities and the Revenue that they are doing work that benefits the community. Although relevant activities and requirements are set out by the state, there is considerable variation in this. The provision of 'uncompensated' care is the community benefit most often identified by both hospitals and studies, as it is relatively easy to measure. The provision of community benefits is of particular relevance in the US, where health care provision is not universal and gaps exist in provision. Conversely a further limitation of these US studies from a UK point of view is their lack of attention to public provision; an exception is a recent GAO (2005) study which found that government hospitals devoted a substantially greater share of activities as uncompensated care than both the other two ownership types. However, community benefits are a key determinant of the value attributed to non profits, and therefore merit attention.

Definitional problems were acknowledged by several studies of community benefits, e.g. [72, 138]. The question of whether profits or community benefits are prioritised was a key concern of many papers comparing ownership types, often producing inconclusive results [81]. Horwitz [26, 281] found a strong correlation between ownership and provision of services, and, consistent with the GAO study, that government hospitals were most likely to offer unprofitable services that are generally needed by poor, underinsured patients. Studies of the range of services provided found nonprofits were more likely to provide a list of identified high-cost services [65, 137], or greater range of services [370] while [255] demonstrated that in circumstances where a

single hospital serves a community nonprofits and for-profits were identical with respect to high-cost service provision. A further study on provision of compassionate care services (including long term care and domiciliary care) [312] found that although Catholic hospitals had provided more services of this type, over time the gap between public hospitals and other nonprofit hospitals had closed, suggesting isomorphism in response to market forces.

Nonprofits must provide a certain amount of uncompensated care for those without insurance, including care for those who present at A&E. The amount of uncompensated care is important since it impacts on both revenue and costs. While the amount of uncompensated care is reported to the regulatory authorities, it is difficult if not impossible to calculate the amount of care provided from the databases generally used in the research studies reviewed. They do not distinguish between the provision of charity care for the indigent, which is a type of community benefit, and bad debt, which is not necessarily a community benefit (Congressional Budget Office, 2006). While there were studies [295, 351] which attempted to measure how much uncompensated care hospitals provided, it was not necessarily clear how this was taken account of.

The extent of uncompensated care also depends to some degree on the capacity of the hospital to provide it (e.g. via cross subsidisation from other more profitable treatments and patients) and on the demand for it. To take cross-subsidisation first, the surplus earned by hospitals on at least some of the Medicare/Medicaid reimbursement categories were, until these were revised in the early 1990s, generous, and therefore covered some uncompensated care. The progressive reduction in reimbursement levels across all categories, particularly after the 1997 Balanced Budget Act, reduced the amount of uncompensated care that is possible without adversely affecting the hospitals' financial performance. But while cross-subsidisation has become more difficult, the demand for uncompensated care has increased [295]. There has recently been a reduction in the number of workers who have employee benefits, leading to an increase in the number of uninsured people. There are, however, various ways of maximising reimbursements, such as upcoding or DRG drift [95], or the employment of extra staff to help patients fill in the requisite forms [281].

Some studies found that nonprofits provided more uncompensated care [304, 351] than for-profits. However, studies which took external pressures into account more often found either inconclusive or converging results. In common with many other areas of this literature review, the impact of managed care was the focus for several studies. Currie *et al* [122] found little evidence that hospitals respond to HMO penetration by turning away uninsured and Medicaid patients, while another study [15] found that higher HMO penetration is associated with lower total margins. Reduced margins may decrease the ability of hospitals to cross-subsidize charitable activities and are associated with lower levels of uncompensated care. Similarly, while [138] found

nonprofits provided more community service than for-profits, there was convergence over time under the impact of external pressures.

### ***Conversions from nonprofits to for-profits***

There has been a growing tendency in recent years on the part of US hospitals and health plans to forego nonprofit status and its corresponding tax benefits and engage in for-profit health care. The reasons are varied and may include weak financial performance, a desire to increase market power, or the need for capital (HCFO 2003). Key concerns about conversions rest on the effect on health care delivery, and particularly the nonprofit charitable mission. Conversions to for-profit status typically involve transfer of assets to a charitable foundation, to continue the good works of the nonprofit provider, although there is movement toward alternative conversion structures (HCFO 2003).

Nineteen studies in this review focused on the impact on performance of conversion or merger. Most papers concerned conversions of nonprofit to for-profit status, though there were other variations, some involving public hospitals [252, 324, 328, 336, 361]. Most relevant papers were concerned with the predominant themes of the review overall, that is the cost and quality implications, and impact on other aspects of public purpose. The studies used a variety of measures reflecting revenues/inputs, costs, profits and outcomes, and present a mixed picture.

While two studies recorded no significant change in cost or quality [70, 88] two studies [252, 324] found that quality declined as a result of conversion to for-profit and [357] found reduced resources provided to the community. On the other hand, [287] found that costs were reduced without reductions in quality or access. The latter study also found that nonprofits mimicked for-profits in raising income by exploiting reimbursement loopholes at the expense of the taxpayer. One study [265] found neither conversion nor ownership status to be significant factors in determining profitability compared with other variables, while [336] reported increased profit margins following conversions, but with different bases for the source of profits according to which type of ownership conversion was involved. Some authors were forced to go beyond their data to interpret their findings. For example [89] observed quality outcomes that were favourable after the nonprofits converted to for-profit status, and attributed this to the fact that the hospitals had been under financial stress for some time prior to conversion and that this had an adverse impact on quality. Two papers on public purpose concerns [59, 241] related to a failed conversion to for-profit status, where the relevant Commissioner had concluded there was insufficient attention to the mission to provide coverage at minimum cost and expense.

While most of the work reviewed here related to conversions, there were also a few studies of mergers, another recent trend since the

Federal Trade Commission relaxed its anti-trust policy in 1993 in order to encourage hospital mergers. The assumption was that mergers would generate cost savings that would be passed on to consumers. This was the focus of three relevant papers [99, 107, 361], all of which found price *increases* following the mergers. In the last of these papers the authors hypothesised that the nature of hospital competition had changed over time and that a merger between two significant competitors in the same market will lead to price increases regardless of type of ownership.

### ***Public trust in/perceptions of nonprofits***

Studies of ownership differences in relation to public perceptions of and trust in health providers were all based in the US. Much of the work on trust has been conducted by Schlesinger *et al* [60, 152, 153], who found that for-profits were seen as less trustworthy. This work found a disjuncture between public perceptions and what economic theory would predict. For example, the public generally believed that nonprofits were cheaper, whereas economic theory would predict otherwise because of the supposedly greater efficiency of for-profits. These studies established that there was little public understanding of the different forms of ownership and organisation [60], although the evidence suggests that among the best-informed respondents, nonprofits are significantly better regarded than for-profits [152]. Other work [153] found that physicians expect for-profit health care providers to be more likely to mislead the public through deceptive advertising, cut back on dimensions of quality, and engage in practices that could exploit more vulnerable patients. Work by Ginn [5] in the US also found a lack of understanding of nonprofits among the public, tending to undermine their legitimacy. There are limits to the relevance of this literature to the UK, however, given the lack of inclusion of public providers.

The issue of public trust was also a concern of the literature on long term care in the US. Arrow (1963) was the first to hypothesize that nonprofits exist in health care markets to provide quality assurance to poorly-informed consumers. The nonprofits' non-distribution constraint softens the incentive to cut costs, leading nonprofit firms to provide a better quality of service. When customers cannot compare, producers may be free to misrepresent quality (Hansmann 1980). The issue is of particular relevance to nursing homes, as it is difficult to access information on quality, and residents may have limited capacity to assess their own circumstances. Theoretically, when information asymmetry exists, nonprofit organisations provide better quality of service. But it is very difficult to attribute the supposed pro-market preferences of consumers to just one factor such as ownership.

Studies [71, 75, 116, 298, 318] tended to support predictions based on asymmetric information theory. Consistent with the findings of other studies in this review, study [75] found that an increase in nonprofit market share improves for-profit and overall nursing home quality. One

study [318] concerned with the impact of family involvement and information asymmetry in relation to quality, found that for-profits had more incentive to compromise on quality of care but that compromises of this type were difficult to detect.

Study [116] concluded that ownership effects exist, with consumers indicating the greatest preference for nonprofit homes and the least for government homes, although the latter may still play a social role as a safety-net for those lacking private funds who may find it difficult to be admitted elsewhere. An important point indicated here is that nonprofits do not necessarily serve those with less access to services. In fact, private self-payers are more likely to seek out nonprofits. This was confirmed by other studies [71, 298], which found that people with the means to pay were more likely to choose nonprofits. Facilities with waiting lists can choose to accept private pay residents in preference to Medicaid residents. Because Medicaid funding is low and nonprofit facilities are heterogeneous, Medicaid residents tend to be relegated to for-profit and lower quality nonprofit facilities. The overall effect of nonprofits for Medicaid residents may be ambiguous.

### ***Staff commitment/satisfaction***

Theoretical arguments for the expansion of nonprofit and voluntary sector provision often rely on the proposition that nonprofits generate community attachment and support, and that this support will be manifest in the unpaid contribution made by employees to the organisation, as well as in higher levels of motivation and commitment [114]. If this is the case, then employees in nonprofit firms should enjoy a higher job satisfaction. This directs attention to studies which explore the work experiences, motivation, and job satisfaction of employees in nonprofits. There were eight relevant studies.

Benz's study [114] generally confirms the hypothesis that employees in nonprofits are more satisfied with their jobs than those in for-profits, and that this result cannot be attributed to differences in financial rewards. However, no comparisons were drawn with the extent of job satisfaction among government employees. One study of social service employees did compare across the three sectors [207], finding a continuum, with workers from public organisations reporting less commitment to both the profession and their employer, and those from nonprofits reporting most. However, there was little attention paid to the factors influencing levels of satisfaction, including differences in the work undertaken.

Two examples from the Canadian literature [204, 272] considered the impact of market segmentation and competition on employee commitment; both found that these factors led to staff concerns and insecurities; segmentation in particular, resulted in the majority of staff leaving the sector. In contrast to these studies, one other study [352] found that commercialisation had a positive impact on an organisation's self-sufficiency, reputation, and ability to attract and retain staff.



In the UK literature, there were two studies which considered employee motivation. One considered nurses' perception of the working environment in the voluntary sector only [270], concluding that the environment was seen as characterised by relatively high levels of support, cohesion and managerial control, and slightly lower levels of autonomy, than the public sector. Another study [150] compared human resource management in the nonprofit and public sectors, finding that different factors operating in each sector affected staff retention.

### ***Asset protection***

One of the concerns of the review has been to assess the extent to which nonprofits can protect public assets. Many of the preceding sections under the theme of public purpose have identified strategies employed by the nonprofit sector to protect their assets, including changes to the services provided, changes in funding arrangements, mergers and conversions. A few studies considered asset protection specifically, including one study [222] of the impact of 'carve-outs' in mental health services in the US (carve-out is a managed care term for a program that separates certain types of services or patient groups—most commonly in the areas of mental health and substance abuse). In the latter case, ownership type was not found to be significant. The authors argued that public and nonprofit entities, like for-profit firms, will reduce costs of care when they are placed at risk.

### **Responsiveness to users and quality of care**

This section looks at what the literature suggests about the outcomes of, and satisfaction with, services provided by nonprofits, and about the extent to which they are responsive to consumers. Bruce (1995, 77) implies that there are several structural reasons why nonprofits cannot automatically be presumed to 'value and respect their consumers', especially because of the numbers of stakeholders involved, and the complexity of their governance arrangements.

### ***Quality of care***

Most studies in this literature review were concerned to measure one or more aspects of quality, using a range of variables, often focusing on inputs rather than on observable measures of service quality. The comparisons are often unfavourable to for-profits, as demonstrated by the concluding section below, on staff ratios. Quality of care is notoriously difficult to measure. Currie *et al* (2003) note that apparent success on one measure of performance may mean that less attention is given to monitoring service quality. Output measures, such as mortality differentials, may be difficult to interpret because the result depends on the timeframe under consideration. The same authors argue that while there is some evidence that for-profit hospitals have

higher mortality rates than nonprofits among elderly patients with heart disease, differences were associated more with the location of these hospitals than ownership per se, and small average differences in mortality masked enormous heterogeneity within ownership types.

### ***User satisfaction/involvement***

Very few studies focused on either user satisfaction and/or user involvement in health and social care services. Three out of five studies on user involvement were based in the UK [158, 356, 364]. Given current policy emphasis in the UK on the role of nonprofits in improving the responsiveness of services, it is worth noting the content of these studies. The UK studies question the extent to which voluntary services can maintain their responsiveness and/or involvement of users in face of institutionalisation and professionalisation, and dependence on government for core funding.

Overall the literature suggests that nonprofits may in practice reduce responsiveness and choice, but this is not an effect of ownership so much as an effect of the process of contracting for services. In order to win contracts organisations must specialise, but this reduces the range of services they can offer [204]. The literature questions how far voluntary action, arguably a defining characteristic of civil society, can define nonprofit behaviour in circumstances where government sets the rules of the game in which nonprofits simply play their assigned role, delivering homogenised and subsistence-level services. One study [182] suggests that user choice and control is a “fantasy” – that levelling the playing field between the different sectors actually reduces consumer participation and restricts choice.

Six studies focused on user satisfaction with services. In contrast with the involvement/choice literature, with one exception [16], these studies [27, 80, 203, 317, 325] consistently found nonprofits to be more positively associated with user satisfaction than for-profits.

### ***Staff ratios/intensities***

Staff ratios and intensities were the focus of several studies on health and particularly long term care. This reflects the fact that while the salaries of health care staff represent one of the major costs of health care provision, staff ratios are also significantly associated with quality of health care. Staff ratios were a particular concern of studies in the nursing home literature, with international concerns evident about quality of care in the sector (see also the discussion of information asymmetry and incomplete contracts in section 2.2.4).

Five studies from Canada and the US [12, 56, 166, 202, 296] produced consistent results, finding staffing levels to be lower in for-profit nursing homes. Study [296] noted, that while it was difficult to weigh the variables, it was possible to conclude that nursing homes that meet staffing standards, meet minimum quality measures, are nonprofit and smaller, will experience fewer lawsuits. While one study [202] found

government-run facilities had the best staffing ratios, another [166], excluded public facilities because 'they are much larger and have more dependent residents'.

In other parts of the health sector, findings were less uniform. While one study from New Zealand [268] found that staff ratios in primary care teams were largest (and the staff most heterogeneous) in community-governed nonprofit practices, the findings of a US study [64] were inconclusive. Another study focusing on chain affiliation [115] found that staff changes were similar in the largest for-profit and nonprofit chains, suggesting that market forces are more important than institutional form.

Cost effectiveness was the focus of four studies on staffing. While study [294] hypothesised that mid-level practitioners represented a more cost-effective option for group medical practices, it found that nonprofits were less likely to employ them. Other studies found variously that there were no significant differences in efficiency across ownership types [125], that efficiency outcomes between different ownership forms converged over time [138], and that an increase in nursing staff led to a statistically significant increase in operating expenses but no significant decrease in profits [367].

## **Capital financing**

UK government policy is to have investment by nonprofits, as with public sector providers, privately financed. We therefore set out to explore the evidence from the literature about the implications of capital investment arrangements for the organisation and delivery of services.

The review included studies which draw attention to the differential ability of nonprofits and for-profits to adapt to external conditions. Thus [202] maintains that regulatory conditions favour for-profits whereas small, individually-owned nonprofit cannot adapt so easily to these conditions. This echoes developments in the British health sector, e.g. when commercial (particularly American) organisations began to invest in private acute hospital capacity in the late 1970s, squeezing the remaining nonprofits.

One study [292] compared the financing methods of the largest hospital chains in the US by ownership. Significant differences were identified between nonprofits and for-profits, including the fact that nonprofits had more variable interest-rate financing, which could be a problem when interest rates rise. For-profits had tiny levels of cash or reserves (equivalent to 2% of their debt) while nonprofits had cash or reserves equivalent to 98.6% of debt, because they must accumulate cash to fund investment and get little for investment from charity. Another study [66] found that nonprofits used operational and investment gains to build and retain a stronger capital position than for-profits.

### ***Integration and planning***

Not-for-profits raise important issues about vertical integration in the NHS and therefore about implementation of centrally-determined plans. A key question here concerns the extent to which nonprofits can be persuaded to act in the public interest and to coordinate their activities with other providers of public health care. A few studies were concerned with this question.

### ***Partnership/cooperation between agencies***

Two studies from the US found results largely favourable to the nonprofit sector. Nonprofit HMOs in New York State were found to be far more likely to participate in state-sponsored safety-net programmes than the for-profit managed care organisations [264]. A second study found that nonprofit insurance plans appeared significantly more likely to engage in alliances with public health agencies than national for-profit plans [37].

The UK literature on the voluntary sector included several studies concerned with the New Labour policy context of partnership working [53, 19, 23, 158, 363]. While some studies emphasised the voluntary sector's relatively weak position compared to the statutory sector [53, 19], there was also concern that more formal partnership could lead to the erosion of flexibility and responsiveness associated with the expansion of the voluntary sector [356]. Very similar concerns were also expressed by voluntary sector managers in a study of a merger [363]. Drivers to cooperate included governmental pressure, public expenditure constraints, the need to identify a niche and increased lobbying power through merger.

### ***Locality or geographic planning***

There were very few papers which considered health service planning and/or provision at the level of the locality, or on the basis of geographic area. Studies by Crampton and colleagues in New Zealand [46, 49] focused on questions of access to primary care. This work included consideration of locality planning and questions of access, identifying whether services targeted high-need populations. Nonprofits were more likely to carry out locality service planning and assessment of community needs. Practices differed in the extent to which they served minority ethnic groups, were located in deprived areas, or used population approaches to the organisation and delivery of services.

There were few studies of locality planning in the US literature. A study of Blue Cross plan conversions [70] reported that following conversion to for-profit status, pressure from the regulator to provide state-wide coverage may weaken, resulting in gaps in rural markets. On balance, however, the authors found no evidence of substantial negative impact on geographic availability: 'Culling specialised products and focusing market efforts geographically are widespread practices, even in

nonprofit plans, as is the normal give-and-take in provider negotiations” (Hall and Conover 2003, 529 [70]).

One UK study on voluntary sector provision in Glasgow, including health-related services, was based on a geographic perspective. This study [356] has some relevance to questions of locality planning, in that it identified factors which promoted or inhibited the development of voluntary sector provision in the city, including access to funding, the availability of premises in certain areas, and access to local and central government.

## **Governance and accountability**

The regulatory context has a crucial bearing on public purpose. Questions here include the representative element in arrangements for governance, and the limits of accountability. We have seen that government policy with respect to the regulation of non-state providers of NHS services is inconsistent, so that different regulatory regimes may apply, depending on the form of incorporation. This has implications for public audit and accountability, raising questions about relations between the state, the citizen and new contracting parties. In our review of performance literature we looked at the extent to which studies have incorporated these issues in their design. Performance measurement should have regard to differences among providers with respect to their legal and regulatory controls.

### ***Boards of governance***

Reflecting wider concerns in the literature, several studies focused specifically on the role of boards or governance in ensuring effective and efficient delivery by service providers. Concerns of these studies included the impact of the external environment and/or organisational features on characteristics of board structure and functioning. Board structure and composition were concerns of several US studies, which found that public- and investor-owned hospitals were more likely than nonprofits to have become answerable to larger, system-affiliated, urban organisations during the 1990s [277], and that poor performance, high administrative costs, and high uncompensated care led to higher CEO turnover [345]. The findings of [357] were consistent with resource dependence theory, suggesting that a CEO's strategic engagement with an organisation's board depends in part on the nature and concentration of the organisation's resources. Other US studies of governance in relation to source of funding and board involvement in decision-making [350], and the quantity and quality of information supplied to boards [371], have limited value because they were based on relatively small samples.

A study from New Zealand represented one of very few international studies identified by this review, and the only international comparison to focus explicitly on regulation [286]. Seeking to identify what lessons on governance might be usefully applied to England, the study

suggested that governance arrangements for nonprofits are important because medical staff may seek to gain the balance of power; not just to directly influence the board, but also to orchestrating participation of the membership to influence decisions taken by residents and patient representatives on the governing bodies. The authors therefore argue that governing bodies should comprise only patients.

### ***Financial reporting***

In the USA health care nonprofits are defined as charitable organisations in terms of their tax exempt status for federal corporate income tax, and have to satisfy the Internal Revenue that their net profit-to-income ratio is below a certain level. This means that nonprofits have to show low profits to satisfy the tax and regulatory authorities as well as their donors. It also means that if nonprofits' costs are higher than those of for-profits, this may be an artefact of accounting. Many papers used financial data derived from hospital, health care provider or HMO annual accounts. While annual audited accounts are important sources of information, they are not unproblematic to use in this way. There is a considerable amount of latitude in how income and costs and hence accounting profits may be reported. One study [47] of the management of earnings found that nonprofits used discretionary accruals (e.g. adjustments to the third-party-allowance, and allowance for doubtful accounts) to meet earnings objectives. This means that evidence seeming to show that nonprofits exhibit less variation in income may at least partly be explained as an accounting phenomenon. They deliberately manage profits (downwards) to satisfy the regulatory authorities (to show 'community benefits'), the Internal Revenue (tax-exempt status), and donors and the public (legitimation). Other studies found that nonprofit hospitals maximised tax exemptions by borrowing, rather than spend their endowments [251], and that nonprofit managers faced with declining profitability are under pressure to alter their behaviour to enhance profitability to avoid merger or takeover by for profits [235], a policy constrained by Internal Revenue rules on their profitability. This has implications for their charitable mission, the full provision of services, and ultimately for public access to health care.

### ***Cost, quality and public purpose***

Regulatory concerns were infrequently taken into account in assessing performance based on cost and quality indicators. A study of Swiss nursing homes [256] found no difference in performance by ownership or regulatory regime. A study of long term care in the US [206] selected five states to represent each of two categories of regulatory regime – either 'limited' or 'extensive' oversight of hospital boards and care facilities. This study found significant quality differences, with for-profit facilities rated lower.

Other studies were more broadly concerned with the public purpose of nonprofits. One paper on Ontario [194] adopted the North American

convention of categorising nonprofits as private self-regulating bodies. However, the study was unusual in that the author recognised a wider public duty of accountability, and identified a set of pre-requisites for effective accountability. Two studies questioned the implications of competition for regulation, including one [99] on the impact of mergers, and another [182] on the impact of competition in a rural setting, both finding that the external benefits of nonprofits could not easily be maintained in a competitive environment. A further study of Blue Cross conversions [70] also gave attention to regulation, assessing the pressures to make profits resulting from conversions, identifying this as one clear effect of conversion. However, the conclusions were otherwise indeterminate, largely due to the complexity of the issues and limitations in available data.

A few UK studies referred to requirements for accountability in the voluntary sector. Two studies identified tensions between advantages associated with the voluntary sector and increased requirements for accountability associated with formal contracts [19], and the implications for partnership working when organisations focus on core business and audit [53]. A further study of the independent evaluation of practice in fostering agencies [23] found it to be practically nonexistent. Some exceptions did exist in the voluntary sector, but the authors speculated that this was motivated by the need to demonstrate effectiveness in a competitive market.

### ***3.4 Discussion and Analysis***

#### **3.4.1 Predominant themes in the literature**

We will now briefly review the predominant themes in the literature, before commenting on the conclusions to be drawn from it. Several themes centred on aspects of the funding and financing of health care; capital investment arrangements, funding sources and payment mechanisms. Relevant studies under these themes were largely American, and reflected conditions in that country. In particular, there was a strong focus on reimbursement of health care costs.

The most common theme identified was public purpose, which also produced the greatest diversity of sub-themes. This is not surprising, given that the objective of so many of the papers was to identify whether and how the nonprofit sector distinguishes itself from the for-profit and/or public sector, with a wide range of variables employed to test this. As anticipated, cost and quality were the two most prevalent themes in the literature.

Some of the other sub-themes identified under 'public purpose' reflected primarily US concerns, while others attracted more international attention. US concerns relevant to the public purpose of nonprofits centred on the extent to which they provide community benefits, including the provision of unprofitable or marginal services, but particularly uncompensated care for the uninsured. There were also

numerous conversion studies, which reflected the trend in recent years in the US for hospitals and health plans to forego nonprofit status and the corresponding tax benefits to engage in providing for-profit health care. These studies generally employed performance measures of cost and quality. Other sub-themes under public purpose attracted more international attention in relation to mission, including studies on whether the public attribute certain values to nonprofits, and whether staff are more committed to them than for-profits.

In reviewing these themes a pattern emerged in the results and conclusions. Consistent with previous literature reviews, particularly that of Currie *et al* (2003), studies which focused on ownership form tended to produce inconclusive results. There were exceptions, such as the sub-theme of staff ratios, where studies of staffing in long term care consistently found higher levels in nonprofits. However, this was a relatively small sample of five studies. Another fairly clear conclusion was found in studies focusing on external factors in addition to ownership, such as competition or market share; they tended to find convergence or isomorphism between different ownership forms. While there may be limitations to the relevance of some of the studies where they focused on specific US concerns, such as aspects of insurance plans, evidence on how the competitive environment impacts on the behaviour of providers has relevance for the UK in relation to the contracting out of health services.

But our review also set out to identify the shortcomings and gaps in the literature, to which we now turn.

### **3.4.2 Methodological limitations**

The literature on the performance of the nonprofit sector displayed several methodological problems. The overwhelming majority of the studies included in the systematic literature review were quantitative and most of the methodological problems faced by these studies are well-known, such as small sample sizes, non-representativeness of the samples, omitted variables, the use of highly aggregated data, selection bias, etc.

A typical weakness in the quantitative research was the omitted variable problem, i.e. that other unmeasured factors not included in the studies may have confounded the results. Crucial in the context of studies evaluating the performance of nonprofits sector compared for-profits or public providers was that often no adjustments were made for case mix – i.e. controlling for crucial patient characteristics such as their health status. However, any comparison of hospital efficiency is meaningless, if it does not control for quality.

Other common methodological problems were related to the samples. First, in many studies sample sizes were rather small with as little as 20 cases of one type represented [61]; (see also [169, 348]). Consequently the cells of some specific subgroups of interest had low frequencies, limiting the inferences that can be drawn from statistical



tests. Nevertheless, most of the studies used quantitative regression techniques, although a significantly large number of cases is a precondition for these. Second, the samples in some studies were non-randomly selected, resulting in likely selection bias. Even when a random sample survey was used, selection bias was a severe problem in some cases. For example, one study of patient satisfaction [27] was based on computer owners; thus it did not represent a true cross-section of the US population, but was a cross-section of middle- and upper middle-class Americans. Although these problems were usually acknowledged by the authors of the studies and it was not purported to be representative for the whole of the country, this is nevertheless a limitation for the generalisability of the findings. In another case [325], a study of health plans, only those plans were included which consented to the public release of their HEDIS results. Not surprisingly, other studies have found that such 'public reporters' perform better on nearly all HEDIS performance measures than those which do not consent to public reporting of their results.

Many studies relied on secondary data sets such as the American Hospital Association (AHA) annual survey. Since such surveys are not created for the particular purposes of the studies in question, some of the measures do not have a high degree of sensitivity and specificity. Moreover, such highly aggregated data are not as adequate as data based on individual hospitals as they do not allow for tight control of potentially confounding variables.

If, by contrast, tailor-made questionnaires were developed for the study purpose, the studies often struggled with low response rates and/or some significant selection biases. A number of studies relied on self-reporting, which is open to respondent bias and the data have yet to be fully validated against other sources.

At the other end of the spectrum there were studies which used qualitative study designs, often with a relatively small number of respondents. These studies varied enormously in terms of depth and quality. For example, not all the qualitative studies described their methods in detail or the nature of the questions they asked in their interviews.

As Table 3 showed, the bulk of the literature reviewed referred to the USA. Many studies referring to only a single US state, rendering general conclusions, even for the whole of the US, difficult. For example, the authors of a study on hospital transfers in California [329] pointed out that their findings were not generalisable to other states with less managed care and/or fewer publicly owned hospitals. Similarly, a study of the effect of capitation which was introduced in Colorado in 1995 [299], acknowledges that the results may not be generalisable as Colorado seemed to have implemented capitation better than other states and may have reimbursed capitated providers more generously than elsewhere. Studies which included health institutions from the whole of the US, on the other hand, face the problem that they cannot

take into account the influence of the differing contexts in each of the states, e.g. differences in legislation or in the composition of the hospital market. Quite often, too, studies were limited to metropolitan areas only, or had other exclusion criteria that limited their generalisability, with implications for policy makers concerned with whole populations, as in the UK.

Some countries were represented by only a single article, or very few articles, identified by our systematic search (see Table 3, p. 42). In such cases it is difficult to generalise from their findings, given the lack of supporting studies done there, and the very different context of their nonprofit sectors from that in the UK (or the US).

In sum, the papers varied greatly in terms of methodological approaches, data sources, and analytical techniques. We therefore have a number of reservations about the quality of much of the research in this area, and in this respect our work echoes previous reviews such as those by Currie, Donaldson and Lu (2003). Much of the qualitative work is a description of the activities of nonprofits, sometimes accompanied by comments on the extent of external pressures on their activities, or the impacts on their staff of organisational changes, but given the scale or scope of these studies they are unable to detect significant differences in, for example, the performance of nonprofits and for-profits. In fact they were simply not designed to do so.

Of the quantitative studies we have reviewed, analytical techniques also varied. Some studies were simply attempts to detect differences in sample means - this can certainly establish differences between organisational types (for example, in respect of the nature of the clientele they serve) or rather unsophisticated multiple regressions, often without a great deal of statistical detail being reported. Such analyses could nevertheless establish, as did [14 and 49] in some work on New Zealand, that nonprofits did indeed serve a distinctive subgroup of the population and were located in less-prosperous areas (this is not, however, a startling finding since the organisations they were steadily set up precisely to serve this purpose). Sometimes these studies were extended, e.g. by performing logistic regression analyses to control for a greater range of factors. More complex techniques were also used such as data envelopment analysis (DEA), the aim of which is to determine how close the performance of an organisation is to what would reasonably be regarded as an efficiency frontier when allowance is made for its organisational characteristics and the context it is operating in. The use of such complicated data analysis techniques, however, cannot conceal that the quality of care, the range of services, case mix and access to care are so difficult to control for. With regard to efficiency studies, in particular, the ways in which the mission or public purpose of a particular health institution – mainly in the case of nonprofits and the public sector – influence any measures of cost efficiency must be taken into account. Future research needs to consider what a change in one is likely to do to the other. A similar

conclusion may be drawn for the relationship between quality and efficiency.

It is crucial that future studies attempt to measure quality and case-mix when evaluating performance. The existing studies which attempt to measure the quality of services, albeit by very crude indicators, also tend to neglect the question of access to services. We need measures with which to compare the different populations within a non-universal health system. For example, the population characteristics of members of a for-profit health plan compared with the members of a nonprofit health plan need to be taken into account. The provider focus of almost all the existing literature overlooks the need to take account of population characteristics if we want to arrive at a meaningful measure of performance. And at least some fundamental requirements need to be met, such as standardisation of data. Instead of drawing on large databases for quantitative modelling purposes it seems advisable to attempt some small-scale studies, even though the level of generalisability is much lower with the latter. A positive example is study [107], an ex post event study within a particular area of California, where diverse potentially confounding factors and differences in regulation were controlled for.

We finally comment on how two themes of particular policy significance for the UK NHS, namely regulation and access, were covered in the literature reviewed.

### **3.4.3 Regulation and access**

Our work on the classification of nonprofits (see section 4) highlights the current inconsistency in the regulation of non-state providers of NHS services, raising questions about audit, accountability and access to health – all crucial to the public interest. The review of the literature on performance therefore sought to assess whether studies identify and adjust for differences in regulatory and legal frameworks, and whether the perspective of geographic coverage and population access to care is evident. Apart from a few valuable studies, most notably [70], regulatory issues and the interests and needs of geographic populations were not dealt with. However, some studies controlled for differences in the regulatory framework by studying a single national sub-unit only, e.g. [120].

It is important to bear in mind the context of US studies of relative performance, where for decades nonprofits have dominated health care provision and where comparison between for-profits and nonprofits dominate the literature. Because of the large numbers of uninsured people, and spiralling costs, the US nonprofit literature is heavily focused on the analysis of health care affordability and the impact of ownership on costs. Changes of the reimbursement system are therefore central in the US literature. This explains why so many US studies deal with issues such as differences in quality of care and the extent of uncompensated care by the different providers. The literature

on uncompensated care itself constitutes one of the few attempts to come to grips with variation in regulatory standards, although attempts to describe regulatory mechanisms in this context were limited.

Other sub-themes relevant to questions of governance and accountability included financial reporting and boards of governance. There were a few studies of boards of governance from the US and New Zealand, of some potential interest and relevance to board structure and composition, particularly one study drawing lessons for England from reforms in New Zealand [286]. There were a few studies of financial reporting with some potential relevance for regulation, though again beset by methodological problems. There were also a few occasions where regulatory concerns were taken into account in assessing performance using cost and quality indicators, and public purpose. However, when taken together these studies, again, produced indeterminate conclusions, and in one national US case [70] the authors acknowledged that data limitations and the complexity of the issues made clear conclusions impossible.

The question of access was a key concern of our review. A few studies considered the ease with which providers in the US able to enter and exit the health care market, and they gave some consideration to provision at the level of population. Studies of uncompensated care again have some relevance here, since they concerned health care provision for the uninsured. A limitation of these studies overall, however, was their focus on providers. Reflecting the complexity of US system, the studies covered a range of fragments of the health care market, attempting to identify impacts of cost control and reimbursement methods on providers. Their main concern was to identify behavioural changes on the part of hospitals, hospices, nursing homes or insurance plans. What they did not do was start from the basis of the population covered. There was therefore little sense of the impacts on patients, or of the implications for access to care. Studies from New Zealand [46, 49] on nonprofit provision for marginal and minority populations were among the very few which considered population coverage. With few exceptions the literature does not, and in most cases cannot, account for variations in access to the different provider schemes and in the entitlements of whole populations.

Overall, there was no strong, consistent evidence from the US literature that nonprofits perform better than for-profit providers. Across a range of themes, the evidence tended to suggest that when studies took external factors into account, in a competitive environment nonprofit providers behave increasingly like for-profit providers. Furthermore, evidence from the UK and other countries has shown that under increased regulation and mainstreaming the voluntary sector loses its innovative and niche character and becomes more bureaucratic [158, 167, 182, 157, 204, 283, 356, 364]. This has relevance to current policy focus in the UK, where emphasis is on moving from largely peripheral provision of services by nonprofits to mainstream NHS provision.

## Section 4 Classification of nonprofits

Many governments are proposing a greater use of nonprofit organisations in the delivery of public services as an alternative to direct provision. The UK government is no exception. However, we have found that economic theory's justification for the policy is weak and there is little research evidence to support their use. In this section we turn to a further dimension of the policy, namely the implications of nonprofit participation in public service provision for government control and regulation with respect to public expenditure.

All governments are under an international obligation to adopt standard rules for determining when services are public and regulated by governments and when they are private and regulated by markets. The switch from public service providers to nonprofit providers introduces a new layer of complexity with which national accountants are struggling to deal. The distinction between government and market control is particularly problematic. EU competition rules add to this complexity. The application of these rules depends on additional criteria for designating services as public and under government control.

These classification questions have already received attention at international and European levels. The United Nations has highlighted 'ambiguities [in the national accounts system] with respect to the borders between [nonprofit institutions] and both corporations and governments' (United Nations, 2003, p.17), and the European Commission recognises substantial uncertainty in the classification of nonprofits under competition law, that is, in determining whether they may be regulated like any other private provider or whether they may be regulated like non-commercial, public sector providers.

First, we examine the basis on which nonprofits are assigned to the public or private sectors in the system of national accounts and we consider the evolution of that system in the face of the growing practice of contracting-out public services to nonprofit providers. Second, we consider European Union Treaty provisions as they relate to the nonprofit sector and specifically under what circumstances national governments lose rights to regulate nonprofits providing public services.

### **4.1 National accounts**

National accounts record aggregate economic activity in an economy by providing measures of national income and output, and changes in stocks and flows of capital. The system involves classifying organisations to government, public or private sectors in order that government and public spending can be calculated and compared with spending in other sectors. It provides the data for government debt and deficit calculation in Europe and for the UK government's fiscal targets. It provides a basis for defining public spending and for assigning rights

of government intervention, public accountability and the identification of public agencies subject to public law. Our primary concern is to determine the extent to which nonprofit status is a factor in this system.

National accounts are compiled in the UK by the Office of National Statistics (ONS) and are harmonised in the European Union (EU) through the European System of Accounts (ESA). The current conceptual framework which is legally binding for EU member states is 'ESA 95' (the European System of National and Regional Accounts). ESA 95 is fully consistent with the international guidance on national accounts known as the System of National Accounts ('SNA93'). SNA93 is the joint responsibility of the United Nations, the IMF, the European commission, the OECD and the World Bank. (HM Treasury, 2000a).

ESA 95 contributes to European policy-making by providing numeric, comparative data on the total economy or parts of it. The accounts are used to calculate and compare public spending and changes in government debt and are used for estimating the contribution of different sectors to economic development and for informing sectoral policy making (European Commission, 2004). The EU uses the data for monitoring and guiding European monetary policy and for granting regional aid.

#### **4.1.1 The absence of a nonprofit sector**

The ESA divides the economy into various sectors or classes. The main classes are public and private sectors and market and non-market activities. Three sub-sectors make up the public sector: 'central government', 'local government' and 'public corporations'. 'Central government' plus 'local government' comprise 'general government', and the general government sector plus public corporations comprise the public sector (HM Treasury, 2005).

An organisation is classified as public if it is controlled by government, as a corporation if it relies on income from sales, and as a public corporation if it relies on income from sales and is controlled by government (ONS, 2003).

Government control is defined as the government's ability to determine general corporate policy and is secured 'by [the government] owning more than half the voting shares or otherwise controlling more than half the shareholders' voting power or as a result of special legislation (ESA, 1996, paragraph 2.26). Assignment to the market sector is based on source of income; an organisation is defined as market sector 'if more than 50 % of the production costs are covered by sales' (ESA, 1996, paragraph 3.32) where 'sales' also include 'all payments made by general government or the institutions of the European Union' (ONS, 2003, p.290).

There is no nonprofit *sector* in this system (other than the group of institutions largely funded from voluntary contributions); but nonprofits are defined as:

*a legal or social entity created for the purpose of producing goods and services whose status does not permit them to be a source of income, profit or other financial gains for the units that establish, control or finance them. In practice, their productive activities are bound to generate either surpluses or deficits but any surpluses they happen to make cannot be appropriated by other institutional units.* (ESA, 1996, paragraphs 2.87 and 3.31)

### 4.1.2 How are nonprofits classified?

All non-market nonprofit institutions (NPIs) are classified as 'general government' when they are 'recognized as independent legal entities which are other non-market producers and which are controlled and mainly financed by general government' (ESA, 1996, paragraph 2.29). They are classified as public corporations when they are market bodies controlled by government, and as private corporations when they are market bodies not controlled by government (ESA, 1996, paragraph 2.30).

For example, NHS foundation trusts are currently classed as non-market government bodies because their corporate policy is controlled by government and because although their income comes from sales they also receive public money designed to guarantee continuity of supply. On the other hand, NHS trusts were formerly classed as public corporations because their income was from sales, and therefore in the market, but were also controlled by government. Other examples of NPIs in the public corporation sector are the BBC and the Post Office. By contrast, it is possible for new third sector bodies serving the NHS to be classed as private, commercial bodies. An example might be community interest companies or other nonprofits undertaking APMS contracts in the primary care market.

The position with regard to market NPIs can be summarised as follows:

*A public producer is a producer that is controlled by the general government. In case of NPIs, a public producer is an NPI that is controlled and mainly financed by the general government. All other producers are private producers'* (ESA, 1996, paragraph 3.28).

Control is understood as 'the ability to determine the general (corporate) policy' (ESA, 1996, *ibid*).

In general, therefore, the ESA classification allows for two possible interpretations of 'non-governmental'. First, a non-governmental organisation can be a public corporation, that is, part of general government as a market body that is controlled by government, but not part of central or local government. Second, it can be a market body

not controlled by government, in which case it is a private corporation. Therefore the UK government's use of the term 'nongovernmental' leaves open the question of whether it intends that third sector policy constitutes privatisation in the sense of the substantial transfer of control and responsibility over services and assets to the private sector.

We turn next to other difficulties with the application of SNA to nonprofits.

#### **4.1.3 Attempts to harmonise national accounts nonprofit classification on the US model**

The transfer of public functions to nonprofits has introduced new complexity to the classificatory process because they are bodies in which private and public sector characteristics coexist. National accountants have for some time tried to improve classificatory criteria in the UN system of national accounts (SNA, see above) to deal with this. Here we examine the attempt in 2003 to define a nonprofit sector through the publication of a special handbook and we show that the approach assumes nonprofits are private sector bodies outside government control.

In 2003 the United Nations published a handbook on nonprofit classification intended to address 'some ambiguities [...] with respect to the borders between NPIs and both corporations and governments' (United Nations, 2003, p.17). In seeking to provide a coherent account of organisations that are 'neither market firms nor state agencies' the handbook draws heavily on the work of the Centre for Civil Society, Johns Hopkins University, and the structural-operational definition of nonprofits developed by Anheier and Salamon (Salamon *et al*, 2000; Salamon and Toepler, 2000) (see section 2).

Its significance for our present purposes is that it is intended to provide the basis for a reform of the SNA system and closely resembles the definitional approach adopted in guidance provided by the UK Treasury (2006). For example, like the Treasury the authors of the handbook refer to nonprofits as synonymous with "voluntary", "civil society" or "non-governmental" organisations, and also to "third", "voluntary", "nonprofit" or "independent" sectors (United Nations, 2003, p.3).

The handbook contains 'satellite accounts' consolidating the data on NPIs found in the various SNA institutional sectors. The satellite accounts follow the structural-operational definition discussed in our theory section (section 2 above). According to this definition, the nonprofit sector includes all entities that 'are: (a) organisations; that (sic) (b) are not-for-profit and, by law or custom, do not distribute any surplus they may generate to those who own or control them; (c) are institutionally separate from government; (d) are self-governing; and (e) are non-compulsory' (United Nations, 2003).



Notwithstanding the fact that under current SNA usage NPIs can be 'substantially controlled by Government' (United Nations, 2003, p14), the authors stipulate that for SNA purposes an NPI shall be defined as 'self-governing' or 'able to control its own activities and [...] not under the effective control of any other entity.' Furthermore, the distinctive feature of NPIs is that they are 'private institutions serving public purposes' that can be used to 'reduce the size of the state' (United Nations, 2003, p4), although no account is given of the ways in which nonprofits roll back the state in this way.

Although this approach may reflect US traditions respecting nonprofit provision it does not reflect the current practice in the UK of classifying nonprofits either to the public or to the private sectors. However, because HM Treasury and SNA both subsume nonprofits within a much larger category of providers, including the 'third sector' and 'civil society', the approach raises questions about what government powers should be retained when nonprofits take over public health care services.

#### **4.1.4 Attempts to define the public/private boundary by refining economic classificatory criteria**

When public services are delivered through nonprofits, SNA accountants have difficulties determining which bodies are operating in a market and which are controlled by government. Much of the Eurostat manual, which is concerned with interpreting SNA guidance, is devoted to developing clarifications in this area (The Task Force on the Harmonization of Public Sector Accounting, 2005).

In 2005, a United Nations Task Force on the Harmonization of Public Sector Accounting was set up to harmonise public sector accounting. It considered that to meet this requirement more guidance was required to determine a) when an organisation is a market body; b) when market bodies are controlled by government, and c) when non-market bodies are controlled by government (The Task Force on the Harmonization of Public Sector Accounting, 2005).

In order to improve the distinction between market and non-market bodies, the Task Force elaborated on the concept 'income from sales', the defining feature of corporations, by utilising the concept of 'economically significant prices'. Economically significant prices are defined in this context as 'prices that have a significant influence on the amounts the producers are willing to supply and on the amounts purchasers wish to buy'. Such prices are characteristic of the private sector because they occur when a producer has an incentive to 'adjust supply either with the goal of making a profit in the long run or, at a minimum, covering capital and other costs' (The Task Force on the Harmonization of Public Sector Accounting, 2005, p7).

Identification of 'economically significant prices' provides a way of incorporating payment characteristics of this type in the classification

criteria. The point of this refinement is that public service providers can be funded in different ways. For example, the public sector can take on demand risk by providing income guarantees to ensure continuity of supply. Such arrangements have been adopted in the UK for foundation trusts and independent treatment centres. The Task Force recommended a definition of market producers as 'producers that sell most or all of their output at prices that are economically significant.' Conversely, non-market producers 'are producers that provide most of their output to others free or at prices that are not economically significant' (The Task Force on the Harmonization of Public Sector Accounting, 2005, p7).

Notwithstanding these refinements, the Task Force recognised that a difficulty remains in determining whether public bodies use economically significant prices. Under public ownership, it said, it is sometimes difficult to determine whether prices are economically significant: 'Units that do not use economically significant prices are working in an environment where supply and demand are controlled by other factors usually because of the interjection of government policy into economic behaviour' (The Task Force on the Harmonization of Public Sector Accounting, 2005, p24). The difficulty is illustrated in the following case study of the classification of a public nonprofit organisation, foundation trusts, in 2003.

#### **4.1.5 UK case study: the application of economic criteria in the ONS classification of NHS trusts and foundation trusts**

When NHS trusts were set up in 1991 they were classified by the ONS as public corporations because they were seen as public trading bodies or 'market units controlled by government' (ONS, 2003, p3). This classification was made on the basis of the then current guidance, the United Kingdom National Accounts Sources and Methods, third edition (Mrs Shanks, Head of Classification, Public Sector Accounts: Personal communication to author September 2006). It was not amended when ESA95 came into force.

In 1999, Eurostat issued new rules for measuring government debt. These rules, based on a survey of public hospitals and homes for the elderly, established a taxonomy of payment types by the government to public hospitals. Four payment methods were identified:

- i) according to their costs;
- ii) according to a negotiation (global budget) between general government and each hospital;
- iii) according to a system of pricing applied only to public hospitals;
- iv) according to a system of pricing applied to both public and private hospitals. (ONS, 2003, p3)

Only payments made under (iv) were classified as sales. Since health authorities could purchase from private or public hospitals, trusts were

deemed to be in the market sector and therefore remained public corporations.

With the creation of foundation trusts in 2003, the ONS reviewed NHS trust classification for a third time and reclassified them to the government sector. On this occasion, the classifying committee adduced evidence from ESA 95 that public service providers in several European countries were assigned to the government sector rather than the corporate sector, even where a single system of pricing applied to both public and private sectors. Its reasoning was as follows. The classification committee (the 'PSCC') reasoned that, pending the full introduction of the national tariff, the system of pricing applied to the trusts did not qualify as sales under international classification rules. These rules define as sales a common system of pricing for public and private sectors. The classification committee decided that unlike private sector suppliers, foundation trusts are paid for availability as well as individual treatments and that therefore the pricing systems are different:

In the UK the purchasing authorities have several types of contracts with health providers. The predominant contract with NHS Trusts is a "block contract", where "service availability" access is purchased rather than particular treatments. There are also "cost and volume" contracts, which contain a mixture of charging for access up to a certain limit, topped up with additional charges according to volume of patients treated. Contracts with private sector providers are more prescriptive and relate to purchases of specific treatments (ONS, 2003, p4).

The committee also decided that the predominant type of NHS payment to trusts was a block grant 'where "service availability" access is purchased rather than particular treatments' (ONS, 2003, p3). Concluding that these payments could not be considered as 'sales' under the Government deficit and debt rules, the committee therefore reclassified NHS trusts as non-market bodies within central government.

The significance of this analysis is that it demonstrates the connection between classification and system of funding. If third sector policy indeed equates nonprofits with private commercial bodies, funding provision will reflect this as funding for continuity of supply is phased out. This raises questions about alternative mechanisms for ensuring continuity of supply among private providers.

Foundation trusts were classified at the same time and to the same (central government) sector. In making this decision the committee considered that foundation trusts were controlled by government through legislation, regulation and contracts in virtue of:

- their borrowing limits;
- their terms of authorisation and legal duties on co-operation;
- their contractual arrangements combined with the restriction on private income;

- the regulator's approval being needed to amend their constitutions.

Community control was not considered to confer a public character on them because their governance arrangements did not secure public control over key committees or a veto of the board. Foundation trusts were thus also assigned to the non-market sector. However when the national tariff system is fully operational, payments will be classified as sales and foundation trusts will be reclassified as public corporations. This example shows that interpretations of the market/non-market divide are subject to change independently of changes in guidance.

#### **4.1.6 Inconsistencies in the classification of nonprofits: differences between government financial reporting and the system of national accounts**

In section 4.1.1-4.1.5 we showed that nonprofits can be classified to either side of the public/private divide and to the market or non-market sectors. In this section we turn our attention to inconsistencies in their classification, and in particular to differences in the classification of nonprofit organisations and assets under the systems of government financial reporting and national accounts.

Government guidance on financial reporting, set out in the manual 'Government Accounting' (GA), covers the proper handling and reporting of the income, expenditure, assets and liabilities of public entities. This guidance is based on the UK's private sector accounting standards known collectively as Generally Accepted Accounting Practice (GAAP). The guidance, which consists of mandatory controls and advice, covers three main categories: parliamentary requirements, Treasury administrative controls, and best practice. Parliamentary requirements may be statutory, customary, or set out in specific agreements between Parliament and the Treasury. Treasury administrative controls deal with propriety, value for money, and accountability in public spending, and are also concerned with regulating public spending. Best practice refers to the promotion of procedures contributing to "good administration" (HM Treasury 2000b, paragraph 1.2).

National accounting and government accounting overlap. National and government financial accounts are both derived from the individual financial accounts of public sector entities. However, government accounts, which the Office of National Statistics takes as input data, are prepared under government guidance on financial reporting and audited by the National Audit Office that can allow for different interpretations of the rules of classification. We show below that this situation has resulted in at least one nonprofit organisation (Network Rail) being classified to different sectors by the Office of National Statistics and the National Audit Office. Nonprofit assets are also treated inconsistently under rules drawn up for public private partnerships.

#### **4.1.7 Case study of inconsistent classification: Network Rail**

GAAP accounting standards can affect the sectoral classification of nonprofit organisations as well as their assets. In 2002, the National Audit Office (the body responsible for auditing government accounts) and the ONS (the body responsible for national statistics) reached different views about the classification of Network Rail, the then newly formed nonprofit body created to take over the rail infrastructure. In the classification of Network Rail, the ONS argued that national accounts prepared in accordance with ESA95 and SNA93 classified Network Rail as a private corporation since it was not controlled by government. Under the national system of accounts guidance, ownership is classified "according to whom exercises control over ability to determine general corporate policy" (Office of National Statistics, 2002, p5). This guidance led therefore to the ONS classifying Network Rail's debt as private sector debt, even though the debt was guaranteed by the government – via the Strategic Rail Authority (SRA) - in the national accounts. The National Audit Office on the other hand, judged that under UK GAAP Network Rail should be classified as a subsidiary of the SRA that is, as part of the public sector, because its finances were dependent upon the state. A joint statement defended the two classifications as "fundamentally different activities undertaken for distinct purposes and using different criteria" (NAO/ONS, 2002, p3).

#### **4.1.8 The rules for assigning nonprofit asset ownership**

Assets as well as organisations are subject to inconsistent classification or their classification is difficult to predict. Allocation of ownership is important because it determines who is responsible for capital assets and who bears the financial risk of ownership and is therefore under an incentive to adjust supply to cover capital costs.

Asset ownership is determined with reference to the type of lease at the centre of a public private partnership (PPP is understood here to be a long term, investment-based contract between a public agency and a provider). There are two relevant types of lease in PPP arrangements. The first is a finance lease, which is method of buying an asset by paying rent over its expected life time. The second is an operating lease, which is a method of renting property or paying for services that does not include acquiring an asset. Ownership is allocated differently according to the type of lease involved.

Both the government's financial reporting regime and the system of national accounts are concerned with the question of whether a public private partnership (PPP) is a financing arrangement for the procurement of public sector infrastructure (a *financing lease*), in which case the asset and the liability are public; or whether the PPP primarily represents the procurement of infrastructure-based services (an

*operating lease*), in which case the asset and liability are not public (though not necessarily private either – see below).

Accounting Standards Board guidance deals with distinctions between lease types. It requires that ownership is allocated according to the test of which party to a PPP bears the risks and enjoys rewards of ownership. This is the test of 'economic ownership', a concept different from and not affected by legal ownership of the underlying asset. However, international accounting guidance has been published by the International Accounting Standards Board (IASB). The IASB adopts an alternative approach, which national regulators will have to consider, that assigns economic ownership not on an analysis of risk and reward but on an analysis of control. Control in this context means the right to control the use of the public service infrastructure created by the PPP.

In practice the complexity of the PPP contract makes it very difficult to judge where risks and rewards lie, as those that relate to the property are often bound up with the risks and rewards of providing the service (Cearns, 1998), thus giving rise to uncertainty about the accounting treatment that will be adopted. Furthermore, auditors acting for the private partner in a PFI deal may assess the risks and rewards differently from the public sector's auditors. As a result, PPP assets can appear in both public and private sectors simultaneously (on-on balance sheet treatment, as in the case of roads) or in no sector at all (off-off balance sheet treatment, as in the case of most hospitals) (Edwards *et al*, 2004).<sup>4</sup>

These matters of judgement are crucial for third sector policy because economic ownership of assets (formally known as 'balance sheet treatment') has significant implications for the cost base of organisations. Assets that are on the public balance sheet are subject to different rules from private assets. They are required by the government's financial regime to show a return of a prescribed amount, to show an annual cost of depreciation at a rate determined by the Treasury, and to be revalued at intervals determined by the Treasury. All these arrangements affect the cost of capital and therefore the unit costs of services. This may be a significant issue under conditions where there is a common pricing regime but not a common capital financing regime, and where there is competition between NHS entities and between the NHS and the private sector, including the nonprofit sector.

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<sup>4</sup> A full treatment of the evolution of guidance in this area is reserved to appendix 3.

## **4.2 The classification of nonprofits in European regulation**

This sub-section links the analysis of classification with that of regulation to show the constraints placed upon national government when decisions are taken to move away from integrated public systems to market provision which includes the use of nonprofit organisations.

A series of landmark judgements by the European Court has established that national health systems involving private or 'market' providers are not necessarily immune from Community law (Hervey, 2000, p.30). The Commission recognises, however, that there is substantial uncertainty with respect to social services: 'a growing proportion of social services in the European Union, until now managed directly by the public authorities, now come under the Community rules on the internal market and competition... [This] new situation for those concerned has meant that the conditions for the application of certain Community rules need to be clarified' (European Commission, 2006, p.2).

The Commission published a green paper in 2003, and a communication in 2006, dealing with how far the rules of the internal market and of open competition should apply to public services.

### **4.2.1 Competition policy and the economic constitution**

The European economic constitution set out in the EC Treaty, to which all members of the European Union are signatories, includes rules that limit state control over commercial firms with the ultimate aim of ensuring competition within the EU. These competition provisions are designed to check anticompetitive behaviour. For example, Articles 81 and 82 of the EC Treaty prevent cartels or the exercise of monopoly power by private companies, while Articles 86 and 87 prevent national governments from giving special subsidies or granting special or exclusive rights to individual providers.

The EC Treaty nevertheless contains countervailing measures to protect member states' autonomy. Article 86 does recognise the rights of member states, in certain circumstances, to breach the rules on competition in order to provide essential services. The general term used to denote such services is 'services of general interest'.

#### **4.2.2 What are services of general interest and how are they defined?**

'Services of general interest' can be both non-economic and 'economic' activities. The EU has no business with services of general interest that are not economic and therefore such services do not require derogations from competition law. Services in this category are those which are provided as 'acts of official authority' or which are of a purely social character. Acts of official authority include matters of vital national interest which are the prerogatives of the state, such as security, justice, diplomacy or the registry of births deaths and marriages, but also public services such as compulsory education and social security (European Commission, 1996). Activities of a purely social character are those that exhibit an element of social solidarity (European Court, 1999).

Services of general economic interest, on the other hand, have a different status under the Treaty. They fall under Community law, but are allowed a derogation from competition rules because of their public interest character. However, services of general economic interest are not defined in the Treaty but by the European Court. The Court judges that a service is 'economic' if it involves 'any activity consisting of offering goods and services on a given market' (European Commission, 2003, p14).

The European Commission acknowledges that for an increasing number of services, the important distinction between economic and non-economic 'has become blurred'. (European Commission, 2003, p.2). One reason for this is that the European Court takes contracting-out into consideration when determining whether services are of a purely social character or commercial. The Court has determined that an organisation with a commercial or industrial character is one which "operates in normal market conditions, aims at making a profit and bears the losses associated with the exercise of its activity" (Lane, 2005, p502). Lane points out that while this seems to exclude charitable bodies and nonprofit institutions, the test is not exhaustive. Lane refers to one case concerning a nonprofit making body responsible for organising trade fairs that the court defined as commercial. The organisation 'was held to meet a need in the general interest, but nonetheless was ultimately held [to have a] commercial and industrial character' because its contractual arrangements put it at risk of commercial failure. (Lane, 2005, p502). The pursuit of profit or surplus, according to the European Court, creates an incentive to trade off quality against cost when financial risk is devolved to the contracting organisation, and such a service is economic. The BetterCare judgement (see case study below) exemplifies this point.



### **4.2.3 What rules can national governments invoke to protect services from EU competition policy when they are services of general economic interest?**

While the European Court decides which services are economic and which are not, European member states are free to decide when an economic service is also a service of general economic interest. This designation triggers rules that allow derogations from competition law so that states can grant special or exclusive rights, regulate activities and also fund the services. (European Commission, 2003, paragraph 31). However, EU rules control the basis on which member states can designate an economic service as of general interest and therefore eligible for derogations.

To qualify as a provider of a 'service of general economic interest' an entity must have been given a specific task by the state, that is, it must have a clearly defined and explicit public service mission such as might be set out in a statute or a contract (European Commission, 2000). So far as this test is concerned, it is irrelevant whether the undertaking is publicly or privately owned; a task will normally be regarded as a service of general economic interest if it is designed to provide a service meeting essential needs of all consumers throughout a defined territory under affordable conditions (Blum and Logue, 1998, p18, 22-23).

Therefore while the regulatory capacity of the European Commission under Article 86 is only triggered for those services which are of an economic nature, it can be seen that the precise method by which member states organise their welfare systems is critically important. The nonprofit status of an agency providing health services is not of itself a guarantee against European jurisdiction; the fact that a service is contracted may lead, irrespective of the sectoral classification of the contractor, to that service coming under EU jurisdiction. That this is not a theoretical question was sharply illustrated by the BetterCare decision in 2001.

### **4.2.4 Case study: the BetterCare judgement**

In November 2000, the BetterCare Group attempted to use the UK's competition law to challenge the price of its contract with North & West Belfast Health and Social Services Trust for private nursing home beds. BetterCare alleged that the contract price was set too low and that the trust was abusing its dominant market position, a violation of competition rules. The Director of Fair Trading originally rejected the complaint, ruling that North & West was not carrying out an economic activity and therefore competition rules did not apply. BetterCare appealed against this ruling on the ground that European jurisprudence defines purchasing care as an economic, not welfare, state activity. The appeal was heard by a tribunal of the UK's Competition Commission. The tribunal reversed the ruling on the ground that commercial contracting is an inherently commercial activity, even when undertaken

by a public body, and must therefore conform to the rules of competition (Competition Commission Appeal Tribunal, 2002).

Under the Competition Act, 1998, the UK's Competition Commission is required to settle competition issues in line with European Community law. In the BetterCare case a tribunal had to decide whether publicly-funded but privately-provided nursing and social care is covered by European competition law, an area of law on which the European Court had not yet ruled. The crucial question was whether the trust was engaging in economic activity.

On the face of it, health and social services trusts bear the hallmarks of traditional public services. They were established in Northern Ireland to carry out the statutory duties of the Department of Health, Social Services and Personal Safety. They are provided with a block grant for this purpose and they redistribute resources by wholly or partly funding those who are eligible for help and would not otherwise be able to afford nursing and residential care.

However, trusts are also the product of market-oriented reforms to health and social services. They were constructed as part of an internal market of competing public providers and on the basis of the 1989 white paper, *People First: Community Care in Northern Ireland for the 1990s*, have been encouraged to use independent providers so far as possible. (*Working for Patients* was the equivalent white paper in England and Wales). By March 2002 North & West had got rid of most of its own beds. Of 1019 residential and nursing home beds in the North & West trust area only 189 were owned and managed by the trust. The remaining 830 were managed by private and voluntary organisations, and of these the trust purchased care in 604 to fulfil its delegated duties towards the elderly population.

In determining whether trust contracting is covered by competition law the tribunal had to assess its status in three categories of exemption: Are trusts sovereign powers exercising official authority? Are they undertakings, that is, are their activities economic? And if they are, would the application of competition law obstruct the provision of essential services?

The tribunal rejected the suggestion that the trust was a sovereign power exercising official authority and therefore exempt. It said that this was not a case of 'exercising ... sovereign powers in the regulatory and administrative sphere' (Competition Commission Appeal Tribunal, 2002, p62), which was normally classified by the European Court as 'the exercise of official authority' (Competition Commission Appeal Tribunal, 2002, p63). Thus provision of social services was not an exercise of official authority. Furthermore, the fact that the trust was financed through taxation was not a ground for exemption because case law had established that the determining factor was economic activity, regardless of legal status or method of financing (Competition Commission Appeal Tribunal, 2002, p74): 'neither public service obligations nor state financing can prevent an operator's activities from

being classified as economic activities (Competition Commission Appeal Tribunal, 2002, p75). Therefore the question was whether or not the trust was engaging in economic activity.

According to European case law 'economic activity' involves offering goods on the market. The tribunal decided that this definition was not sufficient to capture contracting out so they sought to arrive at their own definition of "the essence" of economic activity: 'the essence of many, if not most, "economic" activities is the making of commercial contracts [...] In making such contracts, it seems to us that North & West is necessarily engaged in transactions of an economic character' (Competition Commission Appeal Tribunal, 2002, p66). Thus with questionable logic the tribunal held that since economic activity involves contracting, contracting is an economic activity.

What of the social purposes behind trust activity? The tribunal found that the Trust's activities had two dimensions, a 'social dimension' and a 'business dimension': 'although the *funding* which North & West provides has a social purpose, the way in which North & West carries out or *delivers* its functions is *by using business methods*' (Competition Commission Appeal Tribunal, 2002, p77, emphasis in original) This interpolates a new analysis not present in European case law, reflecting perhaps the tribunal's unshakeable conviction that contracting must be a commercial activity whatever cause it is put to. On the strength of this the tribunal concluded that partnership with the private sector is an economic not a social partnership, (Competition Commission Appeal Tribunal, 2002, p78) a judgement of considerable national significance in the context of public service reform.

On the question of whether competition would damage the financial viability of a solidaristic (that is, redistributive) system, the tribunal declared:

*The argument presupposes that private residential care could not be provided – even in theory – from the resources of a resident with only a state pension, perhaps with further support from the family concerned or charitable bodies* (Competition Commission Appeal Tribunal, 2002, p82)

But 'in theory' this form of financial bailing-out is always a possibility, so that in effect the judgement renders the solidarity exemption unusable. Furthermore, the tribunal was persuaded that redistribution through tax-funded subsidies was not the same as the solidarity among members of an insurance scheme. Insurance scheme members spread risks and costs among themselves, whereas an external commercial contractor could not be a party to risk-sharing; therefore the type of redistribution involved in tax-funded eligibility payments could not provide a ground for exemption: 'Such solidarity is not, in our view, to be *imposed externally* on external trading parties such as independent providers (Competition Commission Appeal Tribunal, 2002, p78, original emphasis). Here the tribunal points to the potential for risk and cost pooling to be dismantled under contracting-out arrangements, a logic it

has in common with the report of the Federal Trade Commission and Department of Justice (2004) report on health care efficiency. The approach favours income support instead of redistribution through services in kind or services provided at less than market price.

The tribunal's general view was that 'once the decision has been taken to rely on private sector transactions for the "delivery" of the services in question, it is logical to expect the rules applicable to private sector transactions to come into play' (Competition Commission Appeal Tribunal, 2002, p83). In their minds this had more force given that trusts were established 'in order to facilitate efficient management and a more market orientated approach' (Competition Commission Appeal Tribunal, 2002, p64). In these circumstances it would be paradoxical to exclude trusts from competition law since they had been constituted to be disciplined by markets.

The tribunal therefore overruled the Director of Fair Trading's decision and ruled that contracting out for nursing care is an economic activity simply because it involves a contract. As for the social purposes of the Trust's activity, the tribunal decided that partnerships with the private sector are economic not social. It could have ruled that although it was an economic activity, application of competition rules to the purchase of private nursing would damage trust financial viability. But it rejected this option on the grounds that more money could be sought from 'the family concerned or charitable bodies.

This judgement represents a Competition Commission tribunal's attempt to interpret European competition law in an area on which the European Court has yet to rule. Nevertheless, it confirms, albeit provisionally, the general conclusion reached above (section, 4.2.3) that contracting-out may lead to a service coming under EU jurisdiction irrespective of the sectoral classification of the contractor.

## Section 5 Recommendations for future research

We set out below a brief rationale and recommendations for future research based on our study of nonprofit classification and review of the literature on nonprofit performance to date.

Current government policy to contract out state run public services to nonprofit bodies raises the crucial issue of government control and in particular how public expenditure is audited and accounted for and how services are regulated to ensure that delivery is consistent with health policy core values and goals. Our review of the literature on government classification systems and contracting policy shows that policy on regulation of non-state providers of NHS services is inconsistent so that the regulatory structures and regulations which govern audit and accountability, access to information, and quality and access to health care are far from transparent. For example, some nonprofit hospitals serving the NHS are currently classed as part of government while others are classed as private. Similarly, nonprofit organisations eligible to participate in the new primary care market can elect to be either public or private bodies linked to the NHS either by NHS (public) or commercial contracts. This means that in either case, a different rule of law applies with consequences for the public interest. We also note that the government's nonprofit policy is in transition. For example, an insolvency regime is still awaited for nonprofit foundation trusts and therefore the regulatory framework for essential health services is incomplete (Department of Health, 2006b). This variation raises key question about relations between the state, the citizen and new contracting parties.

The regulation question is of relevance to our review of ownership and performance literature. We find that the performance literature usually does not and in most cases cannot address differences in access and entitlements in universal health care systems and rarely seeks to describe or control for confounding effects of heterogeneous regulatory frameworks. Furthermore, the majority of performance literature relates to the selective US health care system and involves comparisons between nonprofit and for-profit providers. The literature demonstrates a paucity of work in the area of public health planning for geographic populations. We find therefore that a great deal of the literature on the comparative performance of nonprofits omits basic descriptive data relating to regulatory context that is necessary to make sense of the findings.

These findings inform our recommendation for research, which are as follows:

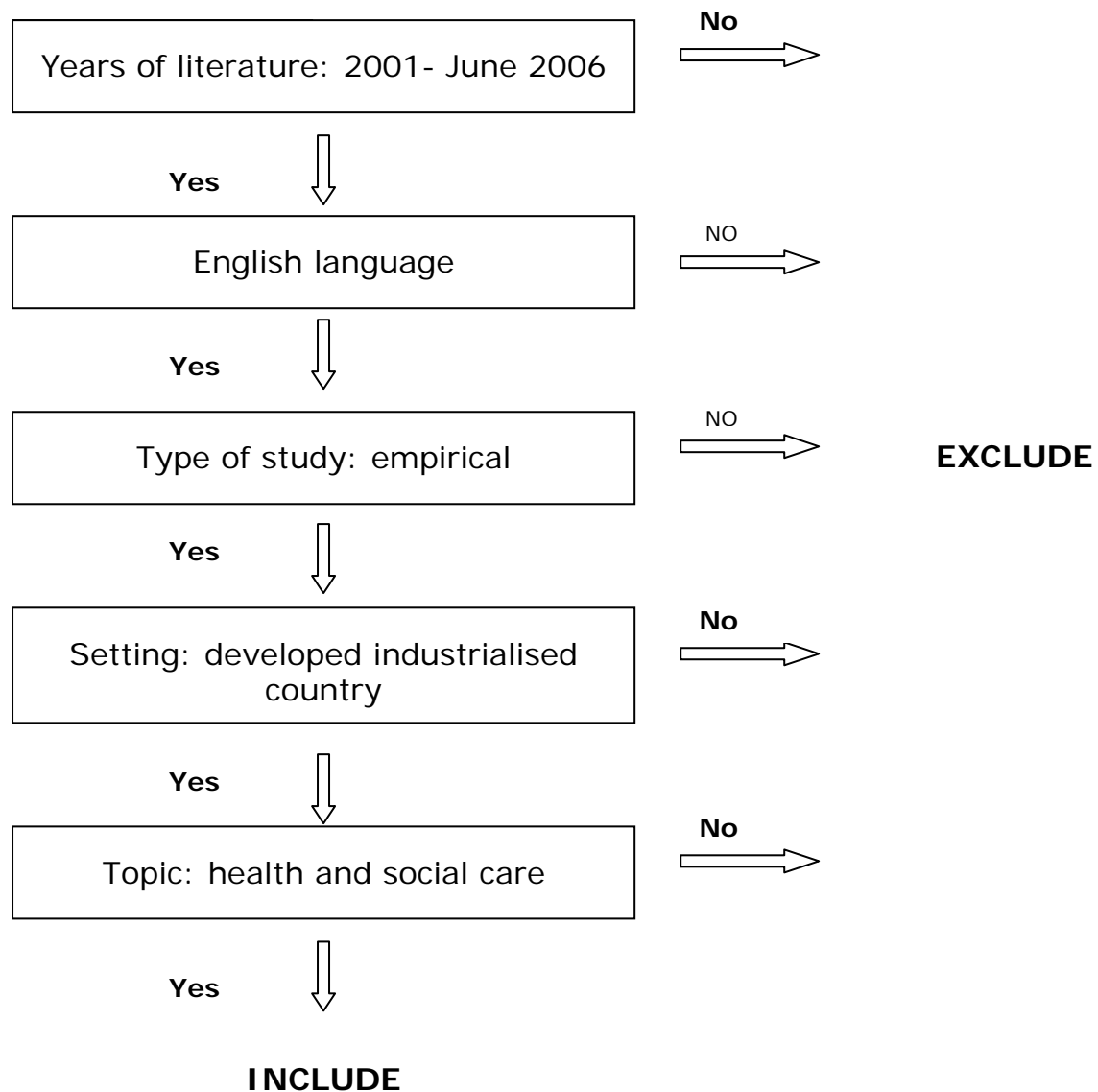
1. A range of empirical studies to develop a methodology to describe and evaluate the regulatory frameworks which govern non-governmental health service providers to the NHS in the following

areas of public control: audit and accountability for public expenditure and value for money; access to and availability of information and data regarding contract price, value for money, the planning and modelling of services, the setting and monitoring of service entitlements including the application of the freedom of information act; the legal status of non-state providers to the NHS under competition law.

2. A literature review of studies of regulation with respect to the above key principles in public services other than health and in other countries.
3. An empirical study of the distributional consequences of contracting out of state functions to non NHS providers at both the level of the geographic population and the provider level for:
  - a) workforce planning including training and education.
  - b) workforce distribution and changes in workforce terms and conditions, with respect to payments to existing staff and payments to new recruits.
  - c) geographic population access to services measured by age standardised supply and utilisation.
  - d) comparative studies of patterns of income and expenditure profiles among state, for-profit and nonprofit providers with respect to staffing administration, capital, marketing, surplus, training and education.

Special attention will be paid to the data required to conduct evaluative research. In the light of the problems we have identified in the literature of undertaking robust comparisons between provider populations, there is a need to establish geographic-based planning norms that are separate from provider-based norms. Such norms will ensure that evaluation is not reliant on problematic and non valid measurements requiring complex adjustments such as case mix for comparisons among different provider populations. They will also recognise that admission rates and finished consultant episodes are inadequate proxy measures for the population's access to treatment and care because they do not take account of repeat admissions (Pollock and Vickers, 1995).

## Appendix 1: Algorithm for inclusion of studies identified by bibliographical databases and internet searches



## Appendix 2: Overview of reviewed literature

Ref ID	Author	Setting and data	Performance Measure	Methods	Results	Other
1	Ettner and Hermann	USA, 1990  All aged Medicare beneficiaries admitted to private general and psychiatric hospitals for a primary psychiatric diagnosis; longitudinal, patient-level data from official files, e.g. AHA	Costs; controlling for quality of care by using rehospitalisation rates as a proxy	Logistic and linear regression	Case mix differences modest: populations looked quite similar in terms of primary diagnosis or prior hospitalisations; FPs actually treated poorer patients. NFP and FP hospitals had similar average total costs of care; longer length of stay and lower daily costs of NFPs were attributable to their other characteristics, e.g. medical school affiliation; neither were NFPs less efficient, nor were they more likely to treat a sicker or poorer patient population, or provide higher quality of care, leading to better patient outcomes; differences between NFP and FP patient populations in rehospitalisation rates were negligible.	No support for concerns that FP growth leads to declining access and quality or contentions that NFPs are less efficient. Data are for the universe of Medicare patients hospitalised during the study period, thus results are nationally generalisable and statistical power is high  <i>Limitations:</i> rehospitalisation rates not ideal as a measure of quality, since only imperfectly related to clinical outcomes; however, mortality rates not very informative for patients with psychiatric disorders
5	Ginn	USA, 2000  Sample included all not-for-profit	Integration and planning (extent to which hospitals	Multiple regression	Only a small proportion see for-profit ownership of hospitals or health plans as having net social benefits. Respondents who could explain NFP ownership were	Overall the key issue raised was the lack of understanding of ownership of hospitals and health plans – this is important as it relates to the public legitimacy of



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		and investor-owned acute-care hospitals	provided health promotion services)		typically more favourable towards NFPs in their assessment of performance than those who could not offer an explanation. These effects were most pronounced for perceptions of fair treatment and trustworthy behaviour, but understanding ownership is associated with a less favourable perception of the relative quality of services provided by NFPs. In the case of respondents who saw themselves as 'empowered' consumers, there were more negative impressions of the performance of NFPs relative to for-profits. Hence, market-oriented reforms may be more likely to undermine the legitimacy of the NFP sector.	the NFP sector, the implication being that if the NFP form were better understood, there would be less questioning of its legitimacy (e.g. fewer people would argue against the tax breaks given to NFPs)
9	McKay <i>et al</i>	USA, 1986 and 1991  Interstudy data for hospitals. Excludes conversions and mergers	Efficiency	Cost frontiers and regression analysis	The results indicate that, in both 1986 and 1991, mean inefficiency was highest for FP hospitals and lowest for NFP hospitals, with government hospitals falling in the middle. Moreover, between 1986 and 1991, both FP and government hospitals had significantly less improvement in efficiency than NFP hospitals, all else equal.	<i>Limitations:</i> Has control variables, but quality not addressed. Changes depend upon how large margins were before. Shows NFPs less inefficient than public or FPs in both years.

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12	Harrington <i>et al</i>	USA, 1998  Data from state inspections of 13 693 nursing facilities.	Quality of care	Multivariate regression	Investor owned facilities averaged nearly 6 deficiencies per home, 46.5% higher than NFP facilities and 43% higher than public facilities. Nurse staffing was lower at investor-owned homes.	Controlled for case mix, facility characteristics and location. The finding that nurse staffing is lower at investor-owned homes is consistent with McGregor's research in Canada [56].
15	Thorpe <i>et al</i>	USA, 1991-1997  Main data from AHA annual survey	Access, uncompensated care	OLS regression	Higher HMO penetration is associated with lower total margins (which may reduce the ability of hospitals to cross-subsidize care for the uninsured) and is associated with lower levels of uncompensated care. Competition is also associated with lower margins.	The authors hypothesise that higher HMO enrolment could reduce uncompensated care by limiting funding for the uninsured and by transferring patients from a fee-for-service basis (which involves high cost sharing) to HMOs (where cost sharing is relatively low), thereby reducing bad debts (one of the categories under which charitable care is frequently listed).
16	Landon and Epstein	USA, 1997/98 Health plans in 11 randomly selected states Random survey utilising a self-report questionnaires to health plan representatives	Quality of care/user satisfaction	Bivariate and multivariate regression analyses	The findings demonstrate that for-profit and not-for-profit plans appear to be more similar than dissimilar in many areas of management, although for-profit plans are more likely to use aggressive utilization review and have slightly less developed quality management systems.	The authors suggest that the findings should reassure critics of for-profit health care  <i>Limitations:</i> possible response bias
17	Born and Simon	USA, 1997	Quality of care	Multivariate analysis	The more profitable plans achieve higher quality scores in later years. Profits may enable a	Factors other than ownership influence performance. HMOs

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		Sample sizes of 140-240 HMO plans; data from HEDIS and the National Association of Insurance Commissioners			plan to pursue higher quality of care and invest in better management systems. Little systematic evidence that FP plans have different HEDIS scores than NFP plans	need profits to ensure quality.
19	Coid <i>et al</i>	Scottish Health Boards  In-depth interviews with health board officials in all 15 Scottish health board authorities	Staff perceptions re voluntary organisations in the health sector	Qualitative study	Formal and financial policies were viewed as insufficiently explicit. Some health boards ensured accountability through audited accounts, annual reports and site visits while others thought this inappropriate for small organisations. Authors conclude the uncertainties of funding may impede the contribution of voluntary organisations. Found ambiguous attitudes to improving accountability in the sector.	The authors tentatively (though not unreasonably) conclude that the precarious position of voluntary organisations may have considerable impacts on patient welfare when withdrawn. The view of the interviewees, reflected by the authors, is that stable funding would improve performance and outcomes.
23	Sellick and Howell	UK  Survey among 75 fostering agencies across public, private and voluntary sectors	Organisational behaviour (innovative fostering practice)	Interviews with agency staff and scrutiny of agency documentation	4 factors underpin more innovative practice: the growth of partnership, ICT contribution to improved placement provision, near absence of independent evaluation of the effectiveness of fostering practice (exceptions were all in the voluntary sector) and the role of non governmental fostering	Study may be unrepresentative in that it asked for positive feedback only, and examples of good practice. The information gathered was selective in that it came from agency staff keen to publicise their work.

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26	Horwitz	<p>USA, 1988-98</p> <p>AHA survey data 1988-98 and 1990 U.S. Census</p> <p>Sample of non-rural, acute care. Some federally-run hospitals were excluded.</p>	Medical services offered; regulatory tools	Multivariate analyses	<p>FP, NFP, and government hospitals offer different types of services. Evidence supports the theory that government hospitals are hospitals of last resort as they are more likely to offer unprofitable services that are generally needed by poor, underinsured patients. FPs seek profits and avoid offering unprofitable services more than the others. FPs exhibited dramatic responsiveness to financial incentives. NFP hospitals are the intermediate type, providing more profitable services than government hospitals and more unprofitable services than FP hospitals. Private ownership and charitable orientation both seem to matter.</p>	<p>Legal categories of corporate form are strongly correlated with behavioural differences. Findings imply that hospitals have different priorities and implement different organisational goals. NFPs act differently than FPs in providing services, likely because they have different missions. No hospital form can substitute any other. The findings provide a new justification for the not-for-profit tax exemption for hospitals, and also suggest new uses for ownership categories as regulatory tools.</p> <p>Study limited to metropolitan areas only.</p>
27	Dellana and Glascoff	<p>USA</p> <p>Random sample survey (with Patient Satisfaction Questionnaire); 581 respondents (computer owners)</p>	User satisfaction (measured as: access to care, availability of resources, technical quality, financial aspects of care, overall	Chi Square analysis and ANOVA	<p>Consumer satisfaction with health care did vary with profit status. Individuals in not-for-profit HMO plans reported greater satisfaction with aspects of health care than those in for-profit HMO plans</p>	<p>Findings support those of other studies, namely that for-profit HMOs are not providing the same level of patient care/satisfaction as NFP HMOs (e.g. Himmelstein [362]).</p> <p><i>Limitations:</i> Self-report survey likely to have subjective bias and possible error;</p> <p>Likert-type scale not completely accurate measure for use in interval-level statistical analysis;</p>

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			satisfaction, continuity of care and humaneness)			sample not representative, but cross-section of middle- and upper middle-class Americans (computer owners); small subgroups in sample
34	McFarland <i>et al</i>	<p>Oregon, 1994-1997</p> <p>Data from the Oregon Client Process Monitoring System. Subjects were Medicaid clients enrolled in the Oregon Health Plan before substance abuse treatment managed care, N = 1751) or after managed care, N = 14,813).</p>	Clinical outcomes for clients with substance abuse problems before and after managed care	Regression analyses (bivariate and logistic)	<p>With the exception of readmission, there were no notable differences in outcomes between the fee-for-service era clients versus those in capitated chemical dependency treatment. There were at most minor differences among various managed care systems (such as for-profit vs not-for-profit). However, duration of Medicaid eligibility was a powerful predictor of positive outcomes. Medicaid managed care does not appear to have had an adverse impact on outcomes for clients with substance abuse problems. On the other hand, state policies influencing Medicaid enrollment may have substantial impact on chemical dependency treatment outcomes.</p>	
35	Parrot <i>et al</i>	<p>Manchester and Newcastle</p> <p>Two additions services</p>	Quality of care	Users completed questionnaires at admission and 6 months later.	Both services delivered a flexible needs-based service to very disadvantaged population at a reasonable cost and were associated with statistically significant reductions in drinking.	This study did not set out to compare the services and tells us little if anything about the distinctive value or otherwise of NFP. Indicates that both the NFP and NHS service were comparable

						and effective.
37	Mays <i>et al</i>	USA, 1994  Non-random sample of counties; Cross-sectional data from official statistics	Integration and planning (public health practice, forming of co-operative alliances)	Multivariate analysis	The incentives for co-operation vary with health plan ownership and market structure. National NFP plans and Blue Shield Blue Cross NFP plans significantly more likely to engage in alliances with public health agencies than national FP plans. Locally owned FP plans also appeared more likely than national FP plans to engage in alliances. The number of competing HMOs in the market was negatively associated with alliance participation whereas HMO market penetration had a positive effect on alliance participation. National NFPs appeared significantly more likely than FPs to participate in alliances with public health agencies, but this difference was larger for clinical alliances than for nonclinical alliances. FP plans respond primarily to economic incentives for participating in local public health activities, and such incentives are limited for plans that operate on a regional or national scale.	These findings call into question the ability of alliances to integrate the practice of public health and medicine on a broad national scale. National FP plans may find more efficient ways of acquiring needed public health resources and expertise, e.g. by employing own public health professionals. In contrast, national NFP plans may have non-economic reasons for cooperating that override any diseconomies of scale. Recent trends such as the for-profit conversion of NFP plans and acquisition of locally owned health plans by national corporations, are likely to dampen alliance participation further.  <i>Limitations:</i> No generalisations beyond the study population possible. Study cannot determine the causation of the associations (are FPs less interested in public health activities or do public health agencies prefer NFP and locally owned institutions because these organisations are assumed to be more responsive to community priorities and needs?). Role of Medicaid programmes could not be disentangled.

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46	Crampton <i>et al</i>	New Zealand  Nationally representative sample of primary care practices	Organisational characteristics including staffing ratios; range of services and management; financing and governance.	Statistical comparisons of sample means using t-tests.	Community-governed NFPs employed higher proportions of women, Maori and Pacific staff, including both doctors and nurses. NFPs provided a different range of services and although there were less likely to have specific items of equipment, they were more likely to have written policies on quality, complaints and responses to critical events, and to carry out locality service planning and assessment of community needs.	
47	Leone and Van Horn	USA, 1990-2002  Data on 1,204 hospitals and 8,179 hospital-year observations. Financial data from accounts.	Spending behaviour	Regression analysis and tests of the distribution of earnings by Burgstahler and Dichev [Burgstahler, D., Dichev, I., 1997.	NFPs use discretionary spending and accounting accruals to manage profits. They use discretionary accruals (e.g., adjustments to the third-party-allowance, and allowance for doubtful accounts) to meet earnings objectives. This means that previous evidence that NFPs show less variation in income may at least partly be explained by an accounting phenomenon.	NFPs deliberately manage profits downwards because don't want to upset donors. But this means that it is not straightforward to use accounts to compare NFPs and FP, due to incentives to fudge (CEOs, tax, donors, etc).  <i>Limitations:</i> Sample only includes hospitals that issue publicly traded debt, which rules out many NFPs since they are not debt financed.
49	Crampton <i>et al</i>	New Zealand  Third sector primary care organisations	Characteristics of practices including demographics of population served; provision of	Face-to-face interviews with managers and other key informants using a semi-structured	Practices differed in the extent to which they served minority ethnic groups, were located in deprived areas, or used population approaches to the organisation and delivery of services. Populations were highly	

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			services including targeting of high needs populations and geographic location	interview schedule	atypical compared to the NZ average being young and largely non-European. They were also generally located in low-income areas with high levels of need, and user charges were lower. Little evidence on health outcomes or the efficiency of provision.	
53	Charlesworth	Milton Keynes, UK	Integration and planning (development of relationships between statutory and voluntary organisations)	Mapping of voluntary organisations within primary care. Qualitative interviews with senior managers	Identifies tensions in partnerships. A particular problem has been the pace and scale of change. Demands for monitoring and audit are forcing organisations to focus more on their own core business while also required to collaborate more and be more outward looking.	Through a combination of mapping of structures, and interviews, highlights tensions around 'partnership' policy, identifies the relatively weak position of the voluntary sector in the UK, and the threat to any distinctive role, in relation to the more powerful statutory sector.
56	McGregor <i>et al</i>	British Colombia  Staffing data for 167 nursing homes	Quality of care (staffing ratios)	Comparison of the mean number of hours per resident-day provided by direct-care staff in NFP vs for-profit facilities, after adjusting for facility size (number of beds) and level	The mean number of hours per resident-day was higher in the not-for-profit facilities than in the for-profit facilities for both direct-care and support staff and for all facility levels of care. Not-for-profit status was associated with an estimated 0.34 more hours per resident-day provided by direct-care staff and 0.23 more hours per resident-day provided by support staff.	The authors point out this is consistent with US findings and suggest that in both countries the financial imperatives of for profit ownership in nursing homes care operate in a similar manner. They argue that the care demands of residents in both sectors are likely to be similar given that managers of both have an interest in maintaining a volume of more dependent clients to ensure adequate funding levels, though they acknowledge the possibility that the care demands of



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				of care.		residents in for profit facilities might be lower in ways not measurable at the facility level of care.
59 and 241	McPherson	Maryland, 2001-2003	Role of responsiveness to users and mission statements; governance and accountability	Case study of one failed conversion of a NFP into a FP based on interviews and documentary review	Barriers to conversion consisted e.g. in the failure to exercise due diligence and conflicts of interest. Commissioner asserted that a NFP board must meet higher standards applied by insurance commissioner or attorney general; inconclusive findings on whether the proposed conversion and sale would have adverse impacts on access to, quality or cost of health care in the state.	Case-study character only, but lessons could be learnt for other states and all types of NFP health care organisations
60	Schlesinger <i>et al</i>	USA  Telephone survey of 5000 respondents.	Public perceptions	Regression models	Only a small proportion of the US population see for-profit ownership of hospitals or health plans as having net social benefits. In general, respondents, who could explain NFP ownership were typically more favourable towards NFPs in their assessment of performance than respondents who could not offer an explanation. These effects were most pronounced for perceptions of fair treatment and trustworthy behaviour, but understanding ownership is associated with a less favourable	Overall the key issue raised was the lack of understanding of ownership of hospitals and health plans – this is important as it relates to the public legitimacy of the NFP sector, the implication being that if the NFP form were better understood, there would be less questioning of its legitimacy.  Study population over representative of the young, the better educated, and high-income strata.

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					perception of the relative quality of services provided by NFPs. In the case of respondents who saw themselves as 'empowered' consumers, there were more negative impressions of the performance of NFPs. Hence, market-oriented reforms may be more likely to undermine the legitimacy of the NFP sector.	
61	Reeves and Ford	USA  Sample of 57 FP and 20 NFP health service organisations	Financial performance measures (equity growth, financial flexibility, and financial efficiency)	Linear regression analysis	Results indicate that FPs and NFPs share a common strategic capacity profile. For NFPs, risk taking, multiplexity of decision-making and control were strategic capabilities of a higher order than for FPs. The model with financial efficiency as the dependent variable explains the most differences in financial performance between FP and NFP firms.	Small sample size; Only cross-sectional data used; Lack of a continuous dependent variable
64	Seago	California, 1997-99  Data for acute care general hospitals from California Office of Statewide Health Planning and	Staffing ratio	Six regression models were estimated using pooled data from the 3 years.	For-profit hospitals had fewer RN productive hours for medical-surgical nursing, and select corporate owners, unrelated to profit status, had consistently fewer RN productive hours for medical-surgical nursing. For-profit hospitals and systems behaved differently in the health care market environment of the late 1990s. Select NFP systems	With minimum staffing ratios scheduled to be implemented in January 2004, this study provided baseline data for evaluating the impact of minimum staffing ratios in California.

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		Development			were also using significantly less RN staffing. As discharges go up, the need for RN hours increases.	
65	Carlson <i>et al</i>	USA, 1998  Data derived from the 1998 National Home and Hospice Care Survey	Quality of care/access	Regression analysis	Patients of for-profit hospices received a significantly narrower range of services than patients of NFP hospices. This result is driven by patients of for-profit hospices receiving significantly fewer types of hospice services that federal regulations term "noncore" or more discretionary services.	
66	Johnson	USA, c. 1992-2002  Blue Cross data for NFP HMOs. FP HMO data tracked by Sherlock Company. FP cost and profit data from CMS	Financial performance, access to capital	Comparison of NFP and FP financial data	NFP's lower operating margins probably reflect their corporate missions to serve their communities by minimizing the cost of coverage and their ability to invest all gains back into the company for the future benefit of their customers, while FPs must generate higher margins for shareholders. NFP plans pay out more and spend less on administration. NFPs have used operational and investment gains to build and retain a stronger capital position than FPs.	Says profits are not an indicator of ability to access funds for capital investment as NFPs have other sources of finance. Notes normal financial measures of performance are not appropriate/limited use to evaluate NFPs.
69	Schneider <i>et al</i>	USA, 1997  Standardized Medicare HEDIS	Access to care/rates of use of 12 high-cost		Contrary to the authors' expectations about the likely effects of financial incentives, the rates of use of high-cost	Case mix adjustment  <i>Limitations:</i> the study did not examine diagnosis or include data

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		data on 3,726,065 Medicare beneficiaries 65 years of age or older enrolled in 254 health plans	operative procedures		operative procedures were not lower among beneficiaries enrolled in for-profit health plans. After adjustment for enrollee case mix and other characteristics of the plans, the for-profit plans had significantly higher rates for 2 of 12 procedures and had lower rates for none. The geographic locations of the health plans did not explain these findings.	on whether the rates of procedure use were objectively justifiable.
70	Hall and Conover	California, Georgia, Missouri, Virginia, c.1993-2002	Health policy impacts (e.g. service accessibility, affordability, geographic coverage) of Blue Cross conversions from NFP to for-profit status	Case studies of BC conversions based on confidential interviews and a review of the published literature and available documents	Conversion increases pressures to generate more profit, which may lead to either negative or positive changes in operations. To date, there is little evidence that converted plans have raised rates faster than medical cost trends or have sharply changed medical underwriting policies. Instead, the most visible effect of conversion is more intense efforts to negotiate deeper price discounts with providers.	On balance, Blue Cross conversions have so far not caused serious harm to statewide measures of health care affordability and accessibility. Even if the historical record is clear elsewhere, each state and each conversion is different. Hence, it is difficult to predict the actual effects in a particular state.
71	O'Neill <i>et al</i>	California, 1998-99  Data on 1098 nursing homes from the California Office	Quality of care	Multivariate regression	Proprietary homes in California had significantly lower quality of care than nonproprietary homes. A stratified analysis revealed that, controlling for resident, facility, and market characteristics, profits located within the highest 14% of the	

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		of Statewide Health Planning and Development			proprietary sector's profit distribution were associated with significantly more total deficiencies and serious deficiencies. This relationship was not found in nonproprietary facilities. Other factors related to deficiencies included the ethnic mix of residents and facility size.	
72	Schlesinger <i>et al</i>	USA, 1999  Nationally representative survey of NFP and for-profit HMO plans	Community benefits	Development of a conceptual framework for identifying these activities	NFP plans exceed their for-profit counterparts on some, but not all, aspects of community benefit activity. The most consistent ownership-related differences involve redistributive programs (subsidized services and general philanthropy), commitments to medical research, and services that benefit the entire local population, beyond the plan's enrollees. Other forms of community benefits show mixed or modest differences between NFP and FP plans. Unexpectedly, for-profit plans appear more active in helping consumers deal with information asymmetries.	
75	Grabowski and Hirth	USA, 1995-96  Data collected with 16,978 unique nursing	Quality of care	Multiple regression	This study finds that an increase in NFP market share improves for-profit and overall nursing home quality, supporting an asymmetric model.	Starts from the basis that empirical research on this topic needs to account for the share of NFP nursing homes in the market. The findings are consistent with the hypothesis that NFPs serve as

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		home surveys. Primary source was the Online Survey, Certification and Reporting system. Four other data sources used.				a quality signal for uninformed nursing home consumers.
77	Crawford <i>et al</i>	Philadelphia and neighbouring hospitals in Pennsylvania, 1997-99  Inpatient data set from PHC4; Hospital discharge database: 1,617,581 discharges from 49 acute-care medical school hospitals	Quality of care	Longitudinal analyses using time series data; trend analyses (5 hospital specific analyses)	The 2 medical school hospitals that became for-profit experienced decreases in volume and resource intensity, coupled at one with an increase in severity. However, these patterns were produced more by the system's financial instability than by consolidation or conversion.	Stresses the importance of time series vs. point data  Conclusions are important in relation to UK Foundation Trusts.
78	Kessler and McClellan	USA, 1985-1996  Various official data sources	Efficiency	Regression analyses in three stages	Effects of ownership status are quantitatively important. Areas with a presence of for-profit hospitals have approximately 2.4% lower levels of hospital expenditures, but virtually the same patient health outcomes.	Controls for selection bias/ patient population and spill over effects. Use of longitudinal data.  <i>Limitations:</i> complexities of Medicare; could have taken advantage of higher prices for

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					Conclude that for-profit hospitals have important spillover benefits for medical productivity.	rehab to shift activity mix, only heart treatments, only net expenditure, could have done less charity work. Does show Medicare reimbursements systems are based on average costs in area so if more FPs that pay lower rates and employ few staff, this will affect reimbursement for whole area. Like other studies, it indicates the complexity and variations in payment mechanisms.
80	Tu and Reschovsky	USA, 1996-98  2 national surveys of 13,271 persons under 65 with employer-sponsored insurance who obtained health care through an HMO.	Users' assessment of quality of care	Logistic regressions	Members of NFP plans were more likely to be satisfied with their care than members of for-profit plans,. Members in poor or fair health were more likely than healthy members to express dissatisfaction with the quality of for-profit care.	<i>Limitation:</i> the study did not include an objective assessment of the quality of care.
81	Deneffe and Mason	Virginia, 1986-87  All NFP hospitals (N = 70 for both years data, N = 144 for pooled sample). Uses	Uncompensated care	Regression methods with complex models and controls Latent variable estimation	Rejects the hypothesis that NFP hospitals maximize profits (i.e. maximize rents for a set of agents who 'control' the hospital). Also rejects pure welfare (output) maximization. These results, combined with	They note that there is cost shifting from charity cases to private cases when charity case load rises. Therefore cost reductions may be inflated if this leads to cost shunting. Any attempts to restrict Medicare and

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		revenue reports to the state but does not explain other data sources			other evidence are consistent with the hypothesis that these hospitals consider both profits and output as objectives. Mergers due to oversupply but more likely to be with FP if NFP has no hospital in area. Ability and incentives to merge depend upon regulations and charter but some board directors profit from mergers.	Medicaid and therefore increase charity cases will have implications for insurance prices. Points out that prices not profit margins are the important variable for understanding NFPs since their lower margins may reflect their tax free status (i.e. do not have to include an element for tax). Controls for case mix (3 proxy variables).
88	Town <i>et al</i>	USA, 1987-2001  HMO level data from InterStudy publications	Conversion studies	Regression analysis	Conversions to FP status do not significantly impact HMO prices, profit margins, use of hospital days or ambulatory visits, and the provision of Medicare and Medicaid products.	Notes however that Blues offer both managed care and other indemnity insurance products and it is unclear how conversion impacts on this and whether the two can be separated clearly in the data.
89	Farsi	California, 1990-1998  Sample of private hospitals. Uses OSHPD Patient Discharge Data and Hospital Disclosure Data for hospitals' financial reports.	Quality of care (for Acute Myocardial Infarction and Congestive Heart Failure patients) after conversion in ownership	Regression analyses	Conversion in either direction may have adverse health care outcomes. But the results suggest that converted hospitals have experienced quality changes before conversion and that ignoring these changes may bias the estimates of conversion effects. Hospitals that converted to FP form show an increase in AMI mortality rates, while those converted to NFP status indicate an increase in CHF mortality	Health outcomes in different diagnostic groups may represent different dimensions of hospital quality.



					outcomes.	
90	Chakravarty <i>et al</i>	USA, 1984-2000  AHA panel data	Entry and exit rates of public, for-profit, and NFP hospitals	Econometric analyses	For-profits have higher <i>entry rates</i> and were more responsive to changes in demand than NFPs. Both FP and NFP entry are negatively related to hospital wages. For-profits have higher <i>exit rates</i> and are more sensitive to demand shifts than NFPs. The difference between FP and NFP exit rates is greater in mixed markets.  In markets with growing elderly populations, the probability that an exiting hospital is for-profit is dramatically reduced.	Evidence consistent with the theory of for-profit marginality
95	Silverman and Skinner	USA, 1989-98  Sample from the MEDPAR file of Medicare claims, use of DRG 79, 14 and 15. Data from AHA, Health Service Areas and Medicare Cost Reports	Use of upcoding practices	Trend analysis and cross tabulation with other data for incidence of upcoding; Cross sectional analysis for impact of market structure; Regression analysis	Between 1989 and 1996, the percentage point share of the most generous DRG for pneumonia and respiratory infections rose by 10 points among NFP hospitals, 23 points among FP hospitals, and 37 points in hospitals converting to FP status. NFP upcoding was also higher in markets with a larger FP hospital share. Upcoding appears to reflect both risk-taking by administrators and a closer alignment between the goals of the administration and the behaviour of the clinical staff. While differences in upcoding	Upcoding cannot be generalised to all treatment categories.

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					reflect ownership status, there is also strong regional variation.	
98	Beaulieu	Delaware, Maryland, and District of Columbia, c. 1998-2002  Official material of CareFirst conversion application	Effects of NFP conversion	Single case study	NFP conversion is a managed care market phenomenon that has frequently occurred as a prelude to merger or acquisition with a for-profit company. Perceived competitive pressures have raised questions about the long term viability of NFPs and also about the justification of tax exempt status.  Finding: Governance structures are important for controlling social mission.	<i>Limitations:</i> did not examine traditional areas of charitable care; insufficient data to examine premium and provider reimbursement policy.
99	Gaynor and Vogt	California, 1997	Conversion study	Structural model of demand and pricing in the hospital industry, then simulation of the effect of the 1997 merger of two hospital chains.	In the simulation, where the merger creates a near monopoly, they found that prices rise by up to 53%, and the predicted price increase would not be substantially smaller were the chains not-for-profit.	Their concern is with implications for regulation of mergers. External factors determine performance as reflected in prices and financial performance. Conclude that since NFPs would also put up prices, courts should not necessarily reject government requests to block mergers. Thus far have allowed mergers to go ahead on basis that NFPs and won't take advantage of oligopolistic situation.
100	Bloom <i>et al</i>	Colorado, 1995-97 (2-year post-capitation)	Quality of care (use of antipsychotics)	Logistic regression	Enrolment in HMOs is associated with a lower probability of using antipsychotics. Consumers enrolled in capitated programs,	Suggests that capitation can affect the use of substitute services not in the capitation rate. Since the medication benefit was not

		<p>period)</p> <p>Random sample of 282 Medicaid beneficiaries over 18 diagnosed with schizophrenia from 1994 Medicaid files and 1995-96 admission files from Community Mental Health Centers (CMHCs)</p>			<p>both NFP and FP firms, have a higher probability of using atypical antipsychotics while their enrolment in HMOs has no impact on their access to atypical antipsychotics. In this setting, capitation of mental health services is the major incentive to adopt atypical antipsychotics. Capitation of mental health services provides incentives for more cost-effective treatments. HMO enrolment was not a crucial factor to determine access to atypical antipsychotic prescriptions.</p>	<p>included in the capitation programme, there are incentives for the capitated systems to prescribe atypical antipsychotics as they are more effective and may actually reduce the rate and length of hospitalisations. Did not determine whether the increased use of atypical antipsychotics leads to better outcomes for consumers.</p> <p><i>Limitations:</i> socio-demographic characteristics of subjects were not equivalent across the three different programmes (FFS, not-for-profit DC and for-profit MBHO); unobservable characteristics that differ among the three programmes may also be attributed to different use patterns of antipsychotics; the fact that HMOs were not available in every area and that there were unobservable consumer characteristics associated with their preference of HMOs result in selection bias. The small number of enrollees limits understanding of how other characteristics may interact with HMO enrolment to affect access to atypical antipsychotics.</p>
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101	Rosko	USA, 1990-1999.  Data from the AHA Annual Survey and Medicare Cost Reports (N = 616 hospitals)	Financial efficiency	Stochastic frontier analysis	Inefficiency decreased with HMO penetration. Increases in inefficiency were associated with for-profit ownership and Medicare share of admissions.	Panel design. The study points to difficulties in funding graduate medical education under the HMO system. Analysis found that the results were moderately sensitive to the specification of the teaching output variable. Thus, although the SFA technique can be useful for detecting differences in inefficiency between groups of hospitals (i.e., those with high versus those with low Medicare shares or for-profit vs NFP hospitals), its relatively low precision indicates it should not be used for exact estimates of the magnitude of differences associated with inefficiency-effects variables.  <i>Limitations:</i> there is no theoretical justification for the basis of the inefficiency estimate
102	Vitaliano	New York State, 1993  228 NFP nursing homes	Profit maximisation ; quality of care	Regression model (estimation of a long-run cost function)	79 % of the homes operate at output levels consistent with profit maximisation; only 21% behave as if they maximize a utility function instead of a profit function. There is no difference in profit-maximising behaviour among voluntary, religious or government NFPs. Utility maximizing homes provide a higher level of resident care.	Findings are consistent with a growing suspicion about increasing commercialisation in the health care sector and the view that many NFPs are really "for-profits in disguise" (Weisbrod 1998). It is possible that NFP managers and employees can appropriate part of the return on capital otherwise due to shareholders, in addition to the

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						<p>subsidies provided by tax-exempt operation. In addition, NFP status may signal higher quality and reputation to prospective residents. One consequence of widespread profit-maximising behaviour is that efforts to constrain the cost of health care by reducing reimbursement is likely to result in reduced access to government provided health care as firms adjust the mix of patients to include more private-pay and fewer Medicaid residents.</p> <p><i>Limitations:</i> Left unanswered is the question of whether NFP managers are duplicitous or are reacting to a harsh regulatory environment</p> <p>Data limitations: only few religious and government sponsored homes in sample</p>
103	Duggan	<p>California, 1990-1996</p> <p>Data from California Office of Statewide Health Planning and Development (OSHDP).</p>	Hospital response to financial constraints/changes in financial incentives or reimbursement	Regression analyses	Shows that NFP hospitals in FP intensive areas are significantly more responsive to the change than where few FPs. Differences in financial constraints and other observable factors correlated with FP hospital penetration do not explain the heterogeneous response. This suggests that NFPs mimic the behavior of private FPs when they actively	Has very useful background data on the sector. Changes in incentives led FPs taking insured low income patients at expense of public hospitals.

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					compete with them.	
107	Vita and Sacher	Santa Cruz, California, 1986-96	Price increase after merger	<i>Ex post</i> event study approach; comparison of pre-and post-merger prices charged by the merged entity and one remaining rival (econometric analysis)	Controlling for case mix, input prices, and other cost- and demand-side characteristics, the results suggest strongly that the merger was followed by significant price increases. hypothesis rejected that these price increases reflect higher post-merger quality.	These price increases suggest that mergers involving NFP hospitals are a legitimate focus of antitrust concern.
110	Harrison and Lybecker	USA  Theoretical modelling only	Prices, quantity of patients served, service to the uninsured, and quality of care	Differentiated Bertrand model comparing equilibrium behaviour between competing hospitals (FP and NFP)	The specification of the NFP motive greatly impacts the results. The impact on prices clearly depends not on the firm's NFP status, but on its objective function. When the motive is maximizing output, prices rise for both hospitals as the NFP moves away from its NFP motive. However, if the NFP cares about serving the uninsured, prices in the market fall. Finally, when hospitals compete on price and quality, more emphasis on profits results in an increase in price at the for-profit hospital and a decrease in price at the NFP hospital.	Results suggest that previous theoretical and empirical work may be sensitive to assumptions about the NFP motive and that the importance of the NFP motive has been underestimated. It is important to control for the percentage of uninsured and quality of care, in addition to ownership and teaching status. An effective analysis must consider the specification of the NFP motive.  <i>Limitations:</i> the NFP hospital's weight on profit maximisation is taken as given, the question of how NFP hospitals choose this weight is not addressed here.

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114	Benz	<p>USA and UK</p> <p>USA National longitudinal study of youth and British household panel survey. Restricted to individuals that either work in a private for-profit firm or in a private NFP firm.</p>	Staff satisfaction	Descriptive statistical analysis	<p>NFP employees are significantly more satisfied with their work than FP employees, even when allowance is made for a range of work-related variables. Analyses also exploit the panel structure of these surveys to analyse circumstances in which people move in and out of NFP employment. These effects are robust across countries. Bias may have arisen from the peculiarities of the NFP sector because it is highly concentrated in one single industry, but when attempts are made to control for this, statistically-significant differences are still found between for-profits and NFPs.</p>	<p>No comparisons are drawn in terms of level of satisfaction between these respondents and those working in the public sector, those who are self-employed, and those working in a family-owned business.</p> <p>Alternative explanations could be possible but cannot be tested using this data set, such as the possibility that NFP workers have fewer stress-related experience at work, or the possibility that subjective evaluations of the social utility of jobs can explain differentials in job satisfaction.</p>
115	Currie	<p>California, 1989-99</p> <p>Data from California's Hospital Disclosure Data (CADD)</p>	Staff conditions	Multivariate regressions	<p>Nurses experienced few declines in wages following takeovers, but did see increases in number of patients per nurse. The authors show that their results are consistent with an extended version of the monopsony model that considers effort and allows for revenue shifts following a takeover. The two largest chains had much in common with each other despite their different ownership status. Finally, they find that these changes were</p>	<p>Concludes nominal ownership matters less than fundamental economic incentives.</p>

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					similar in the largest for-profit and NFP chains, suggesting that market forces are more important than institutional form	
116	Ballou	Wisconsin, 1984-95  Official data on nursing homes (3605 observations for 12 years)	User perceptions	Econometric modelling	The study concludes that ownership effects exist, with consumers indicating the greatest preference for NFP homes and the least for government homes. Consistent with interpretation that market share differentials reflect a consumer preference for ownership types. Private payers prefer private nursing homes to government homes, yet the latter may still play a social role as a safety net for those lacking private funds who may find it difficult to be admitted elsewhere.	Study makes assumptions about people's behaviour and preferences – aggregation assumption. Consistent with several studies which show that private payers prefer NFPs, but does not really tell us why. Argues government owned sector faces soft budget constraints and NFP sector as a consequence of the nondistribution constraint, lacks ability to provide strong incentives to management and therefore encourage efficient behaviour.
120	Farsi and Filipini	Switzerland, 1993-2001  Panel data from 17 public and 10 NFP nursing homes in one canton	Cost efficiency	Translog stochastic cost-frontier model	Institutional form influences the efficiency of the nursing homes: NFPs more cost-efficient than public nursing homes. But a great majority of the nursing homes, irrespective of ownership, do not fully benefit from scale economies. This implies that efficiency gains can be obtained with larger capacities or joint operations.	Unusual study in that compares government sector and NFP. Controls for regulation by looking at one canton only. Study includes 2/3 of all nursing homes in canton.



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121	Friesner and Rosenman	Washington State  Data from hospitals' annual submissions to the Washington State Department of Health	Quality of care/cost adjusting	Econometric modelling	NFP firms that produce multiple outputs may lower service intensity for one patient group in response to lower reimbursements for another group ("cost-adjusting"). Empirical analysis finds that NFP hospitals in Washington State do practise cost-adjusting. The ability of a firm to exploit this welfare transfer depends largely on the demand conditions present in the market. Hospitals lower the quality of care in response to reductions in reimbursement rates. Government hospitals reduce the quality of care for patients "not in the group facing revenue reductions" while NFP hospitals reduce quality "for government patients when government revenue is reduced".	Cost-adjusting implies a serious welfare transfer.  <i>Limitations:</i> 40 % of the sample was excluded due to missing or unreliable data. Cost and utilization variables were not defined. Results were not adjusted for case mix.
122	Currie and Fahr	California, 1988-96  Data on all hospital discharges in California 1988-1996 from the Group Health Association of	Uncompensated care	Multivariate regression	Public hospitals in counties with higher HMO penetration take a larger share of the county's charity caseload. However, these public hospitals also take larger shares of most other types of patients. Little evidence that either for-profit or NFP private hospitals respond to HMO penetration by turning away	Authors note possibility that HMO penetration increases the burden on public hospitals by encouraging exit of private hospitals from the market

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		America, InterStudy and the Office of Statewide Healthcare Planning and development.			uninsured and Medicaid patients. On the contrary, in the for-profit sector higher HMO penetration is linked to reductions in the share of privately insured patients in the caseload, and corresponding increases in the share of Medicare patients and Medicaid births. Since HMO penetration reduces the price paid by privately insured patients they may be less attractive to for-profit hospitals relative to the publicly insured.	
125	Gruca and Nath	Ontario  168 community hospitals	Technical efficiency	Data envelopment analysis techniques	Under a single payer system there were no significant differences in efficiency across ownership types for NFP hospitals. This is significant since prior research from US does not generally consider the importance of payer mix, whereas in Ontario there is a single-payer and no opportunity for different types of hospitals to discriminate between patients based on their insurance status.	Efficiency varies with regulation. Methodology is important because explains other findings.
128	Anderson	Florida, 1996  Sample of 487 nursing homes based on various	Efficiency	Data Envelopment Analysis	Without controlling for quality, for-profit firms and chain-affiliated firms are shown to be slightly more efficient than independent and NFP nursing homes. However, in the presence	Chain affiliation, profit status and quality of care are included. Baseline assumption that FPs are more efficient.

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		official data sources			of the quality control variable, there is no evidence to suggest that chain affiliation impacts efficiency.	
130	Knox <i>et al</i>	Texas, 1998  Data on 1,022 nursing homes Medicaid Nursing Facility Cost Report; Data from Quality Reporting System	Efficiency	Regression models	Although CEOs of more efficient FPs are better paid than NFPs, the statistical evidence is not as convincing as financial economic-agency theorists would assert. Quality of care has no systematic impact on CEO pay.	Controls for quality of care. Admit all studies vary in their results due to different measures for defining quality.
134	Sloan <i>et al</i>	USA, 1982-94  National long term care panel survey – data extract Medicare enrollees aged 65 plus linked to Medicare claims data.	Cost and quality of care (mortality in four conditions)	Regression analyses, adjusted for socio-demographic factors.	Not for profits more expensive than other hospitalisations. No difference in outcomes by hospital ownership.	Very complex modelling and assumptions which were difficult to get behind. Very unconvincing paper
137	Proenca <i>et al</i>	USA, 1995 and 1997  All non-federal general hospitals that reported	Provision of prevention and health promotion services	Negative binomial regression	FP hospitals offered significantly fewer prevention and health promotion services than did NFP hospitals.  This finding supports the contention that organisations find it easier to not conform with	<i>Limitations:</i> It is likely that other factors such as the values and experiences of top managers, multiplicity and conflict in institutional demands, and economic fitness will also shape the perception and response to

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		complete data to the AHA (3453 hospitals)			<p>environmental pressures that are perceived to be inconsistent with organisational objectives. FP hospitals have explicit profit objectives and investment rationales which make it difficult to allocate resources for socially oriented community health improvement interventions. NFP hospitals are predisposed by mission and values to engage more in activities that benefit the community. Economic measures of performance may be less important to them. By providing prevention and health promotion services, they are hoping to maintain the legitimacy of their NFP status.</p> <p>While hospitals respond to institutional stakeholders to secure legitimacy and resources, the level of their response is not uniform. It is affected by the nature of stakeholder demands and the manner in which the demands manifest.</p>	environmental issues. They could not be examined in this study due to the limitations of the secondary data set. Also not examined were activities that may be undertaken by hospital staff on their own. Due to the study design and data set temporal precedence of the independent variables over the dependent variable could not be established. Longitudinal approach and use of panel data to better model the process of adaptation needed.
138	Potter	<p>USA, 1980-1994 (at four time points)</p> <p>AHA survey and Area Resource</p>	Efficiency and community service	OLS regression and latent growth curve model	When external factors are taken into account, variation in efficiency outcomes between NFP hospitals and for-profit hospitals tend to decrease over the research period. On the other	Benefits from longitudinal analysis. Moreover, whereas most studies focus on hospitals' internal structures, this study controls for external pressures that may promote convergence such as

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		Files			hand, NFPs are providing more community service than their for-profit counterparts.	policy and regulation and therefore provides evidence of national trends.
140	Lafferty <i>et al</i>	<p>Seattle</p> <p>3 HMOs ( NFP staff-model HMO, a FP independent practice association, and a NFP alliance of community clinics).</p> <p>N = 1112</p> <p>Medicaid managed care enrollees aged 14 - 18 years.</p>	Provision of sexual health services	Logistic regression	The NFP staff-model plan outperformed the for-profit independent practice association on most measures. Only HMO of enrollment to be a significant predictor of both primary care provision and well care. There was a significant association between well care and sexual history taking. Capitated managed care is particularly unsatisfactory as a mechanism for delivery reproductive health services to a vulnerable teenage male population.	Staff model HMOs now cover less than 3% of people in the US. At least some of the differences in product performance may be attributable to structural differences among the 3 HMOs. Staff model HMOs stress clinical service protocols, standardized charting tools, and centralized laboratory testing. HMOs managed in this way also have the capacity to engage in research efforts that focus on service provision, a factor that will serve to improve service delivery.
150	Parry <i>et al</i>	<p>London</p> <p>Drugs and alcohol services; survey data, case studies and interviews with four HR managers in relevant organisations</p>	Organisational behaviour (management); funding		Both sectors experienced serious recruitment problems. However, differences influenced by both their relative positions and the value-led nature of the voluntary sector. Salaries, particularly for managers, in the voluntary sector, were low. Voluntary sector compared well on flexible work practices. The voluntary sector fared better at retaining staff. The public sector offered more benefits.	<p>Authors argue that the differences are based on the different financial positions of the organisations and the value-led nature of the voluntary sector. Study identifies funding constraints in the voluntary sector.</p> <p><i>Limitation:</i> lack of interviews with staff;</p>

152	Schlesinger <i>et al</i>	USA, 1985-2002  representative national telephone surveys in several years	Public perceptions	Descriptive statistics	Earlier surveys revealed a strong connection between ownership and cost - NFPs costs were anticipated to be lower. A strong link was perceived between ownership and quality. Later surveys, however, indicated that a clear majority believe that for-profits were associated with better quality of care, but that NFPs were strongly associated with lower cost. Despite this, respondents did not generally consider that NFPs were more efficient. In a 2002 survey, about 12% of respondents admitted they had no idea what NFP meant and a further 20% had only a vague idea. Findings showed ownership-related differences: quality of care is seen as a domain of for-profit advantage but NFPs were perceived as being more trustworthy by a substantial margin.	An important finding is that the public's limited understanding of differences in ownership forms may serve to bias the findings in favour of for-profit ownership. Among those who have a clear understanding of the differences between not-for-profit and for-profit ownership, the former are clearly seen as more trustworthy, humane providers of health care and the gap between NFPs and for-profit on quality closed substantially.
153	Schlesinger <i>et al</i>	USA, 1998  Nationally representative sample of 1621 physicians who responded to	Trustworthine ss of NFP health plans (five measures - two of these related to	Regression analyses	Compared with the local NFP plans, for-profits affiliated with multistate corporations are consistently reported by their affiliated physicians to engage in practices associated with reduced trustworthiness. The	Finding is consistent with some other studies, e.g. that the behaviour of for-profit is moderated in circumstances where there is a significant NFP presence in a locality. However, in general trustworthiness of NFP

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		Socioeconomic Monitoring system Survey (SMS) of the AMA	deceptive practices, and three to dimensions of quality that are largely hidden from employees).		magnitude of ownership-related differences declines as the market share of NFP plans rises. For two of the five dependent variables, ownership-related differences in practices related to trustworthiness are entirely eliminated when NFPs enrol more than 30% of the local market. The conclusion is that the combination of for-profit ownership and multistate corporate control appears consistently and substantially to reduce physician-reported measures relating to the trustworthiness of health plans. Preserving a substantial market niche for NFPs appears to reduce this erosion of trust.	plans was unrelated to ownership mix. They caution against some problems of interpretation with the results, e.g. ,to the extent that there are differences in the rates of complaints against for profits and not-for-profits, this could be because consumers trust NFPs more than for-profit, and are therefore more likely to excuse their failings without blaming them for outcomes and voicing concerns to the state.
154	Shen and Melnick	USA, 1989-1998  Metropolitan Statistical Areas only	Hospital cost and revenue growth rates	Multivariate analysis	Hospitals in high HMO areas experienced revenue and cost growth rates substantially lower than hospitals in low HMO areas. In addition, hospitals in areas with high FP HMO penetration experienced lower revenue and cost growth rates than hospitals in areas with low FP penetration areas; the difference was especially evident within high HMO penetration areas.	Findings suggest the importance of market conditions in determining financial outcomes.  Limited to metropolitan areas.
157	Schmid	Israel	Quality of	Longitudinal	Some evidence of organisational	No clear description of

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		Provision of long-term care for the elderly	care, organisational behaviour	study of implementation of the Israeli long-term care insurance Law (1988).	isomorphism -- providers have found that if they conform to policy and regulations they guarantee the resources they need for survival and consequently they do not innovate, instead becoming formal and bureaucratic. Some evidence of negative impact on workers' terms and conditions.	methodology -- study appears to be based largely on a review of secondary literature including the author's own previous work. Does not specifically evaluate the relative performance of for-profits and NFP organisations.
158	Tritter <i>et al</i>	South West England (three health authorities), 3 year study	User involvement in statutory and voluntary cancer care services	Case study and survey data. Questionnaire administered to cancer care organisations and voluntary organisations.	Partnership with the voluntary sector is meant to increase the stake of citizens as the voluntary sector is seen as a proxy for the general population. However, the absence of any common definition of user involvement or its purpose underlines the limited trust between the different actors in the system and highlights the potentially negative impact of a Third way health service. Attempts to include vol orgs as user collectives may be undermined by institutionalisation and professionalisation.	
161	Zechmeister	UK, Germany and Austria	Health care financing	The article is based on secondary data on mental health care reform	Examination of distributional effects of systems of mental health care financing against the backdrop of ongoing reforms and broader welfare state transformations. In all of the	The authors found that the study has been limited by the lack of precise data on resource allocation and expenditure for mental health care. An increasing focus on the relationship between financing



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				processes and financing arrangements.	three countries, shifts towards community care have resulted in a new division of financing responsibilities with a tendency to rising responsibilities for the 'family' and the 'voluntary/community sector'. In addition, strengthening market principles often increases financial burdens for affected individuals and/or their relatives.	and service provision is required in order to prevent new forms of social exclusion of people with mental disorders.
162	Freund	Israel  Random selection of social workers in public, for-profit, and third sector social services	Staff perceptions	ANOVA Participants were asked to report their work and workplace attitudes.	Results showed that type of organisation had a strong effect on work and workplace attitudes. Traditionally, public organisations primarily covered the existing social services needs of the population, with private organisations gradually developing. Over the past 20 years NFP organisations (i.e., third-sector services) have entered the field with the move towards privatization.	
166	Brown and Troutt	Manitoba  3 agencies funded by the family violence prevention programme	Staff perceptions of success of this program	Semi-structured interviews, telephone interviews, and e-mail correspondence.	Assessment of the features that contributed to the success of this program; emphasis on attitudinal features such as political will, a very strong focus on mission, and dedication to a collaborative process.	Study deliberately chose to focus on a set of very small organisations, frequently with fewer than 10 staff, and with very close relationships with their clients. Purposive emphasis on a programme that was perceived to have been successful, and, within that, on organisations that were

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						supportive of the programme.
167	Schmid and Nirel	<p>Israel</p> <p>Sample of 49 home care provider organisations. Questionnaire with open and closed questions. Supplementary sources: official reports and statistics</p>	<p>Performance measures included training executives, marketing effectiveness, diversification, and growth in clientele.</p>	<p>Stepwise multiple regression analysis; where appropriate, logarithmic transformations were used to linearise relationships.</p>	<p>For-profits scored higher on effectiveness of training of home care workers, marketing, and on diversification of services. NFPs scored higher on effectiveness of training for social workers as well as in growth of clientele. Argues that an analysis of similarities and differences between organisations based on ownership, yields inconclusive results, because of the heterogeneity of funding sources, disparate organisational goals and varied constituencies. Differences within sectors are often greater than those between them.</p>	<p>Refers to the possibility of coercive isomorphism -- organisations that seek to ensure a steady flow of resources will tend to conform with government policy stipulation; another reason for this is that professional and therapeutic staff will receive similar training and role socialisation. However, while there is some evidence for isomorphism results generally are rather mixed.</p> <p>Does not fully report results of regression analyses.</p>
169	Mano-Negrin	<p>Israel, 1998-1999</p> <p>Random samples of two data sets of NFP and public sector organisations, n= 127</p>	<p>Organisational behaviour</p>	<p>Bivariate analysis and regression analysis</p>	<p>Because of their different degree of dependence on public resources, public and NFP organisations differ in their organisational behaviour and outcomes. Public organisations are more attentive to environmental effects than NFPs due to the direct contact with institutional agents in political positions. This enables an early evaluation of prospective changes in social policy and budgeting. In contrast, the</p>	<p>Main findings seems to be that public sector = bureaucratic system, independent sector more flexible. Rather trivial.</p> <p><i>Limitations:</i> small sample size; results are solely based on respondents' reports; sectors included which are neither health nor social care</p>

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					operations of independent NFPs often lack the bureaucratisation of the public sector in providing services. NFP adopt organic structures that are easy to change without formal procedures, such as by merely reducing the number of volunteers.	
182	Cloutier-Fisher and Skinner	Ontario  Voluntary sector providers of long-term care in small rural communities	Staff perceptions on service restructuring impact	Qualitative case study; interviews with management staff and direct service workers (N = 10).	Staff reported negative effects on organisations, service quality and service capacity.	<i>Limitations:</i> Small-scale study, which says nothing about potential biases in results arising from methods used to recruit respondents.
192	Twombly	US metropolitan areas, 1992-96  Data on NFP organisations from the National Center for Charitable Statistics in 53 metropolitan areas	Entry and exit of NFP organisations	logistic regression model on exit and OLS regression model on entry	The degree of entry of human service NFPs outpaced their rate of exit. Smaller groups are more likely to exit than larger ones; except for NFPs which are less than 5 years in operation, younger groups are more likely to fail; emergency providers are significantly less likely to exit than core NFPs, despite the congruence between the latter group's mission orientation and emerging policy goals. The most important determinant of NFP entry is the introduction of welfare reform initiatives	The study illustrates that policy initiatives such as welfare reform can substantially affect the composition of local human service sectors. The analysis supports the argument that competition among groups for limited resources produces barriers to entry for new agencies.  <i>Limitations:</i> Confined to metropolitan areas

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194	Miller	Ontario, Canada  Three case studies	Accountability mechanisms	Qualitative study involving semi-structured interviews with employees and stakeholders, documentary analysis, undefined observational data, and participant observation.	NFP organisations are private self-regulating bodies. As their social welfare role expands so the need for greater public transparency and accountability increases. A number of pre-requisites for effective accountability were identified, e.g. accessibility of the Board; diverse mechanisms for critical self-appraisal and evaluative feedback; staff with a specific developmental role; a capacity to respond to criticism; clarity about organisational mission and values; a culture of accountability; strong organisational leadership.	The study is unusual in that the author recognises a wider public duty of accountability. He reports a general concern in Canada about accountability but notes that the emphasis has been on state regulation particularly with respect to funding. By contrast, Miller's focus is on self-regulation or on "how NFP organisations might apply their sense of responsibility to be accountable to those constituencies without formal levers of power." While the author generalises inappropriately on the basis of three case studies, the study is of interest in the North American context because of its use of the concept of a public domain.
200	Warner <i>et al</i>	USA, 1997  Representative sample on youths (ages 17 years and under) in outpatient specialty mental health clinics (N = 2749)	Psychotropic medication receipt among young people	Multivariate analyses	Receipt of psychotropic medication is a function of clients' illness characteristics. However, findings suggest that also factors beyond clinical profile predict medication receipt. Of the organisational variables, only ownership status statistically significantly predicts medication receipt. Compared to youths receiving care in public organisations, youths who receive care in NFP organisations	The statistical significance of the coefficient attached to ownership suggests that the variable captures treatment philosophies or organisation missions that factor into decisions to prescribe psychotropic medications. One implication of the results is that equally ill youths are treated differently depending on the organisational context. <i>Limitations:</i> FPs constitute a very small group; this may limit the

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					have two-thirds the odds of receiving medication. Youths treated in publicly owned outpatient programmes are significantly more likely to receive medication than those in NFP programmes, and no different from youths in programmes with private ownership.	statistical power to detect differences. Neither data set was created for purposes of the study, hence some of the organisational measures do not have a high degree of sensitivity and specificity. Further investigation is needed to understand the mechanisms through which payment sources and programme ownership influence health care, e.g. by interviewing relevant administrative and clinical personnel. E.g. do pharmaceutical marketing strategies differentially target physicians who work in FP, NFP, and public outpatient programmes?
202	Berta <i>et al</i>	Ontario, 1996 - 2002  Long-term care facilities (N=597)	Staff ratios	Tests for differences in sample means between different types of ownership.	Nursing staff intensity and direct care staff levels were significantly higher in government-owned facilities, compared to all other ownership types, whereas proprietary for-profit private operators had significantly lower intensity and staffing levels than other ownership types.	
203	Sikorska-Simmons	Maryland  Interviews with 156 residents of	Quality of care		Residents in the sampled NFP facilities were more satisfied with assisted living than were residents in the for-profit facilities. In particular, residents	

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		assisted living facilities, including 96 residents in 8 FP facilities and 60 residents in five NFP facilities.			in NFP facilities were more satisfied with health care, physical environment, and social life/activities in the facility.	
204	Baines	3 Canadian provinces over a five year period	Staff perceptions of working environment	In-depth, semi-structured interviews with 83 social service workers and a 'small number' of managers, policymakers and advocates.	Qualitative description of workers experience of restructuring, residualisation and market segmentation, due to changed external conditions and competition.	Study does not describe how interviews were selected in any depth, thus it is not feasible to determine whether biases were introduced.
206	Castle	Nursing homes in ten states in the US  Official data on effect of regulation on the quality of care in board and care homes	Quality of care	Regression analysis	The study found one structural measure (providing nursing care), three process measures (food quality, staff treat residents with respect, and staff verbally abuse residents), and two outcomes measures (cleanliness of the facility and complaints to Ombudsman) to be significant. Moreover, the directions of these effects are consistent, with FP facilities rated more poorly.	Data on 10 states which were split between limited and extensive regulatory oversight.
207	Giffords	New York	Staff commitment	One way ANOVA and	It was found that both organisational and professional	

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		Social service employees (N = 207) from public, NFP and FP rganizations		multiple regression analysis of completed questionnaires	commitment are related to ownership with workers from public organisations reporting less commitment. In addition, professional commitment appears related to employees' ages and position within the organisation.	
217	Andrews	USA, 1991-1999  General short-term care hospitals, AHA data	Concentration of hospitals/hospital size	Descriptive study	Concentration of hospitals into systems increased from 1991 to 1999. The share of patient care in systems as opposed to independent hospitals rose from 39 to 57 %. More of the mergers occurred among secular not-for-profit hospitals than among for-profit hospitals.	Systems of hospitals raise the concentration ratio in local markets dramatically. The change in market power challenges traditional proposals and strategies aiming to achieve a national health programme. Author speculates that growth of health systems made the interests of hospital executives more important than those of physicians in the conduct of health policy. Mergers also strengthen private control over investment decisions and weaken public control. <i>Limitations:</i> study did not use network data to identify hospitals that remain independent but make alliances.
222	Hodgkin <i>et al</i>	Michigan, 1998-2000  Data from Medicaid	Spending and utilisation after carve-out	Multivariate regression	By the second year of the risk-based carve-out (2000), Medicaid payments were 9.1% lower than in the last year before the carve-out (1998). Reductions were largely achieved by serving	Public and NFP entities, like for-profit firms, will reduce behavioural health costs when they are placed at risk. Although maximising investor value cannot be a motivation for them, they

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		programme supplemented by interviews with officials at the state Department of Community Health and the coordinating agencies (CAs); 9 public agencies and 6 NFP agencies			fewer clients, not by reducing payments per client. Controlling for NFP ownership, it appears that public CAs attach greater weight to numbers served, and NFP CAs attach more to the intensity of treatment per user, however, analysis of variance indicated that these differences were not statistically significant. Fiscal pressures is statistically significant, but not ownership type; hence ownership less important than contract design in determining the performance of Medicaid carve-out contractors.	may still restrain costs for other reasons, e.g. risk aversion or the need to build reserves. <i>Limitations:</i> A fuller evaluation would require better person-level utilisation data than are currently available, and also measures of quality of care and outcomes. Lack of a comparison group, since the state implemented its carve-out for all regions simultaneously rather than selectively; hence it is possible that the observed spending and utilisation changes reflect other influences that coincided with the carve-out.
223	Schneider <i>et al</i>	USA, 1997  Data derived from Medicare Health Plan Employer Data and Information Set (HEDIS) clinical measures.	Quality of care (scores on 4 clinical services)	Observational study	Compared with NFP health plans, the quality of care was lower in for-profit health plans on all 4 of the HEDIS clinical measures. These differences were reduced by socioeconomic adjustment and health plan characteristics but not eliminated.	The study was unable to identify the effects of a wide range of factors other than ownership that might have contributed to the measured outcomes, for example, differences in the selection of providers that contract with the plan, management priorities and performance monitoring. <i>Limitations:</i> limited adjustment for confounding factors such as case mix.
235	Harrison and Sexton	USA, 2001  Data from AHA annual survey,	Financial performance	Multivariate regression model	NFP hospitals' greater size and increased clinical complexity is the result of their commitment to the organisational mission of	Takes the perspective that organisations can choose their strategy to match environment to enhance performance, but in case



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		Area Resource File, and Centre for Medicare and Medicaid services (3,559 NFP and 412 FP hospitals)			providing a full range of services. NFPs have aging facilities and reduced cash flow due to lower profit margins. So many face potential bankruptcy and closure, which poses a threat to the provision of charity care and the long-term viability of the NFP sector.	of NFPs means behaving like or becoming a FP. Otherwise, they will become financially distressed and have to merge, close or be taken over. This will mean losing care for needy, etc.
236	Trujillo	USA, 1998  254 health plans, data from HEDIS	Access to high-cost procedures	Regression models	In unadjusted analyses, FP health plan beneficiaries had higher rates of all high-cost procedures than NFP plan beneficiaries; the difference was significant for 4 out of 12 procedures. Rates of usage remained higher in FP plans after adjustment for participants' socio-demographic factors, county of residence, and health plan characteristics.	This is a commentary on a cohort study by Schneider, Zaslavsky and Epstein [69]. Introduces control variables.
244	Preyra and Pink	Ontario, Canada, 1995-96  Sample of industrial and NFP CEO compensation schemes	CEOs' earnings	Multivariate regression	All hospital CEOs are increasingly being rewarded for financial performance, however, CEOs in publicly traded firms earn twice as much on average as those in similarly sized NFP hospitals but bear roughly eight times the income variance. Estimates of the associated degree of risk aversion are well within conventional bounds and are consistent with the trade-off	<i>Limitations:</i> non-random sampling methods introduced bias.

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					between insurance and incentives predicted by the theory.	
251	Gentry	USA, 1993-1996  Data on NFP hospitals derived from tax returns and the annual AHA survey	Organisational behaviour (tax planning in order to benefit from special tax rules for NFP hospitals)	Multivariate regression	NFP hospitals have maximised tax exemptions by borrowing rather than spending their endowments. Controlling for hospital size, endowment assets are associated with a higher ratio of tax-exempt (or total) debt to operating assets. In contrast, endowment assets are not related to taxable debt suggesting that the effects of the endowment on borrowing are motivated by tax incentives.	Overall, the results are consistent with substantial tax planning by not-for-profit hospitals.
252	Shen	USA, 1985-1994  Panel of all general, acute, short-term stay hospitals	Quality of care, conversion study	Econometric model comparing outcomes among hospitals that converted with those without changed ownership	For-profit and government hospitals have higher incidence of adverse outcomes than NFPs. Adverse outcomes increase after NFPs convert to for-profit ownership.	The limitation of the study to a single disease is not uncommon. In the Milcent study [313], where the same indicator was chosen, the explanation was that in-hospital death due to heart attack is relatively frequent and therefore easier to study. <i>Limitation:</i> no adjustment for case mix.
255	Zhao <i>et al</i>	USA, 1999  AHA survey and Area Resource File	Health promotion and disease prevention (HPDP)	Bivariate analysis and multiple regression	For both the non-sole and sole hospitals, hospital size, case-mix index, HMO contracts, membership in a hospital alliance or network, and median household income have a	FP hospitals may feel compelled to appear as a community-oriented institution first then as a profit earner. A sole community hospital that wants to gain or maintain legitimacy has to fully consider

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					positively significant influence on HPDP involvement. FP hospitals were significantly less likely to offer HPDP services than their NFP counterparts if the FP hospital is not the sole hospital in a community. However, for-profit and NFP hospitals will provide similar HPDP services when the hospital is the sole hospital in the community.	and satisfy the expectations of the community stakeholders for survival no matter who owns it. <i>Limitations:</i> Only cross-sectional data; the similarity between the sole FP and NFP hospitals may also indicate a trend towards convergence in goals and motivations between the two due to regulatory change and the implementation of similar strategies; such a convergence trend could only be discovered by longitudinal analysis. Chosen HPDP services may not fully represent the range of community-oriented services for individuals. Direct influence of stakeholders not included due to data limitations.
256	Crivelli <i>et al</i>	Switzerland, 1998  886 public, FP and NFP nursing homes. Data from Swiss Federal statistical Office and Health Department	Nursing home efficiency	Stochastic cost frontier analysis	Found no difference in performance by ownership or regulation. Most operating near max efficiency. Size is a factor in relation to efficiency with implications for planning nursing home provisions, up to 88 beds, but even this somewhat limited. So ownership is not important in determining performance.	Relevant to UK because demand > supply, barriers to entry for private sector because regulatory permission needed due to subsidies. Few cantons subsidise FPs.  <i>Limitations:</i> Uses cross-section data
259	Hayden	Massachusetts	Financial	5 mini-case	The viability of NFP organisations depends upon the interaction of	The paper concludes that ad hoc regulation can undermine the

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		(1990s)  24 structured interviews with board members and senior executives.	performance	studies	competent management, an engaged board, and effective regulators. All five of Massachusetts' NFP HMOs have faced difficulties over the past decade. In each instance, the management and boards aggressively pursued market share in a regulatory environment providing minimal statutory guidance and supervision.	viability of a NFP health care system.  <i>Limitations:</i> qualitative data from interested parties.
263	Olmstead and Sindelar	USA, 2000/2002  2000 National survey of substance abuse treatment services and 2002 Area Resource File. Data on 10,513 facilities (virtually all).	Service availability	Multivariate regression	In the absence of MC, FPs offer the narrowest range of services, publics the widest, and NFPs fall in the middle. MC significantly increases the number of services offered at private FPs, has no significant effect on the number of services offered at private NFPs and significantly decreases the number of services offered at public SAT facilities.	No direct control for case mix due to data limitations. Proxies for case mix included types of payment accepted and whether payment assistance was offered. One explanation offered for the differential impact of MC across facility ownership types is that MC results in standardisation across facilities. Or it may be that public and private SAT facilities have contracts with different types of MC organisations, which in turn may have different goals, e.g. publics want to treat as many people as possible with reduced funds.
264	Treo Solutions	New York State, 2001-2002	Differences in performance, efficiency and contributions	Descriptive statistics	NFP insurers offer lower premium options for consumers. The NFP upstate market has proved its viability, while maintaining	Emergence in NY of health care insurance markets that are predominantly for-profit raises significant public policy issues,

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		Managed care data	to safety net programmes	Comparison of upstate and downstate markets	commitments to NYS safety net and Medicare programmes. NFP HMOs participate in state-sponsored safety net programmes to a far greater degree than the downstate FP managed care organisations.	especially with reference to community benefits and services. Likely that there will be diminished access to care for the at-risk population and premium as well as administrative costs will be higher. <i>Limitations:</i> one state only; no longitudinal data, highly aggregated data, no case mix etc.
265	Younis and Forgione	USA, 1996 and 1998  Medicare Cost Report data. 3240 hospitals in 1996 and 3461 in 1998	Hospital profitability	Nonlinear Regression model	Since most hospitals in sample were NFP, IPM was a better measure of profitability than ROE, and profitability was mainly influenced by location, size, occupancy rate, volume of Medicare and Medicaid patients, and teaching status.	Examines potential effects of the Balanced Budget Act of 1997. By implication, ownership status and conversion were not important factors determining profitability.
268	Crampton <i>et al</i>	New Zealand  Representative national cross-sectional survey of GPs	Staff ratios and working conditions according to funding arrangements	Statistical comparisons of proportions of practices exhibiting various characteristics and of differences in sample means using t-tests.	Primary care teams were largest and most heterogeneous in community-governed NFP practices. In contrast, independent practices (mainly FP) had the most parsimonious practice teams. Few practices other than the small minority that were community-governed NFPs employ community workers or midwives.	Possible bias due to the overall GP response rate with significant differences between for-profit and NFPs. Non-responders tended to be male and restored a greater than average patient loads, and if these GPs differ in some systematic way in characteristics of activities, this may bias the results.
270	Dickens <i>et al</i>	England	Staff perception re working	One-way ANOVA	The results are discussed in the context of previous research. This sample of nurses scored	This tells us little about the voluntary sector in the absence of a comparator. It is unclear

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		161 reg. nurses working in five specialist divisions of a large charitable hospital surveyed (Work Environment Scale)	environment in the voluntary sector		differently on a number of subscales, with the working environment characterised by relatively high levels of support, cohesion and managerial control and slightly lower levels of autonomy.	whether the differences reflect the organisational context (i.e. non-NHS context) or a secure environment effect. Cross-sectional data only.
272	Aronson <i>et al</i>	Ontario (one city), 2002  Home care sector	Staff commitment	Qualitative study Includes survey of workers who were employed by a NFP, which was forced to shut due to introduction of managed competition.	Of 317 support workers who were laid off only 38% stayed in the home-care sector; most were absorbed by FP non-unionised agencies where employment conditions deteriorated. For 69 ex-employees who remained in the sector, pay and benefits deteriorated. Also reported loss and dislocation.	Illustrates the impacts of Ontario's contractual approach to home care.  The emphasis on policy context usefully explains the impact of managed competition in Ontario, which is described as the most 'market-mimicking' province in Canada. The impacts on staff terms and conditions is important given concerns about the quality and stability of home care staff.
277	Alexander <i>et al</i>	USA, 1989 and 1997  Two national surveys; response rates to these surveys were 57 percent and 42 percent respectively.	Hospital governance	Comparison of governance characteristics in two survey years	Findings suggest that hospital boards are engaging in selective rather than wholesale change to meet the simultaneous demands of a competitive market and traditional institutional orientations to community and philanthropic service. The study found a tendency for board size to increase with the size of the hospital. Public and investor-	Through reorganisation and consolidation into vertical and horizontal systems, hospitals are often enmeshed in multiple layers of governance and managed by those concerned with the health care operations of multiple provider organisations. The practical question is which entity is accountable for meeting

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					owned hospitals were more likely to have become answerable to larger, system-affiliated, urban organisations in the study period. Overall the survey suggests continuity, closer links between hospital management and hospital governance, and more complex governance arrangements.	community needs. <i>Limitations:</i> both survey samples were biased by an under-representation of investor-owned hospitals. The survey does not evaluate “governing styles” so variation is not associated with patient-based performance standards when larger corporate policy-making processes supersede those of local policy makers.
280	Bertrand <i>et al</i>	USA, 1992-1996  Based on IR data, AHA annual survey, and using database created from Group Health Association of America's National Directory of HMOs	Impact of HMO penetration on the management of NFP hospitals, focusing on the executive labour market	Regression analysis	Top executive turnover increased following increased HMO penetration. This was concentrated among the less profitable hospitals. The link between top executive pay and F{ performance measures was very weak, but as HMO penetration increased, top executives were compensated more for improving the profitability of their hospitals. These results, while of limited economic magnitude, are qualitatively consistent with the view that HMO penetration has increased the weight assigned to FP performance in managing NFP hospitals.	This shows that performance is a function of external factors rather than ownership per se. Also notes behaviour change in run up to conversion. Following HMO penetration, the NFPs mimicked the FP sector.
281	Horwitz	USA, 1988-2000	Availability of profitable and	Econometric	FPs are most likely to offer relatively profitable medical	Activity mix crucial to financial performance and the three types

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		AHA data for every urban, acute hospital	unprofitable services	analysis	services; government hospitals are most likely to offer relatively unprofitable services; NFPs often fall in the middle. FPs also more responsive to changes in service profitability.	vary in this respect.
282	Reed <i>et al</i>	UK, 2001-02  Services for older people; data from a range of users and voluntary providers	Public, user and staff perceptions	Appreciative Inquiry (AI)	Highlighted 'unexpected impacts' which arose in all the schemes. Also emphasises that there was a lack of barriers between providers and users of the services.	Data suggests that these services were flexible and responsive. However, the extent to which these factors are attributable to their voluntary status is difficult to determine in the absence of a control, e.g. public sector comparator. AI has an explicit focus on examining positive aspects of a situation.
283	Gross and Harrison	Israel  Semi-structured in-depth interviews with 145 senior managers; documents from HMO and government archives; Parliamentary committee meetings, other official sources	Description of divergent organisational responses to national policy initiatives	Comparative study of two Israeli Health Maintenance Organisations and their responses to the enactment of the National Health Insurance Law of 1995	Study demonstrates the efforts made by the two HMOs to safeguard their membership profile through selective recruitment of a disproportionate number of the young and healthy. It also shows how managers deliberately adopted certain strategies in response to specific environmental developments, consistent with the argument that regulation and external competitive pressures, rather than ownership, are dominant in this area. However, there were some evidence of divergence in institutional	A qualitative study which highlights the possibility of divergence in organisational responses to change in the external environment, and which shows that the response of NFPs is in some senses path-dependent. However, the extent to which it is so will also depend on other external pressures.



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					strategies reflecting path dependency in the form of their organisations' distinctive experiences and history.	
286	Howell	New Zealand and England		Description of organisational and governance structures introduced in hospital reforms in New Zealand and England.	Argues that the introduction of NHS foundation trusts solves some of the questions of governance associated with the New Zealand health care reforms, but suggests that the extent to which the full range of potential improvements will result remains contingent on specification of members' duties, accountability requirements, and the degree of autonomy that the new trusts will actually possess.	
287	Cutler and Horwitz	Kansas and Colorado  Data from Medicare and Medicaid cost reports	Conversion studies (effects on costs, quality, access, etc.)	Detailed case studies of two hospitals using interviews and documentary analysis	Conversions due to financial pressures and board culture and perceived mission. Effects are mixed: after conversion there was some cost cutting, debt relief, with no evidence on reduced quality or access for the poor	Makes useful points such as FPs raised income via exploiting reimbursement loopholes at the expense of the tax payer. NFPs mimic FPs in this.  Also leads to fragmentation of hospitals between rich and poor, in part at least due to physician actions.
289	McCue <i>et al</i>	USA, 2001  Interstudy data for 228 licensed HMOs; financial	Financial performance	Descriptive analysis	FP and NFP plans had similar profit margins; however, FP plans incurred higher administrative costs ratios and lower medical benefits ratio. Plans with higher Medicaid	Does list various limitations to the study.

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		data SEC 10-K financial filings for two publicly traded FP HMOs			enrolment had higher medical benefits ratios, while both provider-sponsored and non- provider sponsored plans had similar profit margins. Finally, publicly traded Medicaid focused plans achieved profit margins considerably higher than other Medicaid-focused plans.	
291	Mukamel <i>et al</i>	California, 1982 and 1989  Sample of 318 acute care hospitals from Hospital Annual Disclosure Report; risk adjusted mortality data from Medicare Hospital Information Report	Quality of care (mortality rates)	Multivariate regression	In 1989 higher competition was associated with lower clinical expenditures levels compared with 1982. The trend was stronger for NFP (public) hospitals. Lower expenditure was associated with worse mortality outcomes, suggesting that competition and prospective payment led to cost containment at the expense of quality.	Attempts to identify the strategies by hospitals in response to cost control policies. Focus was not on ownership, but on competition. Useful, because by focusing on one state, controls for regulation and variation in payment mechanisms, and shows importance of competition rather than ownership  <i>Limitations:</i> Case mix adjustment was based on the DRG-index. NFP private hospitals are not included in the study. The study is unusual in defining public hospitals as NFPs. It is therefore essentially a comparison of public and for-profit hospitals.
292	Cleverley and Baserman	USA  Annual accounts of 5 largest FP hospital systems	Capital investment financing	Descriptive statistical comparison of the two sectors	FPs had more debt financing. NFPs and FPs had larger debt than average, because sample captured the largest chains. NFPs had more variable interest rate financing which could be a	Straightforward and useful descriptive comparison of NFPs' and FPs' financing methods

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		and 5 largest voluntary hospital systems.			problem when interest rates rise, although cheap now. FPs had tiny levels of cash or reserves (2% debt) while NFPs had 98.6%, because must accumulate cash to fund investment and get little from charity for investment. So must generate a cash surplus. There is little leasing.	
293	McBean <i>et al</i>	USA, 1999 and 2001  Medicare claims data linked with HEDIS quality data; Health care plan data linked to Medicare denominator file (N = 95,515)	Outcomes: six process measures of diabetes care; including blood tests for diabetes control, cholesterol, and renal function.	Ecological study; analysis according to diabetes outcome measures, by demographic variables, income race, plan model and profit status.	Improvements in all 6 measures across the board, but for profit plans performed significantly less well than for profit in 4 of the 6 measures and poorer care experienced more frequently in black and IPA plans.	Generalisability of finding to other plans, exclusions, case mix in for profit plans not examined.
294	Kaissi	Minnesota  Survey of medical group practices. Survey among 157 practices (response rate 72 %).	Staff costs	Regression analysis	The findings suggest that employment of midlevel practitioners (MLPs) and their ratios to primary care physicians (PCPs) in practices are influenced by the organisational characteristics of the group practice but not by the degree of financial risk sharing for patient care. Consequently, risk-sharing financial incentives imposed by	Authors suggest the findings in relation to NFPs could reflect the influence of hospital and health plan ownership of the NFP practices, their orientation towards improving efficiency and their organisational capacity to do so. FP practices are physician owned – while NFPs are owned by larger non-clinic entities with more leverage to employ MLPs.

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					health insurance plans by themselves do not motivate medical groups to restructure their patient care practices to achieve higher levels of efficiency. NFPs less likely to employ MLPs,	
295	Rosko	<p>Pennsylvania, 1995-98</p> <p>Data on 179 private NFP hospitals from PHC4, AHA annual survey, Medicare Hospital Cost Report Minimum Data Set, Area Resource File</p>	Uncompensated care	Regression analysis	The provision of uncompensated care is positively associated with financial surpluses, the provision of uncompensated care by neighbouring hospitals, bed capacity, proportion of outpatient visits that are emergency, and the unemployment rate (a proxy for need for uncompensated care). Other analysis found that the provision of uncompensated care was not associated with operating surplus, except in hospitals that provide very large amounts of uncompensated care. Provision of services to Medicaid patients and HMO penetration had a negative impact on profitability.	Panel design
296	Johnson <i>et al</i>	<p>Florida, 1997-2001</p> <p>478 nursing homes in 30 counties</p>	Quality of care (measured by number of lawsuits)	Negative binomial regression	Higher registered nurse and certified nursing assistant staffing levels associated with fewer lawsuits. More deficiencies on the licensing survey and larger and FP nursing homes were positively related with	This study suggests nursing homes that meet staffing standards and minimum quality measures, are not for profit and smaller.

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					higher numbers of lawsuits.	
298	Konetzka <i>et al</i>	USA, 1996  Nationally representative sample of 5899 nursing home residents in 815 facilities.	Quality of care (decision to hospitalise)	Logistic regression	Residents with suspected pneumonia in NFP facilities are hospitalised at a rate half that of for-profit facilities. The difference is most pronounced for residents who are older and more cognitively impaired and those who are covered by Medicare or private funds. Medicaid residents are most likely overall to be hospitalised, with higher rates in not-for-profit than for-profit facilities.	Consistent with the hypothesis that greater emphasis placed in NFPs on the potential risks of transfer to frail residents. Medicaid residents have highest hospitalisation rates for suspected pneumonia, consistent with financial incentives to hospitalise. Higher Medicaid hospitalisation in NFP facilities is consistent with heterogeneity in the NFP sector, where Medicaid residents are sorted into lower quality facilities.
299	Catalano <i>et al</i>	Colorado, 1994-96  Colorado Medicaid Agency's administrative databases	Quality of care (utilisation of psychiatric emergency services)	Interrupted time-series quasi-experiment (counties with capitation compared with counties with fee-for-service before and after capitation started in 1995)	The number of psychiatric emergencies treated in capitated areas declined by 28 % below the number of psychiatric emergencies expected from trends, cycles, and levels in fee-for-service areas. Findings were similar for for-profit and not-for-profit areas. The decrease persisted through the end of the first year after capitation.	Not very conclusive findings: may not generalise to other states, e.g. Colorado seemed to have implemented capitation better than other states and may have reimbursed capitated providers more generously than other states which may have reduced providers' incentives to restrict access to services that might prevent psychiatric emergencies
300	Jha <i>et al</i>	USA  1,537 hospitals HQA national reporting data	Quality of care (10 indicators)	Comparison of performance in three clinical areas by number of	Characteristics associated with small but significant increases in performance included being an academic hospital, being in the Northeast or Midwest, and being	Problems of provider based data, non universal process measures.

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		derived from HEDIS.		beds, region, specialisation and investor status.	a not-for-profit hospital.	
304	Clement <i>et al</i>	California, 1996  Hospital data	Access/uncompensated care	Multivariate regression	The results indicate that in mixed ownership markets, for-profit hospitals provide significantly less charity care as not-for-profit hospitals in the market provide more. Unexpectedly, for-profit hospitals were not more influenced by price competition than other hospitals with respect to charity care.	Having a unique role in providing charity care may justify continuing tax exemption for NFP hospitals and enhance interest in payment and other policies with regard to conversions to ensure that not-for-profit hospitals continue to be represented in market areas. <i>Limitations:</i> cross-section study only
305	Rosko	USA, 1997  Data from the AHA Annual Survey and Medicare Cost Reports (N = 1966 urban hospitals)	Efficiency	Stochastic frontier regression model	Increases in managed care penetration, dependence on Medicare and Medicaid, membership in a multihospital system, and location in areas where competitive pressures and the pool of uncompensated care are greater were associated with less inefficiency. NFP ownership was associated with increased inefficiency. The findings for multihospital systems and NFP ownership suggest that inefficiency is also affected by the hospitals' internal environment as well as by external pressures.	Policy implications: results provide support for advocated of market-oriented approaches for hospital cost containment; Hospitals can improve efficiency through consolidation; also support for regulatory approaches, such as PPS, that provide financial incentives for improved hospital efficiency. <i>Limitations:</i> Cross-sectional data only; restricted to large metropolitan areas; omitted variables problem: no measure of quality or direct measures of outpatient case mix were used
306	Lorenz <i>et al</i>	California, 1997	Access	Multivariate	For profit status was	Comparing the results

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		<p>All 176 licensed California hospices in 1997 included.</p> <p>California OSHPD annual home care and hospice survey.</p>	(patient selection and service delivery)	analysis	<p>independently associated with providing care to certain types of patients including those from long-term care facilities, persons with noncancer diagnoses, and persons with government insurance. For profits provided more total nursing visits but less skilled visits, and a higher percentage of for-profit patients had stays exceeding 90 days. Differences in patterns of nursing services among hospices were related to patient characteristics. The potential availability of complex palliative services did not differ by profit status.</p>	<p>demonstrated that FPs appear to be selecting patients which in turn explains much of the difference in the way FPs and NFPs deliver care. Hospice care is shaped by current reimbursement policy. A capitated per-diem payment creates strong incentives for cost control because hospices cannot influence reimbursement rates. They may respond to the incentives created by reimbursement mechanisms dissimilarly depending on additional motivations. Demonstrates financial incentives influence patient selection.</p>
307	McCue and Thompson	<p>USA, 2000-2003</p> <p>Data on hospices from Centres for Medicare and Medicaid Services Cost Report Data</p>	Operational and financial performance of hospices in three areas: utilization, services, and financial performance	Descriptive analysis	<p>Small hospices owned by publicly traded companies incurred a longer length of stay, lower operating expenses, generated higher revenue per day and profit margin, and served a greater proportion of Medicare patients compared to NFP counterparts. Large hospices owned by publicly traded hospices served a greater proportion of Medicare patients, offered fewer noncore services, had higher revenue per day and profit margin and incurred lower salary and benefit expense per</p>	<p>Results suggest publicly traded for-profit hospices, in comparison to for-profit and NFP hospices, are able to earn substantially higher profits.</p>

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					day.	
311	Reiter <i>et al</i>	Michigan, 2003-2004  Data from interviews and survey among hospitals participating in a pay-for-performance system (N = 66)	Quality of care	Univariate analyses	Hospitals respond to incentive payments; however, findings also reveal that hospital responses are not universal. Rather, involvement by boards of trustees, willingness to exert leverage with physicians, and financial and competitive motivations are all associated with hospitals' behavioural responses to incentives.	<i>Limitations:</i> findings not very conclusive; use of Likert-scales, relatively low case number; this study is not sensitive to ownership
312	White <i>et al</i>	USA metropolitan areas, 2001  AHA survey, CMS files, and Area Resource File	Hospital service offerings (3 services)	Descriptive analysis, comparison and Poisson regression models	Catholic hospitals rank first on all three services whereas FP hospitals provided fewer services in all three categories, relatively smaller differences exist between Catholic hospitals and public and other NFP hospitals. Controlling for market and organisational characteristics, hospitals of other types are similar to Catholic hospitals in the provision of access services. But compared to Catholic hospitals, FP hospitals provided fewer stigmatised and compassionate services. Public hospitals also provided fewer stigmatised services than Catholic hospitals. No differences between Catholic hospitals and other NFP hospitals in the	The distinctiveness of Catholic hospitals and other NFPs is consistent with their tax-exempt status, and provides some justification for public policy support of the NFP hospital sector. Initially controlled for case mix but deleted this from the regression models as case mix index was highly correlated with hospital size.  <i>Limitations:</i> Study examines service offerings rather than the actual volume of services delivered; sample is limited to metropolitan areas; specialty hospitals were omitted from the sample, i.e. psychiatric and addiction treatment services are not captured; possible selection



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					provisions of the three types of services. Since 1993 public hospitals and other NFPs have been adding compassionate cares services at a higher rate than Catholic hospitals; suggesting isomorphism in response to stronger market forces.	bias since only hospitals were studied that responded to both AHA surveys in 1993 and 2001; sample hospitals offered more services than omitted hospitals in all three categories, hence, findings are not generalisable beyond the study sample
313	Milcent	France, 1997  National database with records on all patients discharged from any acute-care hospital (N = 28410)	Quality of care (patient mortality); reimbursement	Proportional hazard model	The incentive created by fee-for-service reimbursement of for-profit hospital yields a 4 % reduction in the mortality rate. However, this ranking of hospital quality is completely dependent on the characteristics and illness severity of patients. For-profit hospitals have the lowest mortality rates overall but the highest mortality rates for males aged between 50 and 60. They also vary more widely in quality than other ownership types. The capacity to perform innovative procedures has more effect on the mortality than the system of reimbursement and/or ownership. As such, private sector hospitals that perform more innovative procedures provide a better quality of care. Nevertheless, heterogeneity within hospitals is greater in for-	This suggests that, by choosing a for-profit hospital, patients have on average a lower instantaneous probability of dying but are less sure about the quality of the hospital.  <i>Limitations:</i> effects of ownership and reimbursement could have been due to unobserved variation in patient characteristics.

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					profit hospitals than in other types of hospital.	
315	Brown	USA  Nationally representative sample of 300 NFP and 300 FP facilities.	Quality of care	Multiple regression analysis	NFP providers provided a higher level of quality than for-profit facilities when organisational size and facility-mix were controlled. NFP providers offered smaller facilities, on average. Higher level of professional and support staff more likely to be provided by NFPs; more likely to service more severely disabled people and more likely to be small. Highlights complex nature of relationship between quality, indicators and resident outcomes and suggests NFPs and FPs coexist in harmony.	Controls for case-mix. Although acknowledges environmental context plays a role in shaping organisational behaviour, did not attempt to account for this in the research.
317	Landon <i>et al</i>	USA  82583 Medicare beneficiaries from 182 health plans	User assessments of care	Regression analysis	For-profit and nationally affiliated health plans received much worse scores on the outcomes of interest, particularly for overall ratings of the health plan and composite measures of customer service and access to care. Health plans accredited by the National Committee for Quality Assurance did not receive higher scores.	Described as the first study to report health plan characteristics associated with performance based on a uniform national survey. Authors say the findings are consistent with other studies which have found lower performance among for-profits. However, there is also a tendency in the literature to summarise empirical findings as contradictory or mixed.
318	Chou	USA, 1984-94	Quality of care	Econometric modelling	The results on two of four quality indicators suggest that the effect	Longitudinal study

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		Data from 3 National Long term care surveys and Medicare claims data. N = 2992	(measured by mortality and several adverse health outcomes)		of ownership on quality of care is larger when asymmetric info exists between nursing homes and residents. No significant differences when family members involved. So for-profits have more incentive to compromise on quality of care which are hard to monitor.	
321	Harrison and Sexton	USA, 1998 and 2001  National cross-sectional data for these two years (based on annual AHA surveys) on religious NFP hospitals	Efficiency	Data envelopment analysis	Average efficiency score of religious NFP hospitals increased by 2.7% from 1998 to 2001. Increases in admissions (9%) and outpatient visits (14.8%) during the study period have contributed to improved organisational performance. Number of beds cause religious NFP hospital inefficiency. Authors argue that the decline in community support for NFP activities through fewer donations is an indication that religious NFP hospitals are not clearly documenting their contributions to the community.	<i>Limitations:</i> Study rather meaningless as no real explanation why efficiency may have changed. Not really a longitudinal analysis since data was only collected cross-sectionally in two years, so trend is not clear. No comparison made with other sectors or other NFP hospitals. It is noted that NFP hospitals are being challenged to increase efficiency in order to gain greater access to capital and remain competitive in the changing health care market, but hospital environment (market penetration etc.) was not taken into account. Case mix not included.
323	Younis	USA, 1991-95  Data from post-prospective	Financial and economic performance	Regression analysis	The size of hospitals, occupancy rate of hospital beds, ownership status, degree of competition faced in the market, teaching status, and measure of financial	Ownership was not focus of study, but just one variable among others

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		<p>payment system, Medicare Cost Report with support from HCIA Inc.</p> <p>521 FP and 3,406 NFP hospitals</p>			<p>indebtedness of hospitals are significant determinants of hospital performance holding location constant. Also suggests that the relationship between hospital efficiency measure and its various determinants is non-linear in nature and therefore, it is important to adopt appropriate non-linear econometric models for empirical estimation of the performance function. Findings show that rural and small hospitals face significant factors that hinder performance compared to urban and larger hospitals such as lack of (DSH) payments and economy of scale due to their smaller size and lower proportion of Medicaid patients.</p>	
324	Picone <i>et al</i>	<p>USA, 1984-1995</p> <p>73,503 Medicare patients; sample from panel data of National Long Term Care Survey</p>	<p>Quality of care; conversion study</p>	<p>Interviews; multivariate regression analysis</p>	<p>1-2 years after conversion to FP status, mortality of patients, which is difficult for outsiders to monitor, increases while hospital profitability rises markedly and staffing decreases. Thereafter, the decline in quality is much lower. A similar decline in quality is not observed after hospitals switch from FP to government or private NFP status.</p>	<p>Concludes that conversions are harmful.</p>

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325	Gillies <i>et al</i>	USA, 2003  Data on 272 health plans from InterStudy, HEDIS, and CAHPS survey	Responsiveness to users; clinical quality	Multivariate regression	Health plans that rely more on organised physician groups or staff groups perform at a higher level on many clinical measures than other plans  Other variables significantly associated with performance were being geographically located in the Northeast, having NFP status, and not being part of a larger insurance company. For-profit status is frequently negatively related to performance, especially satisfaction with the health plan.	Only plans consenting to public release of their HEDIS results were included, i.e. selection bias. No case-mix adjustment made; however, some of the measures, e.g. screening and immunisation, apply regardless of health status and studies of the impact of case-mix adjustment on HEDIS and CAPHS results have shown a very small effect. Only cross-sectional associations shown, but no causality; other unmeasured factors may have impact.
326	Barro	USA, 1993, 1996 and 1999  Data on cardiac speciality hospitals from various official sources, e.g. AHA annual survey	Cost and quality of care	Regression analysis	Patients from hospital referral regions (HRRs) with speciality hospital entry experience statistically slower growth in expenditure than control HRRs. However, there was also statistically significant data to show that specialty entry for-profit hospitals reduced quality of care, decreased readmissions but may improve overall mortality. The final result showed non-comparability of the data because specialty hospitals were more likely to admit significantly younger, healthier, white male patients, even controlling for DRGs.	Extremely complex modelling which was designed to take account of patient mix, different ownership status, size, teaching, status of hospitals. The results and the conclusions are ambiguous. The technical detail and modelling makes it very difficult to examine any of the assumptions. What is most striking is that there is no attempt to just look at the population's geographic access to health care and adjusted for age and sex.

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327	Szczech <i>et al</i>	USA  Dialysis units - renal data system.	Risk of death in NFPs vs FPs	Risk of death and survival adjusted for socio-demographic factors and analysed by investor status.	Equivocal and interpretable	Study demonstrates all the problems of even trying to attempt this type of analysis.
328	McKay and Deily	Florida  Data from the Shands which purchases patient discharge data from the State, then risk adjusts each discharge.	Quality of care and efficiency	Multivariate regression	Hospitals in the high-performing group were more likely to be for-profit, had higher occupancy rates, had proportionately more Medicare and proportionately fewer Medicaid and self-pay patients, used fewer patient-care personnel per admission, and had higher operating margins than all other hospitals. Managed care presence, measured by proportion of HMO-PPO admissions, was not found to be a significant factor in differentiating hospital performance groups.	One limitation is the use of risk-adjusted excess mortality as the single measure of hospital patient health outcomes. It only measures patient-care labour at admission and does not take into account personnel quality. The authors acknowledge therefore that findings on the effect of patient-care staffing on performance must be interpreted cautiously.
329	Green	California, 2000  California Office of Statewide Health Planning and Development discharge	Access: number of poor payer transfers admitted by different hospital groups (2 of	descriptive and multivariate analyses (linear regression)	Transfer patients were more costly. All hospital groups admitted a higher percentage of good payer than poor payer transfer patients. Likelihood of a hospital admitting a transfer patient affected by both the patient's insurance status and the hospital's ownership as well	Not clear who decides about transfers. Hospitals may be forced to transfer patients within a managed care network. Receiving hospitals may have protocols to be selective about the insurance status of potential transfers to increase their proportion of profitable patients. Hospitals may

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		abstract database; exclusion of Kaiser Permanente hospitals since there is no variation in payer status	them NFP)		as teaching status. Public-owned most likely to admit poorer transfer patients compared to not-for-profits and for-profits, not-for-profits more likely to admit poorer transfer patients than for-profits.	also be building programmes to attract good-payer patients, especially for highly reimbursed services. Alternatively, the selection process may occur at the sending hospital where referrals are made differentially to public hospitals for poorly insured patients and to private hospitals for patients whose insurance is known to reimburse well. <i>Limitations:</i> transfer patterns in California may not be generalisable to other states with less managed care and/or fewer publicly owned hospitals. Data do not allow linking of transferring and receiving hospitals or tracking of individual patients. No attempt to address geographic considerations such as transportation time.
330	Crampton <i>et al</i>	New Zealand  Representative survey of visits to GPs. Study of 10,506 records from 48 NFP and 198 for-profit GP practices.		Observational study	Compared with FP practices, community-governed NFPs served a younger and largely non-European population, the majority of whom lived in the most deprived quintiles of areas in NZ. Patients visiting NFPs were diagnosed with more problems and duration of visit was significantly longer. When confounding variables were	

					controlled for, the odds of specialist referral were higher for patients treated in FP practices.	
331	Hodgkin <i>et al</i>	USA, 1999  60 US market areas; nationally representative sample of commercial MCO products; surveys completed by interviewing a senior administrator of an MCO (92% response rate)	Use of quality standards, e.g. provider satisfaction	Bivariate tests and logistic regression analysis	Use of standards differs markedly by product type for every standard considered, with Preferred Provider Organisations (PPOs) being consistently much less likely than HMOs and point of service (POS) plans to use each standard.  Fully capitated products with no limits are less likely to have any standards and less likely to use four specific standards. Those fully capitated products that did have limits showed no significant difference from no-capitated products in their use of standards.  For-profits were less likely than NFPs to use a provider satisfaction standard.	Finding could emerge for several reasons. MCOs that transfer full risk may be using mechanisms other than quality standards to prevent skimping; may be less concerned about quality; or may be more sceptical about the value of existing standards. The fact that FP plans are equally or more likely to use these standards may reveal that their objectives are not different from those of NFPs, or that competition is constraining them to adopt standards anyway.  <i>Limitations:</i> lack of more detailed data on the nature of financial risk-sharing, and on the types of financial penalties associated with each standard. MCOs might have been using other quality-related standards that were not included in study. Not known whether standards are enforced.
332	Longest and Lin	Massachusetts, c. 2001-2003  Sample of NFP hospitals (n= 48); data from	Financial performance and "corporate citizenship" (i.e. community	Linear regressions	This study demonstrates a significantly positive association between corporate citizenship and financial performance. Without demonstrating causation in either direction, the analysis shows that the NFP hospitals in	This finding may reflect the same relationship found in numerous studies of corporate citizenship and financial performance in business firms. Namely, that business advantages accrue to firms through their practice of



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		the Office of the attorney general, Medicare cost reports, and the AHA.	benefits)		this study can simultaneously do well for themselves financially, and good in terms of the benefits provided to communities. That is, they perform better financially as they spend relatively more on their community benefits initiatives.	good corporate citizenship. <i>Limitations:</i> problems of defining community benefit not addressed.
336	Shen	USA, 1987-98	Effects of ownership conversion on hospital performance; staffing, capacity, financial performance, unprofitable care	Insufficient information (abstract only)	Conversions to government and for-profit ownership both increased the profit margin: the former due to rising revenue, and the latter due to reduced operating costs and rising revenue. Hospitals that converted to FP ownership had the greatest reduction in staffing relative to other converted hospitals. There was little change in bed capacity after conversion to FP status, but reductions in bed capacity after conversion to government or NFP status. No conversion led to a reduced unprofitable care, but conversion to private ownership (NFP and for-profit) increased trauma centre closures.	Any attempt to isolate the effect of ownership on performance must address the confounding effects of market structure.
338	Carter and Porell	Massachusetts 1991-94  Quarterly	Quality of care (hospitalisation rates)	Logistic regressions	Multivariate findings suggest that resident heterogeneity alone does not account for the wide variations in hospitalization rates across nursing homes. Instead,	Implications: Variations in hospitalization rates may reflect underutilization, as well as overutilization. Continued efforts toward identifying medically

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		Medicaid case-mix reimbursement data from 527 nursing homes linked with Medicare Provider Analysis and Review hospital claims and nursing facility attribute data			facility characteristics such as profit status, nurse staffing patterns, NH size, chain affiliation, and percentage of Medicaid and Medicare reimbursed days significantly influence NH residents' risk of hospitalization. Broader area market factors also appear to contribute to variations in hospitalization rates.	necessary hospitalizations are needed.  Longitudinal design; controlling for individual-level resident attributes, including: NH diagnoses, resident-level quality of care indicators, and diagnostic cost grouping classification from previous hospital stays
339	Safran <i>et al</i>	USA  Data from cross-sectional survey of Medicare beneficiaries in 13 states with substantial Medicare HMO markets (64 % response rate)	Quality of care; variables: access, continuity, integration, comprehensiveness, "whole person" orientation, clinical interaction, sustained clinician-patient partnership	Regression analyses	Performance was better in fee-for service Medicare than it was in HMOs. Few differences were associated with HMO profit status.	
341	Helmig and Lapsley	Germany, 1992-96	Relative (technical) efficiency	Data envelopment analysis	At an aggregate level, public and welfare sector relatively more efficient than private hospitals; public and welfare hospitals use	A lot of teaching (one of two output variables) is carried out in public sector hospitals and in public universities; this might

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		German statistical yearbooks and one national hospital report	Measured by: Input: plant size, labour expenses, supplies Output: treated cases, teaching		relatively fewer resources than private hospitals; suggests differences in quality of care arising from ownership.	cause the inefficiency with respect to teaching. In addition, because educational possibilities in private hospitals are worse than those in public hospitals, private hospitals often pay higher salaries in order to recruit personnel. Other factors likely to have influenced result. <i>Limitations:</i> The only measures of efficiency available do not provide a clear picture. DEA cannot assess the maximum level of efficiency, which is theoretically possible beyond the level of performance found empirically in the hospital sectors under study; deriving statistics of precision is problematic with DEA; data is only on aggregate level.
342	Ginn and Moseley	USA, 2000  Acute care hospitals, data from AHA survey and Area Resource File	Integration and planning (extent to which hospitals provided health promotion services)	Cross-sectional multiple regression analysis.	Community health and community-based quality orientations were positively and significantly related to the direct provision of health promotion services by hospitals, and the collaborative provision of health promotion services to systems, joint ventures, and networks. Results suggested that NFP ownership was less significant on the provision of health promotion services than factors such as hospital size and the degree of	It is unprising that health promotion and community orientation appear to be related, but the study relies upon self-reported assessments of whether or not an institution possessed a community orientation; this is highly likely to impart bias since hospitals are likely to exaggerate the extent to which they provide such activities. Study is based on simplistic multiple regression analysis, with little comment on the relative significance of various

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					market competition.	coefficients in the regression equation.
343	Gibelman and Gelman	Cross-national (USA, Australia, England, France, Germany, Israel, Scotland, South Africa), 1998-2000  Health care and human service NFPs	Trust	Qualitative content analysis of publicized incidents of alleged wrongdoing on the part of NFPs (data from newspapers identified through Lexis-Nexis and ProQuest).	The purpose of the research was to identify problems created for NGO credibility and public trust. The author speculates that part of the public perception problem is that NFPs have a vaulted status based on ideas of "inherent purity" which exposes them to the danger of fall from grace.	<i>Limitations:</i> Choice of one medium only; wrongdoing was limited to behaviour of staff or directors. No outcomes of allegations were reported. Cases from a wide range of NFP organisations and countries (hence limited comparability). Finally, no comparison is undertaken. Thus, while a problem of governance (lack of accountability) is identified it is not possible to say whether this is due to ownership.
344	Brickley and Van Horn	USA, 1991-95  Sample of 7301 pooled observations from 2134 NFP hospitals and 499 pooled observations from 220 FP hospitals, data from AHA	Financial performance; public purpose	Descriptive statistics and logistic regressions	This paper examines the incentives of CEOs. The evidence indicates that both turnover and compensation of these CEOs are significantly related to financial performance (return on assets). Finds no evidence that NFP hospitals provide explicit incentives for their CEOs to focus on altruistic activities. The turnover/performance relation appears stronger in NFP hospitals than in for-profit hospitals and other for-profit corporations (our data do not allow us to compare compensation incentives).	Study tests "competition hypothesis": Competition has forced many NFPs to focus on profits and survival so that there is little available surplus for charity care. This hypothesis suggests that CEOs in competitive markets have incentives to focus primarily on financial performance, while CEOs in concentrated, less competitive markets will have greater incentives to focus on altruism. Overall, the results do not support this hypothesis as similar incentives are observed in both

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						concentrated and unconcentrated markets. Results are generally consistent with the “for-profits in disguise” hypothesis that NFP and FP hospital boards have similar objective functions (i.e. financial performance) although statistical tests have low power because of the crudeness of altruism variables and the relatively low level of for-profit presence in most US counties.
345	Eldenburg <i>et al</i>	California  Data derived from California hospitals’ annual hospital accounting reports.	Hospital governance in relation to composition of the board, board turnover, CEO turnover	Regression analysis	The study tests the hypothesis that different objectives lead to different governing structures. The composition of boards of directors differs across ownership types. Director turnover increases with poor performance. Poor performance, high administrative costs, and high uncompensated care lead to higher CEO turnover.	The interest of this study is that it is motivated by the absence of theoretical predictions about the objectives of NFP organisations, and therefore of the objective function of the governing system. Writing in 2001, the authors suggest that little attention had been paid to NFP governance. <i>Limitations:</i> federal and HMO hospitals excluded. Bias arising from missing data.
346	Kendall <i>et al</i>	England	Motivations of domiciliary care providers	Postal questionnaire and interviews with providers	Core motivations revolve round combining a desire to meet the needs of clients with seeking ‘reasonable’ financial reward. Local authority purchasers viewed by the authors as exercising exceptional power in social care markets in England. The regulatory system,	Relies on the self-reports of providers

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					influenced by the National Care Standards Act 2000, is viewed as embryonic and limited (as of 2003).	
348	Zimmermann and Stevens	South Carolina, 2002  Surveys mailed to 577 NFP organisations, return rate only 26.5% (n = 149)	Use of performance measurement	Exploratory case study; descriptive statistics, content analysis	65% of NFP organisations use performance or outcome measures as a part of their evaluation process. There was a significant relationship between agencies using performance measurement and those required to do so by some outside source, mainly in order to meet requirements of grants or contracts for service (52.6%) while another 23.6% listed accountability or effectiveness as their primary motivation.	<i>Limitations:</i> Small sample size; "Performance measure" not defined in detail; Question not answered whether performance measurements have resulted in improved services being provided
350	Hodge and Piccolo	Florida  Survey among CEOs; sample of NFP human service organisations affiliated to a single Florida provider	Governance in relation to source of funding and board involvement in decision-making	Regression analysis	Funding source is significantly related to board involvement techniques: funding source in NFPs appears to be an important and consistent predictor of strategy and performance.	Insufficient information about the calculation of financial vulnerability. Many likely biases: survey is based on a relatively small sample; all the agencies in the study are affiliated to a single organisation the influence of which was not considered; use of CEO self-reports.
351	Lorenz <i>et al</i>	USA, 1998  Data on hospices	Uncompensated care	Multivariate analysis	Only 3% of hospice patients received unreimbursed care. Because 98% of older adults are eligible for Medicare, they	Recipients of unreimbursed hospice care are demographically similar to the uninsured, and whether uninsured persons

		from National Home and Hospice Care Survey (NHHCS) discharge dataset			stratified multivariate analysis on age greater or less than 65 years. Among persons less than 65 years of age, younger, nonwhite persons were more likely to receive unreimbursed care, and persons with cancer. Providers of unreimbursed care to persons over 65 years were more likely to be NFP and freestanding.	receive unreimbursed hospice care depends on clinical and agency organisational factors related to the motivation to provide unreimbursed care.
352	Guo	USA, 2000  Web-based survey data; sample of 155 human service NFPs (analysis limited to those which operated ventures at the time of interview (N = 67)	Effects of commercialisation on NFPs (commercialisation measured as percentage of income from commercial activities)	Path analysis (as an extension of regression analysis)	Commercialisation does not make a significant contribution to an organisation's ability to attract and retain donors and volunteers, mission, and programme and/or service delivery. However, commercialisation has a significant positive impact on the organisation's self-sufficiency, reputation, and ability to attract and retain staff. Path analysis suggests that higher levels of commercial income can lead to higher assessments of the organisation's reputation, and these, in turn, can lead to higher levels of commercial income. Higher levels of commercial income do not appear to affect the relationship between the organisation and donors.	Reliance on participants' replies: bias likely as managers with vested interests were interviewed. Use of Likert-type scale reduced the availability of information; framing of the questions about organisation outcomes likely to solicit positive responses, hence the positive effects of commercialisation yielded not unexpected. Small sample size; sample's representativeness not known. No comparison of venturing with non-venturing NFPs. Measurement of commercialisation on a percentage basis yields problems when interpreting it in relation to donations in correlation-based statistics. Cross-sectional data used, difficult to assess causation.

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355	Matosevic <i>et al</i>	England, 1995 and 1999  261 postal surveys and 111 interviews among independent sector domiciliary care providers	Funding mechanisms/ reimbursement	Two surveys of independent domiciliary care providers	A developing domiciliary care market dominated by small but growing businesses. Common perception among independent providers that in-house services receive favourable treatment and conditions. Spot contracts continue to be the most common form of contract although there are moves toward guaranteed service and more sophisticated patterns of contracting arrangements. Information sharing limited.	Based on the same study referred to in 346. Similar reliance on self-reports from providers.
356	Milligan and Fyfe	Glasgow  Questionnaires and interviews with voluntary organisations and government.	Service availability; access to capital	Qualitative study.	Shifts in territorial boundaries for accessing funding, creates complex patterns of inclusion and exclusion. Devolution has resulted in lobbying of the parliament by voluntary organisations – the three sectors considered here have accessed this opportunity to varying extents, raising questions about the extent to which voluntary partnerships in delivery of welfare may contribute to an increase in the democratic deficit.	This study offered a unique (geographical) perspective on voluntary sector activity in one UK city. The implications are relevant to the question of access.
357	Gurewich <i>et al</i>	USA, 1998-2001  Including cases	Conversion study	Case study approach, Used semi-structured	In all five cases at least some respondents described the hospitals' relationship with the nonacute care delivery system	Has some relevance to partnership literature in the UK. Concern that conversion to investor ownership imposes new



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		of the sale of all of part of any urban NFP hospital to a national investor-owned organisation between 1994 and 1998.		interviews with key informants on resource gains and losses following conversion. Also reviewed published and unpublished materials on the hospitals.	following conversion as providing fewer resources. Largely because fewer material resources flowed from the hospital to community organisations or the hospital was a less active participant in community planning efforts. Conversions affected communities and stakeholders differently. Affected by the degree of political organisation in the community, the dispensation of the hospital's charitable resources and the importance of shared mission.	fiduciary responsibilities that may undermine a hospital's social contract to meet the needs of the community, regardless of profitability (uncompensated care). Restructuring of the health care environment, with providers pulled in two directions: competition through the premium placed on cost-efficient care, while also expected to cooperate with others.
358	Deily	USA, 1986-91 4739 hospitals from the AHA and Area Resource File	Exit of hospitals from market in relation to inefficiency	Stochastic frontier cost approach	Hospitals' exit decisions differed systematically among different ownership types. Less efficient hospitals were more likely to exit when ownership was FP or NFP rather than public. The relative inefficiency residual was the primary determinant of exit for for-profit hospitals. NFP hospitals with higher relative inefficiency were significantly more likely to close, but community need also had a significant effect on exit. The only variables having a significant effect on the exit decision of government hospitals were county population and depreciation and interest	Among privately funded hospitals ownership did not have a significant effect on closure when both ownership and relative inefficiency were controlled for, in contrast to earlier studies that found FP hospitals were more likely to close. Overall, results suggest that NFP hospitals are influenced both by economic factors and community need when deciding whether or not to close. The variables included in the study were poor predictors of exit by government hospitals, suggesting that political factors may be the key determinants of exit for public hospitals. The cost

					expense per bed.	function included variables to control for quality.
359	Hansmann <i>et al</i>	USA, 1985-94  AHA surveys, excluding certain hospital types; several other official sources (data on virtually all elderly Medicare beneficiaries with heart attack in 1985)	Service availability	Regression analysis	FPs are the most responsive to reductions in demand, followed by public and religiously affiliated NFPs, while secular NFPs are the least responsive. FP and public hospitals adjust to demand increases significantly more rapidly in concentrated markets, whereas religious NFPs adjust to demand increases significantly less rapidly, reflecting the conflicting incentives for, and constraints on, expansion of hospitals of different ownership types. Both secular and religious NFP hospitals use reductions in bed capacity more than closure of facilities in response to decreasing demand, consistent with managerialist bias against complete exit that theory suggests among NFPs.	Managers of FP hospitals, and to a lesser degree managers of public or religiously affiliated NFP hospitals, have an incentive to minimise costs of service, and hence to eliminate unused or underused capacity. Managers of unaffiliated NFP institutions, in contrast, may not feel such an incentive so long as net cash flow does not become negative. Even if cash flow is negative, NFP managers are free to maintain capacity by drawing down on accumulated net assets. Indeed, they may feel it is their duty to behave in this fashion, believing that all of the firm's revenues and net assets must be dedicated to providing the maximum care possible.  Limited to metropolitan areas.
360	Becker and Potter	USA, 1994  AHA survey 1994 (4705 hospitals); population data from Area Resource File	Hospital efficiency and social responsibility	OLS regression	Results confirm hypotheses that FP hospitals and hospitals lacking local ties are managing stakeholder relationships in ways that increase the efficiency of these hospitals but decreases their social responsiveness. There appears to be an inverse relationship between hospital	Instead of assuming that both efficiency and social responsibility can be or should be maximised, we may want to consider what a change in one is likely to do to the other. Instead of optimising, we may need to think in terms of balancing and making tradeoffs.

					efficiency and social responsibility. NFP community hospitals, while appearing to be the most likely to provide social responsive services, are the least efficient and probably the most vulnerable to economic problems.	<i>Limitations:</i> Hospital social responsibility measures best indicators? Cross-section analysis only
361	Melnick <i>et al</i> 1999	California, 1986-94  Data on General short-term acute care hospitals from Californian Office of Statewide Health Planning and Development; Medicare prospective payment system impact file; Area Resource File	Price increase after mergers	Multiple regression; Series of simulation models of hypothetical merger scenarios in four different years	After 1986 all hospitals, regardless of ownership type, raised their prices in response to a merger. The amount of expected price increase from two merging hospitals depended on ownership and the market share of the merging hospitals. FP hospital pricing is more affected by market concentration, so FPs will tend to raise prices more after a merger. Data suggests that hospital conversions from NFP to FP status could lead to price increases, as it appears that FP charge about 10 % higher prices given the same level of market concentration. When monopolies are formed, the findings show large price increases, regardless of ownership. Also indirect effect on prices of other competitors in the market, whether FP or NFP.	Implications for antitrust regulators and agencies that must approve NFP conversions. The observed changes in pricing behaviour over time are consistent with the trend of increased price competition and more aggressive, market-based pricing by all hospitals. The increase in the number of NFP systems may contribute to the increase in prices among NFPs. NFP hospitals with boards consisting of local community members are being superseded by NFPs that are part of large regional or multi-state systems, governed and controlled from remote corporate headquarters, which presumably have different objectives.  <i>Limitations:</i> partly only modelling;

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362	Himmelstein <i>et al</i>	USA, 1996  HEDIS data for 329 HMO plans (248 FP and 81 NFP), representing 56% of the total HMO enrolment	Quality of care	Multivariate regression	Investor-owned HMOs deliver lower quality of care than NFP plans for all 14 quality-of-care indicators. In multivariate analyses, FP was consistently associated with lower quality after controlling for model type, geographic region, and the method each HMO used to collect data.	Abstract only  14 HEDIS quality-of-care indicators employed  Sample not very representative
363	Harris <i>et al</i>	UK  HIV/AIDS voluntary sector agencies	Co-operation and merger between voluntary agencies	Literature review of organisational cooperation in the UK and US voluntary sectors, policy analysis and semi-structured interviews with agency CEOs and external stakeholders	Researchers found that all the key drivers identified were present in this case study, except immediate organisational crisis. Public expenditure constraints were a consideration. Also evidence of a search to find a niche for the HIV/AIDS voluntary sector in a competitive policy environment in which evidence of need for their services was diminishing. Resource dependency was a factor as well as the ambitions of some managers to see their agencies become bigger players	The research was commissioned by the agencies. The analysis was based on interviews with CEOs and external stakeholders only. While all the CEOs emphasised their commitment to their users, there were specific drivers related to status within the agencies. The study focuses almost entirely on drivers towards cooperation, tending to ignore barriers which emerged from interviews.
364	Vincent and Harrow	England and Scotland  Data on funding to voluntary organisations in	Funding in the health sector/public purpose	Documentary analysis of the Deakin and Kemp reports; survey and interviews with voluntary	Scottish organisations more likely to rely on central government funding for more than 60% of income. Cross-national unanimity concerning problems posed by government funding on projects rather than	The focus on CEOs as informants gave a predominantly professional account. There was no distinction made between organisations 'of' and 'for' people with health concerns and needs which may influence views of government

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		the health sector by Central government (N = 155 in England and 36 in Scotland)		organisation CEOs.	core funding though over 3/5 of organisations received funding for core purposes. In Scotland core funding predominated, making services more reliant on central government funding. 91% Scottish organisations compared to 45% English organisations had to submit performance measures.	relations. Implications of free personal care, etc remains to be examined.
366	Schramm	USA, 1997-2002  21 independent Blue plans, 7 consolidated NFP Blue plans, 5 investor-owned Blue plans, and 10 commercial health insurance carriers	Financial performance	Descriptive statistics	Conversion of Blue plans does not result in demonstrable economic efficiencies. Most NFP Blue plans continue to operate with sound margins and can be expected to compete with other firms, in part because of their special ties to various customer segments, their geographic market share, their relationships with state governments, and the particular brand identity enjoyed by local Blue plans. Operating margins in health insurance companies are highly tied to local market knowledge, which becomes attenuated in larger, geographically dispersed insurance companies.	Half of the US Blue Cross plans have been consolidated and converted to for-profit companies. This process has gone on without informed debate and with minimal interest or comment from the public policy establishment whose principal interest is expanding coverage to all Americans. A form of corporate organisation has been lost that has provided lower-cost coverage and embraced a corporate identity infused with service to the public.  <i>Limitations:</i> Case study character only.
367	McCue <i>et al</i>	USA (11 states), 1990-1995	Nursing staff, quality of care (risk adjusted	Dynamic econometric model	It found that an increase in nursing staff led to a statistically significant increase in operating expenses but no significant	The study addressed the central policy issue that cost containment and increased competition from managed care organisations erode

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		Sample of 422 hospitals for which data was available in the Healthcare Cost and Utilization Project.	mortality), financial performance (operating margin and natural log of operating expenses)		decrease in profits.	profit margins or quality, and that improved financial performance is often achieved at the expense of hospital size and staffing ratios.  The study was limited by availability of cost data and possibly inconsistencies in financial reporting of operating margins. The study did not control for possible confounding variables, such as variations in discharge policy, outpatient visits, and investment.
369	David	USA, 1960-2000	Change in hospital size; convergence between for-profit and NFP hospitals	Econometric modelling	Changes in economic environment (entry, exit, acquisitions and divestitures) encourages some firms to change ownership type. In 1969 NFPs maintained on average three times as many beds per hospital as their FP counterparts. By 2000 the NFPs were only about 30% larger than the typical for-profit and there is evidence of growing similarity in capacity of for-profit and NFP hospitals following the introduction of prospective payments in 1983.	The author focuses on the possibility that hospitals choose their ownership type and attendant regulatory environments strategically. The literature represents the choice as a result of different organisational objectives or as the result of "balancing the benefits and drawbacks of each status under uncertainty and incomplete markets for risk." But little empirical work has focused on the impact of ownership form on hospitals' capacity choice.
370	Campbell and Jeffrey	USA, 1995 and 2000	Service availability (implementation of health	Regression analysis	Private NFP units were more likely to adopt some services, while FP units were less so. However, in general, neither FP	<i>Limitations:</i> no descriptive account of financial incentives in different sectors.

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		National Drug Abuse Treatment System Survey of outpatient substance abuse treatment units	services for women)		nor NFP units significantly implemented women's services.	
371	Kovner	New York City  4 NFP hospitals and health systems	Accountability and performance of boards	Unstructured interviews and participant observation at board meetings	Boards get too much data in general and too little comparative data.	<i>Limitations:</i> small sample and selection bias (interviews with board members and senior managers); no objective tests of the reliability of responses.

## Appendix 3 Historical perspectives on British nonprofits and on charitable fundraising for NHS services

Can lessons be learnt from history which are relevant to the present day? In this chapter we summarise evidence on the performance of nonprofits in British health care. Our primary focus is on the pre-NHS era, but we also refer to studies of nonprofit provision of health care since the establishment of the NHS which are relevant. This is not merely of antiquarian interest. Taking a long-term view, nonprofits have been around since the middle ages, and have been the dominant providers of health care for most of that time. If the aim of the government is realised (that is, to establish a plurality of provision in which the dominant organisational form is the nonprofit kind) then we may come to see the NHS as the historical aberration, if by that we mean health care that is both funded and provided by the state.

With this in mind an evaluation of the British nonprofit experience is highly relevant. Of course, proposals for reform of the welfare state often draw on historical evidence and precedent to defend an extension of the role of nonprofits. Good examples are to be found in the work of David Green, Robert Whelan and the think tank Civitas, or politicians such as Hazel Blears (2002), who argued that the pre-NHS system embodied real opportunities for ordinary people to get involved in the governance of hospitals. Academics have countered such arguments with "back-to-the-future" scenarios in which the reintroduction of voluntarism reproduces the failings of the pre-NHS system of health care (e.g. Webster, 1988, 1995). Given that the NHS will remain funded substantially from direct taxation it is unlikely that the inequalities of the pre-1948 system will be re-established, but we believe that there are several relevant lessons which can be learnt from that period.

If we begin by considering the rationale for the establishment of nonprofit organisations, the first point to note is that British voluntary hospitals were not established in response to "state failure" (in Weisbrod's terms, understood as the absence of democratic endorsement of public provision); they were in practice the principal means by which health services were established, although in numerical terms they were eventually superseded, firstly by the Poor Law medical service and subsequently by the development of municipal services following the 1929 Local Government Act. What did the term "voluntary hospital" signify in the pre-NHS era? It generally denoted an independent institution characterised by the following: income was not drawn from the public purse but from philanthropy (later in the lifespan of voluntary hospitals, direct patient payments began to play a greater part, and income was also derived from hospital contributory schemes, i.e. small weekly payments often through payroll deduction which were channelled to a specific hospital



or a centralised hospital fund); management was governed by a volunteer governing body, which was accountable only to the hospital subscribers (these were wealthy patrons who pledged an annual sum to the hospital, which gave them certain privileges, notably the ability to grant admission tickets to those in need of the hospital services); and hospital medical staff gave their services on a voluntary basis, deriving their income from private practice. The great majority of these hospitals were nationalised in 1948 but a small private hospital sector continued to exist, mainly consisting of nonprofit hospitals, though funds were generated principally through patient payments (mostly through private medical insurance) and staff were by now paid for their services.

We have separated this historical work from the rest of our literature review, on two grounds: firstly, it could be argued that the purpose of the authors of the historical literature on this topic was not explicitly and formally to assess the "performance" of the pre-NHS hospitals. In contrast to many of the studies reviewed elsewhere, this literature does not generally develop formal statistical procedures to evaluate how successful, efficient or otherwise the hospitals were although there are some basic and descriptive studies of variations in comparative costs which can be dated to the work of Braun (1909). Secondly, the literature reviewed in this section is not derived from systematic searches of the same databases as used elsewhere; it results from Mohan's work over some 20 years on contemporary and historical aspects of British health policy. We are confident that the work reviewed here includes all the major studies of relevance to an assessment of the pre-NHS hospitals.

On what basis might we assess the performance of these hospitals and of the hospital system as a whole? It may be unfair to apply post-hoc collectivist criteria to the evaluation of an essentially individualist and localist system of hospital provision. Our position is different: we argue it is legitimate to apply tests of comprehensiveness, public purpose, and consumer responsiveness to the evidence on the distribution and success of previous nonprofits in the health sector. We need to do so in order to determine whether or not the deficiencies identified by Salamon (1995) – namely philanthropic insufficiency, particularism, amateurism and paternalism – are valid.

### **Capital investment arrangements**

The availability of capital for investment in nonprofit hospitals in Britain was highly variable. The circumstances leading to the establishment of a hospital were idiosyncratic and place-specific. They might include: the desire to provide a valued social service for the benefit of the poor; the wishes of medical professionals to establish a niche in a competitive and overcrowded medical marketplace (hence the foundation of many small specialist institutions); and social pressures on the very wealthy to display their sense of social

obligation in a very visible form (Abel-Smith, 1964; Gorsky, Mohan and Powell, 2002a; Wilson, 2002). Given this complex set of motives, it might be thought unrealistic to expect that the pattern of hospital provision reflected a serious assessment of need. In the NHS second reading debate, Aneurin Bevan commented about the "caprice of charity" which had delivered a patchwork quilt of services. The academic literature certainly reflects this. Brian Abel-Smith (1964) famously argued that the distribution of voluntary hospital resources reflected "the donations of the living and the legacies of the dead, rather than any ascertained need for services". Subsequent research has tested this claim. Gorsky, Mohan and Powell (1999) showed that geographical variations in provision were a feature of the voluntary hospital system from its earliest days, and that in the six decades prior to the establishment of the NHS there was no reduction in the degree of variability in hospital provision. Powell (1992) assessed variations in the distribution of hospital provision (mainly beds and staffing indicators) and related them to patterns of need for services in a basic way (unweighted correlation coefficients). He concluded that substantial inequalities existed, although these were not systematically related to patterns of need.

Arrangements for capital investment therefore generated an uneven pattern of provision. We might also ask whether the asset base of the British voluntary hospitals was sufficient both to insulate them against financial risk and to provide adequate capital for investment. There is some work on the capital assets of the voluntary hospitals in the 1930s (Cherry, 1997; Gorsky, Mohan, and Powell, 2002a; Gorsky and Mohan, 2001). Hospital finances had been squeezed by the expansion of provision, the burgeoning staffing budget, the modernisation of the institutional fabric and the need to exploit new medical technologies. Traditional modes of hierarchical charity were insufficient to sustain these demands. Hospitals therefore increased charges for their services and the period saw the emergence of mass contributory arrangements, whose success was founded upon the local loyalties which voluntary hospitals inspired. However, the late 1930s saw financial crisis looming, as current account deficits multiplied and some institutions sank seriously into debt, surviving only by running overdrafts which were very high relative to their income, or selling off assets in order to continue treating patients. Those hospitals with sufficient capital assets could ride out this storm, but few were in such a fortunate position and many institutions plunged into persistent deficits (Gorsky, Mohan and Powell, 2002b). Hospitals were unable simultaneously to accumulate investment funds and modernise their capital stock (Cherry, 1997, 322). Some recognition of the extent of voluntary failure is evident from the willingness of the government to make grants to hospitals towards the cost of capital projects, though such assistance was limited to the most disadvantaged parts of the country where raising large sums for capital investment was impossible (Mohan, 1997).

The post-war history of the residual private health sector in the UK provides further historical illustrations of nonprofit performance. Most hospitals were nationalised in 1948 but a small private sector remained. This was principally in not for profit ownership until the 1970s. The efforts of the then Labour government to eliminate private practice from NHS hospitals stimulated investment in private hospitals and competitive pressures in American and European health care markets led multinational companies to invest in for-profit hospital provision in the UK. The limited regulatory controls on this process (to do with the size of hospitals) were abolished by the Conservative government in 1980. The result was a steady increase in overseas commercial investment in British health care, led initially by American companies and subsequently by various European companies. The existing nonprofits were unable to respond – most of them were undercapitalised and had therefore no means of raising funds to modernise their facilities. This process is described by a number of authors: Berliner and Regan, 1987; Griffith, Iliffe, and Rayner, 1987; Griffith, Rayner, and Mohan, 1985; Mohan, 1984, 1985; Rayner, 1986, 1987). It is part of the wider process of corporatisation of health care, described by Salamon (1995), in which commercial entities take a dominant place in the health care market, at the expense of nonprofits. The policy lesson is clearly that nonprofits are vulnerable when large international corporations perceive a country as a profitable location for investment, and this is consistent with the emphasis elsewhere in this literature review on the crucial role of competitive pressures and the external regulatory environment.

### **Public purpose, organisational behaviour, and asset protection**

How might we consider the issues of public purpose, organisational behaviour and asset protection in an historical context? Strictly speaking, voluntary hospitals were private institutions (in the sense that they were differentiated from public or state-provided institutions) but on the other hand their mission was to provide health care for those otherwise unable to afford it. Having said that, they varied in terms of their interpretation of this mission, for example in terms of the extent to which patients were charged while in hospital (Gorsky, Mohan and Powell, 2002b) (for accuracy, we should point out that patients typically received treatment free, but they were expected to contribute towards their maintenance while in hospital). They were also independent – and this independence was often jealously guarded. It could therefore plausibly be argued that they should be judged as individual institutions. On the other hand, and certainly by the 1930s, there was awareness of variations in availability of and access to hospital services, and of the varying performance of the components of the hospital system. It is therefore relevant to consider the literature which has evaluated the comprehensiveness of the pre-NHS hospital system.

Some commentators are highly optimistic about this. Writers such as Green (1993; 1996), Seldon (1991), and Jewkes and Jewkes (1962) have all argued for the comprehensiveness of the pre-NHS system. They have suggested that nationalisation stifled a grass-roots wave of innovation which reflected consumer preferences. Certainly, the establishment of some 1200 voluntary hospitals represented a considerable achievement, and other statistics presented by Gray (1991) indicate continued expansion -- for example, hospitals were still being founded into the 1930s. But this does not mean that voluntaries and nonprofits provided a comprehensive service. Although Green (1993) argued that various forms of public, nonprofit and private provision of services gave the population access to a comprehensive system of health care in the 1930s, Morris (2000) has ably criticised his estimates, demonstrating that he can only arrive at this conclusion through double counting.

We can explore the issue of public purpose by looking at evidence concerning the pattern of hospital utilisation. Mohan (2003) has reconstructed the pattern of hospital use in 1938. This work shows that for county boroughs, utilisation rates ranged from 10 to 58 patients per thousand population, and although there are signs of a north-south split, one can also identify boroughs in the North of England where utilisation rates were comparable with any of their southern counterparts. Utilisation was negatively associated with need, and an inverse care situation clearly existed. Broadly similar patterns were evident for counties. On this evidence, there were major gaps in the availability of services, no systematic relationship between provision and need and no mechanism by which the two could be matched. There is also much evidence from the wartime hospital surveys of variations in waiting lists between hospitals, and although interpretation of these is problematic (it is likely that supply constraints operated to dissuade potential patients from applying for admission as was observed by some inter-war reports) in some cities waiting lists equated to between 10 and 20% of the annual caseload treated at hospitals (Mohan, 2002; 2003).

In comparison with post-war standards the variability in the provision and use of services is substantial. It could be argued that this is to apply post-hoc collectivist criteria to the evaluation of hospital services and that this is inappropriate since the provision of a comprehensive service was not in the minds of those who founded the voluntary hospitals. Hence the pro-voluntarist case is that we should be prepared to "take the risk of under-government" (Green, 1993) and accept such variations in provision because of the role of the voluntary sector in providing opportunities for participation and user control. On the other hand a sober assessment of the achievements of nonprofits has to take account of changed social expectations.

To what extent were voluntary hospitals able to provide high-quality medical care? Firstly, the large number of small or single-specialty institutions was not conducive to good medical practice, as was amply demonstrated by the wartime Hospital Surveys (Nuffield Provincial

Hospitals Trust, 1946) and a criticism of surviving post-war nonprofits was also the absence of resident medical staff (Griffith, Iliffe and Rayner, 1987). Secondly, the pre-NHS voluntaries practised careful patient selection, to the point where the municipal hospitals were viewed as dumping grounds for the chaff of the voluntary system (Eckstein, 1964). In a detailed analysis of inpatient registers for a voluntary hospital and its Poor Law neighbour, Edwards (1999) demonstrated that age-based rationing was practised; the voluntary hospitals gave priority to young adults and the middle-aged rather than children or the elderly. Standards were very variable -- the availability of medical staff, who gave their services gratis, depended on the prospects for private practice in the immediate locality, and so outside the major cities, few hospitals had resident medical staff. The same is true of nursing staff and of the availability of advanced medical technology. The analysis by Hollingsworth and Hollingsworth (1985) of differences in the quality and quantity of staffing and other inputs, and in average expenditures per inpatient, suggests that the nonprofit sector offered a higher quality of provision than that provided in the public sector, but that has less to do with the inherent qualities of the nonprofit sector than with the fact that the two served a very different clientele, with the public sector being dominated by provision for chronic conditions and infectious diseases. Moreover, the conditions in which the public sector services provided by local authorities were established during the 1930s were not propitious. Many local authorities could not develop high-quality services due to financial stringency; this means that direct comparisons with the nonprofit sector are inappropriate (for further literature on these points see Pinker, 1966; Powell, 1992; Gray, 1991; Levene, Powell and Stewart, 2004, 2006). As in the present day comparisons are rendered difficult by the problems of agreeing on appropriate indicators of quality, although some key indicators leave little room for dispute, such as the proportion of hospitals without resident medical staff (Gray, 1991, 253).

This evidence challenges arguments that advocate nonprofit ownership on the grounds of its ability to meet social needs. There was great variability in access to voluntary hospital services and in the quality of the services on offer. Superficial comparisons suggest that the existing nonprofits (the voluntary hospitals) offered higher-quality provision than the existing public sector alternative, but this is to ignore the public sector's obligation to treat chronic conditions and infectious disease and also the very significant financial constraints under which local government services laboured in the 1930s.

### **Funding sources and payment mechanisms**

Pro-voluntarists have frequently drawn attention to the steady growth in expenditure on the voluntary hospitals prior to 1938 (Prochaska, 1992), and argued that this provides testimony to the continued success of the nonprofit tradition. Others are more sceptical, drawing attention to variations in absolute levels of resources available to the

hospitals, variations in the funding mix (sources of income) between hospitals, and problems to do with the stability of income sources which might fluctuate considerably from year to year.

Green (1993) and Seldon (1991) relied on Pinker's compilation of English hospital statistics which presented a snapshot of data for several years at different points in time (1861, 1891, 1911, 1921 and 1938) and on a 1937 report by the independent think tank, Political and Economic Planning. In contrast, Abel-Smith (1964), Gray (1991) and Webster (1988; 1995) have all pointed to the financial difficulties of the voluntary system by the late 1930s. The most recent defender of voluntarism is Frank Prochaska (1992, 104), who has argued that charitable sources of income remained vibrant. However, a weakness of those analyses is that they rely upon the annual *Burdett's Hospitals and Charities* and its successor, the *Hospitals Yearbook*, which in turn were based upon voluntary reporting of financial statistics by hospitals. As shown by recent reanalyses of this data, variations in the numbers and type of hospitals reporting in any given year mean that it is impossible to distinguish genuine trends from changes due to the composition of the hospitals reporting to the compilers of these annual volumes. (Gorsky, Mohan and Powell, 2002b; Mohan, 2006 and forthcoming). Analyses of data for consistent sets of hospitals which present financial statistics at constant prices show a less positive picture than that presented by Prochaska. They demonstrate that regional variations in the availability of resources remained a persistent feature of the system -- if anything, the wealthy London hospitals pulled away from the rest over time - and that deficits on ordinary income were a growing problem in the 1930s (Gorsky, Mohan and Powell, 2002a). Hospitals did not go out of business, but if they failed to develop new sources of income it impacted on their ability to treat patients. Regional disparities in the resources available to hospitals were endemic and persistent over time (Mohan, 2007).

The most successful new source of income which was developed in the inter-war period was hospital contributory schemes, whereby employed workers would contribute a regular weekly sum to a fund which was either associated with an individual hospital or with a group of hospitals covering one city (Gorsky, Mohan and Willis, 2006). The largest such fund, the Hospital Saving Association, had 2 million members and there were similar large funds in the other major cities; total membership was probably around 11 million, which meant that, once dependants are allowed for, approximately half the population was covered. These schemes represented an impressive achievement, but the resources which they generated depended heavily on local labour market conditions, which could pose problems for hospitals for which they were the principal source of income (in some industrial areas they could provide up to 80 per cent of the annual income of the hospitals). There were particular problems in coalmining areas around the time of the General strike for example (Mohan, 2002, 1997; Gorsky, Mohan and Willis, 2006, chapter 4; Cherry, 1997). Again there are some contradictory interpretations of success: Doyle (2006),

for example, claims that the voluntary hospitals on Teesside were able to sustain their activities largely through reliance on contributory schemes, but this does not mean that the services provided were adequate, since although the hospitals derived impressive proportions of the income from these schemes, expenditure per bed on Teesside remained relatively low. The general lesson to be drawn is that the schemes were a kind of social insurance which was dependent very heavily on local labour market conditions; therefore the resources they generated could vary considerably, as did their impact on hospital activity.

Nonprofit sources of funds could not, therefore, deliver sufficient resources to underpin a comprehensive and equitable service. The finances of the voluntary hospitals were inherently uneven (depending as they did on local economic circumstances) and there was no mechanism for pooling resources to achieve redistribution. A verdict of philanthropic insufficiency can therefore be defended.

## **Integration and planning**

Not-for-profits raise important issues about vertical integration in the NHS and therefore about implementation of centrally determined NHS plans. The autonomy of nonprofits raises questions about the extent to which they can be persuaded to act in the public interest and to coordinate their activities with other providers of public health care. We can illustrate the potential problems from the pre-NHS era.

Some authors have argued that there was an emerging consensus in the 1930s and 40s within government circles and the medical profession in favour of greater co-ordination of health services (Fox, 1986, ix; Klein, 1989, 2-7; Eckstein, 1964, 101-32). The implication is that the gradual evolution of a mixed economy of health care would eventually have settled differences and made services accessible to all. Other assessments are less certain even if they do not all subscribe to the trenchant views of the former civil servant, John Pater (1981), who suggested that the voluntary hospitals were autocratic, resentful of any interference, and reluctant to entertain proposals for collaboration, or the strictures of the Nuffield Hospital Surveyors, who pronounced in 1946 that 'there is no hospital system now' and deplored 'the results of unco-ordinated development in the past' (Nuffield Provincial Hospitals Trust, 1946, 4).

Recent scholarship has re-evaluated these verdicts drawing on new research in several major cities including Bristol, Aberdeen and Newcastle, but in general it confirms the variability in the extent of cooperation. In a few localities joint planning between the local authority, the voluntary sector and private practitioners was enthusiastically developed. Aberdeen provides a good example: plans were made for public and charitable funds to combine in the removal of the voluntary and public hospitals and the University Medical School to a dedicated greenfield site. This example indicates the difficulties of generalising such solutions – Aberdeen's remoteness meant that it

was de facto the medical centre for a very large region, with natural links to a hierarchy of medical providers. (Gorsky, 2004). There is evidence that in other cities such as Sheffield, Manchester and Birmingham, medical school leadership could lead to progressive reforms (Pickstone, 1986; Sturdy, 1992; Gorsky, Mohan, and Willis, forthcoming) but one could equally quote examples such as Newcastle or Bristol where, although the advantages of cooperation might have appeared equally obvious, hospital vested interests mitigated against it (Mohan, 2002; Gorsky, 2004). Cooperation and integration were therefore the exception rather than the norm.

In locations where medical school leadership was absent, the picture was highly variable. Mohan's work on the North East of England and on the "Special Areas" (locations eligible for regional policy assistance in the inter-war period by virtue of the parlous state of their local economy) has shown that even where one might have thought that economic necessity would have been the mother of invention, institutions jealously guarded their independence and refused to collaborate (Mohan, 1997, 2002).

Nor were voluntary hospitals always well-disposed towards cooperation with their municipal counterparts, although to some extent there were faults on both sides (Levene, Powell and Stewart, 2004, 2006). Mutual suspicion, based on ideological distrust and social differences, coupled with institutional stasis and a habit of independence, were powerful forces inhibiting change.

On the other hand, recent work on hospital contributory schemes, which became a key source of voluntary hospital finances in the interwar years, has shown that the multi-hospital schemes could act as a valuable source for integration by virtue of the effective purchasing power at their command (Cherry, 1996). The original principle of restricting treatment of contributors to the hospital with which a scheme was associated soon proved inadequate: what if specialist treatment was needed, or a patient fell sick away from home, or was moved to a public hospital or a convalescent home? Mutual agreements to treat members of other schemes were therefore made between public and voluntary hospitals, and between large and small voluntaries. This in turn created pressure for more standardisation of contribution and benefit levels from place to place. While they cannot be regarded as purchasers of health care in the sense in which we understand that term today, they did force hospitals to confront obstacles to "money following the patient" – for example, situations in which a hospital refused to acknowledge and admit a member of another hospital contributory scheme. At the same time we should also recognise that these schemes did not always espouse an ethos of mutualism – there is evidence of competitive recruitment and territorial disputes (Gorsky, Mohan and Willis, 2006, chapter 4).

To summarise, despite government encouragement and some promising initiatives, the inter-war period saw relatively few good



examples of cases in which nonprofits co-operated either with each other or with municipal services in pursuance of the broader public good. The requirement for consultation contained in the 1929 Local Government Act gave an impetus for change, and joint authorities made some progress, especially in towns where university medical schools worked with progressive municipal authorities. Public/third sector co-operation might have been more actively enforced by the state, but the traditionally permissive approach to local government legislation prevented this. Self-interest and particularism were the order of the day and although there was widespread recognition of this, only in unusual circumstances were such problems overcome. This does raise difficulties for those advocating a greater role for nonprofit provision of services. It can be suggested that the context is now very different, in that provision of services is now underwritten by the state, but the lesson of the inter-war period is surely that effective levers are necessary to overcome vested interests.

### **Governance and accountability**

To whom and where are not-for-profits accountable, and how representative are their arrangements for governance? In general the British voluntary hospitals were accountable to their subscribers. These were people who pledged an annual sum of a few guineas to the hospital, in return for which they were granted admission privileges in the form of tickets which could be given to those deemed to be deserving of hospital treatment. Given the cost of subscriptions, this imparted an inherent middle-class bias to the composition of the subscriber body, but it can hardly be said that there was enormous enthusiasm among the middle classes, since typically the number of subscribers was only a small proportion of the population who could afford to do so (Gorsky, Mohan and Powell, 2002b). The rise of the contributory schemes was not associated with a significant broadening of the social basis of participation nor with an extension of consumer power over the decisions of professionals. Although Cherry (1996) and Doyle and Nixon (2001) argue that the development of contributory schemes could lead to significant working-class influence on hospital policy and admission decisions, the literature shows that even where there was a strong community presence on governing bodies, the representatives of contributory schemes tended to defer to professionals and to middle-class subscribers (Gorsky, Mohan and Willis, 2006, chapter 5; Trainor, 1993; Waddington, 2003; Thompson, 2003).

There are contrasting verdicts as to whether this system allowed provision and need to be matched. Croxson (2006) has argued that while on the face of it the subscriber ticket system might have allowed subscribers to take a rather capricious approach to the distribution of tickets, in practice their rights to admission privileges were attenuated by professional interests and the existence of hospital governing bodies, who supervised patient admissions. On the other hand Reinartz (2006) takes the view that hospitals were not in a position to

contact systematic investigations into the real needs of those on their waiting lists, nor were they able to work out a rational order of priorities. Such studies indicate the dangers of philanthropic amateurism and paternalism highlighted by Salamon's work. Having said that, it can also be argued that competition for donations and legacies forced hospitals to attend to the question of performance; if they failed to cure patients, they would not attract benefactions.

The evidence that the voluntary hospitals in Britain provided strong channels for the representation of consumer interests is therefore not very strong. Although there were elements of openness, subscriber democracy and accountability in voluntary hospitals from their inception, participation was initially limited to middle-class contributors. The role of private subscribers subsequently diminished and the decision-making roles of medical professionals and lay governing bodies were enhanced. The transition to mass contribution strengthened popular support for the institutions. However, management remained in the hands of traditional elites who were reluctant to adopt constitutions which radically enhanced democratic participation.

## **Users and carers**

There is relatively little material concerning what people thought of their care or about their experiences as users of services. There is a small number of oral histories which cover limited numbers of people and although suggestive, these do not permit definitive conclusions to be drawn. Jacobs' (1993) study of public opinion and state welfare contains some limited work on this, drawing on testimony to Mass Observation, which indicates considerable ambivalence about the merits of continuing with the voluntary tradition (Jacobs, p. 219).

## **Conclusions**

Returning to the points made by Salamon, to what extent is it valid to level the charges identified by him – namely philanthropic insufficiency, particularism, amateurism and paternalism – at nonprofit health care in Britain before the NHS? And what lessons does this experience of nonprofits before the NHS hold for the future development of the service?

It could certainly be argued that philanthropic insufficiency is a defensible verdict. The pre-NHS hospital system was certainly not comprehensive, as is clearly demonstrated by the pattern of hospital utilisation, but a more important criticism is the failure to achieve any degree of matching between provision and need: there was no systematic relationship between utilisation rates, other indicators of provision, and indicators of need for health care. Insufficiency is also evident in the financial and asset base of the hospitals – hospital could not generate the sums needed for new investment, and the evidence

suggests that in the 1930s some were running down their assets in order to balance the books.

Philanthropic particularism is also a valid charge to lay against the voluntary hospitals. Processes of competitive medical specialisation, motivated by a desire to obtain a niche in a competitive medical marketplace, resulted in large numbers of small and specialist institutions, the quality of which was highly variable, and there is ample evidence of patient selection on the part of the voluntary hospitals. What we have therefore is a system in which there were no incentives for institutions to do anything other than pursue their own interests; the only exceptions to this were at a small number of cities in which the need to reorganise medical education led several institutions to collaborate rather than compete.

Amateurism is also evident. We can infer this from the inability of the system to match provision of need, the absence of any strategic direction of investment, tolerance of variations in standards, and the influence of hospital subscribers over admission systems. Finally, although strictly charitable finance was on the wane by the 1930s, strong residues of paternalism pervaded the voluntary hospitals. By extension, therefore, if tests of comprehensiveness, public purpose, and responsiveness are applied to the pre-NHS nonprofit sector, it largely fails them.

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## Appendix 4: Government financial reporting and its relationship with the system of national accounts

Government guidance on financial reporting, set out in the manual 'Government Accounting', covers the proper handling and reporting of the income, expenditure, assets and liabilities of public entities. This guidance is based on the UK's private sector accounting standards known collectively as Generally Accepted Accounting Practice or UK GAAP. GAAP consists of "the accounting and disclosure requirements of the Companies Act 1985 and pronouncements by the Accounting Standards Board (principally accounting standards and Urgent Issues Task Force abstracts), supplemented by accumulated professional judgement." (HM Treasury 2000b, glossary)

The guidance, which consists of mandatory controls and advice, covers three main categories: parliamentary requirements; Treasury administrative controls; and best practice. Parliamentary requirements may be statutory, customary, or set out in specific agreements between parliament and the Treasury. Treasury administrative controls deal with propriety, value for money, and accountability in public spending, are also concerned with regulating public spending. Best practice refers to the promotion of procedures contributing to "good administration." (HM Treasury 2000b, summary)

National accounting and government accounting overlap. National and government financial accounts are both derived from individual financial accounts of public sector entities. However, because the functions of the two systems differ, different criteria are occasionally involved in determining sectoral classification. Ownership is one area in which differences arise. We illustrate this, using the example of public private partnerships (PPPs).

### **The concept of 'economic ownership' in public private partnerships**

Both the government's financial reporting regime and the system of national accounts are concerned with the question as to whether a public private partnership (PPP) is a financing arrangement for the procurement of public sector infrastructure, in which case the asset and the liability should be accounted for as a finance lease on the public sector balance sheet, or whether the PPP primarily represents the procurement of infrastructure-based services, in which the contract is treated as an operating lease and the asset and liability are not recognised on the public sector's balance sheet. However the definition is not straightforward, as the PPP may contain elements of both. Eurostat provides a Private Finance Initiative (PFI) example: "a PFI contract for "school building services" in which the operator

provides a building and agrees to clean the building might be analyzed as containing a lease and contract for cleaning services.” Here guidance differs between the views of the British regulator, the Accounting Standards Board (ASB), the International Accounting Standards Board (IASB) and Eurostat.

Due to the complexity of the issue, and following substantial debate between the Accounting Standards Board (ASB), the British regulator, and the UK government, the ASB issued an Application Note (AN) in an attempt to clarify accounting for PPPs. Essentially the accounting treatment follows the concept of substance over form, whereby there is careful consideration as to which party benefits from the risks and rewards of ownership, and has effective ‘economic ownership’ of the underlying asset, regardless of which party retains legal ownership. The AN states that after separable service elements, which are treated as operating leases, are removed, if the only remaining payments relate to property payments then the provisions of SSAP 21 *Accounting for Leases* are applied because the nature of the transaction is a stand-alone lease. However, if the remaining payments relate both to property and some non-separable service elements then FRS 5 *Reporting the Substance of Transactions* should be applied because these involve a lease within a larger arrangement. The Application Note requires consideration as to whether all the risks and rewards of ownership have been transferred, and the spirit of the regulation appears to be that PPP infrastructure is likely to be a finance lease, implying that it would be recognised as an asset on the public sector balance sheet, together with the long-term liability to pay for it. In practice the complexity of the PPP context makes it very difficult to judge where the risks and rewards lie as those that relate to the property are often bound up with the risks and rewards of providing the service (Cearns 1998), thus giving rise to uncertainty about the accounting treatment that will be adopted.

International accounting regulation has focused on control over and definition of PPP assets, rather than on the substance of the transaction, and is contained in IAS 17 *Leases*, which classifies leases as either finance or operating leases dependent on the level of transfer of the risks and rewards of ownership. However the complexity of PPP contracts is such that the International Financial Reporting Interpretations Committee has recently issued IFRIC 12 *Service Concession Agreements* which states that operators should not recognise infrastructure, falling within the definition of a service concession agreement, as a tangible asset, since the arrangement does not transfer the right to control the use of the public service infrastructure to operators. IFRIC 12, unlike FRS 5 note F, makes a distinction between accounting for these assets depending on whether the primary responsibility for payments rests with the public sector, in which case the operator shall recognise a financial asset, or whether payment comes primarily from users, in which case the operator shall recognise an intangible asset. This distinction between financial and intangible assets in relation to the PPP infrastructure, based on the

formal criterion of 'who is the payer?' is insufficient since it does not take into account the economic substance of the transaction. Similar contracts may be accounted for differently, giving rise to a different impact on financial statements through timing differences in the recognition of revenues and expenses. There may be cases where the difference between the models is finely balanced, for example, where payments are made by users, but there are additional payments from the grantor if those fall below a minimum guarantee income.

The IFRIC preference to define assets based on control is consistent with the IASB's Framework and IAS16, but by way of contrast, the Committee on Monetary, Financial and Balance of Payments Statistics (Eurostat, 2004) adopts a risk-based approach, when it argues that assets in a PPP can only be considered non-governmental assets if there is strong evidence that the partner bears most of the risk (Heald, 2003). This is clarified as meaning that the private sector should bear the construction risk and either the availability or demand risk. However, this risk-based policy may indeed lead to complexity and inconsistency. Despite the wording that seems to indicate that PPP assets would be government assets, Hall (2005) has argued that in practice these guidelines will facilitate off public sector balance sheet accounting and that this is intentional because in principle the EU authorities are in favour of PPPs and see them as a route to enable investment by governments constrained by the EU's own fiscal rules.

Furthermore, as PWC (2004) point out, ESA 95 only covers government accounting from an EU statistical standpoint and so there is no requirement that accounting rules for other purposes should follow suit. For example, auditors acting for the private partner in a PFI deal may assess the risks and rewards differently from the public sector's auditors. As a result, PFI assets can appear in both public and private sectors simultaneously (on-on balance sheet treatment, as in the case of roads) or in no sector at all (off-off balance sheet treatment, as in the case of most hospitals) (Edwards, Shaoul, Stafford and Arblaster 2004). "Since decisions regarding whether or not a body is exposed to the risks and rewards of a PFI project are monitored independently by the private partner's auditors and the public partner's auditors, it is possible that both the public and private sector partners record the capital formation on their own balance sheets (on-on) or for a project to appear on neither balance sheet (off-off)."

While the ASB view is that there is a 'rebuttable presumption' (ASB 2005) that assets should be recognised on the public sector balance sheet, the Financial Reporting Advisory Board to HM Treasury (2005) in its response to the IFRIC has indicated its belief that at least one or other entity ought to hold the assets on balance sheet. The International Public Sector Accounting Standards Board (IPSASB) is now looking at the whole issue of service concession arrangements, from the perspective of public sector entities. The net result of all this is that until IPSASB makes a decision on this, which at best is unlikely to become operational for at least 5 years, there are

considerable uncertainties and discrepancies in how these transactions should be reported.

These matters of judgement as opposed to a clear cut classification are important because third sector policy provides a mechanism for the substitution of private for public asset ownership and balance sheet treatment has significant implications for the cost base of organisations. Assets that are on the public balance sheet are required by the government's financial regime to show a return on public sector capital of a certain amount, to show an annual cost of depreciation at a rate determined by the Treasury, and to be revalued at intervals determined by the Treasury. These arrangements affect the cost of capital and will mean that the cost of capital differs between NHS entities dependent upon how the assets have been reported.

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\* NBER = National Bureau of Economic Research, Inc,

## Searched databases and websites

### a) Databases

ABI/Inform (Global and Trade & Industry)

<http://proquest.umi.com/login>

ASSIA <http://www.rdg.ac.uk/library/resources/assia.html>

BIOETHICSLINE now included in PubMed (see below)

The Cochrane Library (including NHS EED)

<http://www3.interscience.wiley.com/cgi-bin/mrwhome/>

EconLit <http://www.econlit.org/>

IBSS and GLOBAL HEALTH accessed via Ovid

<http://gateway.uk.ovid.com/>

IngentaConnect <http://www.ingentaconnect.com/>

JStor <http://www.jstor.org/>

MEDLINE/ CINAHL/ EMBASE accessed via Ovid

<http://gateway.uk.ovid.com/>

PubMed (U.S. National Library of Medicine)

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?DB=pubmed>

Science Direct <http://www.sciencedirect.com/>

Social Services Abstracts <http://www.csa.com/factsheets/ssa-set-c.php>

Web of Science <http://wos.mimas.ac.uk/>

ZETOC <http://etoc.mimas.ac.uk/>

### b) Websites

Australia Department of Health and Ageing <http://www.health.gov.au/>

European Observatory on Health Systems

<http://www.euro.who.int/observatory>

EU <http://ec.europa.eu/geninfo/query>

Google Scholar <http://scholar.google.com/>

Health Canada <http://www.hc-sc.gc.ca/>

IMF <http://www.imf.org/>

## Not-for-profit health care organisations

The Johns Hopkins Center for Civil Society Studies

<http://www.jhu.edu/~ccss/>

Ministry of Health New Zealand <http://www.moh.govt.nz/>

OECD <http://www.oecd.org/advancedSearch>

Personal Social Services Research Unit (PSSRU)

<http://www.pssru.ac.uk/>

UK Department of Health <http://www.dh.gov.uk/Home/fs/en>

US Department of Health and Human Services <http://www.hhs.gov/>

WHO <http://www.who.int/publications/en/>

WHO CHOICE <http://www.who.int/choice/toolkit/en/>

WHOLIS <http://www.who.int/library/database/index.en.shtml>

World Bank <http://www.worldbank.org/>

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