Title
Corporate Structure And Capital Strategy At Catholic Healthcare West

Journal
Health Affairs, 25(1)

ISSN
0278-2715 1544-5208

Authors
Robinson, James C
Dratler, Sandra

Publication Date
2006

DOI
10.1377/hlthaff.25.1.134

Peer reviewed

Corporate Structure And Capital Strategy At Catholic Healthcare West

Balancing mission and margin in the capital-intensive hospital industry.

by James C. Robinson and Sandra Dratler

PROLOGUE: The hospital competitive landscape has endured often convulsive transformation during the past decade. The industry has been buffeted by conflicting forces, hampering its health as a sector and influencing the strength of its competitive posture with respect to other components of the health care delivery system. Such factors have, at various times, included persistent overcapacity, misallocation of institutional assets and resources, low payment rates, aggressive competition from physician-owned entities and specialty hospitals, and the increasing burden of uncompensated care.

Under the conventional competitive wisdom that size begets strength, such market forces have sparked a trend toward rapid and aggressive hospital mergers and the ascendancy of hospital systems operating as integrated delivery systems. And, as we learned from *Health Affairs*' 2003 thematic issue on hospitals, hospital consolidation, by way of hospital systems acquiring other hospitals, far outstripped the competitive transformation achieved through mergers.

This paper analyzes the market and capital investment strategy at Catholic Healthcare West (CHW) between 1996 and 2005 to illuminate the strengths and weaknesses of chain organization. Abandoning its erstwhile focus on integrated delivery and growth for growth's sake in favor of selective divestments and investments, CHW achieved a remarkable turnaround in operating earnings and financial asset strength. As a nonprofit organization with religious sponsorship, however, CHW also developed a strategic approach to how to balance the financial investment and divestment priorities with those stemming from its charitable mission. The paper illustrates CHW's strategy to distribute capital investments across the system's forty hospitals in terms of each facility's profitability, the economic prospects of the market in which it is located, the extent to which it provides charitable services, and the social and health needs of its community.

James Robinson (jamie@berkeley.edu) is the Kaiser Permanente Distinguished Professor of Health Economics at the University of California (UC), Berkeley, School of Public Health. Sandra Dratler (dratler@haas.berkeley.edu) is a lecturer at the UC Berkeley School of Public Health and Haas School of Business.

DOI 10.1377/hlthaff.25.1.134

ABSTRACT: This paper analyzes the evolution of capital investment strategy at Catholic Healthcare West (CHW) between 1996 and 2005, as the forty-hospital system reversed its financial losses and diversified into ambulatory services and high-growth markets. The system developed a formal process for allocating capital among profitable facilities and those providing charitable services in communities with high social needs. Capital priorities shifted from weak facilities in low-growth markets (from 35 percent to 27 percent of total investment) to strong facilities in high-growth markets (from 32 percent to 45 percent). Mission-related investments were made to sustain, but not expand, the system's presence in low-income communities. [*Health Affairs* 25, no. 1 (2006): 134–147]

POLICY ATTENTION TO THE CONSOLIDATION of the hospital industry has focused on mergers among adjacent facilities, balancing the hope for economies of scale with the fear of stronger pricing power.[1] The striking feature of the contemporary hospital landscape, however, is chain organizations, both nonprofit and for-profit, that extend across multiple cities and, in many instances, across states or regions. The hospital chain should be interpreted as an internal market for capital—the deployment of financial surpluses generated from established facilities to the penetration of new markets and services. Local operating efficiency and pricing power are important for generating the surplus, but a central role of the parent organization lies in evaluating the portfolio of markets in terms of where to increase and where to decrease investments, where to buy and where to sell. Corporate strategy in the chain is inherently about entry and exit, the transfer of capital from markets where expansion opportunities are limited to those where demographics and economics offer the potential for profitable growth.

This paper analyzes the market strategy and role of capital finance at Catholic Healthcare West (CHW) to illuminate the strengths and challenges of chain organization in the hospital sector.[2] CHW is representative of U.S. large nonprofit hospital systems, with forty acute care facilities and numerous ambulatory, physician, and ancillary services spread across California, Arizona, and Nevada. During the heyday of managed care in the 1990s, it embarked on a strategy of vertical and horizontal integration and suffered severe losses from conglomerate overexpansion. CHW subsequently returned to black ink by centralizing governance and imposing performance benchmarks, developing turnaround strategies for underperforming facilities, and divesting unprofitable hospitals in economically unattractive markets. It is now expanding in high-growth cities such as Las Vegas and Phoenix, defending its strongholds in central California, and limiting its losses in economically unfavorable markets such as Los Angeles.

CHW offers a good context for studying chain organization because it is not a monopoly in any market and faces competent competitors even in communities where it is strongest. CHW's recent history sheds additional light on the dynamics of chain structure due to its nonprofit heritage, built through the amalgamation of facilities from seven Catholic orders and now spread over dozens of for-

merly Lutheran, Methodist, nondenominational, and governmental institutions. The organization must continually balance the chain strategy of entering profitable markets and exiting unprofitable ones with the religious mission of focusing on communities with large clinical and financial needs. This imperative pushes CHW beyond the "no margin, no mission" reality facing every nonprofit organization to a continual examination of where it is making money and where it is losing it, and then of ensuring that the losses in the unfavorable markets are targeted, predictable, and sustainable.

The Strategy Of Integrated Delivery

CHW was formed in 1986 as an affiliation of facilities that perceived the increasingly competitive environment as demanding more than a charitable mission and a cost-plus revenue strategy. Because hospitals often have fiercely independent community boards and medical staffs, hospital aggregation rarely generates economies of scale even in the most favorable market environments.[3] CHW experienced the extra challenge of having its most prominent facilities concentrated in Sacramento and San Francisco, where Kaiser Permanente and capitation payment drove prices and utilization to national lows. CHW embarked on a strategy of organizational integration, acquiring and investing in multiple medical groups and independent practice associations (IPAs). The pursuit of physician affiliations, capitation contracts, scale economies, and bargaining power culminated in the decision to expand its statewide and multistate presence, acquiring facilities in Phoenix, Las Vegas, and various southern California communities. The growth frenzy peaked in 1998 with the acquisition of eight non-Catholic facilities in Los Angeles, the most competitive U.S. health care market.

Underpinning CHW's efforts at vertical integration with physicians and horizontal integration with hospitals was the belief that the fundamental unit of service would change from the hospital admission to a continuum of inpatient, outpatient, primary, specialty, and ancillary services for a defined population of patients. This view underlay the system's physician practice acquisitions, designed to feed referrals into the hospitals and to piece together the new, larger health care product. It also supported what became an article of faith: that coordination would reduce overall costs even if the costs of some individual services increased. The emphasis on global revenues and aggregate costs diverted management's attention from the incremental revenues and costs attributable to each site and service. The characteristic failing of fragmented clinical organization and fee-for-service (FFS) payment had been inattention to synergies and systemwide performance. The failing of integrated delivery proved to be inattention to the individual performance of the system's many components.

CHW embedded the logic of integration into its market, brand, operational, and financial strategies. If covered lives rather than individual procedures were to be the economic unit, and if more covered lives brought lower costs and higher

"Integrated delivery requires mechanisms that balance the authority of the system with the autonomy of key service subunits."

revenues, then expansion to the largest regional markets would ensure the success of the enterprise. Consistent with its efforts at integrated organization, CHW attempted to create a systemwide brand identity, blazoning the CHW logo on its hospitals and downplaying local brands. An increasing number of functions were centralized to the corporate level, including billing, purchasing, and information technology (IT). Financial performance was measured at the regional level, and operational shortfalls were covered by investment earnings, which impeded efforts to see where the firm was making money and where it was losing it.

The strategy of integrated delivery is not necessarily flawed, but it requires mechanisms of governance that balance the authority of the system as a whole with the autonomy of its key service subunits. CHW suffered from an inappropriate structure of control, as management sought to make decisions and set direction at the corporate level while facility-specific local boards retained ultimate fiduciary authority. Local autonomy impeded the system from consolidating its financial assets and using the surpluses earned in its established markets as investment capital to deploy in communities with better growth opportunities. The strategy of integrated delivery, and the loss of focus it fostered, permitted CHW to remain a weak empire of strong principalities, a holding company whose distinct businesses hoarded any profit and clamored for subsidies to cover any loss.

CHW's life as a statewide integrated delivery system (IDS) was enthusiastic, traumatic, and short. Already in 1998, when the overexpanded system was acquiring hospitals in Los Angeles and deepening its dependence on overextended physician organizations, the financial alarms were beginning to sound. The Los Angeles facilities carried massive debt and helped swing CHW from a modestly positive operating gain of $26 million in 1996 to a loss of $353 million in 1999 and then to a further loss of $323 million in 2000 (Exhibit 1). Investment profits on its stock portfolio kept CHW afloat, but the bond markets scorned its once-stellar debt, with a costly series of bond downgrades from A+ to BBB. In June 2000, with falling liquidity ratios and the rating agencies threatening to downgrade its bonds to speculative (junk bond) status, CHW brought in a new chief executive officer and, with him, a new market, service, and financial strategy.

Turmoil And Turnaround

The organizational crisis that beset CHW in 2000 had the salutary effect of disposing the system's stakeholders to grant the new executive team a relatively free hand in centralizing financial authority while delegating operational responsibility to the local facilities. To stanch the financial hemorrhaging, CHW began divesting physician practices and financially irremediable hospitals, outsourcing IT,

EXHIBIT 1
Trends In Scale, Profitability, Asset Strength, And Other Characteristics At Catholic Healthcare West (CHW), Selected Years 1996–2005

	Fiscal year ended June 30							
	1996	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Number of hospitals	33	47	47	48	42	41	40	40
Number of beds	7,125	10,003	9,892	9,973	8,173	8,029	8,231	7,843
Number of admissions (thousands)	–[a]	365	350	356	356	364	377	382
Net operating income ($ millions)	26	−353	−323	−134	−47	51	126	183
Investment and non-operating income ($ millions)	134	249	275	47	−6	−1	119	165
Profit ($ millions)	160	−103	−47	−87	−54	50	246	348
Operating margin (%)	1.0	−8.9	−7.2	−2.8	−1.0	1.0	2.4	3.1
Total margin (%)	6.3	−2.6	−1.1	−1.8	−1.2	1.0	4.6	5.8
Days' cash on hand	172	135	101	91	109	109	126	141
Unrestricted cash/long term debt (%)	73	66	62	62	72	74	87	96
Long-term debt/ capitalization (%)	43	45	52	53	56	56	56	52
Standard and Poor's bond rating	A+	BBB+	BBB+	BBB	BBB	BBB	BBB+	A–
Outlook at end of fiscal year	Stable	Stable	Negative	Negative	Stable	Stable	Stable	Stable

SOURCE: Catholic Healthcare West.

[a] Not available.

and sharply restricting capital spending. These budgetary initiatives were predicated on a centralization of governance and consequent transformation of local hospital boards from quasi-independent fiefdoms to nonfiduciary advisory bodies. The corporate office stopped seeking a systemwide operational strategy and focused on developing performance benchmarks by which each local unit could be measured, compared with its peers, and held accountable for improvements.

In its first turnaround year, CHW divested almost all of its physician practices plus several of its hospitals. It abandoned the once-heralded Shared Business Services and outsourced its major IT needs to Perot Systems. Contracts with insurers were renegotiated with an eye toward leveraging any untapped bargaining power in strong markets and toward allowing facilities in weak markets to benefit from better contract language and guarantees of contract enforcement. Capitation was renounced in favor of per diem contracts that included stop-loss thresholds, above which the hospitals were reimbursed a percentage of billed charges.[4] The increase in revenues derived from higher prices and reversion to FFS was a major factor alongside improved productivity and cost reduction in the system's subsequent improvement in earnings. Operating results improved dramatically, from losses of $134 million in 2001 to gains of $183 million in 2005.

The Strategy Of Selective Diversification

The turnaround initiatives at CHW were mandated by its dire financial situation but also reflected a new interpretation of its markets and services, which was able to flower when the worst of the losses were contained. The new interpretation might be denoted the "strategy of selective diversification" and contrasted with the erstwhile strategy of integrated delivery.

The fundamental assumption of selective diversification is that some health care services are inherently profitable while others are inherently unprofitable, and that organizational success is determined by a judicious choice as to which to provide and which to avoid. Gone is the assumption that health care will be aggregated into bundles of physician, hospital, and ancillary services that are priced and purchased per member per month, and hence where the relation between marginal cost and marginal revenue for each individual service is unimportant. The ambitions of managed care are replaced by a more humble acknowledgment that no organization can do all things well and should not try. Firms should focus on services where the relation of price to cost is especially favorable, because of the clumsy reimbursement formulas used by public and private insurers, or where the organization enjoys some comparative advantage in cost or reputation. Hospitals compete with each other not for the entire clinical continuum but for each service separately, and hence the decision of which services to avoid is as important as the decision of which to provide.[5]

The principles of selective diversification carry over from choice of services to choice of geographic markets. Some communities are inherently advantageous, because of a growing, prosperous population and comparatively weak competitive environment, while others are plagued by small populations, low incomes, or aggressive competitors. As CHW reassessed the goal of integrated delivery, it recognized that Los Angeles, its biggest market, was also its least profitable, with millions of Medicaid beneficiaries and uninsured residents, a surplus of hospital bed capacity, and large physician organizations willing to move patient admissions to low-price facilities. The best potential markets were Las Vegas and Phoenix, with rapid growth, economic prosperity, and no capitation. The sunbelt cities already had attracted major investor-owned hospitals chains and, in Phoenix, had a large nonprofit hospital incumbent. But the rising tide of population, prosperity, and FFS payment was lifting all boats.

Capital Investment Priorities: Financial Margin

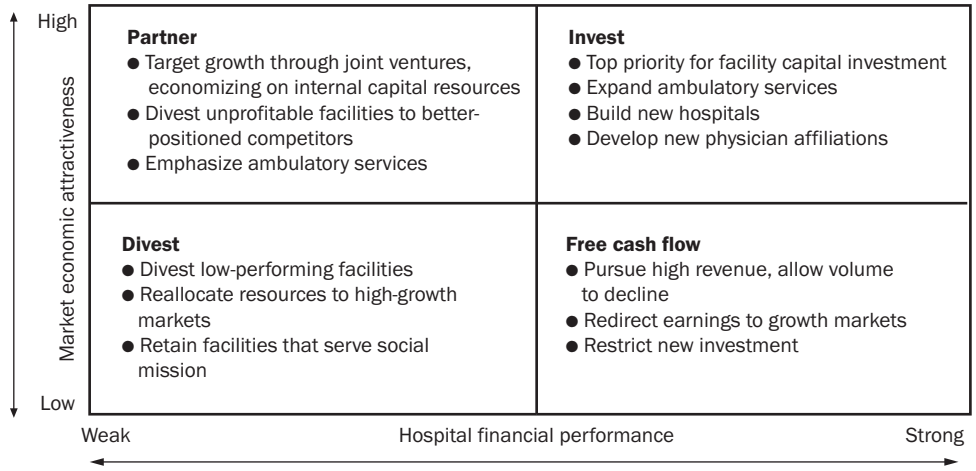
The capital challenge facing the hospital chain is that each additional institution is another mouth to feed, hungry for infrastructure upgrades, enterprisewide IT, advanced clinical equipment, and, for many of CHW's aging facilities, a major renovation or complete replacement. Investment capacity consists of internally generated surpluses and externally available capital, whose price depends on the creditors' perceptions of the system's long-term revenue and growth prospects.

After holding capital spending near $200 million annually during the worst years and at $300 million in 2004, CHW's improving operating performance offered it a capital capacity averaging $600 million annually for the remainder of the decade. Capital spending as a percentage of system revenues rose from 3.9 percent in 2002 to 4.3 percent in 2003, 5.9 percent in 2004, and 7.7 percent in 2005, with a projected average of 9.5 percent through 2009. This increased capacity presumed improvement in operating margins to 2.7 percent, cash-flow margin (earnings before interest and depreciation) above 9.0 percent, days' cash on hand above 130 days, and debt-to-capital ratio below 50 percent. These financial targets largely were attained by 2004, as indicated in Exhibit 1, but the system would need to retain a vigilant eye on its balance sheet as it expanded its capital investments during the remainder of the decade.

CHW imposed a disciplined review on capital requests emanating from individual hospitals, requiring that they be either mandated by regulation, imperative to remediate quality deficiencies, or able to achieve a financial return greater than the system's cost of capital. Even this slimmed-down list exceeded the system's capital capacity, leading to an estimated investment shortfall of $1.8 billion between 2005 and 2009. Without an effective priority-setting mechanism, the system faced the prospect of being forced to expend much of its available funds on mandated but nonremunerative retrofit projects.

The financial strategy of selective diversification, illustrated in Exhibit 2, prioritizes capital investment and divestment decisions according to the economic characteristics of individual hospitals and the markets where they are located. Facilities with poor economic performance and located in unattractive mar-

EXHIBIT 2
Capital Investment Strategies In CHW Hospitals According To Market Economic Attractiveness And Hospital Financial Performance



SOURCE: Catholic Healthcare West (CHW).

"CHW evaluated its contributions in terms of charitable activities and the economic and health-related needs of the communities."

kets, which fall in the lower left quadrant of Exhibit 2, must improve operational performance or become candidates for divestment in order not to bleed capital from the system. Some facilities might be retained because of their social mission. Prior to any divestment decision, CHW embarks on a lengthy process involving stakeholders, weighing options and considering the implications for the availability of health care in the local community. Facilities with strong current performance but in markets with limited growth opportunities, which fall in the lower right quadrant, are to be treated as a source of operating earnings (free cash flow) rather than as a locus of new investment. Weakly performing hospitals in growing markets, featured in the upper left quadrant, should partner with complementary organizations, such as chains of ambulatory surgery centers (ASCs), to improve financial performance without demanding substantial capital investment. Strongly performing facilities in growth markets, featured in the upper right quadrant, offer the potential to sustain and expand the system's long-term capital capacity and, as such, are to be the principal locus for new investment.

Capital Investment Priorities: Social Mission

The strategy illustrated in Exhibit 2 is consistent with any diversified organization's need to prioritize its capital investments; however, the religious orders that founded CHW established hospitals not to maintain a bond rating but to minister to the needy. CHW's strained financial circumstances required in 2002 that charitable activities be directed by an analytic rigor comparable to that applied to financial investments, lest ongoing commitments to underperforming facilities limit the system's ability to influence areas of special need. Over time, a nonstrategic approach to capital investment could render CHW a safety-net provider in financially challenged communities, while its more strategic competitors mobilized the capital to expand in growing markets.

CHW evaluated its social contributions in terms of both the charitable activities of its individual facilities and the economic and health-related needs of the communities in which those facilities were located. The contributions of each facility were quantified in terms of the percentage of operating expenditures devoted to charity care for indigent people, both absolutely and relative to the percentages reported by neighboring hospital systems, plus the absolute and relative percentages of spending devoted to care for Medicaid beneficiaries. The economic and health-related deficiencies of its markets were quantified in terms of a community need index (CNI), a weighted sum of indicators of poverty, cultural diversity, education, housing stock, and (lack of) health insurance coverage in the markets where its facilities were located.[6] Distinguishing between the social

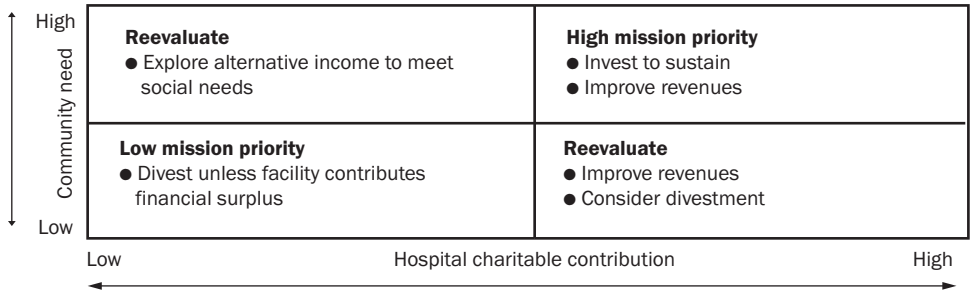
contribution of the hospital and the social needs of the market is important because some facilities in needy communities offer little charity care, while some facilities in wealthy communities provide considerable charity services.

Exhibit 3 illustrates the mission-related capital investment options facing CHW. The horizontal axis measures the social contribution of each hospital while the vertical axis measures the social need of the market. Facilities in the lower left quadrant offer few charitable services and are located in prosperous communities and hence rank low in terms of CHW's mission strategy. They are candidates for divestment unless they perform well financially, in which case they would be retained based on the system's financial strategy. Facilities in the upper right quadrant offer considerable charitable services and are located in communities with sizable social and health-related needs and so are of highest priority for capital investment from a mission-related perspective. The system seeks to improve their operating performance by exploring alternative sources of revenues, particularly from governmental programs. Facilities in high-need communities that offer few charitable services, located in the upper left quadrant, should explore alternative ways of meeting social needs, especially through funding of nonacute and noninstitutional services. Facilities that offer substantial charitable services but are located in wealthy communities, in the lower right quadrant, should seek new revenue sources or be considered for divestment.

Implementing Capital Priorities

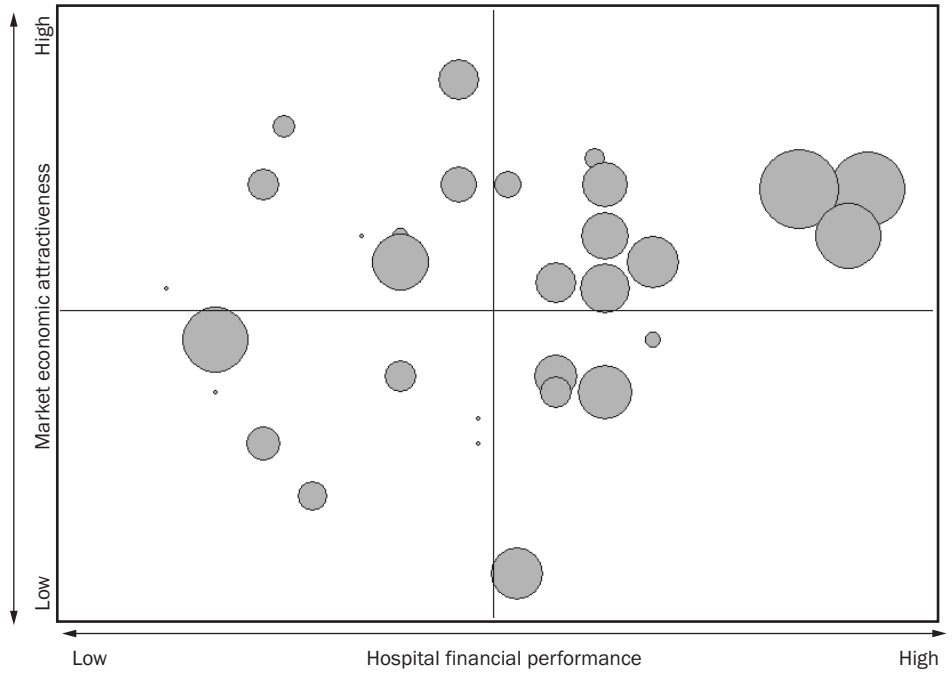
Exhibit 4 portrays scheduled 2005–09 investment that emerged from CHW's improved operating performance and the capital strategy based on it.[7] CHW evaluated the economic performance of each hospital and the attractiveness of each geographic market, the former in terms of a weighted index of revenue growth, earnings, and earnings growth and the latter in terms of a weighted index of population, population growth, family income, bed capacity, capacity utilization, and

EXHIBIT 3
Capital Investment Strategies In CHW Hospitals According To Community Need And Hospital Charitable Contribution



SOURCE: Catholic Healthcare West (CHW).

EXHIBIT 4
Capital Investment In CHW Hospitals According To Market Economic Attractiveness And Hospital Financial Performance



SOURCE: Catholic Healthcare West (CHW).
NOTES: Each bubble represents the quantity of capital scheduled for investment in each CHW hospital between 2005 and 2009. The horizontal axis measures each facility's value on the index of financial performance (for example, revenues, earnings), while the vertical axis represents each facility's market characteristics (for example, population growth, family income).

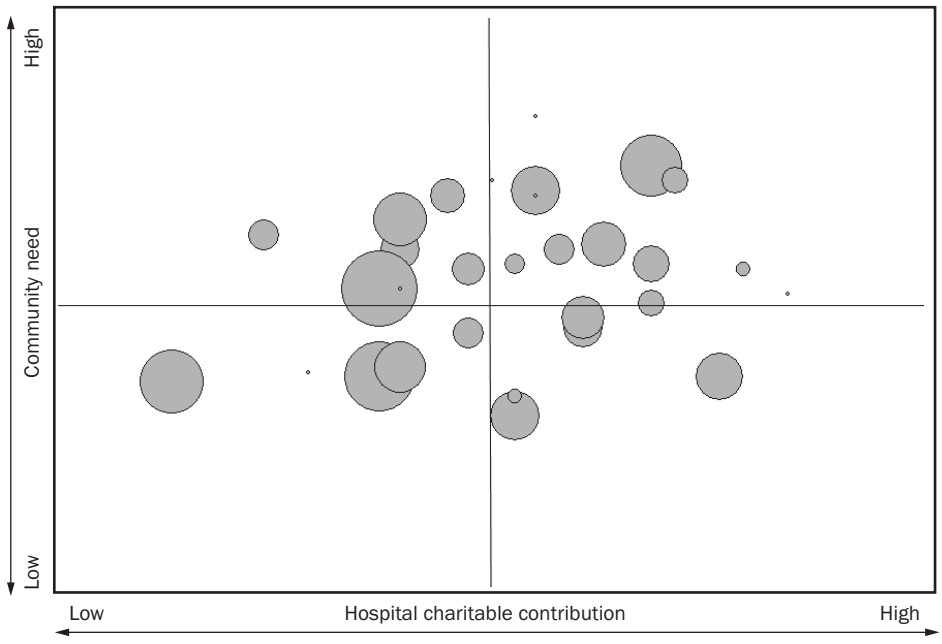
market competitive structure. In Exhibit 4 each hospital is represented by a "bubble," the size of which is determined by the volume of capital the system has allocated for major projects.[8] Facilities are positioned in terms of their status on the index of economic performance (horizontal axis) and the index of market attractiveness (vertical axis), consistent with the strategic framework sketched in Exhibit 2. The upper right quadrant of Exhibit 4 is dominated by hospitals in Las Vegas, Phoenix, and Sacramento, while the lower left is dominated by hospitals in Los Angeles and several rural areas.

CHW shifted both the volume and the location of its capital investments as it moved from the turnaround phase (2000–04) to the growth phase (2005). In the turnaround phase, the system was forced to allocate 35 percent of capital expenditures to poorly performing facilities in unattractive markets (lower left quadrant) and only 32 percent in the best-performing facilities in the most attractive markets (upper right quadrant). For the 2005–09 period, it was able to increase its total capital spending by 39 percent and shift the relative mix in favor of facilities where the financial return on investment is greatest. Capital investments in the

least remunerative facilities increased in absolute dollars but decreased in relative terms to 27 percent of the total. Investments in the best-performing facilities in the most attractive markets (upper right quadrant) doubled in absolute terms and increased to 46 percent of the total.

The allocation of capital investment among individual hospitals in terms of their priority with CHW's social mission strategy is presented in Exhibit 5, which arrays each hospital according to its charitable contribution (including Medicaid volume) on the horizontal axis and the social and health needs of the community it serves on the vertical axis. The largest investments are scheduled for facilities that provide only modest charitable and Medicaid services, relative to the entire portfolio of CHW hospitals; this is consistent with the system's emphasis on expanding its most profitable facilities. However, there are several major projects scheduled for hospitals that rank high in both dimensions of CHW's social mission—renovating or replacing facilities that offer substantial charitable services in low-income communities (upper right quadrant).

EXHIBIT 5
Capital Investment In CHW Hospitals According To Community Need And Hospital Charitable Contribution



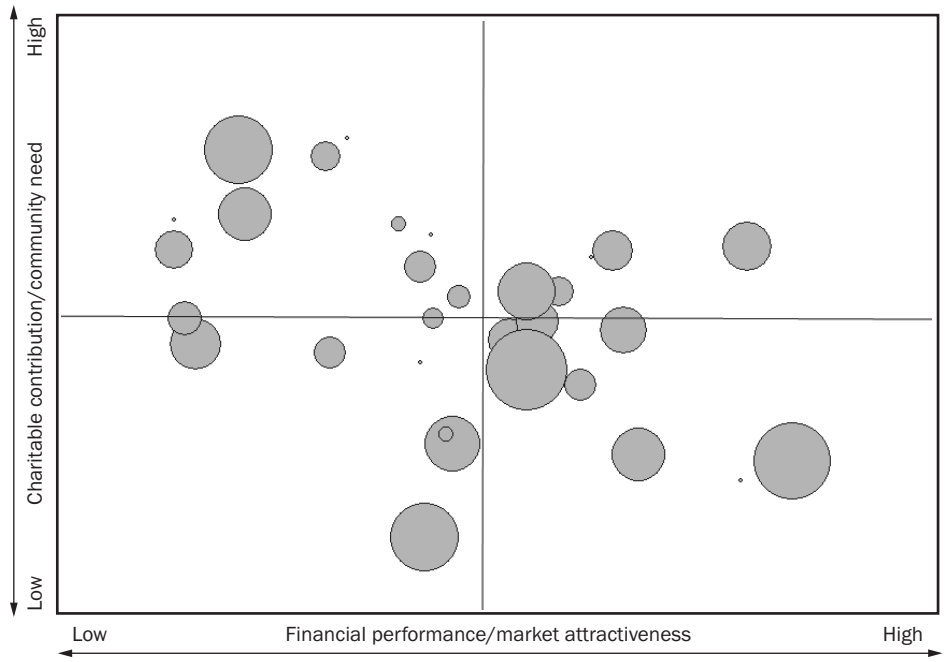
SOURCE: Catholic Healthcare West (CHW).
NOTES: Each bubble represents the quantity of capital scheduled for investment in each CHW hospital between 2005 and 2009. The horizontal axis measures each facility's charitable contribution to its community, while the vertical axis represents the social and health-related needs of the community in which the facility is located.

Balancing Mission And Margin

CHW's efforts to balance mission and margin are highlighted in Exhibit 6, which arrays each hospital and its capital investment in terms of both financial prospects and social need. The horizontal axis is calculated as the sum of the index of facility financial performance and the index of market financial attractiveness (Exhibits 2 and 4). The vertical axis in Exhibit 6 measures charitable contribution and social need and is calculated as the sum of the indexes of hospital charitable contribution and market community need (Exhibits 3 and 5).

CHW's investment commitments are concentrated in the upper left and lower right quadrants of Exhibit 6. The large bubbles in the lower right represent the facility expansions and technology acquisitions in Las Vegas, Phoenix, and other inland markets where the system's future prospects are brightest. The two large bubbles in the upper left quadrant represent major projects in markets where a financial return is difficult but where the system has decided to stay and invest rather than to sell and leave, including Los Angeles and a rural community whose facility needs total replacement. The system has not sought to acquire new hospi-

EXHIBIT 6
Capital Investment In CHW Hospitals According To Financial Performance/Market Attractiveness And Charitable Contribution/Community Need



SOURCE: Catholic Healthcare West (CHW).
NOTES: Each bubble represents the quantity of capital scheduled for investment in each CHW hospital between 2005 and 2009. The horizontal axis measures the sum of the indices for each facility's financial performance and market economic attractiveness, while the vertical axis represents the sum of the charitable contribution and community need indices.

tals in markets with high economic and health-related needs, passing up the opportunity to purchase money-losing facilities in low-income Los Angeles neighborhoods that were put up for sale by Tenet in 2004. Aside from these major commitments, most of the bubbles on the left hand side of Exhibit 6 are small, which illustrates the system's strategy to restrict capital investment in instances that do not rise to the top of the priority list on considerations of either financial return or charitable contribution.

Concluding Comments

The excess capacity has gradually been sweated out of the U.S. hospital industry, as many facilities have reduced bed counts, some have closed altogether, and the population has grown. This has strengthened the bargaining positions and balance sheets of the remaining institutions. The economic revival of the sector remains uneven, however, with some markets hindered by weak population growth and some facilities finding themselves unfavorably placed even within a generally desirable environment.[9] The chain structure is well adapted to this new industry reality, as hospitals come to interpret themselves as sources of capital and operational know-how that can be moved among clinical services and geographic markets depending on the relative advantages and disadvantages of each, rather than as being wedded to any particular service or market for historical reasons. The IDS has been replaced by the diversified organizational chain.[10] The core competencies of the chain include the ability to evaluate existing and potential markets, to analyze the internal capabilities of the firm and understand where best these capabilities can be deployed, to accumulate the financial resources necessary to take advantage of new opportunities, and to maintain the self-discipline essential for decisions to exit underperforming markets and services.

The strategy of selective diversification is central to all conglomerates, but the nonprofit chain must also evaluate services and markets based on social needs as well as financial returns. Those services and markets where the nonprofit can make its most important social contribution often are those with the weakest economic position and from which an investor-owned firm would be quickest to depart. The analysis of each service and market and the matching of social needs with organizational capabilities are important in precisely these contexts, lest the organization's limited resources be expended on activities that made sense only in the past. The quantification of needs and capabilities might serve the nonprofit organization well in an environment of public skepticism toward tax-exempt status. The "trust me" era of nonprofit accountability is being replaced by an attitude of "trust but verify," and a diversification strategy could help nonprofit systems document the practices that distinguish them from their for-profit competitors. A charitable mission inevitably is limited by a financial margin, and the social effectiveness of a nonprofit organization can be furthered by a strategic approach to how best to lose money as well as how best to earn it.

This research was supported by the Robert Wood Johnson Foundation, through its Changes in Health Care Financing and Organization (HCFO) initiative.

NOTES

1. A.E. Cuellar and P.J. Gertler, "Trends in Hospital Consolidation: The Formation of Local Systems," *Health Affairs* 22, no. 6 (2003): 77–87; G.J. Bazzoli, et al., "Two Decades of Organizational Change in Health Care: What Have We Learned?" *Medical Care Research and Review* 61, no. 3 (2004): 247–331; D. Dranove and R. Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence," *Journal of Health Economics* 22, no. 6 (2003): 983–997; Y.K. Kim et al., "The Influence of Hospital Integration on Hospital Financial Performance," *Journal of Health Care Finance* 31, no. 1 (2004): 73–84; C.S. Lesser and L.R. Brewster, "Hospital Mergers and Their Impact on Local Communities," in *Understanding Health System Change: Local Markets, National Trends*, ed. P.B. Ginsburg and C.S. Lesser (Chicago: Health Administration Press, 2001), 19–36; and G.J. Bazzoli, "The Corporatization of American Hospitals," *Journal of Health Politics, Policy and Law* 29, no. 4 (2004): 885–905.
2. Information for this case study was obtained through interviews with senior and midlevel executives at CHW with responsibilities in finance, operations, and strategy; extensive internal documents on capital strategy and investments; revenues, expenditures, and other dimensions of performance on a market and facility-specific basis; publicly available CHW documents such as annual reports and presentations for external audiences; and bond rating reports specific to CHW, to the California market, and to the tax-exempt hospital sector as a whole.
3. L.R. Burns and M.V. Pauly, "Integrated Delivery Networks: A Detour on the Road to Integrated Health Care?" *Health Affairs* 21, no. 4 (2002): 128–143; L. Friedman and J. Goes, "Why Integrated Health Networks Have Failed," *Frontiers of Health Services Management* 17, no. 4 (2001): 3–28; and K. Carey, "Hospital Cost Efficiency and System Membership," *Inquiry* 40, no. 1 (2003): 25–38.
4. CHW continues to contract on a capitated basis with health maintenance organization (HMO) products in Sacramento and selected other areas where it has strong links with physician organizations and where managed care competition is strong.
5. M.E. Porter and E.O. Teisberg, "Redefining Competition in Health Care," *Harvard Business Review* (June 2004): 65–76.
6. R. Roth, P. Presken, and G. Pickens, *A Standardized National Community Needs Index for the Objective High-Level Assessment of Community Health Care* (San Francisco: Catholic Healthcare West, 2004).
7. The capital investments presented in Exhibits 3 and 4 are projections in 2005 for the subsequent four-year period and are subject to revision over time.
8. Major projects, defined as costing in excess of $25 million, account for 58 percent of total capital expenditures for CHW. The remainder are facility renovations costing less than $25 million (22 percent of total), information technology (12 percent), physician alignment and outpatient expansion projects (4 percent), and miscellaneous (4 percent).
9. L. Zuckerman et al., "The California Health Care Market: Recent Strength Defies Expectations," Standard and Poors Ratings Direct (proprietary Web site); and J.E. Wells et al., "2005 Nonprofit Hospitals and Health Care Systems Forecast," FitchRatings (proprietary Web site).
10. J.C. Robinson, "Entrepreneurial Challenges to Integrated Health Care," in *Policy Challenges in Modern Health Care*, ed. D. Mechanic et al. (New Brunswick, N.J.: Rutgers University Press, 2005).