# TRENDS

## Public Expectations Of Nonprofit And For-Profit Ownership In American Medicine: Clarifications And Implications

For much of the American public, ownership does seem to matter.

**by Mark Schlesinger, Shannon Mitchell, and Bradford H. Gray**

**ABSTRACT:** Policymakers, advocates, and scholars frequently make claims about how the American public sees ownership affecting the delivery of medical care. In this paper we provide a comprehensive assessment of how Americans think about nonprofit and for-profit ownership. We summarize findings from surveys fielded between 1985 and 2000 and supplement them with findings from a new survey. Most Americans believe that ownership matters for multiple aspects of medical care; they expect nonprofit hospitals and health plans to be more trustworthy, fair, and humane but lower in quality. People who are better informed about ownership have more positive expectations about nonprofits' performance.

THE APPROPRIATE ROLE and effects of the profit motive in medical care continue to be fiercely contested.[1] From one extreme come claims that the preferential tax treatment of nonprofits should be eliminated because "the case has not been made for a general policy of government preferences for the nonprofit health sector."[2] At the other extreme, some argue that nonprofits' more trustworthy practices and greater commitment to the community justify prohibiting investor ownership in health care.[3]

Both critics and supporters of nonprofit medicine invoke the views of the American public. Skeptics conclude that "the public seems to have little concern about who owns their hospitals" and assert that "the vast majority of consumers either did not know the difference between for-profit and nonprofit insurers, or did not care."[4] These attacks are countered by defenders of the nonprofit sector, who cite evidence indicating that 46 percent of Americans reported that ownership was an important factor for selecting a health plan and nonprofit ownership, their favored choice.[5]

The public's assessments of nonprofit and for-profit health care thus speak to both ongoing policy debates and academic theories about the influence of ownership on organizational behavior. However, understanding of public opinion on these matters has been distorted by strategic manipulation of poll results and clouded by the fragmented state of empirical research, which is scattered across disciplines, often not published in academic journals, and incomplete in its coverage of theoretically relevant differences in health care delivery. This paper provides a comprehensive, more balanced picture of how Americans think ownership matters in medical care. We begin by reviewing and critiquing the surveys conducted between 1985 and 2000. We sup-

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plement these earlier findings with evidence from a newer survey, fielded in the summer of 2002. This survey focuses on dimensions of performance neglected in past surveys and takes into account the public's limited understanding of legal ownership.

## Past Surveys About Ownership

Public opinion researchers began asking about hospital ownership in the mid-1980s, following a wave of expansion among investor-owned hospital corporations and the media coverage that followed.[6] In 1986, for example, 44 percent of Americans said that they had "heard or read anything" about the growth of for-profit hospitals.[7] The Henry J. Kaiser Family Foundation (KFF) fielded a second wave of surveys between 1995 and 1998. These followed a second era of expansion by investor-owned hospital corporations, in which hospitals "emerged as a prime growth industry attractive to entrepreneurs."[8]

■ **Comparative advantages.** The early surveys established two ownership-related questions that would continue to be asked over the next fifteen years: (1) Do nonprofit or for-profit hospitals provide better-quality care, and (2) do nonprofit or for-profit hospitals provide treatment at lower cost to patients? The prevailing wisdom among most economists was that nonprofits provide higher-quality care, but for-profits deliver services at lower cost.[9] Public expectations differed from economists' predictions. In two surveys fielded in 1986, most of the public saw no strong link between ownership and quality (Exhibit 1). The same respondents, however, saw a connection between ownership and cost—one that ran counter to economists' predictions, anticipating nonprofits' costs to be lower.

The distinction between the public's and economists' perceptions became even more pronounced in the 1990s. On the KFF surveys, a majority of Americans reported that for-profit hospitals were likely to offer higher-quality care, but an even larger majority expected nonprofit hospitals to offer treatment at lower cost. Many fewer respondents appeared to think that ownership was unrelated to cost and quality.[10]

■ **Public expectations.** Why does the public expect ownership to matter differently for cost and quality? The KFF surveys help address this question, providing additional measures of ownership-related expectations and additional data in the latter 1990s. By comparing responses from the new and old questions and by tracking how both sets of responses changed over time, we can derive some additional insights.

The KFF fielded surveys on ownership-related perceptions through early 1998. This created an interesting natural experiment about the effects of adverse publicity, based on events that occurred in the summer of 1997. Columbia/HCA, the largest and most prominent U.S. health care corporation, was rocked

**EXHIBIT 1**
**Trends In Public Attitudes About Comparative Cost And Quality, Not-For-Profit Versus For-Profit Hospitals, Selected Years 1986–1997**

| | Quality of care (%) | | | Cost of care to patients (%) | | |
|---|---|---|---|---|---|---|
| Date of survey | NP better | Same | FP better | NP better | Same | FP better |
| July 1986 | 24 | 33 | 19 | 40 | 25 | 10 |
| October 1986 | 8 | 49 | 12 | 29 | 30 | 8 |
| December 1995 | 34 | –[a] | 57 | 73 | –[a] | 22 |
| March 1997 | 32 | 8 | 55 | 71 | 8 | 18 |

**SOURCES:** Roper Center for Public Opinion Research; and Henry J. Kaiser Family Foundation.
**NOTES:** NP is not-for-profit. FP is for-profit.
[a] Question not asked.

by scandals involving fraudulent billing and inappropriate treatment practices at its hospitals.[11] The media covered these events extensively: 27 percent of the public indicated that they had followed the story closely, and 40–50 percent had some knowledge of the events.[12]

Public perceptions of the quality of for-profit hospitals dropped between March and October 1997 and continued to fall through January 1998 (Exhibit 2). Perceptions that nonprofit hospitals offered better quality rose, but not as sharply. (Curiously, the proportion of the public that expected for-profit hospital care to cost less did not change in the face of these media exposés.)

Negative publicity may account for some of the improvement in perceptions of for-profit hospitals between the 1980s and 1990s. During the mid-1980s there was extensive coverage of fraudulent practices among for-profit hospital corporations, much like those involved in the Columbia/HCA scandals.[13] Adverse effects on Americans' attitudes may have faded by the mid-1990s, before being reawakened by the publicity about Columbia/HCA.

Additional insights can be gained by considering two questions that the KFF surveys added. One related to the economic performance of hospitals, the other to the care they provided. On the first, respondents were asked whether nonprofit or for-profit hospitals "are more efficient." Notably, many respondents who expected that care in nonprofit hospitals would cost patients less did not consider them to be more efficient. This suggests that respondents assumed that lower costs to patients were a consequence of nonprofit hospitals' pricing policies, not the resources they used to provide services.[14] This disassociation between efficiency and cost to patients grew more pronounced in the wake of the Columbia/HCA scandal: Perceptions of for-profit efficiency declined, while expectations about costs were unchanged.

The second question asked whether nonprofit or for-profit hospitals were "more responsive to customers." Answers closely matched those on the question comparing quality of care before and after the Columbia/HCA scandal. Between March 1997 and January 1998, public perceptions that for-profit hospitals offered higher-quality care and that they were more responsive to consumers each declined by twenty-one percentage points. This parallel suggests that the public's interpretation of hospital "quality" was closely related to its notions of responsiveness to consumers.

■ **Perceptions of ownership applied to health plans.** Half of the respondents to the KFF surveys were asked about their perceptions of nonprofit versus for-profit health insurers.[15] Perceptions of health plan ownership closely replicated their attitudes toward hos-

**EXHIBIT 2**
**Public Attitudes Before And After The Columbia/HCA Scandal, Not-For-Profit Versus For-Profit Hospitals, 1997–1998**

| | Cost-related dimensions of hospital performance (%) | | | | Quality-related dimensions of hospital performance (%) | | | |
|---|---|---|---|---|---|---|---|---|
| | Cost patients less | | Are more efficient | | Provide better-quality care | | Are more responsive to consumers | |
| Date of survey | NP | FP | NP | FP | NP | FP | NP | FP |
| March 1997 | 71 | 18 | 30 | 57 | 32 | 55 | 37 | 53 |
| October 1997 | 61 | 21 | 39 | 40 | 39 | 38 | 40 | 42 |
| January 1998 | 63 | 17 | 39 | 41 | 43 | 34 | 58 | 32 |

**SOURCE:** S. Srinivasan, *For-Profit Health Care Companies: Trends and Issues* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, February 1998).

**NOTES:** NP is not-for-profit. FP is for-profit.

pital ownership. Through early 1997, for-profit plans were seen as being more efficient and more responsive to customers and as offering better-quality care. Following the HCA scandals in mid-1997, attitudes became more hostile toward for-profit health plans in much the same manner and magnitude as we observed regarding hospitals.

■ **The bottom line.** Is the profit motive good or bad for American medicine? Some scholars who have examined public opinion data related to ownership, such as those presented in Exhibit 1, conclude that Americans must have no strong preferences about ownership in health care, since nonprofits and for-profits are seen as each having certain advantages.[16] That inference turns out to be wrong. In 1986 respondents were asked whether it was a "good idea or a bad idea for hospitals to be operated just like any other profit-making business." Roughly a third thought that profit making in health care was a good idea; half had a negative assessment.

The second wave of ownership surveys contained a similar question. Four times between July 1996 and October 1997, respondents were asked whether it was a "a good thing," "a bad thing," or "doesn't make much difference either way" for American health care that "in recent years, health insurance plans, HMOs, and hospitals have changed from not-for-profit status into for-profit institutions." The proportion who saw the growth of for-profit ownership as pernicious varied from 42 percent to 54 percent across these four surveys. Fewer than one in five viewed it in positive terms.[17] These assessments did not shift much in response to the Columbia/HCA coverage.

This pattern of survey findings leaves us with a puzzle. Why do Americans have such negative attitudes toward for-profit ownership, even in eras in which they see them as having important advantages over their nonprofit counterparts? Perhaps the public is concerned about some implications of for-profit health care that have not been adequately captured in past surveys. Or perhaps the public fears the expansion of for-profit ownership simply because it does not really understand the implications. To more fully explore these alternative explanations, in 2002 we fielded a survey about public attitudes toward nonprofit and for-profit health care.

## Attitudes About Nonprofit And For-Profit Health Care, 2002

■ **Assessing the impact of knowledge about ownership form.** Past surveys suggest that less than half of the public followed media coverage of the expansions of investor-owned health care. When asked about their reaction to the term "for-profit health care" in 1996, 24 percent of respondents indicated that they were not familiar with the term; 3 percent refused to respond.[18] To assess the implications of this limited knowledge, it is not sufficient to simply count the number of respondents reporting that they don't know about the implications of ownership. We must also consider how limited knowledge may affect the expectations of those who think they do understand ownership in medical care.

■ **Examining trust.** The idea that nonprofit health care organizations would be seen by the public as more trustworthy than their for-profit counterparts has been repeated often by advocates of nonprofits but seldom tested empirically. The literature on trust in health care suggests a number of ways in which untrustworthy practices might manifest themselves without affecting quality of care, ranging from inept administration to fraudulent billing practices.[19] The pertinent question is this: What concerns about untrustworthy health care are most salient for the American public and thus most relevant to their assessment of whether nonprofit ownership reduces those threats?

■ **Examining social values.** Another aspect of organizational behavior that has received less attention in health policy circles involves the embedding of social values into nonprofits' organizational missions.[20] These include notions of fairness and the goal of adapting services to meet clients' idiosyncratic needs. This potentially distinctive feature (the "humaneness") of nonprofit behavior has been given the most attention in the literature on

the privatization of government services.[21]

■ **Survey design and methods.** The survey, designed by investigators from Yale University and the New York Academy of Medicine, was completed by telephone between 26 June and 20 September 2002. A total of 5,000 respondents were interviewed; the average interview lasted approximately thirty minutes. The response rate was 49.5 percent.

The survey collected information on respondents' understanding of ownership. Specifically, they were asked whether they were familiar with the term "nonprofit," if they knew "what makes nonprofit organizations different from other kinds of organizations," and what those differences were. Respondents were also asked if they had ever worked in a nonprofit firm or the health care sector, since this would have made them more familiar with nonprofit health care.

**"It is evident that most Americans have a more jaundiced view of health plans than of hospitals, but neither type of organization has a positive image."**

Respondents were then asked ten questions related to their expectations about nonprofit versus for-profit ownership for hospitals and health plans. We first replicated the questions pertaining to quality of care. We adopted the format of the surveys from the 1980s by explicitly asking respondents, for each dimension of performance, whether they expected the behavior to be more common in a nonprofit plan or a for-profit plan, or whether they were "about the same."

To assess the potential linkage between ownership and trustworthiness, we asked about several aspects of hospital and health plan performance that would be difficult for consumers to assess. Two questions were intended to assess cost–quality trade-offs and two more about pricing practices. Trade-offs were assessed by the relative propensity of nonprofit and for-profit hospitals to "discharge sick patients if their insurance runs out" and health plans to "provide all necessary tests and procedures, regardless of cost." Untrustworthy pricing was explored by asking whether nonprofit or for-profit hospitals were more likely to "charge for services that patients don't really need" and health plans to "overcharge for health insurance."

Two aspects of "humane" treatment were examined. For both hospitals and health plans, respondents were asked whether nonprofit or for-profit organizations would be more likely to "treat patients fairly, regardless of race." To assess whether ownership was seen to affect the propensity to adapt to idiosyncratic personal needs, respondents were asked whether nonprofit or for-profit health plans would be more likely "to treat you like a number, rather than a person" and whether nonprofit or for-profit hospitals would be more likely to treat "patients with the dignity and respect that they deserve."

These questions intermixed positive and negative attributions about health care and were presented in random order, to avoid any ordering effects. The ordering of "nonprofit" and "for-profit" in the questions was also randomized for similar reasons. To assess the salience of these aspects of organizational behavior, respondents were asked how frequently they thought each type of behavior occurred in the health care system (on a four-point scale, ranging from "never" to "always").

■ **Survey findings.** *Understanding ownership.* About 12 percent of respondents initially admitted that they had no idea what *nonprofit* meant. This is consistent with the responses from the earlier KFF surveys, which typically had item nonresponse rates of 12–15 percent on questions about ownership-related expectations. However, when we probed further, it became clear that another 19–20 percent of respondents were unable to offer a coherent definition of *nonprofit ownership* (even applying a low standard of coherence). An understanding of ownership was more common among those with higher educational attainment or work experience in either the nonprofit or the health care sector.

Based on these responses, it appears that in

2002 about a third of the public had little understanding of the meaning of ownership, let alone any clear expectations for how ownership might alter organizational performance. This casts suspicion on survey findings that aggregate responses from those who understand ownership and those who do not. We explore later whether this biases the results in favor of either type of organization.

*Expectations of hospital and health plan performance.* Respondents were asked about ten aspects of performance, five related to hospitals and five to health plans. Most had little difficulty answering these questions, although there was higher item nonresponse for the health plan questions, particularly those related to coverage of tests and procedures (7 percent) and quality of care (6 percent). The comparable questions for hospitals had nonresponse rates of 3 percent or lower.

It is evident that most Americans have a more jaundiced view of health plans than of hospitals (Exhibit 3). However, neither type of organization has a very positive image. The public's concerns are most pronounced for measures of trustworthiness—more than 70 percent of respondents saw frequent problems with the trustworthiness of health plans. By contrast, 40–50 percent expected frequent untrustworthy behavior from hospitals—hardly a sterling image for the hospital industry, but certainly better than for health plans. There were similar concerns about quality of care. Indeed, the only dimension of performance that received relatively sanguine assessments involved hospitals' and health plans' willingness to treat people fairly, regardless of race. Even here, more than a third of respondents thought that problems were frequent.

*Expected implications of ownership for health plan and hospital performance.* Most respondents believed that ownership matters for the delivery of medical care. Looking across all ten measures of performance (five for health plans, five for hospitals), 88 percent of respondents expected ownership to be consequential for two or more of the measures reported in Exhibit 4.

One can observe clear differences across the

**EXHIBIT 3**
**Public Expectations About The Prevalence Of Health Care System Problems, 2002**

| | Believe that problems are frequently found among | |
|---|---|---|
| **Types of problems** | **Hospitals (%)** | **Health plans (%)** |
| Question replicating prior surveys (quality) | | |
| Do not provide access to high-quality care | 36.9 | 66.1 |
| Questions related to trustworthiness | | |
| Discharge sick patients if their insurance runs out | 54.1 | –[a] |
| Do not provide all necessary tests and procedures, regardless of cost | –[a] | 82.1 |
| Charge for services that patients don't really need | 42.1 | –[a] |
| Overcharge for health insurance | –[a] | 72.8 |
| Questions related to humaneness | | |
| Do not treat patients/enrollees fairly, regardless of race | 36.9 | 40.1 |
| Treat you like a number rather than a real person | –[a] | 62.3 |
| Do not treat patients with the care and respect that they deserve | 42.1 | –[a] |

**SOURCE:** Yale–New York Academy of Medicine Consumer Experiences Survey, 2002.

[a] Question not asked.

**EXHIBIT 4**
**Public Expectations Relating Ownership To Quality, Trustworthiness, And Humaneness Among Hospitals And Health Plans, 2002**

| | Hospitals (%) | | | Health plans (%) | | |
|---|---|---|---|---|---|---|
| Which organization most likely to | NP better | Same | FP better | NP better | Same | FP better |
| Question replicating prior surveys (quality) | | | | | | |
| Provide access to high-quality care | 13 | 55 | 29 | 19 | 39 | 35 |
| Questions related to trustworthiness | | | | | | |
| Discharge sick patients if their insurance runs out | 60 | 28 | 8 | –[a] | –[a] | –[a] |
| Provide all necessary tests and procedures, regardless of cost | –[a] | –[a] | –[a] | 30 | 34 | 28 |
| Charge for services that patients don't really need | 59 | 33 | 3 | –[a] | –[a] | –[a] |
| Overcharge for health insurance | –[a] | –[a] | –[a] | 69 | 22 | 5 |
| Questions related to humaneness | | | | | | |
| Treat patients/enrollees fairly, regardless of race | 31 | 57 | 7 | 37 | 49 | 9 |
| Treat you like a number rather than a real person | –[a] | –[a] | –[a] | 41 | 39 | 14 |
| Treat patients with the care and respect that they deserve | 27 | 58 | 12 | –[a] | –[a] | –[a] |

**SOURCE:** Yale–New York Academy of Medicine Consumer Experiences Survey, 2002.
**NOTES:** NP is not-for-profit. FP is for-profit.
[a] Question not asked.

three categories of measures. Quality of care is seen as a domain of for-profit advantage, much as it was before the Columbia/HCA scandals, in the mid-1990s. Ownership is judged to affect quality more frequently among health plans than among hospitals. In either case, about twice as many respondents who thought that ownership matters believed that for-profit organizations deliver higher-quality care.

The responses to the trustworthiness questions represent a dramatic contrast to the quality domain. Roughly two-thirds of respondents (as high as three-fourths for overcharging on insurance premiums) expected ownership form to be related to trustworthy practices. For three of the four measures, nonprofit enterprise was more trusted—by a margin of eleven to one. The one exception involves plan coverage of necessary tests and procedures. Here respondents were divided evenly among those expecting for-profits to perform better, expecting nonprofits to perform better, and expecting ownership not to matter at all. Such an even distribution is most often found when respondents are confused by a question, answering more or less at random. Because of the relatively high item nonresponse for this question, these results should be viewed with caution.

The questions related to humane treatment fall into a middle ground. Most respondents expected hospitals to treat patients humanely, whatever the form of ownership. However, among the 40 percent who thought that ownership does matter in this regard, about three times as many favored nonprofit facilities as endorsed for-profit hospitals. Ownership appeared to be viewed as a more reliable predictor of performance among health plans (as was true for the quality question). Nonprofit health plans were seen as being more humane by a four-to-one margin.

*Impact of understanding on ownership-related expectations.* Recall that about one-third of respondents had little understanding of ownership. Because the ownership-related expectations presented in Exhibit 5 have item nonresponse rates of only 3–7 percent, they include responses from many people who didn't really understand what ownership means. One might expect that their answers would be relatively random, obscuring somewhat the relationship between ownership and expectations. In fact, they bias reported expectations

**EXHIBIT 5**
**Expectations Regarding Ownership In Medical Care, By Understanding Of Ownership, 2002**

| | Limited understanding of ownership in health care (%) | | | Greater understanding of ownership in health care (%)[a] | | |
|---|---|---|---|---|---|---|
| **Which organization more likely to do specified action** | **NP better** | **Same** | **FP better** | **NP better** | **Same** | **FP better** |
| Questions replicating prior surveys (quality) | | | | | | |
| Health plan provides access to high-quality care[b] | 17.2 | 37.8 | 37.5 | 22.7 | 41.5 | 29.8 |
| Hospital provides high-quality care[b] | 13.5 | 52.7 | 30.1 | 12.2 | 60.0 | 24.9 |
| Questions related to trustworthiness | | | | | | |
| Hospital discharges sick patients if insurance runs out[b] | 58.6 | 28.7 | 8.5 | 63.3 | 27.6 | 5.9 |
| Health plan provides all necessary tests and procedures[b] | 28.1 | 33.3 | 30.3 | 36.3 | 36.0 | 23.3 |
| Questions related to humaneness | | | | | | |
| Hospital treats patients fairly, regardless of race | 30.6 | 56.7 | 7.4 | 31.5 | 59.2 | 5.8 |
| Health plan treats you like a number rather than a person | 40.0 | 39.1 | 14.8 | 41.8 | 40.3 | 12.8 |

**SOURCE:** Yale–New York Academy of Medicine Consumer Experiences Survey, 2002.

**NOTES:** NP is not-for-profit. FP is for-profit.

[a] Understanding of the implications of ownership based on respondent's ability to describe the meaning of *nonprofit,* educational attainment, and work experience in health care.

[b] Difference between high and low knowledge strata statistically significant at the .01 level.

in ways that favor for-profit ownership.

To assess the impact of understanding about ownership, we divided the study population into those with higher and lower levels of comprehension. To test for sensitivity, we conducted this stratification in a variety of ways, all of which produced broadly similar results. In Exhibit 5 we report the results from stratifying the population based on three questions: (1) whether respondents could offer some definition of *nonprofit ownership,* (2) whether respondents had completed college (including those who had more advanced education), and (3) whether respondents had worked in the health care industry. Our "high understanding" stratum (27 percent of our sample) involved those who could define *nonprofit ownership* and who had high levels of education or experience in health care. The remainder of the sample was categorized for the following analyses as having less understanding of ownership in medical care.

To simplify our presentation, in Exhibit 5 we report only six of ten measures of ownership-related expectations for these stratified samples: two from each of the three categories (quality, trustworthiness, and humane treatment). The most dramatic differences between these two sets of respondents involve expectations about quality. Those with little understanding of ownership perceived for-profits to have the largest advantage in providing high-quality treatment. By contrast, those who understood ownership were more likely to predict that ownership does not matter for the quality of medical care. But among those who thought that it did matter, a majority still perceived for-profit organizations as providing higher-quality services.

A similar shift occurs in our measure of trustworthiness involving plans' willingness to pay for necessary tests and procedures. Among those with limited understanding of ownership, a majority favored for-profit plans in this regard. For those with higher levels of understanding, a majority expected nonprofit plans to be more trustworthy, although supporters of nonprofits held a small plurality. Contrast this with expectations about financially motivated hospital discharges: Among

the best-informed respondents, nonprofit hospitals were seen as better by more than a ten-to-one margin.

In the dimensions of humane health care, the attitudinal differences between informed and ill-informed respondents are less pronounced. Among both sets of respondents, nonprofits were seen to have an advantage. But more than half of respondents expected that ownership did not matter much for most aspects of humane treatment, and this goes up a bit among the respondents who understood the most about ownership form.

**"It is important to recognize that public expectations in themselves may have important consequences for health policy making."**

## Discussion And Policy Implications

We have identified several noteworthy patterns in Americans' expectations about ownership differences in medical care. For much of the American public, ownership does seem to matter. Half of the public perceives the spread of investor ownership as a "bad thing" for the health care system. Roughly two-thirds see nonprofit health care agencies as more trustworthy and less likely to charge high prices for treatment. Between a third and half of the public sees nonprofit health care as being more humane. Ownership-related perceptions appear to be somewhat more pronounced for health plans than for hospitals.

But perceptions of ownership are not entirely one-sided. A modest number of Americans see for-profit enterprise as more trustworthy or humane. A majority of those who expect that ownership affects performance believe that for-profit organizations deliver care more efficiently, more responsively to consumers, and at higher quality (although this latter expectation declines as understanding of ownership increases).

■ **Limitations.** The findings reported here should be considered in light of certain methodological limitations. Throughout the paper we have noted that public attitudes may not always be accurately measured. However, the consistency of ownership-related expectations over time suggests that our findings are not simply artifacts of survey design; they consistently appear despite variation in question wording, placement in the survey, or the content of other survey questions.

Not all expectations, of course, are necessarily consistent with reality. Nonetheless, one would expect that over time the accumulated exposure to nonprofit and for-profit health care providers should leave the public's expectations reasonably consistent with its experiences.[22] This is particularly true for health care organizations with which Americans have the most regular contact. Hence, one would expect public expectations to more closely match experience for health plans than for hospitals and to be more consistent for hospitals than for services that are less frequently used, such as nursing homes.

■ **Implications for policy and economic theory.** In an era in which trust in American health care has eroded, the value of bolstering perceived trustworthiness cannot be readily dismissed. Because sizable portions of the public see nonprofit health care as more trustworthy and humane, policymakers must consider the use of ownership-related policies to bolster public faith. This is particularly relevant for matters of trustworthiness and humane treatment, because these are relatively difficult to measure and reward more directly.

Our findings also have implications for academic theories of the nonprofit sector. Although economists have long hypothesized that nonprofit organizations are seen as more trustworthy, there has been remarkably little past evidence about public expectations.[23] The findings reported here represent the first clear evidence that in at least some aspects of performance, most Americans see nonprofit enterprise as more trustworthy than its for-profit counterparts. Yet other public expectations conflict with theoretical predictions. For example, it remains unclear why some consumers expect for-profit hospitals and health

plans to have higher quality. This may reflect an implicit association between charity care and cut-rate services (metaphorically, like the quality of clothes at a Salvation Army thrift shop); this possible connection merits further study.

To date, health services researchers and students of the nonprofit sector have paid less attention to aspects of performance that we call "humane" treatment. A key feature of the health care system involves its capacity to "care," as opposed to cure. However, prior to this research, there has been little sense that this caring dimension might be related to ownership. Because the public sees such a link, future research should determine whether these aspects of performance are a realistic justification for nonprofit medicine.

Ultimately, the key challenge for researchers and policymakers is to better understand the relationship between the public's expectations of ownership and its actual experiences. Are those who expect nonprofits to be more trustworthy or humane more likely to seek care at nonprofit venues, particularly if they see themselves to be at risk of exploitation or less personalized treatment? To what extent does ownership substitute for or complement other markers of organizational performance in health care markets?

Apart from these connections between expectations and behavior, it is important to recognize that public expectations in themselves may have important consequences for health policy making. For example, whatever the relationship between plans' ownership and trustworthiness, our findings suggest that the spread of for-profit ownership in the managed care industry almost certainly exacerbated public fears and the resultant "backlash" against managed care. One can better understand the proliferation of state managed care regulation by recognizing the extent to which the public saw investor-owned health plans as a source of untrustworthy practices. Precisely because public perceptions can shape policy making, it is important for researchers and policymakers to better understand how those perceptions emerge, how they are altered by the public's understanding of complex concepts such as ownership, and how those understandings make particular policy initiatives legitimate.

For all of these reasons, we expect that the role of nonprofit and for-profit ownership in American medicine will remain an important theme in contemporary health policy, despite efforts by some academics to dismiss these issues as irrelevant or misleading. It seems essential that policymakers and researchers continue to pay attention to ownership in health care, particularly as it is understood by the American public.

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## NOTES

1. See M. Schlesinger and B.H. Gray, "Nonprofit Organizations and Health Care: The Paradox of Persistent Attention," in *The Nonprofit Sector: A Research Handbook*, 2d ed., ed. W.W. Powell and R. Steinberg (New Haven, Conn.: Yale University Press, 2004). Also, compare A. Malani, T. Philpson, and G. David, "Theories of Firm Behavior in the Nonprofit Sector: A Synthesis and Empirical Evaluation," in *The Governance of Not-for-Profit Organizations*, ed. E. Glaeser (Chicago: University of Chicago Press, 2003), 181–215; with J. Needleman, "The Role of Nonprofits in Health Care," *Journal of Health Politics, Policy and Law* 26, no. 5 (2001): 1113–1130.
2. M.G. Bloche, "Should Government Intervene to Protect Nonprofits?" *Health Affairs* 17, no. 5 (1998): 7–26 (quote, page 9).
3. S. Woolhandler et al., "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," *Journal of the American Medical Association* 290, no. 6 (2003): 798–805.
4. The first quote is from F. Sloan, "Commercialism in Nonprofit Hospitals," in *To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector*, ed. B. Weisbrod (New York: Cambridge Univer-

sity Press, 1998), 151–168 (quote, p. 167). The second is from M. Orloff, "A Perspective from the National Blue Cross and Blue Shield Organizations," *Bulletin of the New York Academy of Medicine* 74, no. 2 (1997): 286–291 (quote, p. 290).

5. Towers Perrin, *Navigating the Changing Healthcare System: The Towers Perrin Survey of What Americans Know and Need to Know* (New York: Louis Harris, 1995).
6. See, for example, B.H Gray, ed., *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment* (Washington: National Academies Press, 1983); and B.H. Gray, ed., *For-Profit Enterprise in Health Care* (Washington: National Academies Press, 1986).
7. All survey questions that are not cited in a publication are from the archives of the Roper Center for Public Opinion Research at the University of Connecticut. Specific questions from the Roper Center are identified by their identification numbers—in this case, Question USROPER.86-7 .R52X.
8. R. Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business," *New England Journal of Medicine* 335, no. 5 (1996): 362–367 (quote, p. 362).
9. Quality was expected to be higher in nonprofit settings because administrators will pursue quality rather than a financial "bottom line" (J.P. Newhouse, "Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital," *American Economic Review* 60, no. 1 [1970]: 64–74) and have less incentive to mislead customers by shirking on quality (K. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 58, no. 4 [1963]: 941–969). Costs were expected to be higher in nonprofits because administrators had incentives to build overly large physical plants (M.L. Lee, "A Conspicuous Production Theory of Hospital Behavior," *Southern Economic Journal* 38, no. 1 [1971]: 48–58) and less incentive to motivate workers (A. Alchian and H. Demsetz, "Production, Information Costs, and Economic Organization," *American Economic Review* 62, no. 3 [1972]: 777–795).
10. This is in part an artifact of survey design, since the Kaiser Family Foundation (KFF) surveys required respondents to volunteer this middle response.
11. See Kuttner, "Columbia/HCA."
12. Unpublished KFF data. The survey was fielded 7–10 August 1997. This is moderate public attention for a news event, ranking below attention to Medicare reform and roughly equal to awareness of the development of a new flu vaccine.
13. See B.H. Gray, *The Profit Motive and Patient Care* (Cambridge, Mass.: Harvard University Press, 1992).
14. The public sees nonprofit hospitals as basing charges on a philanthropic mission. In 1986 respondents were asked whether for-profit hospitals were more or less likely "to provide health care to uninsured people who cannot afford to pay for the care provided." Sixty percent reported that for-profit hospitals would be less likely to do so (Roper ID Number: USCAMBREP.860CT.R165). For-profits may also exploit monopoly power to mark-up prices more than do nonprofits. See E.B. Keeler, G. Melnick, and J. Zwanziger, "The Changing Effects of Competition on Non-profit and For-Profit Hospital Pricing Behavior," *Journal of Health Economics* 18, no. 1 (1999): 69–86.
15. The survey asked about expectations for "health insurance plans including HMOs and other managed care plans."
16. See, for example, Needleman, "The Role of Nonprofits in Health Care"; and Sloan, "Commercialism in Nonprofit Hospitals."
17. Lest readers suspect that these negative assessments are the result of biased wording, the *Wall Street Journal* recently concluded from its own survey that "most of the public do not view health care as a business which should be driven by the profit motive...There is little appetite for businesses to run home care, health insurance, nursing homes, hospitals, or medical research." Harris Interactive, "Most People Uncomfortable with Profit Motive in Health Care," *Harris Interactive* 2, no. 12 (2004): 1.
18. This question was a part of a survey conducted in the summer of 1996 by Princeton Survey Research Associates. The question cited in the text has the Roper Center identification number USPSRA.073086,R05H.
19. M.A. Hall et al., "Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?" *Milbank Quarterly* 79, no. 3 (2001): 613–639.
20. S. Rose-Ackerman, "Altruism, Ideological Entrepreneurs, and the Non-Profit Firm," *Voluntas* 8, no. 2 (1997): 120–135.
21. S. Smith and M Lipsky, *Nonprofits for Hire: The Welfare State in the Age of Contracting* (Cambridge, Mass.: Harvard University Press, 1993).
22. To meet some other study objectives, we oversampled communities in which there was a mix of ownership for hospitals and health plans: About 85 percent of our sample had local exposure to both forms of ownership.
23. See A. Ortmann and M. Schlesinger, "Trust, Repute, and the Role of Nonprofit Enterprise," *Voluntas* 8, no. 2 (1997): 97–119.