

# Changes in Hospital Ownership in California

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PUBLIC POLICY INSTITUTE OF CALIFORNIA

# Foreword

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Californians are understandably concerned about rapid changes in the health care industry. One concern that has prompted state legislation is the increased merger activity between for-profit and nonprofit hospitals. Many critics view the potential decline of nonprofit hospitals as another restriction on choice in health care.

In response to this concern, Joanne Spetz and her colleagues Jean Ann Seago and Shannon Mitchell have undertaken a careful study of the state's hospital mergers and their consequences. Their findings indicate that nonprofit hospitals are in no danger of extinction. About 80 percent of hospital mergers and acquisitions between 1986 and 1996 did not involve any change in the profit status of the hospitals. The remaining mergers were almost equally divided between conversions to for-profit and to nonprofit status.

Although these mergers have not altered the overall balance between for-profit and nonprofit hospitals, they have raised new concerns about the concentration of hospital ownership in California. At least half of the

state's hospitals are now affiliated with multi-site hospital corporations, and the six largest firms in the state operate over one-third of its hospitals. The three largest hospital firms in both Sacramento and San Diego control more than 60 percent of the beds. Although hospital ownership is less concentrated in the Los Angeles and San Francisco metropolitan areas, both markets are far more consolidated than they were ten years ago.

With these patterns in mind, the authors plan to continue their study of ownership changes and their consequences. Their questions speak directly to hospital competitiveness and accountability. If some regions are served by fewer firms, will hospitals be less responsive to the needs of patients and local communities? How will mergers affect professional staffing, access to care, and quality of care? If big corporations enjoy economies of scale, will cost reductions be passed on to insurers and consumers? The authors' early findings differ significantly from popular characterizations. Change is certainly under way, but the conclusion that this change will necessarily reduce quality of care and consumer service is premature. The authors will have more to say on these topics in subsequent PPIC publications.

David W. Lyon  
President and CEO  
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# Summary

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In the past five years, legislators, health care workers, and the public have expressed concern that for-profit companies are taking over hospitals and health care organizations. Many observers argue that for-profit hospitals give little thought to patient care, remove charitable assets from public control, and focus too intently on the financial “bottom line.” In 1996, the California Legislature passed Assembly Bill 3101, which requires that the state Attorney General review proposed conversions of hospitals from nonprofit to for-profit status. Recent studies indicate that mergers of nonprofit firms may affect the provision of health care in California as well. This year the California legislature passed AB 254, which would regulate *most* hospital transactions in a fashion similar to that established by AB 3101.

Despite spirited debate about hospital conversions to for-profit status, there are no systematic studies of hospital ownership changes in California. Furthermore, the effects of these ownership changes on costs, services, access to care, and patient outcomes are largely unknown.

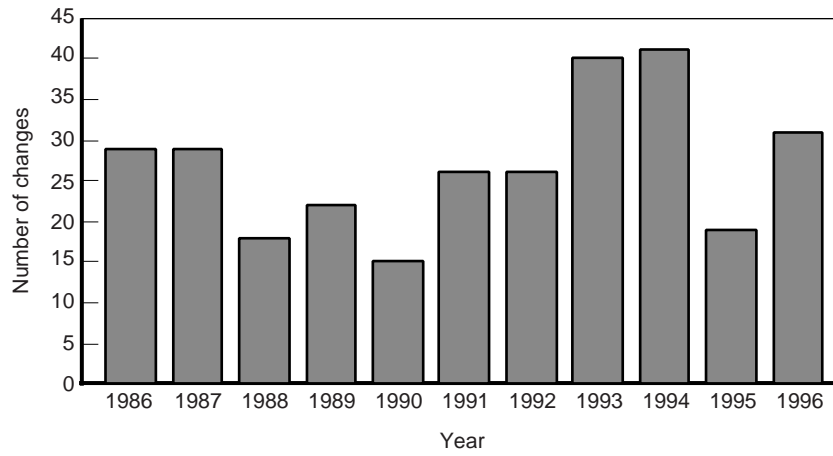
Thus, there is little empirical evidence to guide the Attorney General and state policymakers in deciding whether hospital purchases and mergers should be allowed.

This report is the first part of a longer study of hospital ownership and its effect on health care in California. It tracks ownership changes in short-term general hospitals from 1986 to 1996, describes the major hospital corporations in California, examines regional patterns of hospital ownership, and offers ideas for future research.

## **Changes in Hospital Ownership in California**

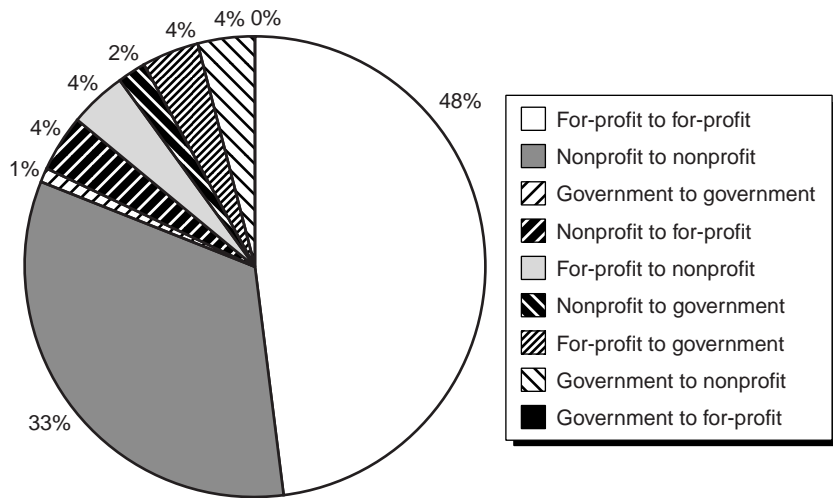
There has been little change over the past 15 years in the overall share of hospitals held by nonprofit and for-profit owners. Of the 296 ownership changes between 1986 and 1996 (Figure S.1), only 13 involved conversions from nonprofit to for-profit ownership (Figure S.2). During that same period, 12 hospitals switched from for-profit to nonprofit status. About 80 percent of hospital ownership changes in California did not involve any change in the nonprofit or for-profit status of the hospital. These figures indicate that the public debate has focused disproportionately on conversions to for-profit ownership.

At the same time, other aspects of hospital ownership changed dramatically. Most of the ownership changes between 1986 and 1996 were the result of hospital mergers. As a result of these consolidations, multi-hospital organizations grew significantly. At least half of all hospitals in California are now affiliated with multi-site hospital corporations, and six organizations operate over one-third of the state's hospitals. This increased concentration of hospital ownership may affect the cost and quality of health care and therefore has important policy implications. These implications are perhaps best understood in



NOTE: 1996 data are incomplete.

**Figure S.1—Number of Changes in Hospital Ownership per Year in California, 1986–1996**



**Figure S.2—Types of Ownership Change as Percentages of the Total, 1986–1996**

their regional contexts, where there were substantial variations in ownership and merger activity.

### Regional Patterns of Hospital Ownership

The most striking changes in hospital ownership occurred in California’s urban areas, which accounted for 90 percent of the state’s mergers. Among major cities, Sacramento now has the most concentrated hospital market. Ten changes in hospital ownership in Sacramento between 1986 and 1995 led to a steady increase in the percentage of hospital beds owned by multi-hospital firms (Figure S.3). By 1995, 82 percent of Sacramento’s hospital beds were owned by the three largest firms in the area, and over 95 percent were controlled by multi-hospital corporations.

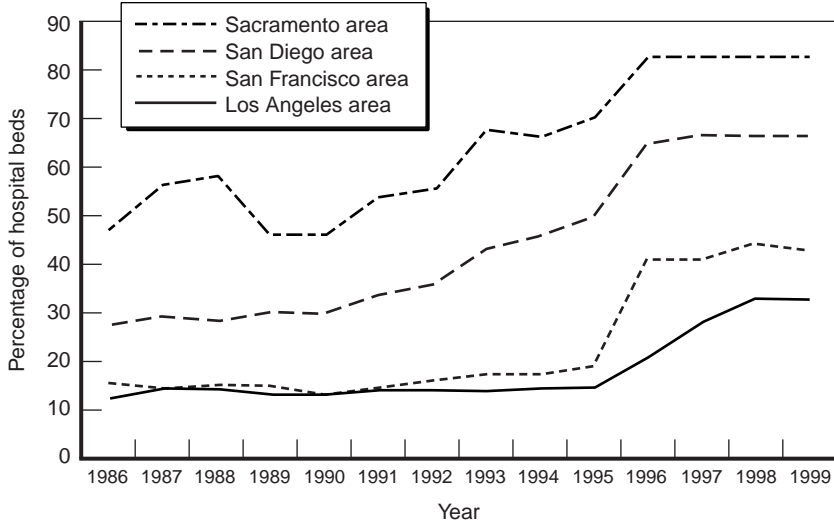


Figure S.3—Percentage of Hospital Beds Controlled by the Three Largest Owners in Major Cities in California, 1986–1999

The San Diego market is also highly concentrated. Two multi-hospital corporations own over half of the hospital beds in San Diego County, and a third company operates another 11 percent of the region's hospital beds (Figure S.3). Between 1986 and 1995, there were 12 changes in hospital ownership in San Diego County (Figure S.3).

The greater Los Angeles and San Francisco areas accounted for most of the state's merger activity, and hospital ownership in both areas became more concentrated. In 1994, only 14 percent of hospital beds in the greater Los Angeles area were controlled by the largest three firms; by 1998, that figure had risen to 33 percent (Figure S.3). In the San Francisco area, where ownership is heavily concentrated among nonprofit organizations, the three largest corporations controlled 43 percent of the region's hospital beds in 1998 compared to 18 percent four years earlier.

California's smaller urban areas, which have seen relatively few hospital transactions since 1986, vary widely in their ownership patterns. For example, none of the hospitals in the Visalia-Tulare-Porterville, Yuba City, or Monterey-Salinas metropolitan areas are owned by multi-hospital corporations, yet two firms control over 90 percent of Merced's hospital beds. About half of California's rural hospitals are owned by four nonprofit multi-hospital corporations.

## **Policy Issues and Directions for Future Research**

These patterns of hospital ownership raise new questions about hospital costs, quality, and access. Previous research has focused primarily on differences between for-profit and nonprofit hospitals. Many studies have examined whether for-profit hospitals provide less charity care than nonprofit and public hospitals. Most found that for-profit hospitals spend less on uncompensated care, although such



comparisons might be complicated by regional differences. For example, one study found that for-profit and nonprofit hospitals located in the same area serve an equal number of uninsured patients, but that for-profit hospitals avoid uninsured patients by locating in areas with high rates of health insurance coverage.

Although for-profit hospitals have incentives to operate more efficiently than their nonprofit competitors, few studies have found differences in efficiency between the two sorts of hospitals. In general, for-profit hospitals charge higher prices, enjoy higher net income, and employ fewer staff than nonprofit hospitals. However, they also pay significantly higher administrative costs. There has been virtually no investigation of the relationship between a hospital's profit status and the mix of services it provides.

Financial incentives for nonprofit and for-profit hospitals could lead to differences in the quality of care as well. Of the few studies investigating this question, however, most detected no overall pattern. Most of these studies compare for-profit hospitals to nonprofit hospitals in a single year; it would be valuable to examine whether mortality rates change among hospitals that convert their ownership status relative to those with stable ownership across several years.

The growth of multi-hospital corporations suggests a new set of policy issues and research questions. Multi-hospital organizations may benefit from increased access to capital, lower administrative costs, and the consolidation of expensive services, but they also may be less responsive to local needs than their independent counterparts. In addition, larger multi-hospital organizations have pushed insurers to reimburse at higher rates, thus raising health care costs, although these same firms could lower costs by consolidating services and technologies

into referral centers. Most studies indicate that concentrated hospital markets have higher hospital prices and that mergers raise those prices. These increases may be caused by inefficiencies among multi-hospital corporations. There is little research exploring whether multi-hospital corporations enjoy economies of scale; in particular, we do not know the extent to which these firms consolidate services, alter staffing, or decrease administrative overhead.

Analysts have expressed concern about the transfer of charitable assets from independent nonprofit hospitals to multi-hospital and for-profit firms. Differences among hospital organizations regarding charity care are likely to affect access to care in local communities. California's Senate Bill 697, passed in 1994, requires that nonprofit hospitals develop charitable benefits plans in conjunction with their local communities to ensure that hospitals focus on local needs.

Changes in the services offered by multi-hospital firms may affect access to and quality of care. For example, consolidating expensive services into referral centers could reduce access for local residents. At the same time, such consolidations could increase the quality of that care, as hospitals with high volumes of specialized procedures tend to have better patient outcomes. These effects would depend on which services were consolidated as well as the characteristics of the communities involved. We identified no research on these issues.

## **What's Next? The Ongoing PPIC Study**

More information is needed concerning the effects of ownership changes on hospital operations in California. For this reason, we are continuing our research, using the data described in this report as a starting point for our analyses. In our ongoing study, we examine

- Whether changes in hospital ownership affect the staffing of registered nurses, licensed vocational nurses, unlicensed aides and orderlies, salaried physicians, management and supervisory staff, and clerical and administrative staff;
- Whether multi-hospital firms consolidate their services into referral centers. If they do, we will examine which services are consolidated and what factors lead a corporation to create referral centers;
- The effects of ownership changes on access to care and the provision of charity care; and
- Whether changes in hospital ownership affect the quality of medical care, as measured by mortality rates, cesarean section rates, and complication rates.

We hope that this preliminary report, as well as the ongoing study of which it is a part, will help policymakers make informed decisions about changes in hospital ownership.

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# 1. Introduction and Background

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In the past five years, legislators, health care workers, and the public have expressed concern that for-profit companies are taking over hospitals and health care organizations (*Health Care Strategic Management*, 1994; *Healthcare Systems Strategy Report*, 1995; *Business and Health*, 1997; Anderson, 1997; Butler, 1997). Many observers argue that for-profit hospitals give little thought to patient care, remove charitable assets from public control, and focus too intently on the financial “bottom line” (Butler, 1997; Woolhandler and Himmelstein, 1997). In response to these concerns, the California legislature passed Assembly Bill 3101 in 1996 (Isenberg and Battson, 1997). This legislation requires that the state Attorney General scrutinize proposed conversions of hospitals from nonprofit to for-profit status. Most of the discussion regarding conversions of nonprofit hospitals to for-profit ownership revolves around issues of asset valuation and definitions of community benefit.

Although policymakers have focused on conversions of nonprofit hospitals to for-profit status, recent examinations of the data suggest that these conversions are relatively uncommon and that mergers of nonprofit organizations are becoming more important (Bellandi, 1999; Hassett and Hubbard, 1998; Hyman, 1998). California has experienced a high level of hospital merger activity. For example, in 1995, 43 mergers and purchases were initiated in California's approximately 400 hospitals—the highest number in the United States (Simonson, Zwanziger, and Chung, 1997). This year, Assembly Member Gil Cedillo introduced AB 254 to regulate a large share of hospital transactions in a fashion similar to that established with AB 3101.<sup>1</sup> At present, regulatory authorities have limited ability to scrutinize ownership changes that do not involve a conversion to for-profit ownership, even though these changes have significant effects on the provision of health care.

Despite substantial debate about hospital conversions to for-profit status, little systematic study of hospital ownership changes in California has been conducted (Mateo and Rossi, 1999). Furthermore, the effects of these ownership changes on costs, services, access to care, and patient outcomes are largely unknown. Thus, there are few empirical studies about the effects of ownership changes to guide the Attorney General and state policymakers in deciding whether purchases, mergers, and affiliations should be allowed.

This report is the first part of a study of how changes in hospital ownership affect hospital operations, access to care, and quality of care.

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<sup>1</sup>The legislature has passed AB 254; Governor Davis has not yet signed this bill. Last year, Cedillo introduced similar legislation (AB 2527), an amended version of which was passed by the legislature but was vetoed by Governor Wilson.

Before we can study these effects, however, we must understand current patterns of hospital ownership. This report provides

- A complete accounting of ownership changes in acute care hospitals in California from 1986 to 1996, with additional information on more recent ownership changes;
- A description of the major hospital corporations in California, their histories, their strategies, and their market power;
- An examination of regional patterns of hospital ownership; and
- Directions for future research.

We find that most hospital ownership changes in California are associated with the growth of large multi-hospital corporations, not with nonprofit to for-profit conversions. These multi-hospital corporations are changing the structure of the hospital industry and are likely to affect health care quality and costs. The larger study will help state policymakers keep pace with the rapid changes in the hospital industry.

## 2. Changes in California Hospital Ownership Since 1986

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### Data and Methods

To track changes in hospital ownership in California, we examined annual *Hospital Disclosure Reports* collected by California's Office of Statewide Health Planning and Development (OSHPD) from 1986–87 to 1996–97 (California Office of Statewide Health Planning and Development, 1986–1997). In these reports, OSHPD gathers information about hospital service provision, finances, and resource utilization in a fiscal year.<sup>1</sup> We further limited our study to short-term general (acute care) hospitals because they have generated the most public concern.

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<sup>1</sup>Every non-federal hospital in California is required to submit a short report to OSHPD. However, OSHPD does not collect information about federal hospitals (Veterans Affairs, military, Bureau of Indian Affairs), but these rarely change ownership and thus are not of interest here. Kaiser Foundation hospitals do not respond to every page of the survey, but they provide enough information for the analysis presented here.

Although hospitals provide information to OSHPD for their fiscal years, OSHPD collects these data by its own reporting year. For example, the most recent year of OSHPD's *Hospital Disclosure Reports* contains hospital information for June 30, 1996, to June 29, 1997. If a hospital's fiscal year ended during this period, its data will be included in the 1996–97 reporting year. Thus, the 1996–97 OSHPD data will contain information about hospitals covering the calendar years from 1995 through 1997, depending on when each hospital's fiscal year ended.

To identify changes in hospital ownership, we looked for changes in the name of the hospital, the name of the owner, and the type of control (for-profit, nonprofit, church, state, or county). We focused on the reported name of the owner to identify changes. Some hospitals filed multiple reports in a reporting year; this practice was usually associated with a change in the hospital's fiscal year (often due to a change in ownership). Many changes in hospital ownership were apparent, but some hospitals reported their ownership in ways that made it unclear whether an ownership change had occurred.

The concept of ownership among hospitals, especially nonprofit organizations, can be confusing; indeed, a hospital's personnel may not know who "owns" the hospital. Hospital and corporate office personnel make a distinction between "ownership," as the term is used with for-profit corporations, and "affiliation." One official at the corporate office of Catholic Healthcare West commented that each of their hospitals is closely tied to a specific religious order and that all the hospitals are owned by their individual orders under canonical law (personal communication, Sister Terese Marie Perry, September 30, 1998). It is unclear how much control of the hospital is exercised by the larger

organization, although it is unlikely that the hospital could withdraw from the organization at will. Unfortunately, we were unable to identify the subtleties of every nonprofit affiliation; thus, we state that a hospital is “owned” by a nonprofit corporation if it is clearly affiliated with and operated by that corporation. The exact contractual relationships, however, may vary greatly between nonprofit corporations and the individual hospitals affiliated with them. By comparison, for-profit multi-hospital systems are easily identified and the ownership of their facilities is usually obvious. Some partnerships between for-profit and nonprofit organizations make relationships more difficult to track.

To determine whether unclear reports represented real ownership changes, we compared our list of ownership changes with a History of Hospitals file provided by OSHPD (Werdegar, Smoley, and Wilson, 1998). Most of the ownership changes listed in the History of Hospitals file appear to be identified by changes in the *name* of the hospital rather than the *owner*. We found that some of the changes listed in OSHPD’s History of Hospitals file did not correspond to actual changes in hospital ownership. When our identification of an ownership change did not coincide with OSHPD’s list or we were uncertain whether an ownership change had occurred, we contacted the hospital directly. We made over 100 phone calls to verify changes in ownership.

OSHPD data on hospital ownership are often inaccurate. To illustrate this, we carefully examined the differences between data provided by Catholic Healthcare West (CHW) and OSHPD. Of 23 changes to CHW ownership that could have been matched to OSHPD data, 11 were reported more than one year late or not at all.

We also examined our data to identify consolidations of multiple hospitals into single organizations. Consolidations are identified in the

OSHPD History of Hospitals file and can be defined as hospitals that close or are merged into, become a part of, are acquired by, or are subsumed into another hospital. Consolidations may or may not involve a change in ownership. We compared the consolidations reported by OSHPD with our list of actual changes in ownership to identify which consolidations involved change in ownership and which did not.

Our analysis identifies the date of ownership change as nearly as possible and provides information about these changes for calendar years rather than for OSHPD reporting years. We define an ownership change as occurring on the first day that we see a new owner listed in the data. For example, if a hospital's report for July 1, 1994, to June 30, 1995, has one owner and that hospital lists another owner for the report from July 1, 1995, to June 30, 1996, we say that ownership change occurred on July 1, 1995. In some cases, ownership changes occurred during the fiscal year (e.g., on January 1, 1996). We thus misclassify the year of the ownership change with our methodology. This error is not substantial and does not affect our analysis or conclusions.

In the last year of available data, 190 hospitals had fiscal years ending before December 31, 1996. Therefore, it is possible that an ownership change occurred in calendar year 1996 but was reported in next year's OSHPD data. To track recent trends in hospital ownership, we obtained lists of owned and affiliated hospitals from the major hospital corporations in California. Many hospital corporations provide this information on the Internet. When our list of hospital owners in 1996 did not agree with a corporation's list, we contacted individual hospitals and corporations to determine whether and when a change in ownership occurred.

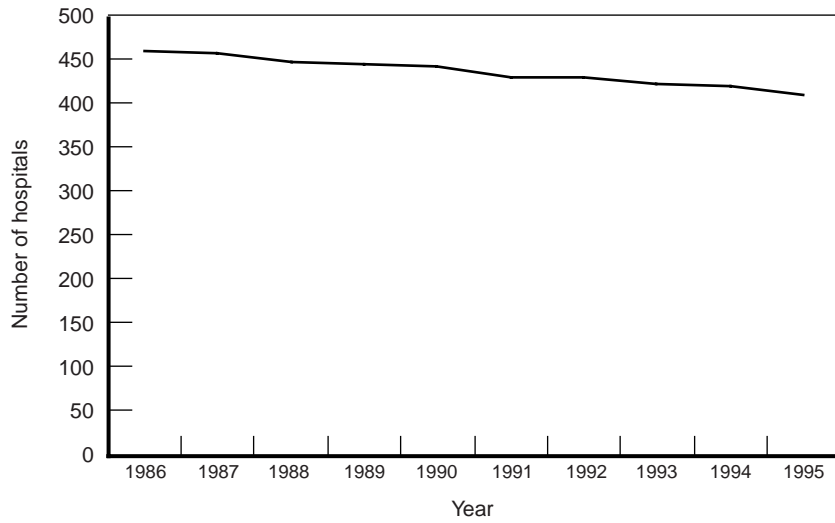


OSHPD asks hospitals to report whether their ownership falls into a number of for-profit, nonprofit, and government categories. We found that many hospitals did not consistently report their ownership; for example, some district hospitals reported in various years that nonprofit corporations owned them. (District and other government hospitals were most likely to report ownership inconsistently.) We corrected the data as much as possible. We also grouped these ownership types into three main categories: nonprofit, for-profit, and government. In most of this analysis, we categorized district hospitals as nonprofit entities because their operations often resemble nonprofits more than they do state, city, or county hospitals.

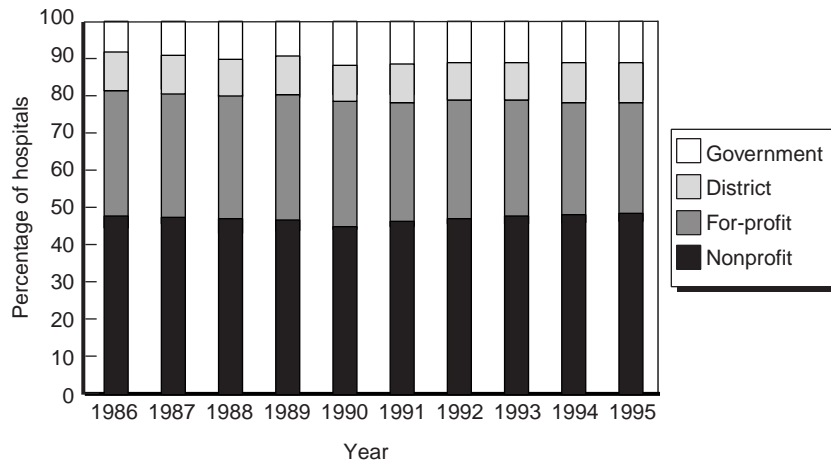
## **The Hospital Industry in California**

The number of hospitals in California has declined over time; we identified 457 short-term general hospitals in 1987 and 408 in 1995 (Figure 2.1). On average, hospitals are the same size (approximately 185 beds) as a decade ago, resulting in a net loss of hospital beds in California.

There has been little change over the past 15 years in the overall share of hospitals held by nonprofit, for-profit, and government owners. As seen in Figure 2.2, between 44 and 48 percent of hospitals have been owned by nonprofit organizations in the past decade. Another 31 to 35 percent of hospitals have for-profit ownership, with that share declining slightly over the decade. Hospital districts control 10 to 11 percent of California's hospitals, and government entities operate 9 to 12 percent.

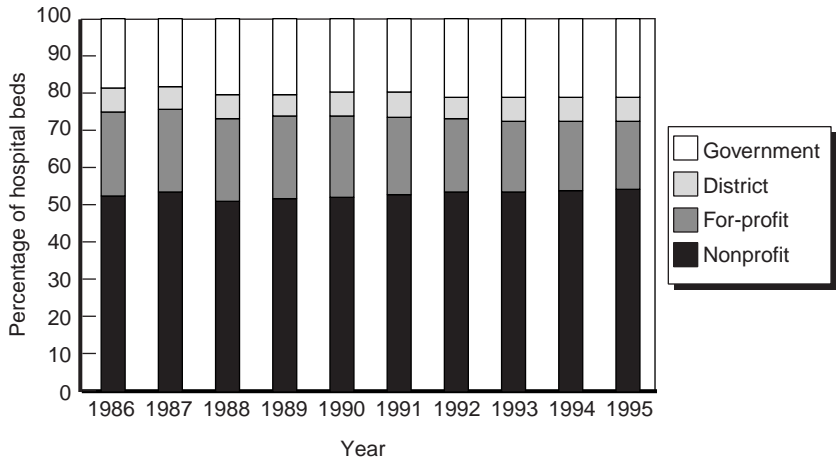


**Figure 2.1—Number of Hospitals in California, 1986–1995**



**Figure 2.2—Percentage of Hospitals by Ownership Type, 1986–1995**

California’s for-profit hospitals are, on average, smaller than their nonprofit counterparts, as seen in Figure 2.3. Although 31 percent of hospitals had for-profit ownership in 1995, these hospitals accounted for only 18 percent of hospital beds in the state. District hospitals also are smaller than average, accounting for 6 percent of beds (compared to 11 percent of hospitals in 1995). Nonprofit organizations operate over 50 percent of the hospital beds in California, and government agencies operate over 20 percent of the beds.



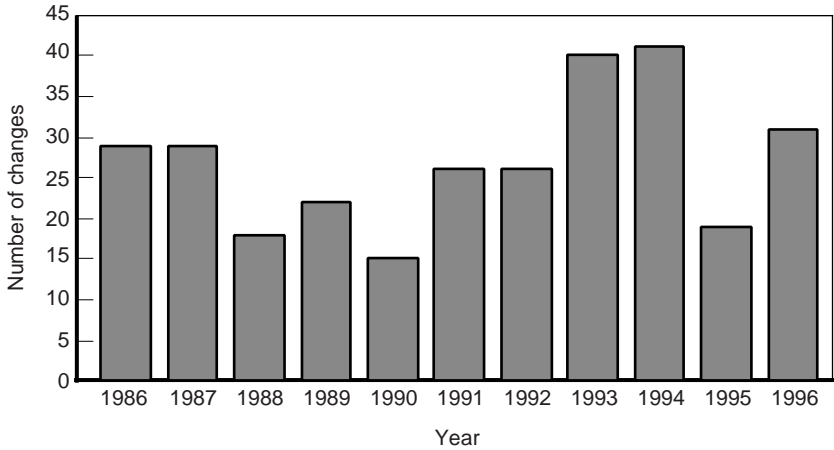
**Figure 2.3—Distribution of Hospital Beds Across Ownership Types, 1986–1995**

**The Number of Changes in Hospital Ownership**

Although there has been little change in the relative shares of nonprofit and for-profit ownership, there has been a high degree of change in hospital ownership in California. In the ten years between 1986 and 1995, we identified 265 hospital ownership changes in

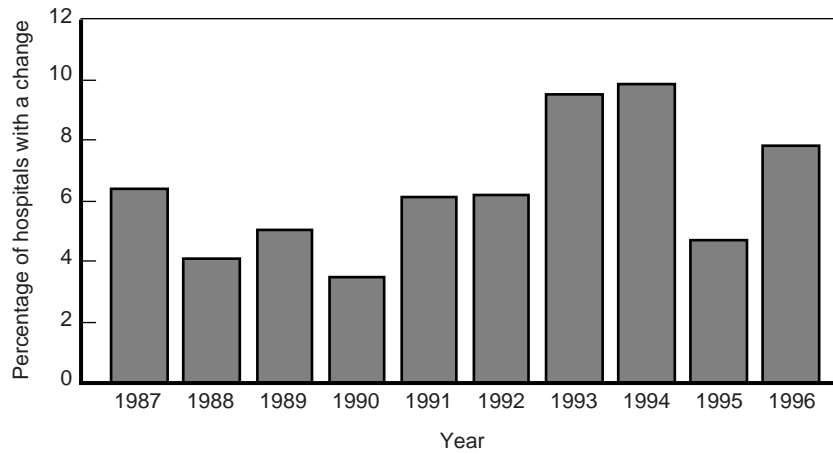
California. An additional 31 changes occurred in 1996, as seen in the available OSHPD data, for a total of 296 changes. OSHPD's History of Hospital file reports five changes in 1996 that we could not observe in the most recently released data. We do not yet have OSHPD data for about 190 other hospitals that might have changed ownership in 1996.

The number of changes varies widely over time, ranging from 15 to 41 per year (Figure 2.4). The portion of hospitals changing ownership in a single year ranged from 3.4 percent in 1990 to 9.8 percent in 1994 (Figure 2.5). There were many ownership changes in the mid-1980s, with 29 changes in 1986 and 29 changes in 1987. There was another flurry of activity in 1993, with 40 changes accounting for 9.5 percent of hospitals. In 1994, 41 hospitals changed ownership, accounting for 9.8 percent of hospitals.



NOTE: 1996 data are incomplete.

**Figure 2.4—Number of Changes in Hospital Ownership per Year in California, 1986–1996**



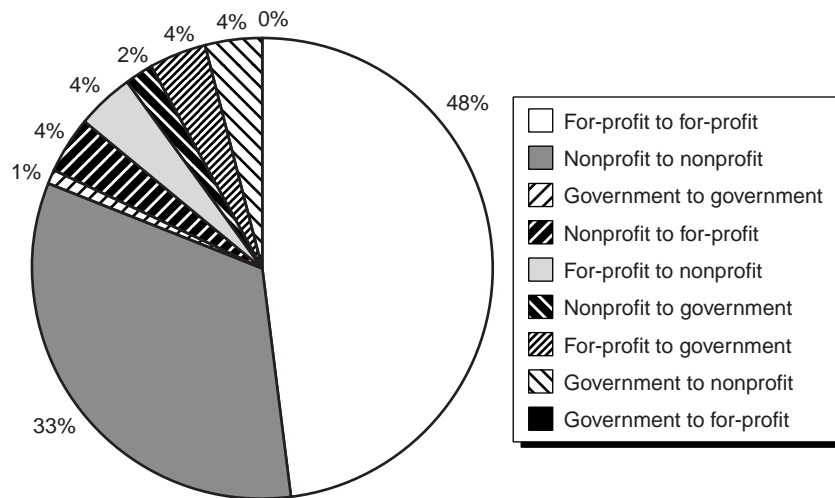
NOTE: 1996 data are incomplete.

**Figure 2.5—Percentage of Hospitals Changing Ownership per Year in California, 1987–1996**

### **Nonprofit, For-Profit, and Government Ownership**

About 80 percent of hospital ownership changes in California did not involve a change in the nonprofit or for-profit status of the hospital (Figure 2.6 and Table 2.1). Of the 296 changes we identified over the 11-year period, 140 (48 percent) were transfers between for-profit owners. Another 96 changes (33 percent) were between nonprofit owners.

Policymakers, the public, and the media have focused largely on conversions of nonprofit hospitals to for-profit ownership. Only 13 such conversions occurred in the 11-year period for which we have data. Over the same period, 12 hospitals switched from for-profit to nonprofit status. These figures suggest that the attention paid to nonprofit to for-



**Figure 2.6—Types of Ownership Change as Percentages of the Total, 1986-1996**

**Table 2.1  
Types of Ownership Changes in Each Year in California, 1986-1996**

	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	Total
For-profit to for-profit	9	13	8	8	8	7	14	20	31	7	15	140
Nonprofit to nonprofit	15	9	8	7	2	9	7	14	8	7	10	96
Govt. to govt.	0	0	0	1	1	2	0	0	0	0	0	4
Nonprofit to for-profit	1	0	0	1	0	2	0	3	0	2	4	13
For-profit to nonprofit	0	0	0	1	0	4	2	2	1	1	1	12
Nonprofit to govt.	0	0	1	2	1	0	1	0	0	1	0	6
For-profit to govt.	1	6	0	2	0	1	0	0	1	0	0	11
Govt. to nonprofit	2	1	1	0	3	1	2	1	0	1	1	13
Govt. to for-profit	1	0	0	0	0	0	0	0	0	0	0	1
Total	29	29	18	22	15	26	26	40	41	19	31	296

profit conversions in California is disproportionate to the actual number of conversions.

Some ownership changes involved the sale or purchase of a government hospital by a nonprofit or for-profit company. Thirteen hospitals switched from government to nonprofit ownership and another six changed from nonprofit to government ownership. One hospital was sold by a government entity to a for-profit organization. For-profit owners sold 11 hospitals to government agencies. Of these, eight involved Westworld Community Healthcare, Inc., which sold one hospital to a county, one to a city, and six to hospital districts. Westworld Community Healthcare was a for-profit company that sought to specialize in the management of troubled rural hospitals. At its peak in 1986, Westworld operated 40 hospitals. Over the next two years, it reduced its operations to 14 hospitals and filed for bankruptcy. Many of its hospitals were closed, but several were returned to local control and continue to operate.

## **Corporate Mergers and Takeovers**

Many ownership changes between 1986 and 1996 were the result of consolidations. For example, nearly half of the 15 nonprofit to nonprofit changes recorded in 1986 resulted from the merger of two Catholic healthcare associations to form Catholic Healthcare West. The following year, seven of the 13 for-profit to for-profit changes occurred when Healthtrust acquired hospitals from the Hospital Corporation of America. Over half of the for-profit ownership changes observed between 1993 and 1996 arose from large mergers between for-profit corporations. The next chapter provides more information about these corporations.

# The Size of Hospitals Involved in Ownership Changes

Hospitals that changed ownership in California were smaller than average, as seen in Figure 2.7. Between 1986 and 1995, the average size of a hospital in California was approximately 185 beds. Before 1991, hospitals that changed ownership were 40 to 50 beds smaller than average. In 1991 and 1995, the hospitals changing ownership were slightly larger than those that did not experience an ownership change. Between 1992 and 1994, hospitals that changed ownership were about 25 beds smaller than other facilities.

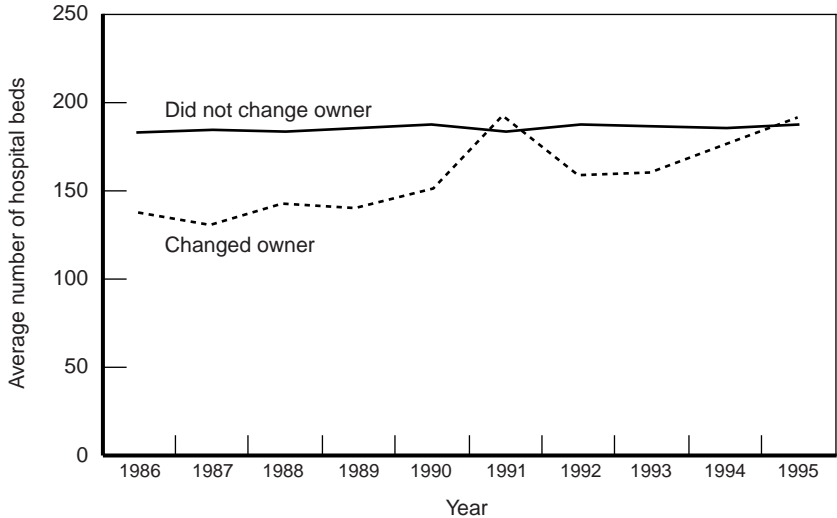


Figure 2.7—Average Size of Hospitals That Did and Did Not Change Ownership, 1986–1995



## **Ownership Changes in Recent Years**

The OSHPD data analyzed above end in 1996; a substantial number of ownership changes have occurred since then. We examined OSHPD's History of Hospitals file and documents from the major hospital corporations in California to identify recent changes in hospital ownership. Although the data obtained from these sources are incomplete, they provide some indication of current trends in hospital ownership.

The most significant event in hospital ownership in California in recent years was Tenet Healthcare Corporation's acquisition of OrNda. Sixteen hospitals changed hands in this transaction, making Tenet the largest for-profit hospital corporation in California. Four hospitals acquired by Tenet were subsequently closed. Tenet has continued to acquire hospitals in addition to incorporating OrNda's facilities to its system. Tenet also agreed to lease Desert Hospital in Palm Springs and acquired Pioneer Hospital in Artesia from MedPartners in 1997. In late 1998, Tenet acquired Sharp Healthcare Murrieta Hospital (now named Rancho Springs Medical Center). Tenet recently has reported that it intends to sell up to 20 of its hospitals this year; analysts speculate that it will divest hospitals in regions where it does not have a strong market presence (Kirchheimer, 1999).

Columbia/HCA, the second largest for-profit hospital corporation in California, has been selling hospitals throughout the United States to address large financial losses and debts acquired in recent years. In the past six months, Columbia/HCA sold Palm Drive Hospital in Sebastopol and Healdsburg General Hospital, thus ending its involvement in Sonoma County. At the same time, Columbia/HCA has sought to expand its holdings in other parts of California. In 1997, it finalized a

joint venture with nonprofit Riverside Community Hospital, leaving Columbia/HCA with a 75 percent stake in the operation of the hospital. More recently, Columbia/HCA acquired Alexian Brothers Hospital in San Jose in an exchange of hospitals that did not come under the scrutiny of AB 3101.

Several other for-profit hospital conversions have occurred in the past two years or are under way now. Long Beach Community Medical Center became a for-profit corporation in 1997 when it was sold to a group of local physicians. The Attorney General approved the sale of Watsonville Community Hospital to Community Health Systems in late 1998. Proceeds from the sale will be used to establish a new foundation.

Over the past three years, Catholic Healthcare West has affiliated with several hospital corporations. Most of these affiliations involve various charitable Catholic orders. In 1996, the Sisters of Charity of the Incarnate Word and the Dominican Sisters of San Rafael joined the CHW family, adding four acute care hospitals to the organization. In the same year, CHW affiliated with Woodland Memorial Hospital, Sequoia Hospital in Redwood City, the Robert F. Kennedy Medical Center, Bakersfield Memorial Hospital, and Mercy Hospital and Health Services in Merced. In 1997, two more Catholic orders affiliated with CHW, adding two hospitals to the system. In 1998, CHW added Community Hospital of San Bernardino and merged with UniHealth, which owned eight hospitals in the Los Angeles area.

Sutter Health is also continuing to expand. In 1997, Merced Community Medical Center joined the Sutter Health system and changed its name to Sutter Merced hospital. Eden Medical Center and Davies Medical Center were added to Sutter Health in 1998. At present,

Sutter is negotiating to buy Summit Medical Center in Alameda County, as discussed below.

At least two for-profit hospitals returned to nonprofit ownership in 1998. As noted above, two of Columbia/HCA's hospitals were sold to community organizations in Sonoma County.

Other small mergers and ownership changes have occurred recently or are under way. In 1996, Citrus Valley Health Partners bought Foothill Presbyterian Hospital, Memorial Health Services bought Anaheim Memorial Hospital, Southern California Healthcare Systems bought Beverly Hospital and Verdugo Hills Hospital, and Santa Barbara Cottage Hospital bought Santa Ynez Valley Hospital and Goleta Valley Community Hospital. In 1997, Sharp Healthcare bought Mesa Vista Hospital and Legacy Health System bought Baldwin Park Medical Center. In 1998, Enloe Medical Center purchased Chico Community Hospital. In that same year, Kaweah Delta Health Care District purchased Exeter-based Memorial Hospital. More transactions will be identified as new data become available.

## **Management Companies**

Some hospitals hire firms to provide management services, and some companies both own hospitals and offer management services. At present in California, management companies do not control a significant number of hospitals. In the most recent OSHPD data, 34 California hospitals reported that other corporations managed them. Brim Healthcare, Inc., manages five hospitals, and Pacific Health Corporation of Long Beach, California, manages four hospitals. Adventist Health, FHP, Alpha Partners, Primus Hospital Management, Delta-One Management, and Valley Health manage two hospitals each.

In the 1980s, mergers and consolidations of companies with varying interests accelerated nationwide (Nemes, 1992). Brim and Associates, based in Portland, Oregon, was the first private non-profit firm to provide contract management services (Kim, 1989). Principal Hospital Company acquired Brim's hospital business in 1997 (Japsen 1996, 1997), and Brim recently has taken over Aligned Business Consortium, a medical group purchasing firm, formerly run by Columbia/HCA.

Some companies, such as Adventist Health, both own and manage hospitals. Sutter Health has managed two hospitals: Amador Hospital, owned by Amador County until 1993 when it became affiliated with Sutter, and Plumas District Hospital. Other relationships, such as those between Tenet and MedPartners and between Catholic Healthcare West and MedPartners, combine hospitals and medical practice management companies (Nordhaus-Bike, 1997; Shinkman, 1997). These relationships further confuse the public about who controls hospitals in California.

Without a clear understanding of hospital ownership, corporate structures, and management companies, it is difficult for legislators to determine the type and level of regulation necessary to protect consumers. More information about the effects of ownership on hospital operations is needed to make decisions about the delivery of care that affects the health of Californians.

### **3. What Are the Major Hospital Corporations in California?**

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#### **California's Major Hospital Corporations**

Most of the ownership changes between 1986 and 1996 were the result of consolidations and mergers between hospital corporations. Multi-hospital firms have grown substantially over the past decade; at least half of all hospitals in California are now affiliated with multi-site hospital corporations. Six hospital organizations operate over one-third of the state's hospitals. The nonprofit organizations with the largest number of hospitals are Catholic Healthcare West, Kaiser Foundation Hospitals, Sutter Health, and Adventist Health. The largest for-profit hospital corporations in California are Tenet Healthcare Corporation and Columbia/HCA. The University of California is also an important player in California's hospital industry, operating five medical centers and two neuropsychiatric institutes. These organizations are changing

hospital markets throughout the state. In this chapter, we describe them, their histories, and their strategies.

### ***Catholic Healthcare West***

Catholic Healthcare West (CHW) was formed in 1986 by the merger of two communities of the Sisters of Mercy: the Sisters of Mercy, Auburn, and the Sisters of Mercy, Burlingame. Ten California hospitals were affected by the creation of Catholic Healthcare West, accounting for nearly half of the 16 nonprofit to nonprofit changes we observed in 1986. Between 1988 and 1997, several other religious orders became co-sponsors of CHW: the Sisters of St. Dominic of Adrian, Michigan (1988, two hospitals, one in California); the Daughters of Charity of St. Vincent De Paul, Province of the West (1995, five hospitals); the Sisters of Charity of the Incarnate Word of Houston, Texas (1996, two hospitals); the Dominican Sisters of San Rafael (1996, two acute care hospitals); the Sisters of St. Catherine of Siena of Kenosha, Wisconsin (1996, one hospital); the Franciscan Sisters of the Sacred Heart of Frankfort, Illinois (1997, one hospital); and the Sisters of St. Francis of Penance and Christian Charity of Redwood City (1997; one hospital). Several of these affiliations occurred in the mid-1990s, increasing CHW's presence substantially.

In 1998, CHW acquired eight hospitals from UniHealth. This was CHW's first acquisition of a large hospital corporation that was not sponsored by a Catholic order. The acquisition provided CHW with a strong presence in the Los Angeles area. CHW now represents nine religious orders and operates 46 acute care hospitals throughout California, Arizona, and Nevada; of these, 44 are in California. CHW has managed one district hospital on a contractual basis since 1998

(which we do not count as an ownership change). The organization is the largest nonprofit hospital group in California.<sup>1</sup> CHW has been financially healthy in past years, recording positive net income in between 1995 and 1998. However, CHW expects to report an operating loss of \$225 million in the fiscal year ending in 1999.

### ***Tenet/OrNda***

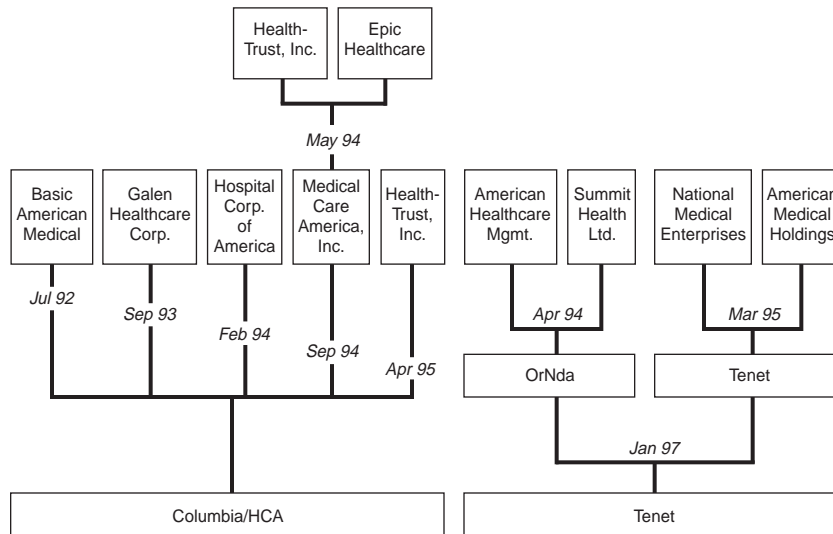
Tenet Healthcare Corporation owns or operates 130 acute care hospitals and related businesses serving communities in 18 states.<sup>2</sup> Of these, 42 hospitals are in California. Tenet was formed in 1995 by the merger of two for-profit hospital corporations, National Medical Enterprises (NME) and American Medical Holdings (AMI). This merger of NME and AMI accounts for 18 of the ownership changes we identify in 1994 and two in 1995. Figure 3.1 charts the history of Tenet and the companies that have been incorporated into Tenet. The company, which is headquartered in Santa Barbara, is publicly held.

In January 1997, Tenet Healthcare Corporation merged with OrNda, another for-profit corporation. OrNda owned 17 hospitals in California at the time it merged with Tenet. OrNda HealthCorp was created in 1994 by the merger of for-profit American Healthcare Management and for-profit Summit Health Ltd. (see Figure 3.1). Our data indicate that eight ownership changes in 1993 and two ownership changes in 1994 resulted from the merger of Summit Health and American Healthcare Management. At the time of its merger with Tenet, OrNda was the country's third largest for-profit healthcare

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<sup>1</sup>Information about Catholic Healthcare West was obtained from [www.chw.org.edu](http://www.chw.org.edu) and other sites linked to this page.

<sup>2</sup>Tenet's information can be found at [www.tenethealth.com](http://www.tenethealth.com).



**Figure 3.1—Family Tree of For-Profit Companies**

provider, with 48 facilities throughout the United States. Six of the ownership changes reported for fiscal years starting in 1996 were caused by the acquisition of OrNda by Tenet. Another ten California hospitals were owned by OrNda in 1996 and were transferred to Tenet in 1997.<sup>3</sup>

In contrast to Tenet’s aggressive expansion in the past, Tenet is now selling at least 18 hospitals outside California. Lower-than-expected earnings in the third quarter of the 1999 fiscal year may have prompted the sell-off. Tenet has reported positive net income for the past several years but experienced a 4 percent drop in net income between 1998 and 1999.

<sup>3</sup>Four of these hospitals subsequently closed.



### ***Kaiser Foundation Hospitals***

In 1933, Sidney A. Garfield, M.D., began to deliver health care on a prepaid basis to men building the Los Angeles Aqueduct. In 1938, Henry J. Kaiser's son, Edgar, invited Garfield to provide the same health care program to Kaiser's workers, who were building the Grand Coulee Dam, and their families. This health program expanded during World War II, when Kaiser operated wartime shipyards in California and Oregon. Kaiser bought and renovated a hospital in Oakland in 1942 to improve the health care services provided to employees at the Richmond shipyard.

In 1945, Kaiser's health plan opened to the general public as a nonprofit corporation. Two unions—the International Longshoremen and Warehousemen Union and the Retail Clerks Union—were instrumental in taking the health plan to Los Angeles. Many opposed this prepaid health plan; some observers believed it was a “communist” system, and the American Medical Society actively undermined it and the physicians who worked for it. Kaiser Permanente built a second hospital in Walnut Creek in 1953, in part because other hospitals were reluctant to allow Kaiser physicians to admit patients to their facilities.<sup>4</sup>

Kaiser Permanente is now the largest nonprofit health maintenance organization in the United States, serving 9.2 million members in 19 states and the District of Columbia. It is an integrated health delivery system, providing care through exclusively contracted physicians and its hospitals and outpatient centers. Kaiser is engaged in many social benefit activities, including assistance to the uninsured and special populations,

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<sup>4</sup>The information in this section was obtained from Kaiser Permanente's pages at [www.kaiserpermanente.org](http://www.kaiserpermanente.org).

instruction for new health professionals, medical research, and cost-effectiveness research. Kaiser Foundation Hospitals, one part of Kaiser Permanente, owns 27 hospitals in California.

### ***Sutter Health***

Sutter Health traces its history to 1923, when Sutter Hospital was established in Sacramento. In 1937, Sutter Hospital opened a maternity hospital in Sacramento, and in 1981 the governing organization of these two hospitals established Sutter Health. Between 1981 and 1996, Sutter became affiliated with several hospitals in Northern California. In 1996, Sutter merged with the California Healthcare System, which was founded in 1986 by Alta Bates Medical Center, California Pacific Medical Center, Marin General Hospital, and Mills–Peninsula Medical Center. In our analyses, we do not consider the California Healthcare System an “owner,” as none of the member hospitals reported it as such. The merger between Sutter and the California Healthcare System gave Sutter a strong presence in the San Francisco area. In more recent years, Sutter has affiliated with Merced Medical Center, Memorial Hospitals Association, Davies Medical Center, and Eden Medical Center.

Sutter Health is in the process of merging Alta Bates Medical Center with Summit Medical Center, a major independent hospital in Oakland. Although the Federal Trade Commission investigated this merger on antitrust grounds, as of this writing, the merger has been approved by federal regulators. However, California’s Attorney General is challenging the transaction. Sutter Health’s position in the Oakland market is discussed in more detail in Chapter 4.

Sutter Health serves more than three million people throughout Northern California. The organization operates a provider network that

includes 21 acute care general hospitals, eight long-term care facilities, two behavioral health hospitals, various physician offices and outpatient centers, and home health, hospice, and occupational health services.<sup>5</sup> Sutter is financially healthy, recording positive net income in 1997 and 1998.

### ***Adventist Health***

Adventist Health is a nonprofit healthcare system sponsored by the Seventh-Day Adventist Church and is headquartered in Roseville, California.<sup>6</sup> The West Coast system is part of an international network that includes hospitals, medical clinics and groups, hospices, home-health agencies, and pharmacy and medical equipment services in California, Hawaii, Oregon, and Washington. In the West Coast system, Adventist Health owns 20 hospitals, 15 of which are in California. Adventist Health has not expanded aggressively and remains one of the smallest systems in California. It has recorded positive net revenue for the past few years, but faced operating losses in 1998. Adventist is in the process of purchasing Selma District Hospital, which would provide Adventist with five hospitals in the Central Valley and three in the Hanford area.

### ***Columbia/HCA***

As the largest for-profit hospital corporation in the United States, Columbia/HCA has garnered much public scrutiny. Over the past decade, Columbia/HCA expanded as a result of mergers between and acquisitions of many for-profit hospital companies (Figure 3.1). Basic American Medical was acquired by Columbia in 1992, Galen Healthcare

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<sup>5</sup>Information about Sutter Health is available at [www.sutterhealth.org](http://www.sutterhealth.org).

<sup>6</sup>Information about Adventist Health was obtained from [www.adventisthealth.org](http://www.adventisthealth.org).

Corp. was added in 1993, and a merger with Hospital Corporation of America (HCA) followed in 1994. This last merger accounted for eight of the for-profit to for-profit ownership changes identified between 1993 and 1995. Medical Care America, Inc., was also acquired in 1994. In 1995 HealthTrust Inc. was added to the system. HealthTrust itself had acquired seven hospitals from the Hospital Corporation of America in 1987, accounting for over half of the 13 for-profit to for-profit changes observed in 1987.<sup>7</sup>

Columbia/HCA made newspaper headlines in 1997 and 1998 when the federal government began a large Medicare fraud investigation. The investigation led to unprecedented turnover in senior management. At the same time, Columbia/HCA faced declining profits and sold a substantial number of its hospitals. Columbia/HCA now owns and operates 221 hospitals, down from its peak of 340, 11 of which are in California.

### ***University of California***

The University of California has five medical schools: Davis, Irvine, Los Angeles, San Diego, and San Francisco. Each of these medical schools is associated with at least one acute care hospital. The university medical centers influence the markets in which they operate because they provide a wide range of advanced medical services. In 1997, the UCSF Medical Center and UCSF/Mt. Zion Hospital merged with Stanford University's two hospitals to form UCSF Stanford Health Care. This new health care system was controversial, largely because it involved the transfer of public assets to an independent (though nonprofit)

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<sup>7</sup>Columbia/HCA provides information at [www.columbia-hca.com](http://www.columbia-hca.com).

corporation. UCSF Stanford reported an operating return of \$20 million in its first year but experienced a \$10 million loss in the first quarter of its second year. Losses are mounting, and the future of the merger is in question.

## 4. Regional Ownership Patterns and Market Concentration

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There is substantial regional variation in hospital ownership in California. The degree to which a region's hospital market is concentrated in the hands of one or two hospital corporations is likely to affect the cost of medical care and also may affect access to and quality of care. In this chapter, we describe the level of merger activity and the degree of hospital market concentration for the different regions of California.<sup>1</sup> The policy issues raised by the concentration of hospital ownership are discussed in more detail in Chapter 5.

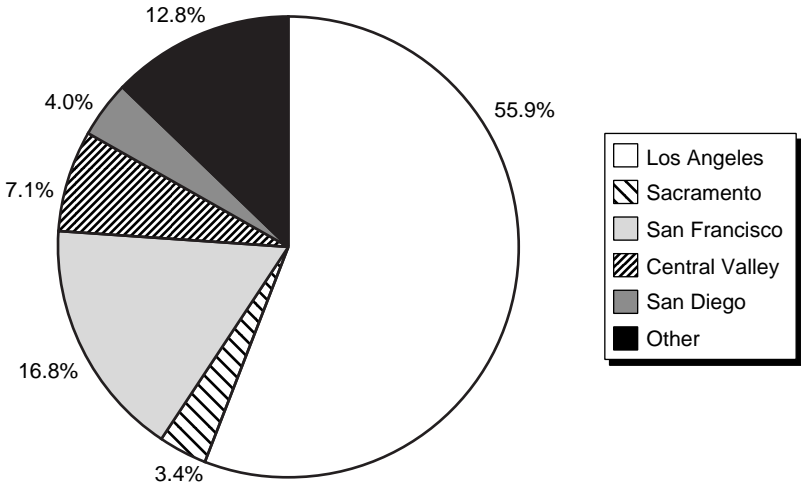
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<sup>1</sup>For this study, we define metropolitan areas according to the Census regions. Metropolitan Statistical Areas (MSAs) are composed of counties that house urban centers and are not contiguous with other major urban centers (e.g., Fresno, Redding, San Diego). Consolidated Metropolitan Statistical Areas (CMSAs) are composed of more than one Primary Metropolitan Statistical Area (PMSA). There are three CMSAs in California: Los Angeles-Orange-San Bernardino-Riverside, San Francisco-Oakland-San Jose, and Sacramento-Yolo. A PMSA is an urban component of a CMSA and is analogous to a MSA. For example, the Los Angeles CMSA consists of four PMSAs: Los Angeles, Orange, Ventura, and San Bernardino-Riverside.

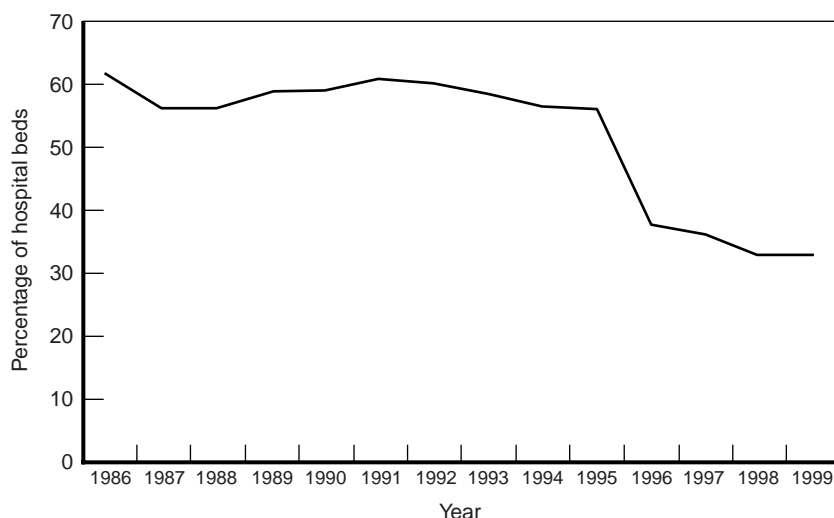
## The Los Angeles-Orange-Riverside-San Bernardino Area

The Los Angeles CMSA has experienced the greatest share of hospital ownership change activity. There have been 166 changes (56 percent) in the greater Los Angeles area (Figure 4.1), where approximately 45 percent of California’s hospitals are located. The majority of ownership changes occurred in Los Angeles and Orange counties, which account for 77 percent of the hospitals in the consolidated Los Angeles metropolitan area and 83 percent of the changes in this region.

In the Los Angeles CMSA, many hospitals have become part of multi-hospital corporations. As seen in Figure 4.2, fewer than 35 percent of the region’s hospital beds are independent of a major corporation, down from 60 percent in 1986. Between 1986 and 1995, the share of



**Figure 4.1—Regional Percentage Distribution of Changes in Hospital Ownership, 1986–1996**



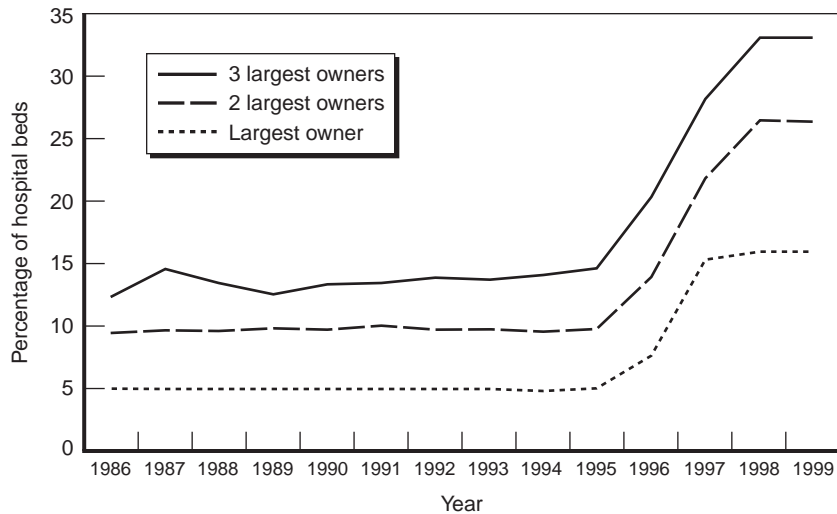
**Figure 4.2—Percentage of Hospital Beds with No Major Affiliation, Los Angeles CMSA, 1986–1999**

independent hospital beds remained relatively stable. However, between 1995 and 1996 there was a dramatic decrease in independent beds, indicating that a number of hospitals were purchased by or affiliated with multi-hospital firms in those years.

Figure 4.3 charts the percentage of hospital beds over time controlled by the largest, two largest, and three largest owners in the Los Angeles area.<sup>2</sup> Consistent with Figure 4.2, the largest owners in the Los Angeles CMSA have experienced significant increases in market share since 1995. In that year, the three largest firms controlled only 14 percent of the

<sup>2</sup>The figures for 1986 through 1995 were computed directly from the OSHPD data. After 1995, we estimated the share of beds owned by each system based on the number of beds in each hospital in the most recent year of OSHPD data. Because the ownership data may be incomplete and hospitals may have changed the number of beds they have available, the figures for 1996 through 1999 should be considered preliminary.





**Figure 4.3—Percentage of Hospital Beds Controlled by Three Largest Owners, Los Angeles CMSA, 1986–1999**

region’s hospital beds. By 1998, the three largest owners held 33 percent of the beds.

In Figure 4.3 and subsequent similar figures, the largest owners are not the same in every year. Between 1988 and 1993, the three largest owners in the Los Angeles CMSA were Los Angeles County, Kaiser, and Unihealth. In 1994, OrNda displaced Unihealth from its “top three” status. By 1998, after the Tenet-OrNda and the CHW-Unihealth mergers, the largest owners in the Los Angeles CMSA were Tenet, Catholic Healthcare West, and Kaiser.

A wide range of corporations owns hospitals in the Los Angeles CMSA. For-profit hospitals are more common in this region than elsewhere in the state, largely due to the presence of Tenet, which holds 29 hospitals in the Los Angeles region, 17 of which are in Los Angeles County and 10 of which are in Orange County. Each of these hospitals

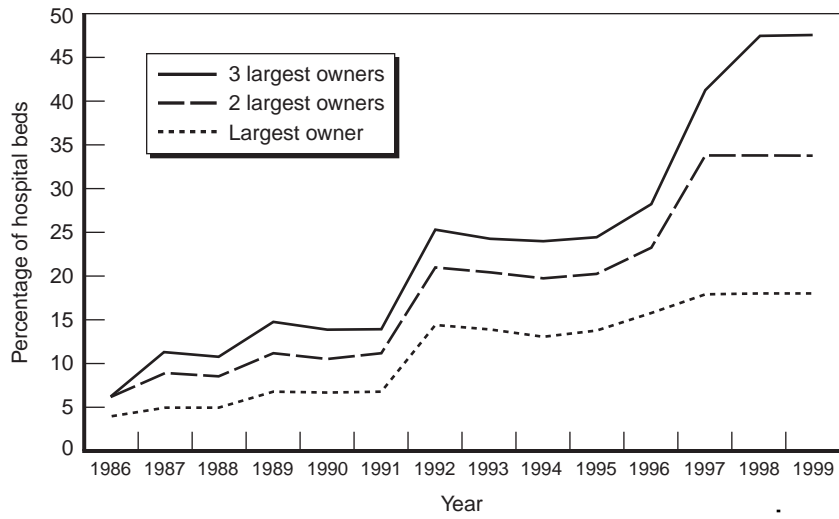
has over 100 available beds and four have over 300 beds.<sup>3</sup> Catholic Healthcare West owns the largest number of nonprofit hospitals in the region. It now operates 10 percent of the total beds in the region. Kaiser Permanente's nine hospitals also establish a strong presence. All of Kaiser's facilities are large, ranging from 150 to nearly 600 beds. Columbia/HCA owns seven hospitals and Paracelsus (a for-profit corporation) owns six. Columbia's hospitals are smaller than average in the region. Paracelsus's are somewhat smaller than average for the region, ranging from 85 to 244 beds. The University of California has a significant presence in the Los Angeles area, operating medical centers at UCLA and UC Irvine. UCLA's medical center includes Santa Monica Hospital, the UCLA Medical Center, UCLA Children's Hospital, and the UCLA Neuropsychiatric Hospital. Sutter Health, one of the state's largest hospital corporations, does not operate any hospitals in the Los Angeles area.

The main urban areas within the Los Angeles CMSA have similar levels of consolidation as the CMSA as a whole, although there are differences in which corporations are dominant. In the Los Angeles primary statistical area (PMSA),<sup>4</sup> 47 percent of hospital beds are controlled by the three largest owners: Tenet, Valley Hospital System, and Columbia/HCA (Figure 4.4). It is notable that two for-profit corporations are dominant in this county. In Orange County, nonprofit owners control 38 percent of the hospital beds: CHW, Kaiser, and St. Joseph of Orange (Figure 4.5). Tenet, St. Joseph of Orange, and Columbia/HCA operate 48 percent of the available hospital beds in the

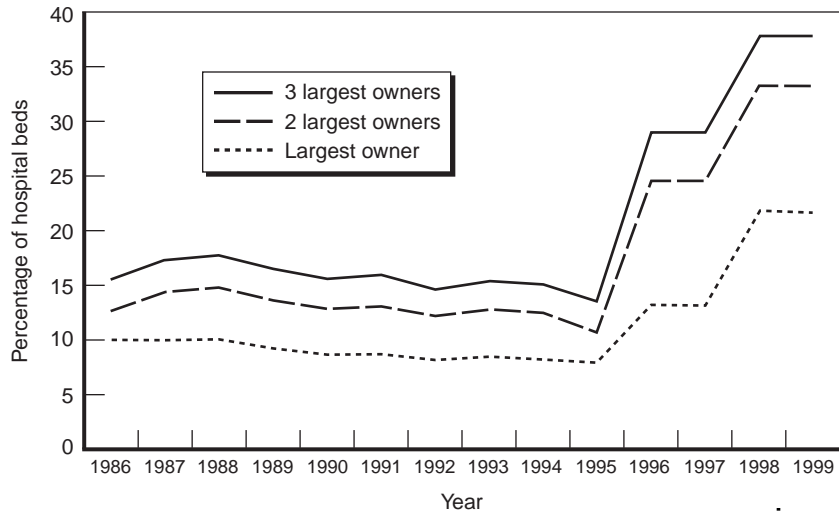
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<sup>3</sup>The median hospital size in the Los Angeles area is 221 beds. All bed size figures are from the 1995–96 OSHPD data.

<sup>4</sup>The Los Angeles PMSA consists of Los Angeles County.



**Figure 4.4—Percentage of Hospital Beds Controlled by Three Largest Owners, Los Angeles-Long Beach PMSA, 1986–1999**

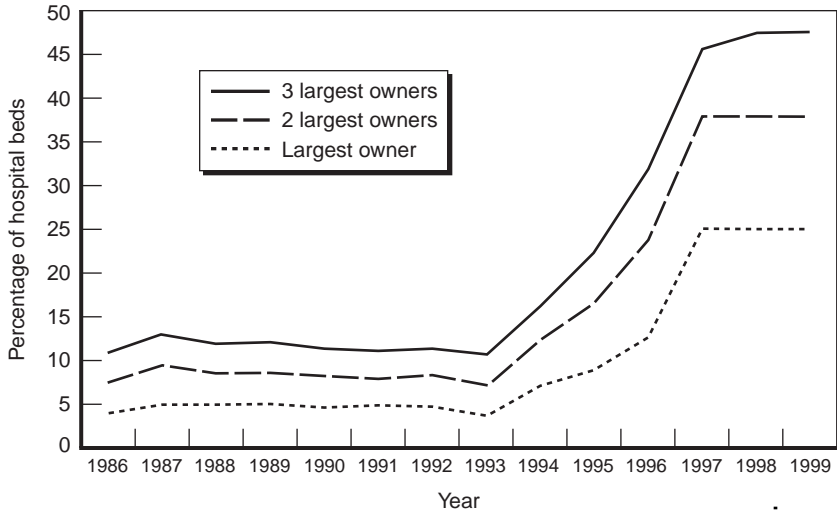


**Figure 4.5—Percentage of Hospital Beds Controlled by Three Largest Owners, Orange County MSA, 1986–1999**

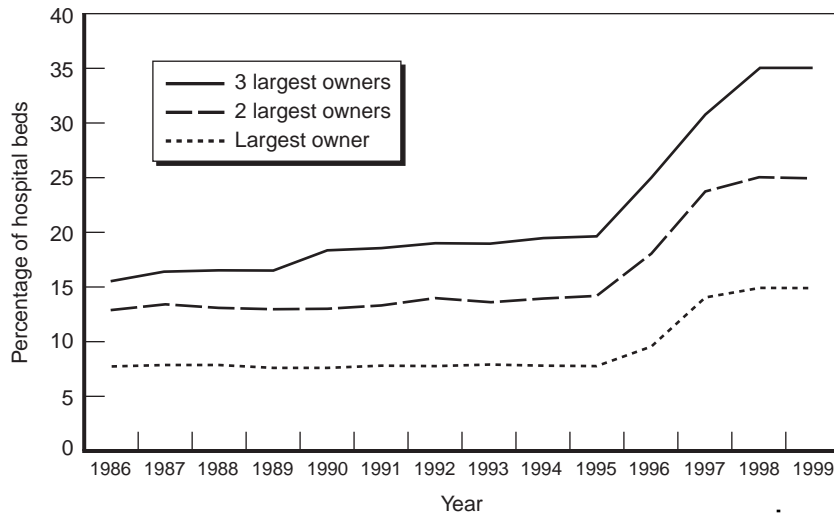
Riverside-San Bernardino PMSA (Figure 4.6). In the Ventura PMSA, the major owners are Tenet, Catholic Healthcare West, and Los Angeles County, accounting for 35 percent of the region’s hospital beds (Figure 4.7).

**The San Francisco-Oakland-San Jose Area**

The San Francisco CMSA (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma Counties), which is home to about 18 percent of California’s hospitals, experienced 16.6 percent of California’s changes in hospital ownership. Nearly a third of these changes occurred in Santa Clara County, where only one-sixth of the Bay Area’s hospitals are located. Several hospitals in Santa Clara County have changed hands multiple times.



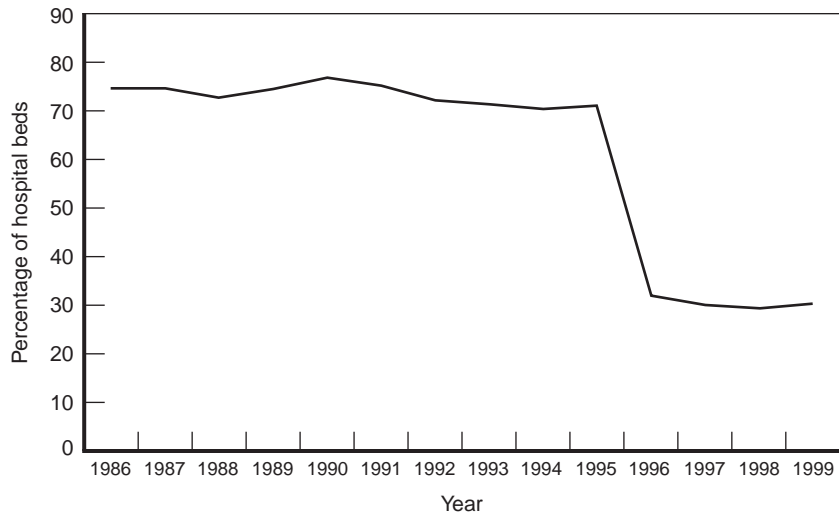
**Figure 4.6—Percentage of Hospital Beds Controlled by Three Largest Owners, San Bernardino MSA, 1986–1999**



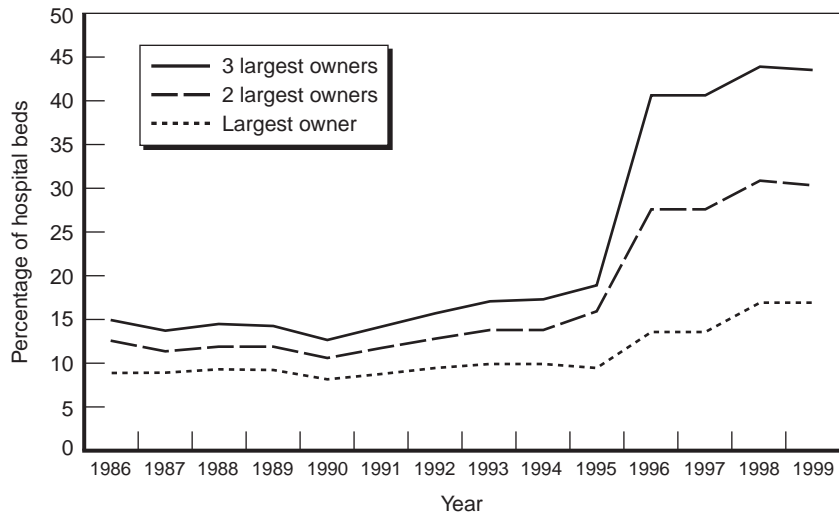
**Figure 4.7—Percentage of Hospital Beds Controlled by Three Largest Owners, Ventura MSA, 1986–1999**

The San Francisco CMSA has a more consolidated hospital market than the Los Angeles region. As seen in Figure 4.8, 30 percent of the San Francisco region’s hospitals are not affiliated with a major corporation. Between 1995 and 1996, the share of unaffiliated hospitals dropped precipitously from 71 percent to 32 percent. A significant proportion of this decline can be attributed to the merger between Sutter Health and the California Healthcare System in 1996 and acquisitions by CHW (Figure 4.9). By 1996, the three largest corporations (Sutter, Kaiser, and CHW) controlled 41 percent of the region’s hospital beds; in 1999, these same three corporations control 43 percent of beds.

In contrast to the Los Angeles CMSA, hospital ownership in the San Francisco Bay Area is heavily concentrated among nonprofit corporations. Kaiser Permanente operates 13 hospitals, most of which



**Figure 4.8—Percentage of Hospital Beds with No Major Affiliation, San Francisco-Oakland-San Jose CMSA, 1986–1999**



**Figure 4.9—Percentage of Hospital Beds Controlled by Three Largest Owners, San Francisco-Oakland-San Jose CMSA, 1986–1999**

have between 150 and 250 beds.<sup>5</sup> Sutter Health has 10 hospitals ranging from the 51-bed Novato Community Hospital to the 534-bed California Pacific Medical Center. Catholic Healthcare West operates seven hospitals, all but one of which have more than 270 beds. The major for-profit presence in the region is Columbia/HCA, with five hospitals. Four of Columbia's hospitals are in Santa Clara County and two of these four have over 500 beds.

Within the San Francisco CMSA, the San Francisco PMSA has become very concentrated in the past five years.<sup>6</sup> As seen in Figure 4.10, the three largest entities (CHW, the University of California, and Kaiser) held 30 percent of San Francisco's hospital beds in 1995. This share jumped to 69 percent in 1996 as a result of growth in CHW's system and the merger between Sutter Health and the California Healthcare System.<sup>7</sup>

San Jose's hospital market is less concentrated than that of the San Francisco PMSA: in recent years, 57 percent of San Jose's hospital beds have been owned by Columbia/HCA, Kaiser, and Catholic Healthcare West (Figure 4.11). Columbia/HCA owns one-third of this region's beds, and this figure will rise when Columbia/HCA's purchase of Alexian Brothers Hospital is complete.

The Oakland PMSA's three biggest owners (Sutter, Kaiser, and Tenet) control 44 percent of the beds (Figure 4.12).<sup>8</sup> There has not

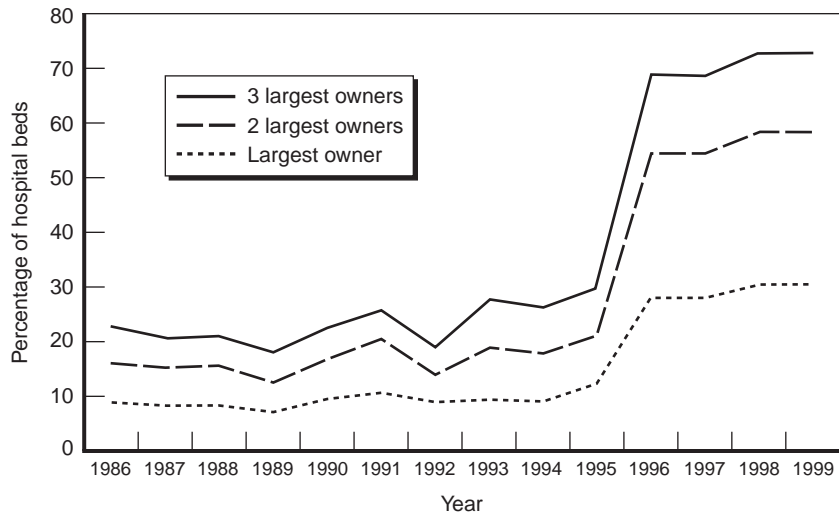
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<sup>5</sup>The median hospital size in the San Francisco area is 212 beds.

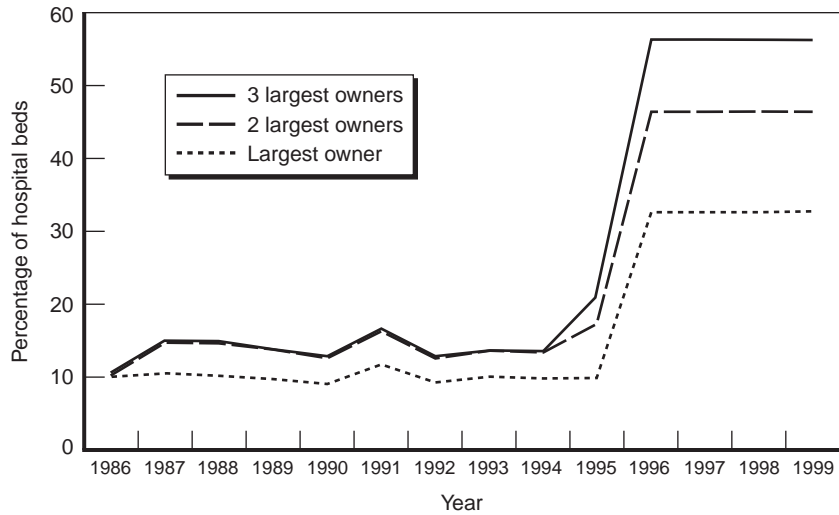
<sup>6</sup>The San Francisco PMSA consists of San Francisco, Marin, and San Mateo Counties.

<sup>7</sup>As noted above, we do not consider the California Healthcare System an "owner."

<sup>8</sup>The Oakland PMSA consists of Alameda and Contra Costa Counties.

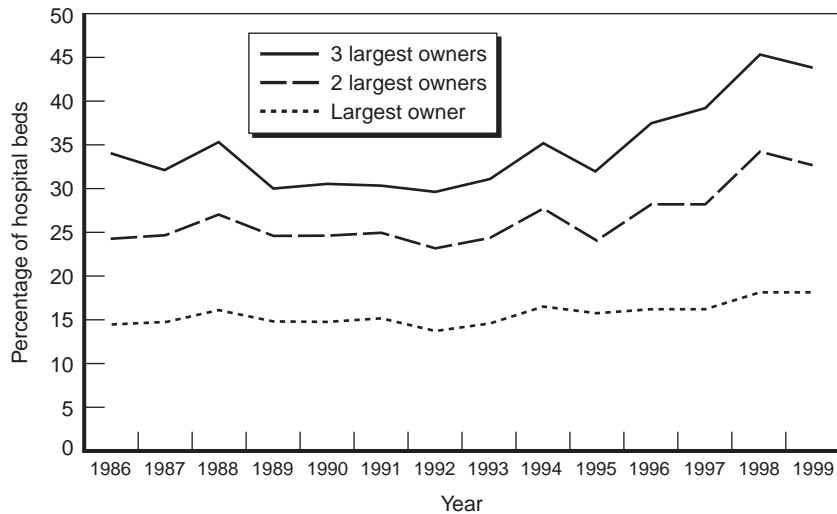


**Figure 4.10—Percentage of Hospital Beds Controlled by Three Largest Owners, San Francisco PMSA, 1986–1999**



**Figure 4.11—Percentage of Hospital Beds Controlled by Three Largest Owners, San Jose PMSA, 1986–1999**





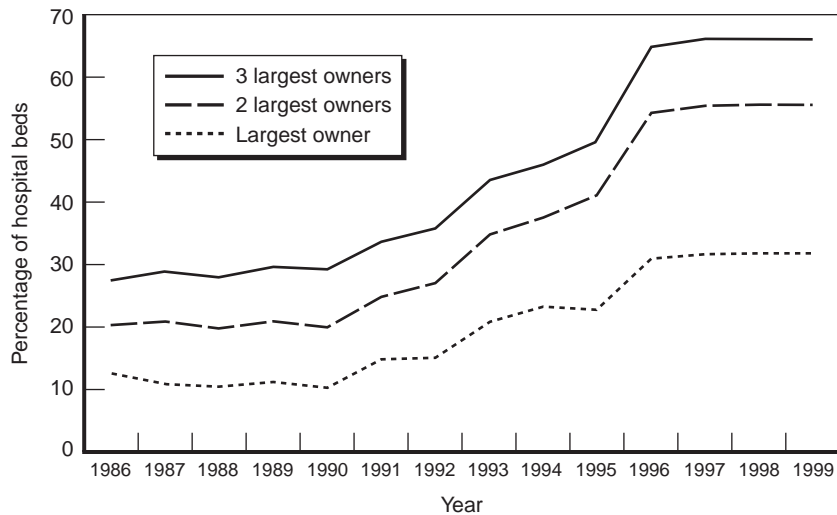
**Figure 4.12—Percentage of Hospital Beds Controlled by Three Largest Owners, Oakland PMSA, 1986–1999**

been as much growth in the Oakland PMSA as in other San Francisco Bay Area PMSAs. In 1986, 34 percent of Oakland’s beds were held by Kaiser, Summit Medical Center, and Alameda County.

The smaller PMSAs in the San Francisco CMSA have relatively concentrated hospital markets. There are relatively few hospitals in these regions, however, so it is easy for a single owner to become dominant. In Santa Cruz, 68 percent of the hospital beds are in Dominican Hospital, which joined Catholic Healthcare West in 1988. In Sonoma County, the Sisters of St. Joseph of Orange, Sutter Health, and Kaiser operate 58 percent of the hospital beds. The Sisters of St. Joseph of Orange and Kaiser also have a strong presence in the Napa-Vallejo PMSA. Together with Adventist Health, they own 66 percent of the area’s beds.

## The San Diego Area

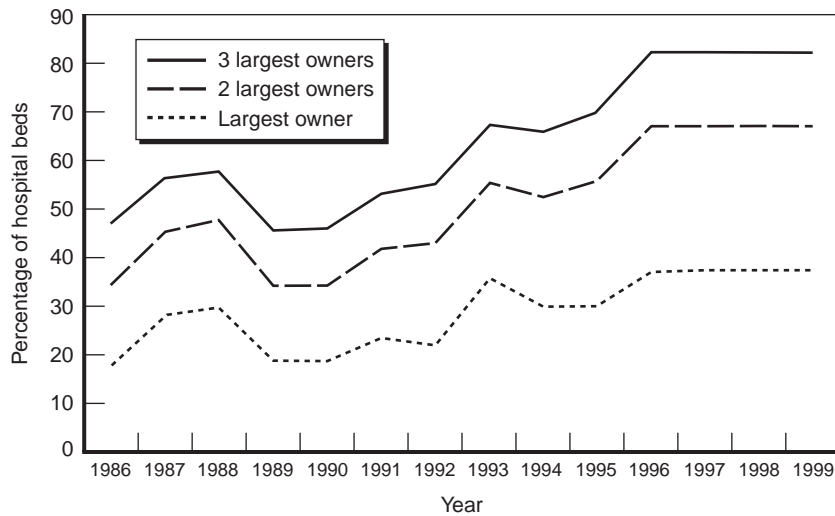
The San Diego area experienced 12 changes in hospital ownership between 1986 and 1996 (4.1 percent of statewide changes). Today, the San Diego market is concentrated in the hands of Scripps Healthcare and San Diego Hospital Association (also known as Sharp HealthCare). Scripps owns six hospitals and Sharp HealthCare owns seven hospitals. Together, they control over half of the hospital beds in San Diego County (Figure 4.13). Palomar Pomerado Health System operates another 11 percent of the region's hospital beds. The UC-San Diego Medical Center is a significant presence in this market as well, with hospitals in San Diego and La Jolla. UCSD recently discontinued merger discussions with Sharp HealthCare and is planning to commence merger talks with Scripps Health. Tenet, Columbia/HCA, Kaiser, and Adventist Health also own hospitals in San Diego County.



**Figure 4.13—Percentage of Hospital Beds Controlled by Three Largest Owners, San Diego PMSA, 1986–1999**

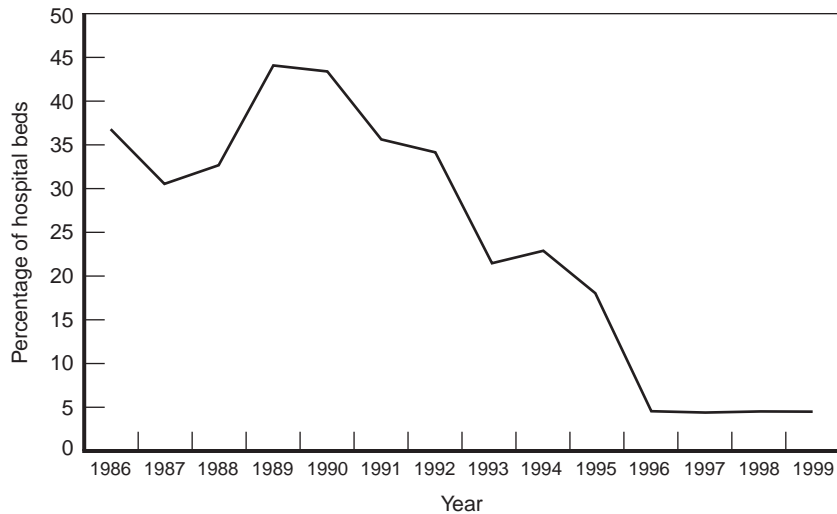
## The Sacramento Area

In the Sacramento CMSA, there were ten changes in hospital ownership between 1986 and 1996. The Sacramento CMSA area is similar to that of San Diego in that two corporations own over half of the hospitals in the area.<sup>9</sup> Catholic Healthcare West operates six facilities and Sutter Health owns five hospitals, together controlling over two-thirds of the hospitals in the region (Figure 4.14). Kaiser owns an additional 15 percent of the area's hospital beds, placing 82 percent of the Sacramento area's beds in the hands of the three largest owners. The University of California holds another 13 percent of the area's hospital beds, leaving less than 5 percent of the beds without a system affiliation (Figure 4.15).



**Figure 4.14—Percentage of Hospital Beds Controlled by Three Largest Owners, Sacramento-Yolo CMSA, 1986–1999**

<sup>9</sup>The Sacramento CMSA consists of the Sacramento PMSA (Sacramento, El Dorado, and Placer Counties) and the Yolo PMSA (Yolo County).



**Figure 4.15—Percentage of Hospital Beds with No Major Affiliation, Sacramento-Yolo CMSA, 1986–1999**

### **Other Urban Areas**

California has smaller urban areas in the Central Valley, along the central coast, and in the Sacramento Valley. Most of these metropolitan areas have only a few hospitals, and thus ownership may appear to be concentrated in the hands of a few corporations when each corporation owns only one hospital. Some of California’s smaller cities have no hospitals with corporate affiliations, whereas in other cities major corporations own nearly all hospitals. In general, nonprofit ownership is dominant in small cities.

### **Central Valley Cities**

Between 1986 and 1996, relatively few hospital transactions occurred in the Central Valley (Fresno, Kern, Kings, Madera, Merced,

San Joaquin, Stanislaus, and Tulare Counties). We identified 21 changes in hospital ownership over our 11-year period, accounting for 7.1 percent of the changes. Nearly 12 percent of California's hospitals are located in this region. As the Central Valley grows and there are fewer opportunities to purchase hospitals in the major cities of California, corporate ownership is likely to increase in the valley.

Through 1995, fewer than 5 percent of Stockton's beds were held by multi-hospital corporations (NME, which became part of Tenet in 1995, and Paracelsus). In 1996, CHW and Sutter both completed purchases of hospitals, giving these corporations 34 and 7 percent of the area's hospital beds, respectively. Now, 48 percent of the Stockton area's hospital beds are controlled by three corporations: CHW, Sutter, and Tenet.

In Modesto, NME (now Tenet) and Memorial Hospitals Association held about half of the area's hospital beds until 1996. In 1996, the hospital controlled by Memorial Health Services affiliated with Sutter. Several Stanislaus County hospitals have closed since 1987, increasing the market share of Tenet and Sutter in this region. As of 1996, Tenet's stake in the market is higher than Sutter's, with Tenet owning nearly a third of the area's hospital beds. Catholic Healthcare West has recently entered the market by contracting to manage with a district hospital, accounting for approximately 11 percent of hospital beds.

Merced's hospital market has experienced a rapid consolidation in recent years. Until 1993, none of the county's hospitals were controlled by a major hospital corporation. In 1994, Memorial Hospitals Association established a presence in the area, controlling about 12 percent of hospital beds. This hospital became part of Sutter in 1996. Between 1996 and 1997, the county hospital affiliated with Sutter,

increasing its share of hospital beds to 60 percent. Also in 1996, CHW acquired a hospital through its affiliation with the Dominican Sisters of St. Catherine of Sienna of Kenosha, Wisconsin. Now, Sutter and CHW control all of Merced's hospital beds.

Fresno's large hospital market is still largely independent of the major hospital corporations. Community Hospitals of Central California operates two hospitals with 32 percent of the beds in the county, and Kaiser has one hospital with about five percent of the area's hospital beds. St. Agnes Hospital is part of the Holy Cross Health Care System headquartered in Indiana. The remaining hospitals are owned by independent nonprofit corporations, districts, or the county. There is one small for-profit surgery center in Fresno County.

Bakersfield's hospital market has become more concentrated in recent years. Between 1986 and 1995, about 30 percent of the region's hospital beds were held by two or three multi-hospital firms. Catholic Healthcare West has had a steady presence since 1986, as Mercy Hospital in Bakersfield was one of the original CHW hospitals. Westworld owned one hospital in Kern County until 1987, and Adventist Health entered the market in 1987. In 1996, CHW's presence in the Bakersfield region increased markedly with the acquisition of Memorial Hospital, previously an independent nonprofit hospital. Local community members, who argued that Memorial Hospital's merger with CHW resulted in a loss of community assets, filed two lawsuits contesting this merger. One suit was settled in 1999 with the establishment of a \$150,000 nonprofit charitable corporation. The other lawsuit is still pending. Today, CHW controls nearly half the hospital beds in Kern County, and Adventist Health has ownership of about 13 percent of beds in Kern County.

At this time, none of the hospitals in the Visalia-Tulare-Porterville metropolitan area are owned by a multi-hospital corporation; all are owned by hospital districts.

### ***Central Coast Cities***

In contrast to the Central Valley, for-profit corporations own a large share of hospitals in cities along the central coast. Seventy percent of the hospital beds in San Luis Obispo County are owned by Tenet. Another 29 percent of Santa Barbara's hospital beds were acquired by CHW in 1997 with the affiliation of the Sisters of St. Francis. Independent companies hold all of Monterey County's hospital beds at this time.

### ***Sacramento Valley Cities***

Two of Redding's major hospitals are affiliated with multi-hospital corporations. Catholic Healthcare West has owned over one-third of the area's hospital beds since Mercy Hospital of Redding became one of the original CHW hospitals in 1986. In 1987, NME acquired a hospital in Redding, accounting for another third of Shasta County's hospital beds. This hospital is now owned by Tenet.

Chico has also experienced stable hospital ownership in the past decade. Enloe Medical Center and Adventist Health control just less than 20 percent of the region's beds each. None of the Yuba City metropolitan area's hospitals are affiliated with a multi-hospital corporation.

### ***Rural California***

The bulk of hospital merger activity in California has occurred in urban areas; less than 10 percent of ownership changes between 1986

and 1996 occurred in rural areas. About one-third of the rural ownership changes involved Westworld Community Healthcare. Since Westworld's bankruptcy a decade ago, for-profit multi-hospital corporations have not been willing to enter rural markets in California. Some of California's rural hospitals are owned by nonprofit multi-hospital corporations. Adventist Health has a strong presence in rural California, controlling 21 percent of the state's rural hospital beds. CHW owns 13 percent of rural beds, and Sutter owns 8 percent. The Sisters of St. Joseph of Orange own 5 percent of the rural hospital beds in the state. Over half of the state's rural hospital beds are not affiliated with one of these corporations.



## 5. Directions for Future Research

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The data presented in this report show that most ownership changes in California's hospital industry involved mergers into large, multi-hospital corporations. The majority of ownership changes occurred in urban areas and did not involve changes in the profit status of the hospital. Substantial public attention has been given to the purchases of nonprofit hospitals by for-profit corporations. Only now is California considering the implications of other kinds of ownership changes. Although AB 254 would regulate many hospital sales, regardless of whether they involve a change in profit status, there is little information that state regulators can use to make decisions about which hospital ownership changes should be permitted.

A hospital's profit status and ownership may affect its organization, service mix, and costs as well as access to and quality of care. Researchers have not reached consensus about the relationships between hospital ownership and these policy concerns. In this chapter, we review some of

the research that has been conducted in this area and identify issues that need further research. We then outline related research now under way at PPIC.

## **The Importance of Profit Status**

Research on the effects of changes in hospital ownership has focused primarily on differences between for-profit and nonprofit hospitals. In a for-profit hospital, the owner receives all profits, which are taxable by federal and state jurisdictions. Nonprofit hospitals are not allowed to distribute the “profits” from their operations to individuals. In exchange for exemption from most state and federal taxes, nonprofit hospitals are expected to use any net gains to provide community services and to invest in their facilities.

Nonprofit hospital organizations generally view themselves differently than for-profit corporations because of their historical affiliation with charitable and religious groups. Many of the first hospitals in the United States were charity institutions organized by religious organizations and wealthy patrons. By the late nineteenth century, however, the role of hospitals had changed from that of poor houses to institutions of high-level care for all income groups. Growth of the hospital industry to current levels occurred primarily in the nonprofit private sector. In the United States, nonprofit hospitals constitute the majority of the hospital industry, with nearly 80 percent of all hospitals categorized as nonprofits (Sanders, 1995).

## ***Community Services and Benefits***

Most discussions of nonprofit hospitals focus on the charitable and community services they provide. Several researchers have argued that

nonprofit hospitals do not provide enough services to the community for the value of their preferential tax treatment (Sanders, 1995). In this argument, however, the definition of “community benefit” is controversial. A narrow view of community benefit focuses on the amount of charity care provided by a hospital, which is easy to define and measure. A broader view of community benefit includes activities that benefit the public more generally, such as contracting with essential community providers or conducting research and health education (Gray, 1997). Although the broader view of community benefit is difficult to quantify and measure, it may be the most appropriate one for policymakers to consider.

California has wrestled with measuring the community benefits provided by nonprofit hospitals. In 1994, Governor Wilson signed SB 697, which requires that private nonprofit hospitals report annually on the community benefits they provide. The legislation also requires that hospitals assess the health needs of their communities and develop plans in collaboration with the community for addressing these needs.<sup>1</sup> Hospitals were given flexibility in defining “community benefit,” and multi-hospital systems were allowed to provide one report for their member hospitals.<sup>2</sup> OSHPD was asked to implement the legislation and to prepare a report to the legislature after the first set of reports were filed (Werdegar, Smoley, and Wilson, 1998). The community benefits most often cited by hospitals include health education classes, charity care, counseling and support groups, health information resources (such as

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<sup>1</sup>The legislation requires that the needs assessment be reviewed at least once every three years.

<sup>2</sup>Kaiser Permanente, Adventist Health Systems, and Catholic Healthcare West provided system reports, and some other hospitals with the same ownership reported jointly.

health fairs and helplines), patient transportation and home health services, and health screenings. A variety of other services and programs were reported, including the provision of career development support to schools, medical professional training, and “social activities.” OSHPD recommends that consistent methods be developed for measuring the economic value of community benefits activities, as there was substantial variation in the values assigned by hospitals.

Adopting the narrow definition of community benefit, many researchers have examined whether for-profit hospitals provide less charity care than nonprofit and public hospitals. One reason for this approach is that charity care is easily measured using hospital financial reports.<sup>3</sup> Not surprisingly, most studies find that nonprofit facilities spend more on uncompensated and charity care than do for-profit hospitals (Lewin, Eckles, and Miller, 1988; Marmor, Schlesinger, and Smithey, 1986; Shukla, Pestian, and Clement, 1997). Nonprofit hospitals also appear to admit more uninsured and Medicaid patients than do for-profit hospitals (Frank, Salkever, and Mullan, 1990; Gray, 1997). However, it is difficult to compare charity care provided by nonprofit and for-profit hospitals because the need for charity care varies across cities and states. One study found that for-profit and nonprofit hospitals located in the same area serve an equal number of uninsured patients, but that for-profit hospitals indirectly avoid uninsured patients

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<sup>3</sup>Most researchers define charity care to include uncompensated care, charity care, and bad debt. Bad debt usually consists of unpaid medical bills due from uninsured recipients of hospital services. These self-paying patients are typically from low-income households and often have limited ability to pay their medical bills. For-profit hospitals appear to be more likely to seek payment from low-income patients (Mateo and Rossi, 1999). Thus, a higher share of the “charity care” they provide is bad debt. Some observers object to considering bad debts as part of charity care (Mateo and Rossi, 1999; Sister Terese Marie Perry, personal communication, September 7, 1999).

by locating in areas with high rates of health insurance coverage (Norton and Staiger, 1994).

Studies of charity care and other measurable benefits provided by hospitals do not examine all the benefits nonprofit hospitals provide to communities. Nonprofit hospitals may generate several intangible benefits not provided by their for-profit counterparts. First, it can be advantageous for regulators to work with nonprofit hospitals. Because tax exemptions can be used to further government objectives, policymakers have more influence over nonprofit hospitals. For example, policymakers can establish charity care requirements for hospitals to maintain their nonprofit tax status.

Second, nonprofit hospitals may be more trustworthy. Because patients have less information about the care they should receive than physicians and hospitals, they are at risk for being exploited by unscrupulous health care providers. Many researchers have established that physician behavior is influenced by the profit motive (Gray, 1997; Gruber and Owings, 1996). Theoretically, nonprofit health care organizations do not have as much conflict between their self-interest and the interests of their patients. Thus, nonprofit hospitals provide additional value to the community insofar as their decisions are less influenced by the desire to maximize profit.

Unfortunately, it is not possible to quantify the social value of either tax exemption as a policy tool or the trustworthiness of nonprofit hospitals. Although there are differences in the amount of charity care provided by nonprofit and for-profit hospitals, the full community benefit of nonprofit hospitals cannot be assessed objectively.

### ***Hospital Operations, Costs, and Prices***

Most studies find that for-profit hospitals price their services more aggressively than their nonprofit competitors and thus enjoy higher net incomes (Keeler, Melnick, and Zwanziger, 1999; Lynk, 1995a, 1995b; Pattison and Katz, 1983; Shukla, Pestian, and Clement, 1997; Watt et al., 1986). In addition, they have an incentive to operate more efficiently than nonprofit hospitals. However, many researchers have found no clear difference between the costs and efficiency of nonprofit and for-profit hospitals (Becker and Sloan, 1985; Ermann and Gabel, 1984; Mobley and Bradford, 1997; Register and Bruning, 1987; Renn et al., 1985; Shukla, Pestian, and Clement, 1997; Watt et al., 1986). In fact, some researchers have found that there are higher costs and lower efficiency among for-profit hospitals (Ozcan, Luke, and Haksever, 1992; Pattison and Katz, 1983; Woolhandler and Himmelstein, 1997).

For-profit hospitals could achieve lower costs than nonprofit hospitals in several ways. They could use inputs more efficiently (staff, facilities, and supplies), decrease administrative costs, or change the mix of services they provide. Several of the aforementioned studies of hospital costs have examined whether the staffing levels of nonprofit and for-profit hospitals differ. Most researchers find that for-profit hospitals employ fewer staff per patient day or discharge (Mark, 1999; Renn et al., 1985; Watt et al., 1986). However, none of these studies disaggregates staffing enough to consider implications of staffing differences for the quality of care.

Most studies find that for-profit hospitals have significantly higher administrative costs than do nonprofit facilities (Watt et al., 1986; Woolhandler and Himmelstein, 1997). There has been virtually no

examination of the effect of profit status on the mix of services provided by hospitals.

### ***Patient Outcomes***

Because for-profit and nonprofit hospitals have different financial incentives regarding patient care, there may be ownership-based differences in the quality of care. A few researchers have examined this issue. The Institute of Medicine examined data from the 1980s and concluded there was no overall pattern of either inferior or superior quality in for-profit chain hospitals compared to nonprofit hospitals (Gray, 1986; Gray and McNerney, 1986). Other researchers have reached similar conclusions (Keeler et al., 1992; Shortell and Hughes, 1988), but other studies have identified higher adjusted mortality rates in for-profit hospitals (Hartz et al., 1989). Most of these studies compare for-profit hospitals to nonprofit hospitals in a single year or several-year cross-section. It would be valuable to compare mortality rates of hospitals that convert their ownership status to those with stable ownership.

### ***Nonprofit to For-Profit Conversions: Special Policy Issues***

Under current law, the Attorney General is required to evaluate whether a proposed conversion deal is fair and reasonable, whether there is breach of trust, whether private gain is a possibility, and whether the sale is in the public interest (Isenberg and Battson, 1997). Under this legislation, the Attorney General retains consultants to create a health effect statement for the proposed merger. Protection of public assets in a conversion is governed by state charitable trust laws, under which the dissolution of a charitable organization requires that all proceeds from

the sale be used toward charitable purposes to continue to carry out the original purpose of the charitable organization. In most cases, a new foundation is formed. Charitable trust doctrine also applies to the sale of one nonprofit hospital to another nonprofit hospital, although this is rarely an issue.

A major issue in the creation of a charitable foundation is the valuation of charitable assets of the hospital. Another issue is the way in which foundations choose to spend the public's money. One cause for concern is the overlap of board membership and management of the for-profit hospital and the nonprofit foundation. Under Internal Revenue Service rules, charitable foundations and for-profit hospitals must operate independently from each other, but individuals may hold board membership in both organizations. Critics fear that foundations could allow for-profit hospitals to avoid providing services for the community. There is a need for systematic research and monitoring of newly created conversion foundations.

## **The Behavior of Multi-Hospital Corporations**

The growth of multi-hospital corporations raises a different set of issues than the distinction between for-profit and nonprofit hospitals. Regardless of their profit status, hospitals affiliated with multi-hospital organizations may reap benefits from their affiliation, including increased access to capital, lower local administrative costs, and the ability to consolidate expensive services into referral centers. Nonprofit multi-hospital firms also may allow independent nonprofit hospitals that are losing money to maintain their charitable missions (Claxton et al., 1997). Even so, policymakers and analysts are concerned that multi-hospital firms are less responsive to local needs than locally controlled hospitals,



that they reduce charitable services to communities, and that they raise costs by engaging in monopolistic behavior. There is a small but growing literature on these issues.

### ***Hospital Costs and Market Power***

In regions with concentrated hospital ownership, it is possible that hospitals use their market power to increase reimbursement rates from insurance companies. In fact, this happened in Sacramento last year. In May 1998, Sutter Health, which has a strong presence in the San Francisco and Sacramento areas, threatened to cancel its contracts for Blue Cross's Prudent Buyer and CaliforniaCare insurance plans because the reimbursements offered by Blue Cross were lower than Sutter desired. While negotiations continued between Sutter and Blue Cross, Mercy Healthcare of Sacramento, an affiliate of Catholic Healthcare West, threatened to drop its contract unless reimbursements were increased. These developments left Blue Cross with the prospect that only the UC Davis Medical Center would accept Blue Cross patients in the Sacramento area. In June, Blue Cross and Sutter reached a three-year agreement for Sutter's acute care hospitals. By this time, however, Catholic Healthcare West and Columbia/HCA had joined the group of hospitals demanding higher reimbursements from Blue Cross. As in the Sutter Health negotiations, Catholic Healthcare West announced the cancellation of its contract with Blue Cross. A last-minute agreement was reached in early July. Although the details of these agreements were not made public, they almost certainly involved substantial increases in hospital reimbursements.

Recent reports indicate that other hospitals have learned from the experience of Sutter and Catholic Healthcare West in Sacramento.

Three San Gabriel Valley hospitals reportedly forced Blue Cross to increase reimbursement rates (Reich, 1999), Orange County's St. Joseph Health System reportedly is pushing two health maintenance organizations to provide greater reimbursements, and the San Mateo County independent practice association is taking a firm stance in its negotiation with Aetna (Crabtree, 1999). In all of these cases, the hospitals state that insurance reimbursements have not been covering their costs and they are bargaining more aggressively to maintain their financial viability.

Systematic studies of hospital mergers generally found that hospital prices are higher in more concentrated markets (Gaynor and Vogt, 1999). In addition, most studies of hospital mergers found that these mergers increase prices (Gaynor and Vogt, 1999). In their own analysis, Melnick, Keeler, and Zwanziger (1999) also found significant price increases among hospitals that merge.

The price increases identified in most of the studies published to date do not necessarily reflect increases in the cost of hospital care. For example, using 1990 data, Menke (1997) found that hospitals affiliated with multi-hospital corporations had lower costs. Other studies, however, have measured higher costs among affiliated hospitals (Ermann and Gabel, 1984; Levitz and Brooke, 1985).

Multi-hospital firms might be more efficient and thus have lower costs than independent hospitals for several reasons. First, corporate and system-affiliated hospitals may have greater access to capital and thus be better able to invest in improvements, as found in some studies (Levitz and Brooke, 1985). Second, multi-hospital corporations might lead to a reorganization of hospital services by the new owner. For example, Sinay (1997) found that hospital mergers led to a reduction of costs because

hospitals eliminated excess beds and hired part-time personnel. In contrast, Ermann and Gabel (1984), using data from 1960 through 1980, found no difference in service mix or staff qualifications after hospital mergers. Alexander, Halpern, and Lee (1996) found modest operational changes with mergers, and that those mergers occurring in the late 1980s produced more pronounced changes than those in the early part of the decade. There is a dearth of recent research on the effects of hospital mergers on the operations of hospitals; we do not know whether and to what extent multi-hospital corporations consolidate services, alter staffing, or increase administrative overhead.

State and federal agencies can challenge mergers and acquisitions on antitrust grounds. Merger decisions of the Federal Trade Commission and the Department of Justice are based on careful definition of the relevant hospital market (which may not be the MSA in which the hospital is located), examination of the concentration of the hospital market, consideration of other independent hospitals in the market, and an assessment of whether efficiencies gained from the merger might offset anticompetitive effects (Gaynor and Vogt, 1999; Vistnes, 1995). The possibility that multi-hospital firms are more efficient than independent hospitals has affected some antitrust decisions. In Michigan, the courts were persuaded that a nonprofit merger would lead to price reductions rather than increases and allowed the merger to proceed (Pak, 1997). Moreover, increasing health care costs are not necessarily detrimental to the public. Rising health care costs may reflect higher quality of patient care or a greater dedication of resources to charity care; on the other hand, increases in health care costs can reduce access to medical care for the poor.

A recent study found that state agencies are more willing to approve mergers than federal authorities (Hellinger, 1998). State agencies often establish requirements for mergers, such as agreements to restrain price increases, provide charity care, and limit profits. The acquisition of Alexian Brothers Hospital in San Jose by Columbia/HCA provides an example of conditional approval provided by state authorities (Shinkman, 1999). The Alexian Brothers, a Catholic health system based in Illinois, and Columbia/HCA agreed to exchange Alexian Brothers Hospital in San Jose for two Columbia/HCA hospitals in Illinois. Columbia/HCA owns three other hospitals in Santa Clara County, and the addition of Alexian Brothers Hospital would give Columbia/HCA over half the hospital beds in San Jose. The Attorney General delayed the transaction to complete an anti-trust analysis and approved the deal with the provision that Columbia/HCA make \$15 million in capital improvements, spend at least \$2 million annually on charity care, limit price increases, donate \$4 million to a nearby Catholic-owned hospital, and file annual compliance reports for five years (Consumers Union and Community Catalyst, 1999).

### ***Access to Care***

Analysts have expressed concern about the transfer of charitable assets from local control in independent nonprofit hospitals to corporate control in multi-hospital firms (Alexander and Schroer, 1985; Scott, 1997). Differences in the charitable strategies of independent and affiliated hospitals may lead to differences in access to care in local communities. For example, if a multi-hospital firm dedicates its charitable resources to inpatient hospital care rather than operating outpatient clinics, primary care access may decline when that multi-

hospital firm acquires a local hospital. This possibility is partially offset by California's requirement that nonprofit hospitals develop charitable benefits plans in conjunction with their local communities.

Access to care also might be affected by changes in the services offered by multi-hospital firms. A multi-hospital firm may elect to consolidate expensive services into referral centers, thus reducing unnecessary duplication of services and lowering costs. This cost-saving behavior may reduce access to care by local residents. The extent to which this is a concern depends on which services are consolidated and characteristics of the communities involved. We identified no research that considers these issues.

### ***Patient Outcomes***

Changes in the operations of hospitals and the consolidation of services may lead to changes in the quality of medical care. Quality of care can be measured in several ways, including length of stay and mortality, readmission, complication, and procedure rates. In a recent study, Hamilton and Ho (1998) found that mergers and acquisitions did not have an effect on inpatient mortality for myocardial infarction and stroke, but that consolidations increased readmission rates for Medicare patients with myocardial infarction. They also identified a correlation between hospital consolidations and length of stay for certain groups of patients. They concluded that there was no systematic evidence that changes in hospital ownership were associated with increases in length of stay or mortality. We hope this study lays the groundwork for further research on whether multi-hospital firms provide higher or lower quality medical care than independent hospitals.

## The PPIC Study

More information about the effects of ownership on hospital operations is necessary to make decisions about the delivery of care that affects the health of Californians. For this reason, we are continuing our research of changes in hospital ownership in California, using the data described in this report as a starting point for our analyses. We plan to continue updating our data on changes in hospital ownership, but we hope that OSHPD will track this information more thoroughly in the future. If AB 254 is enacted, many future ownership changes will be considered by the Attorney General, providing policymakers and researchers with substantially more information about changes in hospital ownership than is available now.

In our ongoing study, we are examining

- Whether changes in hospital ownership affect the staffing of registered nurses, licensed vocational nurses, unlicensed aides and orderlies, salaried physicians, management and supervisory staff, and clerical and administrative staff. We are considering the effects of both mergers and changes in profit status on staffing patterns and whether the major hospital corporations in California have standard staffing patterns to which their newly acquired hospitals conform.
- Whether multi-hospital firms consolidate their services into referral centers. If they do, we will examine which services are consolidated and what factors might lead a corporation to decide to create referral centers. We also are studying whether for-profit conversions result in changes in the mix of services provided by hospitals.
- The effects of hospital ownership changes on access to care and the provision of charity care.

- Whether changes in hospital ownership affect the quality of medical care provided, by considering mortality rates, cesarean section rates, and complication rates.

We hope that our analyses, combined with previous and new research by others, will help policymakers make informed decisions about changes in hospital ownership.

## 6. Conclusion

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Over the past decade, a large number of hospitals changed ownership. In 1993 and 1994, nearly 10 percent of California's hospitals changed hands. Contrary to public perception, however, few of these transactions involved the conversion of a hospital from nonprofit to for-profit ownership. The vast majority of ownership changes have been affiliations and transfers either between nonprofit hospitals and nonprofit organizations or among for-profit companies. The consolidation of hospitals into multi-hospital corporations is becoming increasingly important in the health care industry, as multi-hospital firms are associated with higher prices for medical care (Bellandi, 1999; Hassett and Hubbard, 1998; Hyman, 1998).

The trend toward consolidation in the hospital industry has led to the concentration of hospital ownership in the hands of several major nonprofit and for-profit corporations in California, including Tenet Healthcare Corporation, Columbia/HCA, Catholic Healthcare West, and Sutter Health. Catholic Healthcare West controls the largest



number of hospitals in California and, with the recent purchase of UniHealth, has a strong presence in the Sacramento, San Francisco, and Los Angeles regions. Kaiser Permanente also operates a large number of hospitals in these three regions. Sutter Health is expanding its presence in the San Francisco Bay area to the extent that the Attorney General is seeking to block a proposed merger.

Sales of nonprofit hospitals to for-profit corporations caused such concern that state legislators intervened. Assembly Bill 3101 strengthened the state's authority over the conversion of assets from nonprofit hospitals. This bill was landmark legislation in the health care arena. Previously unregulated transactions involving nonprofit hospitals are now carefully scrutinized by state regulators using new criteria to protect the loss of public assets.

At the same time, the vast majority of hospital ownership changes in California have not involved a change in the profit status of the hospital and thus have not been closely examined. The state has relatively little ability to regulate these transactions, and there is little documentation of them.

Changes in hospital ownership raise many concerns for policymakers. Community health and hospital costs may be affected by the development of monopolies, the conversion of nonprofit hospitals, the loss of local control over charitable assets, the consolidation of services, and changes in staffing. Because there is an urgent need for policymakers and regulators to understand how hospital ownership changes affect Californians, we are continuing our research on this important issue. By providing information about how the ownership of hospitals is changing in California, we hope this report sparks a discussion of the issues raised here and encourages other researchers to examine the changing hospital industry in California.

## **Appendix**

### **Hospital Ownership Changes**

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This appendix lists changes in hospital ownership identified for this study. We list the date of the ownership change as the beginning of the first fiscal year for which the new owner reported data to OSHPD. Although we made every effort to ensure that these data are accurate, there may be errors. We ask that we be notified of any additions or corrections so that these data are as complete as possible.

**Table A.1**

**List of Hospitals That Changed Ownership Between 1986 and 1996 in California**

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1986	North Kern Hospital	Westworld Community Healthcare, Inc.	Lynne E. Gair, MD, and Thetis Gair	Wasco
1986	Church of St. Matthew Mills Memorial Hospital	Mills-Peninsula Corporation	Church of St. Matthew Mills	San Mateo
1986	Sutter Solano Medical Center	Sutter Solano Medical Center	Vallejo General Hospital	Vallejo
1986	St. Luke Medical Center	Summit Health, Ltd.	Sisters of St. Joseph of Orange	Pasadena
1986	Mercy General Hospital	Catholic Healthcare West	Sisters of Mercy of Auburn	Sacramento
1986	Mercy San Juan Hospital	Catholic Healthcare West	Sisters of Mercy of Auburn	Carmichael
1986	Mercy Hospital of Folsom	Catholic Healthcare West	Sister of Mercy of Auburn	Folsom
1986	French Hospital Medical Center	Summit Health, Ltd.	American Medical International, Inc.	San Luis Obispo
1986	Modoc Medical Center	Washoe Medical Center/County of Modoc	Mercy Hospitals of Modoc, Inc.	Alturas
1986	Bay Cities Medical Center	Jupiter Hospital Corporation	American Medical International, Inc.	Hawthorne
1986	Buena Park Doctors Hospital	Jupiter Hospital Corporation	American Medical International	Buena Park
1986	Anaheim General Hospital	Anaheim General Hospital Ltd. Partnership	American Medical International	Anaheim

**Table A.1 (continued)**

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1986	The General Hospital	Brim and Associates	Hospital Corporation of California	Eureka
1986	Mercy Hospital, Bakersfield	Catholic Healthcare West	Sisters of Mercy	Bakersfield
1986	Lassen Community Hospital, Inc.	St. Mary's Central Nevada Health Care Corp.	Eskaton Health Corporation	Susanville
1986	Mercy Hospital	Catholic Healthcare West	Sisters of Mercy	San Diego
1986	St. Mary's Hospital and Medical Center	Catholic Healthcare West	Mercy Health System	San Francisco
1986	Mayers Memorial Hospital	Washoe Health System	Mayers Memorial Hospital District	Fall River Mills
1986	Sierra Valley Community Hospital	Washoe Health System	Sierra Valley Hospital District	Loyalton
1986	Mercy Hospital of Mt. Shasta	Catholic Healthcare West	Eskaton Health Corp.	Mt. Shasta
1986	St. John's Regional Medical Center	Catholic Healthcare West	Sisters of Mercy, Burlingame	Oxnard
1986	Calexico Hospital	Westworld Community Healthcare, Inc.	Heffernan Memorial Hospital District	Calexico
1986	Long Beach Health and Allied Services, Inc.	Long Beach Health and Allied Services, Inc.	Long Beach Hospital, Inc.	Long Beach
1986	Huntington Intercommunity Hospital, Inc.	Humana Hospitals, Inc.	Huntington Intercommunity Hospital	Huntington Beach
1986	Willits Hospital, Inc.	Adventist Health Systems	Frank R. Howard Memorial Hospital	Willits

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1986	Scripps Memorial Hospital-Chula Vista	Scripps Memorial Corporation	Bay Hospital Medical Center	Chula Vista
1986	Laurel Grove Hospital	Eden Township Hospital District	Republic Health Corporation	Castro Valley
1986	American Hospital Management Corp.	Community Hospital Association	Westworld Community Healthcare, Inc.	Hoopa
1986	American River Hospital	Alta Bates Health Corporation	Eskaton Health Corporation	Carmichael
1987	Sutter Coast Hospital	Sutter Health	District hospital	Crescent City
1987	Hanford Community Hospital	Adventist Health Systems	Hanford Community Hospital	Hanford
1987	Robert F. Kennedy Medical Center	Robert F. Kennedy Medical Center	Hawthorne Community Hospital, Inc.	Hawthorne
1987	Chowchilla District Memorial Hospital	Chowchilla District Memorial Hospital	Westworld Community Healthcare, Inc.	Chowchilla
1987	Mission Community Hospital	Mission Viejo Medical Company	Mission Community Hospital, Inc.	Mission Viejo
1987	Northbay Hospital Group	Northbay Hospital Group	Central Solano County Hospital Foundation	Fairfield
1987	Sonora Community Hospital	Adventist Health Systems	Sonora Community Hospital	Sonora
1987	Valley Hospital Limited Partnership	Valley Hospital Limited Partnership	American Healthcare Management, Inc.	Pomona
1987	Corning Hospital District	Corning Hospital District	Westworld Community Healthcare, Inc.	Corning

**Table A.1 (continued)**

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1987	Heffernan Memorial Hospital District	Heffernan Memorial Hospital District	Westworld Community Healthcare, Inc.	Calexico
1987	Trinity Hospital	Trinity County	Westworld Community Healthcare, Inc.	Weaverville
1987	H & W Medical Facilities, Inc.	H & W Medical Facilities, Inc.	Metropolitan Investment Company, Inc.	Los Angeles
1987	Ojai Valley Community Hospital	Affiliated Medical Enterprises, Inc.	Nme Hospitals, Inc.	Ojai
1987	Marin General Hospital	Marin Health Systems, Inc.	Marin Hospital District	Greenbrae
1987	Bear Valley Community Hospital	Bear Valley Community Hospital District	Westworld Community Healthcare, Inc.	Big Bear Lake
1987	Mountains Community Hospital	Mountains Community Hospital District	Westworld Community Healthcare, Inc.	Lake Arrowhead
1987	City of Needles, California	City of Needles, California	Westworld Community Healthcare, Inc.	Needles
1987	General Health Services, Inc.	Healthtrust, Inc.	Hospital Corporation of America, Inc.	Culver City
1987	Community Hospital of Gardena	Healthtrust, Inc.	Hospital Corporation of America, Inc.	Gardena
1987	Encino Hospital Corp., Inc.	Healthtrust, Inc.	Hospital Corporation of America, Inc.	Encino
1987	Ukiah Hospital Corporation	Healthtrust, Inc.	Hospital Corporation of America	Ukiah

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1987	College Hospital Costa Mesa	College Hospital	Costa Mesa Medical Center Hospital	Costa Mesa
1987	La Habra Community Hospital, Inc.	Healthtrust, Inc.	Hospital Corporation of America	La Habra
1987	Health Services Acquisition, Inc.	Healthtrust, Inc.	Hospital Corporation of America	Chino
1987	Sebastopol Hospital Corporation	Healthtrust, Inc.	Hospital Corporation of America	Sebastopol
1987	Unihealth America	Unihealth America	Lutheran Hospital Society of Southern California	Los Angeles
1987	Pioneer Hospital, a California Ltd. Partnership	Delamo Corp., Medical Vesting Corp.	Del Amo Corporation and Kathryn Mullikin-Johnson	Artesia
1987	Santa Monica Hospital Medical Center	Unihealth America	Lutheran Hospital Society of Southern California	Santa Monica
1987	Martin Luther Hospital Medical Center	Unihealth America	Martin Luther Hospital, Inc.	Anaheim
1987	Herrick Foundation	Alta Bates Corporation	Herrick Foundation	Berkeley
1988	Hospital Corporation of La Habra	Hospital Associates of La Habra	Healthtrust, Inc.	La Habra
1988	Methodist Hospital of Sacramento	Valley Health Care Corporation	Methodist Hospital of Sacramento	Sacramento
1988	Barstow Health Systems, Inc.	City of Barstow	City of Barstow	Barstow
1988	Ralph K. Davies Medical Center	Franklin Holding Corporation	Ralph K. Davies Medical Center	San Francisco
1988	Santa Barbara Cottage Care Center	Santa Barbara Cottage Care Center	Pinecrest Hospital	Santa Barbara
1988	Healdsburg General Hospital	Epic Healthcare Group, Inc.	American Medical International, Inc.	Healdsburg

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1988	Sun Valley Health Group, Inc.	Affiliated Medical Enterprises	American Health Group International, Inc.	Sun Valley
1988	Huntington Health Group, Inc.	Affiliated Medical Enterprises	American Health Group International, Inc.	Huntington Beach
1988	Northridge Hospital Medical Center	Unihealth America	Healthwest Foundation	Northridge
1988	Valley Hospital Medical Center	Unihealth America	Healthwest Foundation	Van Nuys
1988	La Palma Hospital Medical Center	Unihealth America	Healthwest	La Palma
1988	Lindsay Hospital Medical Center	Unihealth America	Healthwest	Lindsay
1988	Visalia Community Hospital	Epic Healthcare Group	American Medical International, Inc.	Visalia
1988	Centinela Mammoth Hospital	Southern Mono Hospital District	Centinela Mammoth Hospital	Mammoth Lakes
1988	Dominican Santa Cruz Hospital	Catholic Healthcare West	Dominican Santa Cruz Hospital	Santa Cruz
1988	Westside Hospital	Epic Healthcare Group	American Medical International, Inc.	Los Angeles
1988	Valley Medical Center	Epic Healthcare Group	American Medical International, Inc.	El Cajon
1988	TPHC, Inc.	Nu Med, Inc., and TPHC, Inc.	Nu Med, Inc.	Baldwin Park
1989	Herrick Foundation	Alta Bates Corporation	Alta Bates Corporation	Berkeley
1989	Loma Linda Community Hospital	Adventist Health Systems	Loma Linda Community Hospital	Loma Linda
1989	Affiliated Medical Enterprises	Affiliated Medical Enterprises	Palmdale Health Group, Inc.	Palmdale
1989	Brotman Partners, Ltd. Partnership	Brotman Partners, Ltd. Partnership	Healthtrust, Inc.	Culver City



Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1989	Samaritan Medical Center-San Clemente	Physican Associates Committed to Excellence (PACE)	American Healthcare Management Corp.	San Clemente
1989	Long Beach Doctors Hospital	Long Beach Beach Doctors Hospital	Long Beach Health and Allied Services, Inc.	Long Beach
1989	Modoc Medical Center	County of Modoc	Washoe Health Network/Modoc County	Alturas
1989	O'Connor Hospital	Daughters of Charity Health Systems West	O'Connor Health Services Corporation	San Jose
1989	Mayers Memorial Hospital	Mayers Memorial Hospital District	Washoe Health Systems	Fall River Mills
1989	Kingsburg District Hospital	Kingsburg Hospital District	Westworld Community Healthcare, Inc.	Kingsburg
1989	Bellflower Doctors Hospital	Asklepios Hospital Corporation	Jupiter Hospital Corporation	Bellflower
1989	Bay Cities Medical Center	Asklepios Hospital Corporation	Jupiter Hospital Corporation	Hawthorne
1989	Rio Hondo Hospital	Rio Hondo Hospital	Republic Health Corporation	Downey
1989	Los Angeles Doctors Hospital	Asklepios Hospital Corporation	Jupiter Hospital Corporation	Los Angeles
1989	CHHSC, Inc.	CHHSC, Inc.	Republic Health Corporation	Sacramento
1989	San Bernardino Mountains Community Hospital District	Mountains Community Hospital District	Mountains Community Hospital District	Lake Arrowhead
1989	San Gabriel Valley Medical Center	Unihealth	San Gabriel Valley Medical Center	San Gabriel
1989	Long Beach Community Hospital Association	Unihealth	Long Beach Community Hospital, Inc.	Long Beach

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1989	Henry Mayo Newhall Memorial Hospital	Santa Clarita Health Care Association	Henry Mayo Newhall Memorial Hospital	Valencia
1989	Doctors Hospital of West Covina	Doctors Hospital of West Covina	Paracelsus Healthcare Corporation	West Covina
1989	Pacific Alliance Medical Center	Pacific Alliance Medical Center Ltd.	French Hospital of Los Angeles	Los Angeles
1990	Mark Twain Saint Joseph's Hospital	Mark Twain St. Joseph's Healthcare Corporation	Mark Twain Hospital District	San Andreas
1990	Marina Hills Hospital	Ladera Heights Community Hospital, Inc.	Marina Hills	Los Angeles
1990	Glendale Adventist Medical Center	Adventist Health Systems	Glendale Adventist Medical Center	Glendale
1990	Universal Health Services of Westlake, Inc.	Westlake Community Hospital	Universal Health Services, Inc.	Westlake Village
1990	Linda Vista Community Hospital Partners	Linda Vista Hospital Partners	American Healthcare Management, Inc.	Los Angeles
1990	Glencomm Ltd.	Glencomm Ltd.	American Medical International, Inc.	Glendora
1990	TPHC, Inc.	Terrace Plaza Joint Venture	Nu Med, Inc., and TPHC, Inc.	Baldwin Park
1990	Sanders Medical Complex, Inc.	Sanders Medical Complex, Inc.	O. Richard Harris	Sanger
1990	Rio Hondo Memorial Hospital	Downey Health Services Foundation	Rio Hondo Hospital	Downey
1990	Desert Hospital Corporation	Desert Hospital Systems	Desert Hospital Systems	Palm Springs

**Table A.1 (continued)**

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1990	Mount Zion Hospital & Medical Center of UCSF	University of California	Mount Zion Hospital and Medical Center	San Francisco
1990	Rideout Hospital Foundation	United Communities Medical Services	Rideout Hospital Foundation, Inc.	Marysville
1990	Healthcare Medical Center of Tustin	Concept Health Group, Inc.	Healthcare International, Inc.	Tustin
1990	Buena Park Doctors Hospital	Asklepios Hospital Corporation	Jupiter Hospital Corporation	Buena Park
1990	Bear Valley Community Hospital District	Bear Valley Community Hospital District	Bear Valley Hospital District	Big Bear Lake
1991	Thompson Memorial Medical Center	Gateway Healthcare of Burbank, Inc.	Burbank Community Hospital	Burbank
1991	Valley Hospital	Linda Valenti	Valley Hospital Ltd. Partnership	Pomona
1991	Coast Plaza Doctors Hospital	Coast Plaza Doctors Hospital	Nu-Med, Inc.	Norwalk
1991	California Pacific Medical Center—California Campus	California Pacific Medical Center	Children’s Hospital of San Francisco	San Francisco
1991	Hospital Affiliates of Florida, Inc.	Hospital Affiliates of Florida, Inc.	Republic Health Corporation	Los Angeles
1991	Vista Hospital Systems, Inc.	Vista Hospital Systems, Inc.	American Medical International, Inc.	Arroyo Grande
1991	Sherman Oaks Hospital & Health Center	Triad Healthcare	Nu Med, Inc.	Sherman Oaks

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1991	West Valley Hospital & Health Center	Triad Healthcare	Nu Med, Inc.	Canoga Park
1991	Mercy American River Hospital	Catholic Healthcare West	Alta Bates Corporation	Carmichael
1991	Sanger General Hospital	Sanger General Hospital, a General Partnership	Sanders Medical Complex, Inc.	Sanger
1991	Grossmont Hospital Corporation	Grossmont Hospital Corporation	Grossmont District Hospital	La Mesa
1991	Bakersfield Memorial Hospital	Memorial Health System, Inc.	Bakersfield Memorial Hospital Association	Bakersfield
1991	Hemet Valley Medical Center	Valley Health System, A California Hospital District	Hemet Valley Hospital District	Hemet
1991	Menifee Valley Medical Center	Valley Health System	Hemet Valley Hospital District	Sun City
1991	California Pacific Medical Center—Pacific Campus	California Pacific Medical Center	Pacific Presbyterian Medical Center	San Francisco
1991	The Good Samaritan Hospital of Santa Clara Valley	Health Dimensions, Inc.	Good Samaritan Hospital of Santa Clara Valley	San Jose
1991	San Jose Medical Center	Health Dimensions, Inc.	San Jose Medical Center	San Jose
1991	Fremont Hospital	Fremont Rideout Health Group	Fremont Hospital	Yuba City
1991	Rideout Hospital Foundation	Fremont Rideout Health Group	United Communities Medical Services	Marysville
1991	Memorial Hospital of Gardena	Century Medicorp	Republic Health Corporation	Gardena

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1991	Alhambra Hospital	Alhambra Community Hospital Ltd. Partnership	Alhambra Community Hospital	Alhambra
1991	Coastal Communities Hospital	OrNda HealthCorp	Republic Health Corporation	Santa Ana
1991	Harbor View Health Partners	OrNda HealthCorp	Republic Health Corporation	San Diego
1991	Glendale Memorial Hospital and Health Center	Unihealth America	Glendale Memorial Health Corporation	Glendale
1991	Green Hospital of Scripps Clinic	Scripps Memorial Corporation	Hospital Corporation of America	La Jolla
1992	Delta Memorial Hospital	Sutter Health	Delta Memorial Hospital	Antioch
1992	Lassen Community Hospital, Inc.	Lassen Community Hospital, Inc.	St. Mary's Central Nevada Health Care Corp.	Susanville
1992	Gardena Physicians' Hospital	Gardena Physicians Hospital	Healthtrust, Inc.	Gardena
1992	Auburn Faith Community Hospital, Inc.	Sutter Healthcommunity Hospital, Inc.	Auburn Faith Community Hospital, Inc.	Auburn
1992	Corona Regional Medical Center	Corona Regional Medical Center	Circle City Medical Center—Vista Hospital System	Corona
1992	Summit Medical Center	Summit Medical Center	Merritt Peralta Medical Center	Oakland
1992	National Health Administrators	National Health Administrators	Sunshine Health Systems, Inc.	Perris
1992	Healthcare Medical Center of Tustin	Healthcare International, Inc.	Concept Health Group, Inc.	Tustin
1992	Central California Foundation for Health	Central California Foundation for Health	Wesley Bilson	Delano

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1992	Lakeside Community Hospital	Sutter Lakeside Hospital	Lakeside Community Hospital	Lakeport
1992	Hospital Subsidiary, Inc.	Foundation Health	Century Medicorp	Gardena
1992	El Camino Healthcare System	El Camino Healthcare System	El Camino Hospital District	Mountain View
1992	South Valley Hospital	Health Dimensions, Inc.	South Valley Hospital	Gilroy
1992	Mercy Hospital of Redding, Inc.	Catholic Healthcare West	Mercy Hospital of Redding, Inc.	Redding
1992	Sierra Valley Hospital District	Sierra Valley Hospital	Washoe Health System	Loyalton
1992	SLCO, Inc.	SLCO, Inc.	Humana, Inc.	San Leandro
1992	Bellflower Medical Center	Pacific Health Corporation	Asklepios Hospital Corporation	Bellflower
1992	Hawthorne Hospital	Pacific Health Corporation	Asklepios Hospital Corporation	Hawthorne
1992	Los Angeles Metropolitan Medical Center	Pacific Health Corporation	Asklepios Hospital Corporation	Los Angeles
1992	West Hills Hospital	Galen, Inc.	Humana, Inc.	West Hills
1992	Buena Park Medical Center	Pacific Health Corporation	Asklepios Hospital Corporation	Buena Park
1992	Huntington Intercommunity Hospital	Columbia/HCA Healthcare Corporation	Humana, Inc.	Huntington Beach
1992	West Anaheim Community Hospital	Columbia Healthcare Corporation	Humana, Inc.	Anaheim
1992	Grossmont Hospital Corporation	San Diego Hospital Association	Grossmont Hospital	La Mesa
1992	Panorama Community Hospital	Panorama Community Hospital	Universal Health Services, Inc.	Panorama City
1992	Pacifica Hospital Care Center	Tom Broderick, Craig Johnson and Burr Dilday	Affiliated Medical Enterprises	Huntington Beach

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1993	Biggs-Gridley Memorial Hospital	Bloss Memorial Hospital	Biggs-Gridley Memorial Hospital, Inc.	Gridley
1993	Encino/Tarzana Regional Medical Center	American Medical International	Health Trust, Inc.	Encino
1993	Cigna Hospital of Los Angeles, Inc.	Cigna Hospital of Los Angeles	Power, Inc.	Los Angeles
1993	AHM/CGH, Inc.	OrNda HealthCorp	American Healthcare Management, Inc.	Orange
1993	Friendly Hills Healthcare Network	Friendly Hills Healthcare Network	Hospital Associates of La Habra	La Habra
1993	Samaritan Medical Center—San Clemente	Samaritan Health Services	Physician Associates Committed to Excellence	San Clemente
1993	Palo Verde Hospital	Brim Hospitals, Inc.	Palo Verde Hospital Association	Blythe
1993	St. Mary Desert Valley Hospital	St. Joseph Health System	St. Mary Desert Valley Hospital	Apple Valley
1993	Mills Peninsula Hospitals—Mills Hospital	Mills-Peninsula Health System	Mills-Peninsula Corporation	San Mateo
1993	Mills Peninsula Hospitals—Peninsula Hospital	Mills-Peninsula Health System	Mills-Peninsula Corporation	Burlingame
1993	Hospital of Barstow, Inc.	Community Health Systems, Inc.	City of Barstow	Barstow
1993	Central Valley General Hospital	Central Valley General Hospital	Catholic Health Corp.	Hanford
1993	Sutter Amador Hospital	Sutter Health	Amador County	Jackson
1993	Scripps Hospital East County	Scripps Hospital Institutes	Epic Healthcare Group	El Cajon

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1993	Greater El Monte Community Hospital	OrNda HealthCorp	American Healthcare Management	South El Monte
1993	Visalia Community Hospital	Kaweah Delta Hospital District	Epic Healthcare Group	Visalia
1993	Avalon Medical Development Corporation	Avalon Medical Development Corporation	City of Avalon	Avalon
1993	Inter-Community Medical Center	Citrus Valley Health Partners	Inter-Community Health Services	Covina
1993	Long Beach Doctors Hospital	Paced Properties	Long Beach Doctors Hospital	Long Beach
1993	Midway Hospital Medical Center	OrNda HealthCorp	Summit Health Ltd.	Los Angeles
1993	San Pedro Peninsula Hospital	Little Company of Mary Health Services	San Pedro Peninsula Hospital	San Pedro
1993	Santa Marta Hospital	Carondelet Health System	Daughters of Saint Joseph	Los Angeles
1993	Whittier Hospital Medical Center	OrNda HealthCorp	Summit Health Ltd.	Whittier
1993	Santa Ana Hospital Medical Center	OrNda HealthCorp	Summit Health Ltd.	Santa Ana
1993	Methodist Hospital of Sacramento	Catholic Healthcare West	Valley Health Care Corporation	Sacramento
1993	French Hospital Medical Center	OrNda HealthCorp	Summit Health Ltd.	San Luis Obispo
1993	Valley Community Hospital	OrNda HealthCorp	Summit Health Ltd.	Santa Maria
1993	Good Samaritan Hospital of Santa Clara Valley	Good Samaritan Health System	Health Dimensions, Inc.	San Jose
1993	San Jose Medical Center	Good Samaritan Health System	Health Dimensions, Inc.	San Jose
1993	South Valley Hospital	Good Samaritan Health System	Health Dimensions, Inc.	Gilroy



Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1993	St. John's Pleasant Valley Hospital	Sisters of Mercy, Burlingame	St. John's Pleasant Valley Hospital	Camarillo
1993	Brotman Medical Center	OrNda HealthCorp	Brotman Partners Ltd. Partnership	Culver City
1993	Monterey Park Hospital	OrNda HealthCorp	American Health Care Management, Inc.	Monterey Park
1993	Palmdale Hospital Medical Center	Paracelsus Healthcare Corporation	Affiliated Medical Enterprises	Palmdale
1993	West Hills Hospital	Columbia HCA Healthcare Corporation	Galen, Inc.	West Hills
1993	Coastal Communities Hospital	Republic Health	OrNda Healthcorp	Santa Ana
1993	Covina Valley Community Hospital	Covina Valley Community Hospital Ltd.	San Gabriel Valley Medical Investments	West Covina
1993	Charter Suburban Hospital	Quorum Health Resources	Charter Medical Corporation	Paramount
1993	Fountain Valley Regional Hospital	OrNda HealthCorp	Fountain Valley Medical Development Company	Fountain Valley
1993	Mission Bay Memorial Hospital	Healthtrust, Inc.	Epic Healthcare Group	San Diego
1994	Lassen Community Hospital, Inc.	Saint Mary's Health Care Corporation	Lassen Community Hospital, Inc.	Susanville
1994	Mullikin Medical Enterprises	Mullikin Management, Inc.	Del Amo Corporation; Medical Vesting Corporation	Artesia
1994	Sun Valley Health Group, Inc.	Pacifica Optima Partners	Affiliated Medical Enterprises	Sun Valley
1994	Woodruff Community Hospital	OrNda HealthCorp	American Healthcare Management, Inc.	Long Beach

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1994	Los Robles Regional Medical Center	Columbia/HCA	Hospital Corporation of America	Thousand Oaks
1994	Ojai Valley Community Hospital	Brim Hospitals, Inc.	Affiliated Medical Enterprises	Ojai
1994	Notami Hospitals of California	Healthtrust, Inc.	Epic Healthcare Group	Healdsburg
1994	Tustin Hospital, Inc.	Healthcare America Management	Healthcare International, Inc.	Tustin
1994	Tarzana/Encino Regional Medical Center	Tenet Healthcare Corporation	American Medical International, Inc.	Tarzana
1994	Doctors Hospital of Pinole	Tenet Healthcare Corporation	National Medical Enterprises	Pinole
1994	San Ramon Regional Medical Center	Tenet Healthcare Corporation	National Medical Enterprises	San Ramon
1994	Garfield Medical Center	Tenet Healthcare Corporation	National Medical Enterprises	Monterey Park
1994	USC University Hospital—Richard K. Eamer	Tenet Healthcare Corporation	National Medical Enterprises	Los Angeles
1994	Los Alamitos Medical Center	Tenet Healthcare Corporation	National Medical Enterprises	Los Alamitos
1994	Placentia Linda Community Hospital	Tenet Healthcare Corporation	National Medical Enterprises	Placentia
1994	John F. Kennedy Memorial Hospital	Tenet Healthcare Corporation	National Medical Enterprises	Indio
1994	Alvarado Hospital Medical Center	Tenet Healthcare Corporation	National Medical Enterprises	San Diego
1994	Doctors Hospital of Manteca	Tenet Healthcare Corporation	National Medical Enterprises	Manteca
1994	Twin Cities Community Hospital	Tenet Healthcare Corporation	National Medical Enterprises	Templeton
1994	Community Hospital of Los Gatos	Tenet Healthcare Corporation	National Medical Enterprises	Los Gatos
1994	Redding Medical Center	Tenet Healthcare Corporation	National Medical Enterprises	Redding

**Table A.1 (continued)**

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1994	Doctors Medical Center of Modesto	Tenet Healthcare Corporation	National Medical Enterprise, Inc.	Modesto
1994	Camino Healthcare	Camino Healthcare	El Camino Healthcare System	Mountain View
1994	San Fernando Community Hospital	Mission Community Hospital	Panorama Community Hospital	Panorama City
1994	Tenet (South Bay Community Hospital)	Tenet Healthcare Corporation	American Medical International, Inc.	Redondo Beach
1994	St. Francis Medical Center	Catholic Healthcare West	Daughters of Charity National Health System	Lynwood
1994	St. Francis Memorial Hospital	Catholic Healthcare West	St. Francis Memorial Hospital	San Francisco
1994	Seton Medical Center	Catholic Healthcare West	Daughters of Charity National Health System	Daly City
1994	O'Connor Hospital	Catholic Healthcare West	Daughters of Charity Health Systems West	San Jose
1994	Saint Louise Hospital	Catholic Healthcare West	Daughters of Charity Health Systems West	Morgan Hill
1994	U.S. Family Care Medical Center—Montclair	U.S. Family Care Medical Center	National Medical Enterprises	Montclair
1994	Sierra Vista Regional Medical Center	Tenet Healthcare Corporation	American Medical International, Inc.	San Luis Obispo
1994	San Dimas Community Hospital	Tenet Healthcare Corporation	American Medical International, Inc.	San Dimas

**Table A.1 (continued)**

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1994	St. Luke Medical Center	OrNda HealthCorp	Summit Health Ltd.	Pasadena
1994	Mission Hospital Regional Medical Center	St. Joseph Health System	Mission Viejo Medical Development Co.	Mission Viejo
1994	Irvine Medical Center	Tenet Healthcare Corporation	American Medical International, Inc.	Irvine
1994	Sebastopol Hospital Corporation	Columbia/HCA Healthcare Corp.	Healthtrust, Inc.	Sebastopol
1994	Visalia Community Hospital	Kaweah Delta Health Care District	Kaweah Delta Hospital District	Visalia
1994	Suburban Medical Center	OrNda HealthCorp	Quorum Health Resources	Paramount
1994	Brea Community Hospital Corp.	Capital America	Brea Medical Development	Brea
1994	Mission Bay Memorial Hospital	Columbia/HCA Corp.	Healthtrust, Inc.	San Diego
1995	East Valley Huntington Hospital	Southern California Healthcare Systems	Glencomm Limited	Glendora
1995	Medical Center of North Hollywood	Tenet Healthcare Corporation	American Medical International, Inc.	North Hollywood
1995	Sutter Roseville Medical Center	Sutter Roseville Medical Center	Roseville Hospital	Roseville
1995	Southwest Hospital Development Group, Inc.	Southwest Hospital Development	National Health Administrators	Perris
1995	Vencor Hospital California, Inc.	Vencor, Inc.	National Medical Enterprises	Ontario
1995	Sherman Oaks Health System	Sherman Oaks Health System	Triad Healthcare	Sherman Oaks
1995	Tenet-Garden Grove Hospital and Medical Center	Tenet Healthcare Corporation	American Medical International, Inc.	Garden Grove

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1995	Notami Hospitals of California	Columbia/HCA	Healthtrust, Inc.	Healdsburg
1995	Westside Hospital	Columbia Healthcare	Epic Healthcare Group	Los Angeles
1995	Samaritan Medical Center	Columbia/HCA	Samaritan Health Systems	San Clemente
1995	Friendly Hills Healthcare Network	Caremark	Friendly Hills Healthcare Network	La Habra
1995	Bakersfield Memorial Hospital	Catholic Healthcare West	Memorial Health Systems	Bakersfield
1995	St. Mary Medical Center	Catholic Healthcare West	Sisters of Charity of the Incarnate Word	Long Beach
1995	Santa Monica Hospital Medical Center	Regents of the University of California	Unihealth	Santa Monica
1995	St. Vincent Medical Center	Catholic Healthcare West	Daughters of Charity of St. Vincent De Paul	Los Angeles
1995	Mercy Hospital	Scripps Health	Catholic Healthcare West	San Diego
1995	Mercy Healthcare North	Catholic Healthcare West	Sisters of Mercy	Red Bluff
1995	Columbia Chino Valley Medical Center	Columbia Healthcare	Health Trust, Inc.	Chino
1995	Lindsay District Hospital	Sierra View District Hospital	Unihealth	Lindsay
1995	Alta Bates Medical Center	Sutter Health	Alta Bates Health System	Berkeley
1996	Columbia-San Leandro Hospital	Columbia/HCA	SLCO Inc., Columbia	San Leandro
1996	Foothill Hospital—Morris C. Johnston	Citrus Valley Health Partners, Inc.	Foothill Hospital—Morris L. Johnston Memorial	Glendora
1996	Medpartners	Medpartners	Mullikin Management, Inc.	Artesia

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1996	Citrus Valley Medical Center—Queen of the Valley Campus	Citrus Valley Health Partners	Queen of the Valley Hospital, a California Corp.	West Covina
1996	Westlake Regional Medical Center, Inc.	Columbia/HCA	Westlake Community Hospital	Westlake Village
1996	Marin General Hospital	Sutter Health	Marin Health Systems, Inc.	Greenbrae
1996	Friendly Hills Healthcare Network	Medpartners	Caremark	La Habra
1996	Columbia San Clemente Hospital	Samaritan/Columbia/HCA Joint Venture	Columbia/HCA	San Clemente
1996	Palo Verde Hospital	Principal Hospital Corporation	Brim Hospitals, Inc.	Blythe
1996	California Pacific Medical Center—Pacific Campus	Sutter Health	California Pacific Medical Center	San Francisco
1996	Sutter Tracy Community Hospital	Sutter Health	Tracy Community Memorial Hospital	Tracy
1996	Mills Peninsula Hospitals—Mills Hospital	Sutter Health	Mills-Peninsula Health System	San Mateo
1996	Mills Peninsula Hospitals—Peninsula Hospital	Sutter Health	Mills-Peninsula Health System	Burlingame
1996	Columbia—Good Samaritan Hospital	Columbia/HCA	Good Samaritan Health System	San Jose
1996	Columbia—San Jose Medical Ctr.	Columbia/HCA	Good Samaritan Health System	San Jose
1996	Columbia—South Valley Hospital	Columbia/HCA	Good Samaritan Health System	Gilroy

Table A.1 (continued)

First Fiscal Year of New Owner	Hospital Name	New Owner	Previous Owner	City
1996	Orange Coast Memorial Medical Center	Memorial Health Services	FHP, Inc.	Fountain Valley
1996	Medpartners	Medpartners	U.S. Family Care Medical Center	Montclair
1996	Sutter Sonoma Medical Center	Sutter Health	County of Sonoma	Santa Rosa
1996	Providence Holy Cross Medical Center	Sister of Providence Health System	Sister of the Holy Cross (Non-Profit Corp.)	Mission Hills
1996	Westside Hospital	OrNda HealthCorp	Columbia Healthcare	Los Angeles
1996	Centinela Hospital Medical Center	Tenet Healthcare Corporation	Centinela Valley Health Services, Inc.	Inglewood
1996	Brotman Medical Center	Tenet Healthcare Corporation	OrNda Healthcorp	Culver City
1996	Monterey Park Hospital	Tenet Healthcare Corporation	OrNda Healthcare Corp.	Monterey Park
1996	Suburban Medical Center	Tenet Healthcare Corporation	OrNda	Paramount
1996	Woodruff Community Hospital	Tenet Healthcare Corporation	OrNda Healthcorp	Long Beach
1996	Coastal Communities Hospital	Tenet Healthcare Corporation	OrNda	Santa Ana
1996	Santa Ana Hospital Medical Center	Tenet Healthcare Corporation	OrNda Health Corporation	Santa Ana
1996	Charter Community Hospital	Magellan Health Services	Charter Medical Corporation	Hawaiian Gardens
1996	Memorial Hospital Los Banos	Sutter Health	Memorial Hospitals Association	Los Banos
1996	Memorial Medical Center	Sutter Health	Memorial Hospitals Association	Modesto
1997	Brookside Hospital (now Doctors Medical Center—San Pablo Campus)	Tenet Healthcare Corporation	West Contra Costa Hospital District	San Pablo

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