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Bond-Market Skepticism And Stock-Market Exuberance In The Hospital Industry

From a stodgy past of philanthropic donations and insured debt, hospital finance rushes into a new world of growth stocks and junk bonds.

by James C. Robinson

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ABSTRACT: The hospital industry needs funds to refurbish physical facilities, upgrade clinical and information technologies, and rebuild financial positions weakened by past external challenges and unwise organizational strategies. The financial markets offer a marked contrast in capital access, as bond creditors remain skeptical while stock investors plunge back into the once-shunned industry. Ironically, high stock prices may drive the for-profit chains to repeat past cycles of overexpansion, while weak bond ratings may save non-profit systems from a comparable loss of focus on the core business of operating and improving inpatient facilities. This turbulence has implications for public payment, antitrust, and financial disclosure policies.

THE FINANCIAL MARKETS SERVE as both mirror and motor to economic performance in the hospital industry. Bondholders intent on regular interest payments and stockholders intent on share price appreciation are attracted to popular and profitable institutions while shunning those with thin margins and weak balance sheets. In periods when the hospital industry needs outside funds to renovate facilities, acquire clinical equipment, and upgrade information technology, however, access to capital becomes cause and not merely consequence of organizational success. Confident bondholders and exuberant stockholders spur a virtuous cycle of investment, improved operations, rising patient volume, and continued financial profitability, leading to further rounds of capital access and investment. Conversely, skepticism among investors generates a vicious cycle of deteriorating infrastructure, declining admissions, deepening deficits, and ever greater difficulty in raising funds.

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The track record of the hospital sector and of particular organizations within it has been mixed over the past several years: Some institutions have developed strong market positions and financial reserves, while others spin downward toward sale or closure.¹ The positive industry news includes hospital consolidation and nascent oligopoly power against health insurance plans in many markets; the dismantling of money-losing integrated delivery systems; a gradual reduction in excess capacity; and the blunting of governmental efforts to reduce payments and enforce fraud-and-abuse regulations. Negative industry news includes escalating labor and pharmaceutical costs; a weak balance sheet overhang from failed efforts at vertical and horizontal integration; an erosion of endowment earnings and philanthropic contributions subsequent to the stock market decline; and prospects for Medicare and Medicaid payment constraints in the event of a federal budgetary deficit.

The diversity in hospital performance has been reflected in the diversity of perspectives in the financial community, including individual and institutional investors, bond underwriters and insurers, debt-rating agencies, investment bankers, and equity analysts. The most palpable difference of mood has divided the bond markets, which have remained cautious about industry prospects, from the stock markets, which have plunged back into this once shunned sector with alacrity. The disparities hold particular relevance for patterns of hospital ownership, since nonprofit institutions are reliant on debt, while for-profit chains can mix debt and equity finance based on their relative costs. The nonprofit sector retains its dominant position in terms of bed capacity and brand-name reputation but struggles with weak bond ratings and ever more restrictive bond covenants. The investor-owned sector is flush with equity capital but is under pressure from investors to increase revenues and earnings at a rate that may drive the firms to repeat past cycles of overexpansion, financial shortfall, and stock-price collapse.

The divergent perspectives of the debt and equity markets hold important implications for three areas of public policy. The hospital industry's political drive for higher Medicare payments and teaching subsidies, based on tales of financial woe, is easily undermined by investors' enthusiastic projections of high and rising profitability. The drumbeat of support by bond-rating agencies and investment bankers for hospital consolidation as a means toward monopoly pricing risks invigorating opposition from state and federal antitrust authorities. Bond issuers, analysts, and insurers are pushing for rules that would force nonprofit hospitals to disclose financial data in the relatively prompt and complete manner traditionally required of investor-owned chains.

Bond-Market Skepticism

The bond market is the principal source of outside capital for the asset-intensive and slow-growth hospital industry and the exclusive source for nonprofit institutions, which are forbidden to sell ownership shares.² Approximately 15 percent of the industry's bed capacity is owned by the dozen investor-owned chains, which mix stock and bond offerings based on the cost of each, although without the tax-exempt bond subsidies available to their nonprofit competitors. Both nonprofit and for-profit hospitals finance their short-term capital needs through retained earnings and bank loans, but these rarely are sufficient to fund major investments in physical structures, clinical equipment, and information technology.³

Bond investors are supported by a variety of institutional mechanisms that evaluate the creditworthiness of prospective borrowers and track the faithfulness of past borrowers. The most prominent role is played by bond-rating firms such as Moody's, Standard and Poor's (S&P), and Fitch, which evaluate the credit status of issuing organizations and thereby influence the interest rates that bond buyers will demand. Over the past several years the rating agencies have issued a stream of pessimistic analyses of the nonprofit hospital industry and have continually downgraded the credit ratings of many would-be borrowers. In 1999, for example, Moody's downgraded the credit ratings of sixty-four nonprofit hospitals and hospital systems, covering \$13.4 billion in debt, while upgrading only fourteen organizations issuing \$1.7 billion in debt. In 2000 it downgraded fifty-six hospital organizations and bonds worth \$15.0 billion while upgrading twelve hospitals with \$2.0 billion in debt.⁴ S&P highlighted the decline in ratings prospects for the nonprofit hospital sector from 1995, when 19 percent of rated organizations had positive outlooks and only 3 percent negative outlooks, to 2000, when 27 percent had negative outlooks and only 3 percent, positive outlooks.⁵

The negative news has not been confined to any particular type of hospital. Downgrades have afflicted the most prestigious hospitals as well as their meeker peers and driven some well-known local institutions into "speculative" (junk bond) territory. This pessimistic perspective on new issues is particularly striking in light of the substantial decline in the volume of hospital bond offerings over the period, as weak nonprofit organizations simply stayed away from the capital markets. Bond issues by nonprofit hospitals dropped by 33 percent in 1998–1999 and then another 40 percent in 1999–2000.⁶

The rating agencies' perspective brightened slightly in 2001, with a comparatively upbeat tone and less downbeat direction of rating

changes. Both Moody's and S&P predict ratings stabilization, because of higher revenues and possibly lower hospital cost inflation. Moody's notes that the ratio of downgrades to upgrades has moderated over time, from 8 to 1 for calendar year 1999 to 2.3 to 1 for the first quarter of 2001. No one is willing to be truly optimistic, however, and the rating agencies highlight the continued rise in labor and pharmaceutical costs, the employer backlash against higher insurance premiums and the hospital prices that underlie them, and the prospects for renewed penny-pinching by Medicare and Medicaid if faced with recession-driven budgetary deficits.

Gloom and doom among bond-rating agencies has been accompanied by a partial retreat from the once reliable hospital industry by the bond insurance firms MBIA, Ambac, FSA, and FGIC.⁷ Over past years these firms have devoted only a modest portion of their portfolios but an increasing portion of their anxieties to the sector and have come to view the nonprofit hospital market as similar in volatility to the default-plagued corporate bond market, which generally is not eligible for insurance. FGIC has exited the hospital debt market altogether, and the remaining three have tightened their underwriting standards, resulting in a rising number of low-rated hospital bonds' coming to market without insurance coverage. The overall mood of the bond markets is somber, because of both the record-breaking number of defaults worldwide (especially in the telecommunications sector) and the once unthinkable hospital bankruptcies and bond defaults at the Allegheny (AHERF) system and several smaller facilities.⁸ Commercial banks have almost entirely stopped providing letters of credit to nonprofit hospitals.

The debt markets are seeking mechanisms to reduce risk and enhance the probability of repayment. First and most obviously, the spread between the interest rates charged to nonprofit hospitals and the general index of tax-exempt borrowers has widened, although the effect has been counterbalanced by marketwide declines in interest rates. At the beginning of 1999, for example, the premium charged to the typical S&P-rated BBB hospital credit was a trivial five basis points (0.05 percentage points) above the general revenue bond index.⁹ This grew to seventy-five basis points by the end of the year and to 130 basis points in 2000. Bond buyers are imposing a variety of nonprice restrictions ("covenants") on the behavior of hospital bond issuers, including requirements for maintenance of financial liquidity sufficient to cover debt-service obligations, mortgages on land and buildings, and limits on future bond issuance. These covenants have proved successful in achieving their short-term goals, as liquid reserves (days of cash on hand) remain high and debt leverage remains low by historical standards. (Low debt issu-

ance also, however, can be a marker for deferred maintenance and underinvestment in clinical and information technologies.)

Stock-Market Exuberance

In 2000 and 2001 the public equity markets looked at the challenges facing the hospital industry but arrived at a diametrically different evaluation from that of the debt markets. By the fall of 1999 the effects of Medicare payment cutbacks, federal fraud-and-abuse investigations, managed care price discounts, and excessive horizontal and vertical integration were already baked into the stock prices of the investor-owned hospital chains. Two years of falling revenues and rising costs, from 1997 to 1998, had cut hospital stock prices by almost half at a time when the larger stock market was engaged in its greatest boom ever. While the S&P 500 index of large corporate stocks rose 27 percent in 1998, for example, stock prices at HCA fell 17 percent, at Tenet by 21 percent, and for the sector as a whole by 13 percent.¹⁰ Any improvement in industry performance, whether derived from Medicare givebacks, the backlash against managed care, resolution of legal and regulatory difficulties, or the unwinding of integrated delivery systems, could drive substantial share-price appreciation from these lows. In its turn, an increase in equity prices would bring substantial new capital into the industry and propel further growth in revenues and earnings.

Equity investors also liked the changes they observed in the structure and strategy of the for-profit hospital firms. Several organizations had emerged from purgatory with new management teams and with leaner and more focused structures. Diversification had been reduced dramatically in terms of both products and geographic markets. Product focus had been regained by the abandonment of the integrated delivery strategy, including physician practices, home health agencies, ambulatory surgery facilities, and other ancillary services. Geographic market focus had been sharpened by exiting from urban markets in which the investor-owned firms could not achieve dominance and by spinning off rural hospitals. The industry was separating into one component structured as chains of rural monopolies (for example, LifePoint, Province, Community Health Systems) and another component structured as chains of urban oligopolies (for example, HCA, Tenet). Multimarket diversification through chain structures reduced the reliance of the firm on the idiosyncratic economic health of any one community (a serious business risk to the undiversified independent hospital), while focus on one market type facilitated consistency in operations and some degree of market power.

Optimism among analysts and investors rolled into enthusiasm as

“The investor-owned hospital sector suffered a repricing hangover after New Year’s Eve of the millennium.”

equity prices for the industry surged almost 150 percent from the fall of 1999 through the end of 2000.¹¹ The year 2000 was a banner event for the investor-owned sector, with stock prices for HCA increasing by 32 percent, its spinoffs Lifepoint and Triad by 240 percent and 76 percent, Tenet by 76 percent, Province by 155 percent, Universal by 168 percent, Community Health Systems by 142 percent, Quorum by 50 percent, and Health Management Associates by 50 percent.¹² In the same year the broader S&P 500 stock market index dropped by 10 percent as the Internet and telecommunications bubble burst. The surge in stock prices resulted mainly from increases in the price/earnings multiple, reflecting both enhanced growth expectations and some rotation by institutional investors out of the technology sector, rather than from any major improvements in earnings. The investment banks reveled in the rediscovery of a long-lost friend and sponsored multiple rounds of secondary stock offerings and corporate taxable debt offerings. Equity analysts, who had evinced caution at the beginning of the upswing, were exuberant by the end.¹³

All good things must end, of course, and the investor-owned hospital sector suffered a repricing hangover after New Year’s Eve of the millennium. By the middle of 2001 equity prices were off by single digits for most firms and by almost a quarter for the hottest names of the previous year, including Lifepoint, Province, and Universal. Equity prices remained high relative to earnings projections, moreover, creating the possibility of continued price declines, especially if investors regained enthusiasm for the beaten-down technology sector and rotated away from old-economy stocks. Nevertheless, the investor-owned hospital chains remained flush with capital and in search of ways to spend it.

Bondholders Versus Stockholders

The opposing perspectives of the debt and equity markets are not attributable primarily to differences in the expected future performance of the nonprofit and for-profit hospitals, respectively. Most of the industry news, both good and bad, pertains to both sectors. Both kinds of hospitals indulged in the ecstasy of vertical and horizontal integration during the 1990s, and both were blindsided by the Balanced Budget Act (BBA) in the middle of the decade. The rising tide of federal payment givebacks and monopoly pricing leverage subsequently lifted all boats. The bond-market skepticism and stock-

market enthusiasm derive from the different characteristics of debt and equity, respectively, as financial instruments, with bond purchasers focusing on asset strength and stock purchasers focusing on growth prospects. These differences in orientation reflect the differing rights of creditors and investors in organizational governance.

■ **Differences of function.** Bonds function as a loan to the hospital issuer from the creditor (bondholder), while stocks function as an ownership share sold by the hospital to the investor (stockholder).¹⁴ As owners of the organization, stockholders collectively select (vote for) the board of directors, which in turn appoints and controls management. Management has a fiduciary duty, as well as a direct mandate from the directors, to maximize stockholders' return on investment, which typically is pursued through increases in the value of the firm and thence through increases in stock prices over time. Aside from their right to vote for the board of directors and to oust directors with whom they are displeased, stockholders wield no power to force management to change strategy, issue dividends, repurchase shares, or otherwise disgorge the firm's assets. Bondholders have no direct role in organizational governance, cannot vote for the board of directors, and cannot attempt to change management by accumulating a controlling ownership position. In contrast to stockholders, however, bond creditors can use the power of the courts to mandate the full and timely payment of interest and principal, as specified in the prospectus, and can force the issuer into bankruptcy in the event of default.

Under bankruptcy court rules, bondholders stand in front of stockholders to obtain the proceeds from any forced sale of assets and may be granted operational control of the defaulting organization to ensure good-faith efforts to maximize these proceeds. Under neither normal nor bankruptcy conditions are bondholders entitled to receive more than the value of the invested principal and accumulated interest; this contrasts sharply with stockholders' entitlement to a pro rata share of any increased value in the firm. Generally, bondholders enjoy a stronger position than stockholders do under stable operating circumstances and in the event of financial crisis, but a less attractive position in the event of exceptional organizational success and profitability.

■ **Divergent treatment of hospital chains.** The contrasting perspectives of the debt and equity markets were most evident in their divergent treatment of the investor-owned hospital chains. During the period when stock prices were surging on expectations of growth and profitability, the corporate bond market continued to rate the for-profit systems far below their nonprofit competitors. In 2001, after several years of ratings downgrades, the bond-rating

agencies still accorded almost all of the major nonprofit hospitals and hospital systems investment grade ratings, which meant that their debt could be purchased by mutual funds, university endowments, pension funds, and other institutional investors. At the same time, however, three-fourths of the investor-owned hospital firms were relegated to junk-bond status.¹⁵ The differences in treatment did not reflect different views on the market position or organizational strategy of the investor-owned hospitals compared with the nonprofit sector. On the contrary, the bond-rating agencies highlighted several financial strengths of the investor-owned facilities. These systems maintain a straightforward focus on profitability, in contrast with the nonprofits' mixed objectives of selling and donating health care services; develop better market positions as rural monopolies or urban oligopolies; are geographically diversified and thus buffered from unpredictable events in any one market; and are quicker to adapt their organizational strategies to changing environmental factors.¹⁶

■ **Stability versus growth.** The skepticism in the bond market concerning the investor-owned hospital systems stemmed from precisely the same perspective that drove enthusiasm in the stock market. The focus within the investor-owned sector on growth in revenues and ultimately earnings is an upside opportunity for the stockholders but a credit risk for the bondholders. For-profit firms in general, and hospital chains in particular, are willing to take greater risks than are nonprofit organizations through same-facility investments, mergers and acquisitions, and diversification into related services. This risk-taking approach derives in part from managerial culture but also is embedded in investors' expectations of continual growth. Stock prices reflect both earnings and expectations of earnings growth, referred to as the price/earnings multiple. (Stock prices also reflect hope, fear, greed, momentum, and mindless stupidity.) Any shortfall in growth relative to expectations results in contraction of the multiple, thereby slicing share prices, diluting equity as a currency for mergers and acquisitions, and dragging managerial stock options underwater. The growth focus of the for-profit firm works to the advantage of the shareholder and to the disadvantage of the bondholder. Bondholders never obtain more than their principal and interest, even from the most profitable firm, and thus see no benefit to growth beyond that necessary to sustain the cash flow that services the debt.¹⁷ In the event of failure, bondholders are better positioned than stockholders are, but this priority in the bankruptcy queue does not compensate for the missing upside from successful growth.

Bondholders' focus on stability and stockholders' on growth is

reflected in their contrasting views on cash management. Bondholders interpret cash as a means to pay principal and interest and tend to take the view that more is better. Stockholders, in contrast, interpret cash as a means to further growth, if invested appropriately, and rely on short-term bank loans to fund day-to-day operations. Nonprofit hospitals, which serve the bondholders, maintain cash balances that are large relative to debt levels. For-profit hospitals, which serve their stockholders, maintain less cash on hand than their bond creditors would like. If they earn revenues in excess of costs and of their (minimal) debt-coverage targets, for-profit hospital chains are likely to use their free cash flow to repurchase equity on the open market. These repurchases reduce the denominator in earnings-per-share calculations, often leading to stock-price appreciation, but are despised by bondholders as a useless transfer of cash from debt coverage to shareholder value. The bond-rating downgrades of investor-owned chains, made in the face of exceptional profitability, reflected displeasure with share-price repurchases.

Hubris In The Investor-Owned Sector

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The divergent views of the bond and stock markets will influence future strategies and the market shares held by the nonprofit and for-profit sectors. After two boom years investor-owned chains face strong expectations by equity investors and junk-bond creditors to sustain high rates of growth in revenues and earnings. Failure to satisfy expectations would plunge individual firms and the sector as a whole into a vortex of contracting price/earnings multiples and continued obligation to service high-yield debt. It is to be predicted that the investor-owned hospital chains will seek to meet market expectations over the coming years, pursuing one of three growth strategies: investing in their existing hospitals by refurbishing physical infrastructures, upgrading clinical equipment, and acquiring information technologies; merging with or acquiring new hospital facilities; or diversifying into related health care services. Each of these strategies, if successful, will shift a greater fraction of total health care services from nonprofit to for-profit ownership. Each will, if unsuccessful, reproduce the roller coaster of overexpansion, earnings shortfalls, retrenchment, and divestiture that has characterized the investor-owned hospital chains since their creation.

■ **Strategy 1: rebuilding.** The most promising growth strategy for investor-owned hospitals unfortunately is the most boring. The rebuilding of deteriorated facilities, purchase or leasing of new equipment, experimentation with information technologies, and general sprucing up of the current stable of hospitals promises to attract physicians (especially to rural communities where they are

needed most), retain patients, and permit the investor-owned chains to capture more than their fair share of the rise in admissions that is reversing the long-term decline in hospital use nationwide. Same-facility growth is slow but solid, achieved by winning the hearts and minds of clinicians and consumers one at a time. Its problem lies in the difficulty of accelerating growth in a context where almost every patient gained is some other hospital's loss. It works best in rapidly expanding urban and suburban communities such as those in the Southwest.

■ **Strategy 2: merger and acquisition.** The second and most important growth strategy for investor-owned chains is merger and acquisition. The most attractive acquisition targets are second- and third-tier nonprofit hospitals that lack the scale, scope, and strategic orientation to obtain operating efficiencies and monopoly power in their local markets. These hospitals are being screened out of the capital markets by the rating agencies and bond insurers, who view them as unacceptable credit risks, and are locked into a vicious cycle of underinvestment, declining performance, and continued underinvestment. Judicious acquisition of facilities in growing rural communities or of urban facilities where the acquiring chain already possesses a market position can lead to improved top- and bottom-line growth, as desired. This growth-through-acquisition strategy is inherently self-limiting, however. The nonprofit hospitals most likely to offer themselves for sale are in need of major investments of capital and managerial attention; adverse selection is the name of this game. They have the weakest physician and patient loyalty, the oldest infrastructure, the highest operating costs, the least reliable accounting methods, and the lowest bond ratings in the industry. Relatively few of them are in the specific geographic markets where the investor-owned chains most want to expand. Prospects are strong for bidding wars among potential acquirers, as between Tenet and HCA for the two-facility Intercoastal Health System in Florida, that will drive up prices and thereby weaken chances for the desired return on investment. The exhaustion of nonprofit acquisition candidates may be evidenced through mergers among for-profit chains, along the lines of the recent joining of Triad and Quorum. The pooling of interests among overvalued firms often embodies an artificial pumping of top-line revenues, however, rather than a strategy for real growth; more of the same will mark the top of the industry expansion curve and serve as the prelude to a fall.

■ **Strategy 3: diversification.** The third growth strategy, diversification into services and facilities outside the core of acute inpatient care, is perilous yet probable as the investor-owned chains come to the end of growth possibilities from same-facility invest-

ments and hospital acquisitions. The historical record gives no indication that for-profit hospitals are any more successful than their nonprofit counterparts are at vertical integration. Expansion into ambulatory surgery, subacute and rehabilitation care, skilled nursing facilities, home health, inpatient psychiatry, physician practices, and managed care mostly came at the expense of shareholders, with the heights of folly being pursued by industry leaders such as Columbia/HCA (home health, ambulatory surgery, Blue Cross Blue Shield of Ohio) and Tenet (inpatient psychiatry, physician practices). Most of these efforts at diversification have been terminated, but the chains are always ready to dip a toe and then jump with both feet into the new thing. The mirage of the moment may be the single-specialty hospital, structured as a joint venture with local physicians to escape the high overhead and uninsured patients plaguing traditional hospitals and focusing on high-revenue services such as cardiology, oncology, and women's health. The record of these "focused factories" has been underwhelming, but so has been that of their unfocused, multiservice competitors.

Financial Markets And Public Policy

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Turbulence in the financial markets is exerting at least three important influences on public policy and hence indirectly on the policy-dependent hospital industry. Most obviously, it is difficult to sustain a drive for higher Medicare payments and more-generous medical education subsidies based on predictions of financial collapse amid an unprecedented run-up in hospital stock prices. The difficulty simultaneously of forecasting losses to Congress and profits to Wall Street was illustrated by the unfortunate dissemination of an investment banking report on Capitol Hill at the moment when BBA givebacks were being debated. The report's author predicted (accurately, in retrospect) phenomenal growth in hospital revenues and earnings and asserted that Medicare was the industry's best payer, but then was forced to testify on Capitol Hill that such prognostications were for investors' eyes only.¹⁸

The hospital industry has benefited from the backlash against managed care, as state and national politicians hurry to legislate mandated benefits, prompt payment rules, and constraints on utilization review to protect endangered community facilities from predatory insurance firms. Judges and juries have frustrated efforts by antitrust enforcement agencies to prevent mergers and rate increases. Stock-market euphoria and bond-market criticism may undermine this favorable regulatory treatment, which derives ultimately from a public perception of hospitals as underfunded eleemosynary institutions rather than well-funded incipient monopolies.

The recent turbulence has increased demands by both capital-market participants and some health policymakers for more timely, complete, and comparable disclosure of hospital financial data.¹⁹ One of the many ironies of the hospital ownership controversy has been that nonprofit organizations, which belong to everyone (and hence to no one), disclose much less information on their performance than do for-profit organizations (which spill their financial secrets to the Securities and Exchange Commission and onto their Web sites every ninety days). The Municipal Securities Rulemaking Board, a nongovernmental entity charged by Congress to establish rules for municipal securities dealers, has targeted nonprofit hospital data disclosure, as have associations of bond traders, analysts, lawyers, and underwriters. The wish list begins with annual audited financial statements using consistent and comparable definitions and extends to quarterly statements that cover operating results, changes in assets, and consolidated balance sheets from the many subsidiaries of the structurally complex hospital holding companies. Demands for financial information disclosure can be serious. S&P withdrew its rating for the bond issue of one nonprofit hospital that refused full disclosure; the institution subsequently went into bankruptcy and was sold to a for-profit chain. Criminal conspiracy cases have been filed against executives of the bankrupt AHERF system charging fraudulent misstatements on financial reports.

A New World Of Hospital Finance

The asymmetric access to capital by the nonprofit and for-profit hospital sectors challenges the heretofore dominant institutions. The exuberance of the stock markets and skepticism of the bond markets could reflect a joint conviction that the for-profit chains are poised to grow at the expense of the nonprofits. After decades of stability, relative market shares could tip in favor of publicly traded corporations in a manner akin to the accelerating for-profit conversion of the health insurance industry. Yet apocalyptic visions need a grounding in the culture and compulsions of the respective sectors. High stock prices embody investors' expectations for accelerating growth, which pressures for-profit chains to expand, diversify, merge, acquire, and then fall into the all-too-familiar difficulties of yesteryear. The best chance of the nonprofit sector, ironically, may be that bond-market skepticism will force leading as well as lagging institutions to improve efficiency and upgrade technology at their existing facilities rather than engage in strategic adventures into new products and markets.

Reliance on bonds to the exclusion of equity often is interpreted as a weakness of the nonprofit organization. As embodied in the

etymology and argued in the finance literature, however, a “bond” functions as a bonding mechanism that restrains the allocation of free cash flows to activities that offer meager return on investment.²⁰ The balance-sheet focus of the bond markets may save the nonprofit hospitals from themselves, keeping them focused on operations while allowing the growth-driven for-profit systems to embark on another cycle of expansion and contraction. Whatever the extent of divergence between nonprofit and for-profit hospitals in market strategy, the once divergent ways in which they were perceived, paid, and regulated by the public sector appear to be converging. The whole industry is drifting from administered prices, tax subsidies, certificate-of-need barriers to entry, and local control toward market prices, corporate taxation, competitive threats from single-specialty upstarts, and multifacility chain control. From a stodgy past of philanthropic donations and insured debt, hospital finance rushes into a new world of growth stocks and junk bonds.

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16. Investor-owned hospital chains tend to maintain stronger income statements but weaker balance sheets than otherwise similar nonprofit chains do. D. Lee et al., *Rating Methodology: For-Profit Hospitals versus Not-for-Profit Hospitals: Explaining the Gap* (New York: Moody's, May 1999); and Peknay et al., *Not-for-Profit and For-Profit U.S. Health Care Ratings*.
17. Bonds do trade in the secondary market at prices that reflect the changing economic environment and hence can bring capital gains and losses to purchasers even in the absence of default.
18. J. Gardner, "Caught in the Fray: Analyst's Report Used to Bolster Case against Provider Relief," *Modern Healthcare* (29 May 2000): 2, 10.
19. Arrick et al., *Special Report: Health Care at a Crossroads*; M.C. Jaklevic, "Toward Full Disclosure: As Healthcare Bond Issuers Face More Troubles, Pressure Mounts for More Information Sharing with Investors," *Modern Healthcare* (19 February 2001): 50-54; and D. Carpenter, "Filling the Information Gap: Nonprofits Are Gradually Opening Up to Bondholders," *Investor Relations* (published jointly by Health Forum Journal and Salomon Smith Barney, 2001).
20. M.C. Jensen and W.H. Meckling, "Theory of the Firm: Managerial Behavior, Agency Costs, and Ownership Structure," *Journal of Financial Economics* 3, no. 4 (1976): 305-360; and M.C. Jensen, "Eclipse of the Public Corporation," *Harvard Business Review* 67, no. 5 (1989): 61-74.