The Effects of Corporate Restructuring on Hospital Policymaking

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Hospital corporate restructuring is the segmentation of assets or functions of the hospital into separate corporations. While these functions are almost always legally separated from the hospital, their impact on hospital policymaking may be far more direct. This study examines the effects of corporate restructuring by community hospitals on the structure, composition, and activity of hospital governing boards. In general, we expect that the policymaking function of the hospital will change to adapt to the multicorporate structure implemented under corporate restructuring, as well as the overlapping boards and diversified business responsibilities of the new corporate entity. Specifically, we hypothesize that the hospital board under corporate restructuring will conform more to the "corporate" model found in the business/industrial sector and less to the "philanthropic" model common to most community hospitals to date. Analysis of survey data from 1,037 hospitals undergoing corporate restructuring from 1979–1985 and a comparison group of 1,883 noncorporately restructured hospitals suggests general support for this hypothesis. Implications for health care governance and research are discussed.

As a reflection of vigorous and well-publicized policy debates (Relman, 1980), the recent literature in health services has produced numerous studies analyzing the differences between investor-owned and not-for-profit activity in the health care sector (for example, Sloan and Vraciu, 1983; Institute of Medicine, 1986; Halner et al., 1984). Unfortunately,

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this research has diverted attention from another important, but less publicized change affecting the organization of health care delivery—specifically, the trend toward privatization of nonprofit institutions and the transformation of many not-for-profit health delivery organizations into more corporate-like entities, typically including a combination of both not-for-profit and for-profit organizational units.

The recently released Institute of Medicine (IOM) report on investor-owned activity in health care states that what we shall be witnessing in the future will not be a contrast of differences between for-profit and not-for-profit health care but a blurring of those distinctions. The report emphasizes that cost and competitive pressures facing all health care sectors will require similar adaptive responses to ensure survival, and "as all health care systems become hybridized, it will be a challenge in the future for the not-for-profits to define what makes them different" (IOM, 1986).

The goal of this article is to examine one aspect of the transformation of not-for-profit hospitals—corporate restructuring—and its impact on the policymaking body of the hospital. We argue that the segmentation of assets or functions of the hospital into separate corporations will require adaptive changes in the management and the governance of the hospital to better fit the new multicorporate entity. Further, this new management and governance structure will reflect the "corporate"-style organization of the non-health care sector as contrasted with the philanthropic or trustee model of governance traditionally found in the hospital sector.

We focus on hospital governance for several reasons. As Starr has stated, "The extension of the voluntary hospital into profit making businesses and the penetration of the corporation into the hospital signal the breakdown of the traditional boundaries of voluntarism" (Starr, 1982, p. 438). The evidence of such breakdown is most likely to be felt in the governance area where voluntarism has historically been expressed (Wisler and Kaufman, 1986).

Second, boards act as the policymaking body of the hospital and render critical decisions that affect both the operations and strategic direction of the hospital. Governing boards will assume an even more important role in the hospital policymaking process as the health care environment becomes even more turbulent and uncertain (Barrett and Windham, 1984; Kovner, 1985, 1974, 1981). Under these conditions, boards are expected to play key roles in formulating the strategic plan of the institution and in rendering increasingly difficult resource allocation decisions in an era of resource scarcity (Wessel, 1986; Ritvo, 1980). New legal precedents establishing board accountability for hos-

pital activity have further enhanced the role of the board in hospital policymaking (Blaes, 1982).

Third, corporate restructuring imposes tiered or multiple-governance structures, or both, on the health care delivery organization. These structures introduce considerable decision-making complexity and potential communication and coordination difficulties among the various organizational entities involved. The CEO, for example, must relate to multiple boards, with potentially many more meetings to attend, more board chairpersons to be briefed and, in general, more management time needed to coordinate the activities of the various boards (Ewell, 1987). The hospital board stands at the center of this elaborate structure and is responsible for ensuring that decisions and policies are made in the most effective and efficient fashion possible (Morlock and Alexander, 1986; Alexander and Schroer, 1985; Plant, 1985).

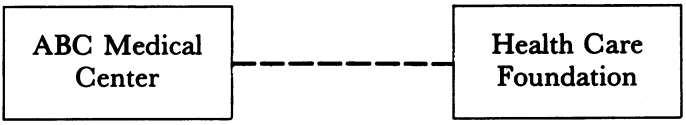
Finally, the relative absence of research on corporate restructuring raises the fundamental issue of whether corporate restructuring is simply a legal artifice or a substantive change in health services organizations (Gerber, 1983; Kerr, 1985). Demonstrating significant relationships between corporate restructuring and various dimensions of hospital governance would suggest that corporate restructuring may lead to important changes in the way hospitals are operated.

BACKGROUND

In the main, the literature on corporate restructuring has concentrated on discussions of why hospitals restructure, what they hope to gain from restructuring, and what types of hospitals have undergone restructuring (Johnson, 1986; Memel, 1986; Wiles, 1981; Ewell, 1972). The literature suggests that corporate restructuring is a strategic vehicle that allows the hospital to adapt to a rapidly changing and uncertain environment (Porter, 1981). It is the hospital's response to such environmental changes as decline in philanthropic giving, reduced ability to shift cost, lower occupancy rates, increased competition, medical staff resistance under prospective payment, shrinking capital markets, and a general shift to a more "business-like" orientation in the health care sector (Ernst and Whinney, 1982; Gerber, 1983).

Expectations of restructuring benefits vary widely. However, those most commonly cited include increased management efficiency, removal of activities that would jeopardize the tax-exempt status of the

Figure 1: Exempt Brother-Sister Structure



hospital, creation of a shield from state regulation for activities not directly related to inpatient services, avoidance of certificate-of-need regulations, more favorable treatment by third-party payers, reduced legal liability and, perhaps most importantly, increased flexibility and the creation of an organizational framework for diversification in the face of an uncertain and increasingly competitive health care market (Gerber, 1983; Ernst and Whinney, 1982).

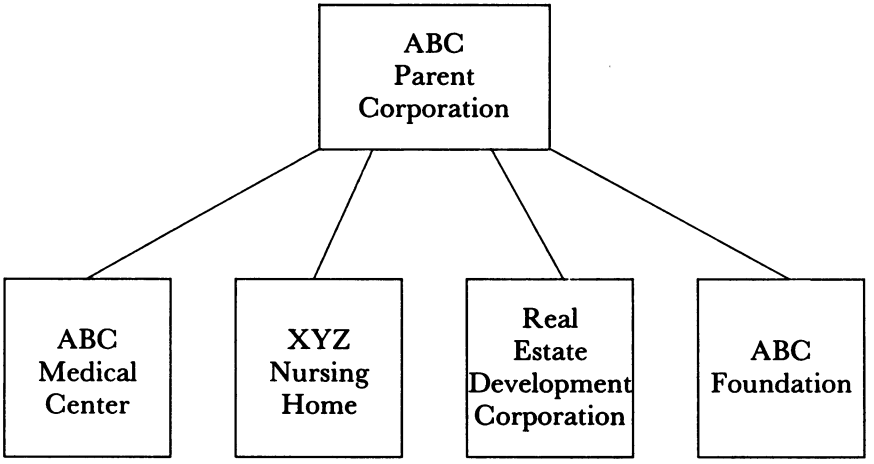
With few exceptions, the literature citing the causes and effects of corporate restructuring has been theoretical rather than empirical. Few studies have attempted to test the precise causes of corporate restructuring or the resulting benefits from reorganization. To assess such questions, it is first necessary to describe what happens when a hospital undergoes corporate restructuring.

Numerous variations in corporate restructuring activity exist, but all have in common the segmentation of certain assets or functions of the hospital into separate corporations to reflect specific profit, regulatory, or market objectives (Gerber, 1983). Two forms of corporate restructuring tend to dominate. The first is the establishment of a related or unrelated foundation (see Figure 1). In most cases, the hospital establishes a foundation to broaden the base of fund raising and/or philanthropic giving to the hospital. These foundations are typically 501(C)(3) organizations with a separate board of directors. A key characteristic of this restructuring form is the absence of direct lines of control between the hospital and foundation. In fact, to maintain its status as a separate foundation there is usually minimal board overlap between the hospital and the foundation board of directors (Brasher, 1984; Gerber, 1983).

The second, more common form of corporate restructuring consists of establishing a parent holding company under which the hospital and a number of other subsidiary organizations fall (see Figure 2). These subsidiaries may be organized under for-profit or not-for-profit control. All subsidiaries and the parent holding company corporation have separate boards of directors (Hoch, 1984; Squires, 1984).

A key feature of the parent holding company model is the exercise of direct control over the hospital and other subsidiaries by the parent

Figure 2: Expanded Exempt Parent Structure



corporation (Ernst and Whinney, 1982). This may be accomplished through several legal mechanisms, such as:

1. *The charter and bylaws of the hospital.* Total control of the hospital is given in these documents to a named holding company.
2. *Sole member of a membership corporation.* Often the hospital's governing board becomes the board of directors of the holding company. The hospital becomes a membership corporation whose sole member is the holding company, which thus controls the operations of the hospital.
3. *Overlapping board of directors.* Members of the hospital board also sit on the board of the holding company. Control is exercised in that the same individuals direct both organizations.
4. *Stock ownership.* When the hospital is legally a stock company, the holding company can exercise control by owning stock in the hospital corporation.

Several general points are important to consider in corporate restructuring. First, corporate restructuring is usually instituted by the hospital. This suggests that the hospital and its functions remain the focal point of this expanded organization form, despite any organizational changes that subordinate the hospital to a higher organizational entity (Hoch, 1984). Second, corporate restructuring is essentially a legal rearrangement of a hospital and its related components. It does not in and of itself require major alterations in the management and

governance of the hospital. However, a key issue to be addressed is whether or not such alterations are in fact adopted to establish a better fit with a new corporate form (Gerber, 1983).

Third, corporate restructuring is an ongoing process rather than a one-point-in-time occurrence. Typically, a hospital will begin with a "mainframe" organization and add on to that structure as the strategic plan of the hospital dictates. This may occur over several months or several years (Gerber, 1983; Ernst and Whinney, 1982). In addition, once decisions are made to make management or governance changes, considerable time may be required for implementation. A decision to reduce hospital board size, for example, might be accomplished through a strategy of not replacing members who resign.

Finally, corporate restructuring should be a vehicle for implementing a strategic plan and not an end in itself. Indeed, a primary purpose of this investigation is to examine whether hospitals appear to implement restructuring in order to effect substantive changes in their operations, as opposed to mimicking fashionable trends in the hospital industry (Gerber, 1983; Squires, 1984).

THEORY AND HYPOTHESES

Little theory or empirical research exists that would provide a framework for explaining the relationship of corporate restructuring and hospital policymaking. We elected, therefore, to develop our own classification system for hospital boards to serve as the basis for predicting differences between governance in restructured and nonrestructured hospitals. Based on a review of the literature, we identified two basic board types: philanthropic and corporate. The philanthropic model is based on descriptions of boards of not-for-profit organizations, while the corporate model is derived from descriptions of boards of directors of non-health care, private sector corporations (Johnson, 1986).

Eight key characteristics of these two board types are presented in Figure 3 and discussed below. It should be noted that this typology is an ideal one and has not been empirically derived. We do not expect these two types to manifest themselves perfectly in practice.

1. Board Size. Philanthropic boards are characterized by a large number of members owing to the voluntaristic nature of their activity and the broad range of interests they represent (Pfeffer, 1973). Historically, the major role of hospital trustees has been to maintain or enhance the legitimacy and prestige of the institution within the community, as well as to attract resources to the hospital from the sur-

Figure 3: Governing Board Types

PHILANTHROPIC	CORPORATE
Large Board Size	Small Board Size
Wide Range of Perspectives/ Backgrounds	Narrow, More Focused Perspectives/ Backgrounds
Small Number of Inside Directors	Large Number of Inside Directors
Little Management Participation on Board	Active Management Participation on Board
No Formal Management Accountability to Board	Direct Management Accountability to Board
No Limit to Consecutive Terms for Board Members	Limit to Consecutive Terms for Board Members
No Compensation for Board Service	Compensation Provided for Board Service
Emphasis on Asset Preservation	Emphasis on Strategic Activity

rounding environment. Corporate boards, in contrast, tend to be smaller and more focused as a function of the narrower constituencies to which the organization is accountable (Mace, 1971; Zald, 1969; Ewell, 1987).

2. *Heterogeneity.* For similar reasons, the range of perspectives and backgrounds on philanthropic boards tends to be much broader than that of their corporate counterparts (Pfeffer, 1973, 1972). This is due to the influence of a wide range of constituencies and stakeholders in philanthropic organizations as contrasted with the narrower shareholder representation role assumed by most corporate boards (Johnson, 1986). For these reasons, philanthropic boards are more likely than corporate boards to have members with diverse characteristics in terms of age, gender, racial or ethnic background, area of residence, and occupation. The more "business-like" orientation of corporate boards is particularly likely to be reflected in greater occupational homogeneity.

3. *Inside Directors.* Inside directors are those board members who also have operational roles in the organization. Corporate boards contain a large number of inside directors to allow outside directors to take advantage of the insiders' knowledge of the business, to confer prestige as a form of reward to a manager, and to achieve greater correspondence between organizational operations and policymaking (Mace,

1971; Juran, 1966). Philanthropic boards typically contain fewer inside directors because of their emphasis on environmental linkages and community relations (Deegan, 1982; Morlock and Alexander, 1986).

4. CEO Participation on Board. In a corporate model board, CEOs in the organization play a more important role in board affairs than their counterparts on philanthropic boards. This results because the CEO of a philanthropic organization typically shares power with other professional and management groups, thus diluting his influence with the board (Alexander and Morlock, 1985; Zuckerman et al., 1979). The corporate CEO has traditionally held more power vis-à-vis the board and the business because of his or her ultimate authority over all aspects of operating the organization (Mizruchi, 1983). Strong executive influence on the board is viewed as improving the linkage between policymaking and operations, lessening conflict between management and board members, and facilitating selection of directors whose views are consistent with the philosophy of the organization (Johnson, 1986).

5. CEO Accountability to Board. Management involvement on the board, however, is a double-edged sword. The corporate model board, in contrast to the philanthropic board, tends to distinguish more sharply between policymaking and operations of the organization (Mace, 1976; Vance, 1968). It is more likely to see its own role as that of formulating institutional policy and strategic decision making, with delegation of responsibility and authority to the CEO for day-to-day operations. This distancing of the board from operational decisions increases the need for mechanisms that enable the board to monitor and assess CEO activities and hospital performance. Routine, formal CEO evaluations by the board are seen as an important method of monitoring and improving CEO performance, as well as indirectly establishing stronger linkages between operations and policymaking (Alexander and Morlock, 1985; Ewell, 1972).

6. Limit to Consecutive Terms. Philanthropic boards in contrast to corporate boards tend to be self-perpetuating bodies wherein members of the board may either select their successors or serve on the board indefinitely (Ewell, 1982). Corporate boards tend to put limitations on the number of consecutive terms board members may serve, to keep the board from becoming too conservative and stale (Pfeffer, 1973; Johnson, 1986; Kovner, 1978).

7. Board Compensation. Corporate boards are also more likely than philanthropic boards to compensate their members for board service (Rehm and Alexander, 1986; Ewell, 1982). Although corporate board members are only rarely fully compensated for the value of their time,

it is felt that even a token gesture in this regard strengthens the bond between the board member and the organization. Philanthropic boards, by contrast, have traditionally avoided compensating board members because of the voluntary nature of board service (Johnson, 1986).

8. Strategic Activity. In terms of board activity, philanthropic board members are likely to view themselves as trustees concerned with preserving the assets of the organization and fulfilling fiduciary responsibilities. Corporate board members are more likely to emphasize their role also in establishing overall policy direction (Prybil and Starkweather, 1976; Kaufman, 1979; Ritvo, 1980). In the current health care climate, for example, they are more likely to be concerned with the hospital's competitive position; proposals for diversification, mergers, and joint ventures; and strategic planning.

We anticipate that corporate restructuring will precipitate changes in the structure, composition, and activity of the hospital governing board. Such changes will occur as adaptations to the new multicorporate entity as the hospital attempts to achieve a better "fit" between its own institutional policymaking and the goals and objectives of the larger organization.

We further expect that hospital boards under corporate restructuring will reflect characteristics of the corporate model board to a greater degree than nonrestructured hospitals. Several factors will drive the restructured hospital to adopt a more corporate style board. First, corporate restructuring often segments or unbundles organizational activities other than inpatient care into separate corporations. This permits the hospital to adopt a board structure more tailored to the specific needs and activities of the hospital itself. This situation lends itself to a less diffuse, more focused corporate style board, in which the interests, talents, and disciplines of board members can be better matched to the specific requirements of the hospital.

Second, the establishment of multiple boards of directors under corporate restructuring implies that some governance functions originally performed by the hospital board will pass to other boards. Specifically, many of the hospital fund-raising and community relations activities will be transferred to the parent holding company or foundation boards. This transfer of responsibilities again frees the hospital board to attend to the internal activities involved in running the hospital, leaving the environmental linkage functions to the parent board (Pfeffer, 1973). Those functions remaining with the hospital board

would most likely include professional relationships, quality assurance, joint conferencing, hospital finance, and hospital planning (Hoch, 1984). These responsibilities are likely to require corporate attributes such as increased management and medical staff participation and strategic planning.

Third, because the hospital remains the principal organizational component under corporate restructuring, the board of the hospital must be cognizant and in control of the activities of the other corporate entities. The communications problems and control complexities introduced by a multicorporate system will require a more maneuverable, flexible board at the hospital level to "make the system work." This translates into more management and insider control on the board, smaller board size, and a more unified control structure—all characteristics of the corporate board model.

Finally, and perhaps most fundamentally, corporate restructuring represents in practice the notion of health care delivery as a business. It is reasonable to expect, therefore, that the policymaking body of the hospital will assume a configuration consistent with this orientation by adopting the corporate board model.

Due to the theoretical rationale just outlined, we would hypothesize that in comparison to more traditional hospital boards, the governing boards of hospitals that have corporately restructured are more likely to be characterized by:

- Smaller size
- Less occupational heterogeneity
- Insider representation on the governing board from the active medical staff
- Voting membership on the governing board for the hospital CEO
- A formalized process for routine performance evaluations of the hospital CEO
- A limit to the number of consecutive terms that board members may serve
- Some type of compensation for board members
- Substantial board involvement in strategic activities (for example, discussions of the hospital's competitive position; proposed diversification, mergers, and joint ventures; and strategic planning).

METHODS

DATA

Data for this investigation were obtained from two sources: (1) the 1985 American Hospital Association (AHA) survey on hospital governance and (2) the 1984 AHA annual survey of hospitals. The governing board survey was mailed in May 1985 to the population of 5,800 acute care, community hospitals. Although the survey was addressed to the hospital CEO, it was requested that a key member of the governing board collaborate in its completion. The survey covered a range of topics, including structure and composition of the board, corporate restructuring, board-CEO relations, board-medical staff relations, board development and orientation, and board compensation. Final responses to the survey totaled 3,189 hospitals, a 55 percent response rate. A comparison of respondents to the universe of acute care community hospitals with respect to bed-size, geographic location, and ownership revealed no significant differences among the groups except for the proportion within each group that are investor-owned (14 percent of the universe in comparison to 7 percent of responding hospitals).

Selected data from the AHA annual survey were merged with the governing board data set to create the working data file.

MEASUREMENT

The measurement model developed in this investigation (Table 1) was designed to test the association of corporate restructuring and the two models of hospital governance—corporate and philanthropic. The eight dependent variables in this study reflect the characteristics of the corporate and philanthropic board models as presented in Figure 3 and the hypotheses. The unit of analysis is the individual hospital governing board.[1]

The primary independent variable in the investigation is whether or not the hospital has undergone corporate restructuring in the past five years. However, the measurement model also incorporates specific features of corporate restructuring, including the period during which restructuring occurred, the form of control exercised by the parent holding company over the hospital, and whether or not there is operational accountability by the hospital to a higher authority.

To control for alternative explanations of the effects of corporate restructuring, we also included a series of control variables in our model. These include hospital size, regional location, whether or not a

Table 1: Study Measures and Descriptive Statistics

		Mean	*Standard Deviation*
Corporate Restructuring			
Corporate restructuring	Hospital has legally rearranged its corporate structure in past five years (0 = no, 1 = yes)	0.340	0.474
Period of restructuring*	1979–1981 (0 = no, 1 = yes)	0.106	0.306
	1982–1983 (0 = no, 1 = yes)	0.372	0.484
	1984–1985 (reference category)	0.493	0.500
Type of control exercised† by parent corporation	Charter and bylaws (reference category)	0.514	0.500
	Sole member of membership corporation (0 = no, 1 = yes)	0.306	0.461
	Overlapping board (0 = no, 1 = yes)	0.119	0.324
	Stock ownership (0 = no, 1 = yes)	0.039	0.193
Hospital accountability to higher authority	Hospital board is accountable to higher authority (0 = no, 1 = yes)	0.776	0.417
Governing Board Characteristics			
Board size	Number of members serving on hospital governing board	14.325	10.087
Occupational heterogeneity	Number of different occupations represented on the board (of 17 possible)	6.872	2.279
Physician representation	Number of physician board members from active medical staff/total board members	0.191	0.144
Board-management relations	Hospital CEO serves as voting member of board (0 = no, 1 = yes)	0.370	0.483
	Board conducts formal performance evaluation of hospital CEO (0 = no, 1 = yes)	0.539	0.498

Board member turnover	Limit to consecutive terms of board members (0 = no, 1 = yes)	0.414	0.492
Board member compensation	Board members receive either per meeting fee, annual fee, travel plus fee, or discounted medical services (0 = no, 1 = yes)	0.333	0.491
Board strategic activity	In past year board has spent most time on: (1) hospital competitive position, (2) diversification-merger-joint ventures, or (3) strategic planning vs. (1) financial viability, (2) clinical privileges, (3) CEO performance, (4) fund raising, (5) litigation, (6) capital projects, or (7) professional standards (0 = no, 1 = yes)	0.428	0.495
Hospital-Environmental Characteristics			
Hospital bed-size	Number of beds set up and staffed for use	192	186
Hospital teaching status	Hospital has approved residency program (0 = no, 1 = yes)	0.178	0.383
Multihospital system membership	Hospital owned, leased, sponsored or managed by a MHS (0 = no, 1 = yes)	0.391	0.488
Urban location	Hospital located in SMSA (0 = no, 1 = yes)	0.533	0.499
Regional location	Northeast (0 = no, 1 = yes)	0.162	0.369
	South (0 = no, 1 = yes)	0.324	0.468
	Midwest (0 = no, 1 = yes)	0.343	0.475
	West (reference category)	0.170	0.376
Hospital control status	Investor-owned (0 = no, 1 = yes)	0.075	0.263
	Religious (0 = no, 1 = yes)	0.144	0.351
	Government (0 = no, 1 = yes)	0.288	0.453
	Secular nonprofit (reference category)	0.492	0.500

*Descriptive statistics based on subset of sample undergoing corporate restructuring.
†Descriptive statistics based on subset of sample undergoing corporate restructuring and adopting parent holding company form.

Table 2: Hospitals Undergoing Corporate Restructuring since 1979 (Percentage of All Responding Hospitals in Each Category)

	%
Total Sample	34
Bed-size	
<100	18
100-199	33
200-299	51
>300	55
Ownership	
Investor-owned	36
Secular nonprofit	42
Church	53
Government	10

hospital is a member of a multihospital system, whether or not a hospital is a teaching institution, hospital location in a rural or urban area, and the ownership or control status of the institution.

Formal definitions and descriptive statistics for each of the measures described above are presented in Table 1.

The first step in the analysis was to ascertain whether or not the ideal corporate-philanthropic board structure exists empirically. Using cross-tabulations and factor-analytic techniques, we examined the extent to which our eight measures of board structure covaried. Results of these analyses indicated that little association obtained among these eight measures, suggesting that the ideal model does not have a strong empirical counterpart in the hospital industry. We therefore elected to analyze each of the eight measures separately to assess the effects of corporate restructuring on hospital governance.

RESULTS

DESCRIPTIVE FINDINGS

Tables 2-4 describe the extent and type of restructuring undertaken by hospitals in our sample. Table 2 indicates that, of the 3,189 hospitals responding to the governing board survey, 34 percent (1,039) had undergone corporate restructuring in the past five years. The frequency of restructuring increases as a function of hospital size. Given the cost of the restructuring process and subsequent management costs

Table 3: Year of Most Recent Restructuring (Percentage of Hospitals Undergoing Corporate Restructuring in Last Five Years)

Year	%	N
1980	3	28
1981	8	76
1982	14	134
1983	25	233
1984	35	334
1985*	16	153

*Figures through June 1985.

Table 4: Form of Corporate Restructuring (Percentage of Hospitals Undergoing Corporate Restructuring)

Hospital:		%
Became	subsidiary of parent holding company	80
Formed	a related foundation	11
Formed	an unrelated foundation	5
Merged	with another hospital	2
Merged	with another health care organization	2

once restructuring has been implemented, larger hospitals can probably better "afford" to restructure. Importantly, these findings also may suggest that restructuring as a vehicle for strategic planning may only be available to certain types of institutions (that is, those with considerable available resources) (Alexander and Orlikoff, 1987).

Church-affiliated hospitals experienced the most restructuring of the four control categories (53 percent), followed by secular not-for-profit, investor-owned, and government hospitals. The higher frequency of restructuring among secular and religious not-for-profit hospitals most likely reflects the common objective of establishing a foundation and/or for-profit subsidiaries under the new parent corporation while retaining the tax-exempt status of the hospital itself.

Table 3 indicates that corporate restructuring has been on the rise since 1980 and appears to be gaining in popularity. Given the distribution of restructured hospitals by year, it is also reasonable to assume that little if any restructuring occurred before 1979.

As Table 4 indicates, the parent holding company model is by far the most common form of corporate restructuring (80 percent of hospitals undergoing restructuring). In distant second, representing 11 per-

Table 5: Effects of Corporate Restructuring on Selected Hospital Governing Board Characteristics (Unstandardized Coefficients [SE])

	Board Characteristics							
Independent Variables	*Board Size* (1)	*Physician Representation* (2)	*Occupational Heterogeneity* (3)	*CEO Voting Board Member* (4)	*Formal CEO Evaluation* (5)	*Board Compensation* (6)	*Limit to Consecutive Terms* (7)	*Strategic Activity* (8)
Restructuring	0.450	0.011**	0.162*	0.487***	0.373**	0.152*	0.132	0.457***
	(0.432)	(0.005)	(0.087)	(0.095)	(0.086)	(0.089)	(0.086)	(0.087)
MHS membership	-0.573*	0.001	-0.112	0.085	0.396***	-0.099	0.216**	0.036
	(0.312)	(0.005)	(0.092)	(0.104)	(0.086)	(0.088)	(0.089)	(0.089)
Teaching hospital	0.880**	0.017**	-0.251**	-0.185	0.111	-0.059	0.074	-0.214**
	(0.417)	(0.006)	(0.116)	(0.129)	(0.116)	(0.116)	(0.115)	(0.116)
Bed-size	0.012***	-0.003**	0.002***	0.002***	0.001***	0.001	0.001*	0.007***
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.000)	(0.000)	(0.002)
Northeast region	6.230***	-0.064***	1.120***	0.147	-0.117	-0.885***	-0.063	-0.180
	(0.491)	(0.008)	(0.140)	(0.153)	(0.136)	(0.143)	(0.138)	(0.138)
South region	0.620	-0.022***	-0.065	-0.377***	-0.314***	-0.433***	0.256**	-0.174
	(0.406)	(0.007)	(0.124)	(0.141)	(0.112)	(0.112)	(0.118)	(0.118)

West region	0.370	-0.044***	0.201	-0.172***	-0.157	-0.294***	0.206*	-0.346
	(0.405)	(0.007)	(0.126)	(0.137)	(0.112)	(0.111)	(0.117)	(0.116)
Urban	2.025***	0.032***	0.052	0.436***	0.094	-0.038	-0.124	0.291***
	(0.329)	(0.005)	(0.096)	(0.107)	(0.090)	(0.097)	(0.093)	(0.093)
Investor-owned	-6.833***	0.283***	2.309***	1.708***	-0.367**	-0.329**	0.061	-0.198
	(0.581)	(0.009)	(0.161)	(0.183)	(0.158)	(0.174)	(0.157)	(0.167)
Religious	-2.790***	-0.026***	0.212*	-2.228***	0.245**	-0.034	0.420***	0.045
	(0.432)	(0.006)	(0.121)	(0.177)	(0.123)	(0.123)	(0.118)	(0.120)
Government	-7.730***	0.019	1.583***	0.486***	-0.246***	0.216**	-1.203***	-0.316***
	(0.346)	(0.007)***	(0.117)	(0.095)	(0.094)	(0.096)	(0.104)	(0.101)
Constant	12.601***	0.178***	6.739***	-1.177***	-0.137**	0.376***	-0.417***	-0.684
	(0.432)	(0.007)	(0.130)	(0.142)	(0.119)	(0.119)	(0.123)	(0.124)
R^2 (pseudo R)	.41	.41	.26	(.51)	(.20)	(.11)	(.25)	(.18)
N	3146	2389	2389	3110	3116	3150	3121	2929

*Significant at 90 percent.
**Significant at 95 percent.
***Significant at 99 percent.

cent of the hospitals undergoing restructuring, is the formation of a related foundation. Other, less frequently adopted forms of corporate restructuring include the formation of an unrelated foundation, merger with another hospital, or merger with a nonhospital health care organization.

CORPORATE RESTRUCTURING EFFECTS

The next phase of the analysis examined the effects of corporate restructuring on the eight characteristics of the corporate-philanthropic model. The primary question addressed in this analysis was whether corporate restructuring per se has an effect on the nature of governance and policymaking in the hospital. A combination of ordinary least-squares and logistic regression techniques was employed to accommodate different forms of the dependent variables (continuous or binary). Table 5 displays the results of these analyses.

In six of the eight models tested, corporate restructuring was positively and significantly associated with the dependent variable. Specifically, corporate restructuring was positively related to medical staff representation on the board, the CEO as a voting board member, occupational heterogeneity, formal performance evaluation of the CEO, compensation for board members, and board involvement in strategic activity. Only the occupational heterogeneity effect was contrary to our hypothesis that corporate restructuring will lead to a more corporate-style board of directors. A more detailed analysis of the occupational composition of board members revealed that in comparison to the more traditional boards, corporately restructured hospital boards were significantly ($<.05$) more likely to have bankers/financiers, corporate executives, CEOs from other hospitals, representatives from religious groups, and hospital auxiliary representatives, and less likely to have nurses, other health professionals, educators, independent businessmen, farmers, government representatives, organized labor representatives, homemakers, or other occupations. Thus, boards of corporately restructured hospitals appear to have relatively more representation from the corporate business community.

Although these results are generally supportive of our predictions, one notable exception was disconcerting. Our results indicated that board size was unaffected by corporate restructuring, controlling for hospital and environmental characteristics. This result was surprising because much of the literature points to establishing a smaller and more flexible board as a primary reason for corporate restructuring. However, strong effects on board size were noted for hospital owner-

ship, urban-rural location, bed-size, and region. These relationships may have negated any effect attributable to the corporate restructuring variable.

Our findings suggest that although boards of hospitals undergoing restructuring were no larger or smaller than those that did not, they displayed greater insider involvement in board affairs, were somewhat more heterogeneous in their occupational makeup, had greater management influence, provided compensation to board members, and engaged in strategic activities to a greater extent than nonrestructured boards. While this pattern of results does not correspond exactly to our model of corporate directorships, it may be interpreted as a modified version of the corporate model. In particular, strong medical staff involvement, a greater role for hospital management, and concentration on strategic activity are consistent with the literature, which suggests that hospital board responsibilities after restructuring center on professional relationships, quality assurance, joint conferencing, hospital finance, and hospital planning. These functions and the accompanying structures noted in our analysis indicate that corporately restructured hospital boards may be moving away from the community-linkage function and concentrating more on internal affairs or the "business" of running the hospital.

As part of the analysis we also contrasted this profile of the restructured hospital board with that of boards of investor-owned and secular not-for-profit hospitals. Relative to secular not-for-profit hospitals, investor-owned institutions tend to have relatively small, heterogeneous boards with heavy medical staff representation and strong management influence on the board. A major difference from the not-for-profit hospital board is the absence of direct management accountability to the board through formal performance evaluation. In all likelihood, such evaluations are performed by the corporate headquarters of the system to which the investor-owned hospital belongs (Morlock and Alexander, 1986).

RESTRUCTURING FEATURES

We earlier referred to the fact that corporate restructuring varied considerably in terms of both activity and organization. It is reasonable, therefore, to expect corresponding differences in the effects of corporate restructuring on subsequent adaptations by hospital boards. In the final stage of our analysis, we examined the relationship of specific restructuring features and the eight variables corresponding to the philanthropic–corporate board model.

Three categories of restructuring variables were considered in this analysis: (1) the period during which the hospital restructured, (2) the type of control exercised by the parent holding company over the hospital, and (3) vertical accountability, whether or not the hospital board is operationally accountable to the parent holding company board. For this phase of the analysis we subdivided the sample to include only those hospitals that had undergone corporate restructuring *and* had adopted the parent holding company form. Whereas the previous analysis compared restructured and nonrestructured hospitals, this phase of the analysis attempts to explain variance within the group of restructured hospitals, controlling for other hospital and environmental characteristics. Results of this analysis are presented in Table 6.

Period of restructuring primarily affects board activity rather than board size and composition. Relative to hospitals undergoing recent restructuring (the reference group), older cohorts of restructured hospitals featured no limits to consecutive terms and less involvement in strategic activity relative to those hospitals that more recently restructured. Boards of restructured hospitals in older cohorts were less likely to conduct formal performance evaluations of the hospital CEO. These results indicate that greater time since restructuring is associated with board characteristics common to the philanthropic model.

Parent holding company control mechanisms were examined relative to control through the charter and bylaws of the hospital, the most common form of parent holding company control. These legal mechanisms of control displayed highly selective effects on board characteristics. For example, control through sole member of a membership corporation was characterized by less board compensation and reduced likelihood of limiting the consecutive terms of board members. The overlapping board, relative to charter and bylaw control, was associated with greater medical staff representation on the board, reduced likelihood of a CEO performance evaluation, and lower likelihood of limiting the consecutive terms served by board members.

Although a clear pattern does not emerge from these results, the significant relationships between different control mechanisms and board characteristics suggests that the various mechanisms are more than simply substitutable legal conventions for establishing control by the parent holding company over the hospital board.

Vertical accountability had the most pronounced and consistent impact on board structure, composition, and activity. Six of the eight governing board characteristics were significantly related to board accountability to higher authority (only occupational heterogeneity

Table 6: Effects of Corporate Restructuring Features on Selected Hospital Governing Board Characteristics (Unstandardized Coefficients [SE])

	Board Characteristics							
Restructuring Features†	*Board Size* (1)	*Physician Representation* (2)	*Occupational Heterogeneity* (3)	*CEO Voting Board Member* (4)	*CEO Performance Evaluation* (5)	*Board Compensation* (6)	*Limit to Consecutive Terms* (7)	*Strategic Activity* (8)
Restructuring in 1979–1981	-0.396 (1.092)	0.002 (0.013)	0.336 (0.252)	0.026 (0.266)	-0.743*** (0.267)	-0.374 (0.256)	-0.085 (0.060)	-0.469* (0.265)
Restructuring in 1982–1983	-0.973 (0.680)	0.001 (0.008)	0.179 (0.256)	0.165 (0.169)	-0.208 (0.169)	-0.263 (0.170)	-0.105*** (0.037)	-0.332** (0.161)
Sole member of membership corporation	-0.438 (0.752)	-0.001 (0.009)	-0.048 (0.172)	-0.238 (0.185)	-0.288 (0.187)	-0.078 (0.185)	-0.041* (0.041)	-0.49 (0.178)
Overlapping board of directors	-0.347 (1.046)	0.032** (0.013)	-0.171 (0.242)	-0.347 (0.253)	-0.464* (0.254)	0.052 (0.254)	-0.105** (0.058)	-0.015 (0.247)
Stock ownership	-1.658 (1.791)	0.076*** (0.026)	-0.692 (0.491)	-0.308 (0.425)	-0.190 (0.419)	-0.435 (0.477)	-0.208 (0.100)	-0.379 (0.449)
Hospital board accountable to higher authority	-1.353* (0.819)	0.018* (0.010)	-0.119 (0.190)	0.431*** (0.196)	-0.344* (0.203)	0.136 (0.202)	0.135*** (0.045)	0.349* (0.196)
Constant	14.442*** (1.409)	0.201*** (0.017)	6.88*** (0.324)	-0.642* (0.342)	0.875** (0.349)	0.095 (0.338)	0.533** (0.078)	0.126** (0.335)
R^2 (pseudo R)	.35	.43	.20	(.24)	(.19)	(.04)	(.25)	(.11)
N	737	701	784	788	788	788	788	788

*Significant at 90 percent.
**Significant at 95 percent.
***Significant at 99 percent.
†Restructuring feature effects control for all hospital characteristics contained in Table 5. Complete model specifications available from authors.

and board compensation were not). In addition, five of the six significant effects supported the prediction of board shift to the corporate model. The one exception to this pattern was CEO evaluation by the hospital board, which was less likely to occur in those restructured hospitals where the board itself was accountable to higher authority. One possible explanation might be that this function tends to be assumed by the parent board.

DISCUSSION

Based on comparisons between restructured and nonrestructured hospitals, the findings of our study suggest that under corporate restructuring, hospital governance in the not-for-profit sector conforms less to the philanthropic model and more to the corporate approach found in the non-health care sector. This is manifested primarily by increased management and insider involvement in board affairs and by increased strategic activity by the board.

Governance in restructured hospitals, however, has not reverted completely to the corporate end of the philanthropic-corporate continuum: most importantly, study results indicate that board size has not been affected by corporate restructuring. One likely explanation is that a policy decision to reduce board size is most easily implemented through a strategy of attrition—not replacing board members who retire or resign. If this is the most common approach, the time frame for our study was not long enough to capture the effects of corporate restructuring on board size.

It also is possible, however, that a hybrid form of board structure may result from corporate restructuring—one that is perhaps unique to the hospital industry. Ewell (1987) recently noted, for example, that the average-size board in both hospitals and the business sector is 13 or 14 individuals. In large business enterprises, such as Boeing with $15 billion in annual sales or Chevron with $41 billion, boards of directors still have only about 14 members. In large hospitals, however, boards often have two to three times this number. Ewell raises the question of why hospitals, which are considerably smaller than enterprises such as Chevron or the Bank of America, require boards that are far larger in size.

One reasonable explanation is that the traditional functions of philanthropic boards—including constituency representation, maintenance of institutional legitimacy and prestige, and linkage to key resources in the hospital's environment—usually require a relatively

greater number of board members, particularly in larger hospitals. Further, these functions may remain important for the viability of not-for-profit institutions, regardless of corporate form. Thus, perhaps we should not expect to observe, even over time, a decrease in board size among corporately restructured hospitals. This line of reasoning also may help to explain why corporately restructured hospitals are no more likely than the nonrestructured to place a limit on consecutive terms for board members: turnover of members according to a mechanistic formula would disrupt these more traditional functions of governing boards.

Our results also point to some similarities between the boards of investor-owned hospitals and corporately restructured hospitals, particularly in the areas of physician participation, management influence, and occupational heterogeneity. These findings support the notion that through corporate restructuring, sector differences in health care may be blurring rather than becoming more acute. Concerns over the potential consequences of corporatization and decreasing voluntarism in the health care sector should be focused not only on the growing proportion of investor-owned hospitals, but also on the extent to which not-for-profit, corporately restructured hospitals are becoming—at least structurally—more like the investor-owned institutions. The differences discussed in the literature between for-profit and not-for-profit institutions soon may apply largely to the public hospital segment of the not-for-profit hospital sector. These institutions, due to legal and political constraints, are much less likely to undergo corporate restructuring (Gerber, 1983).

Our study also suggests that corporate restructuring is more than a simple legal mechanism enabling hospitals to avoid regulation or to maintain their tax status. The influence of corporate restructuring on hospital governance indicates that hospitals may make structural adaptations to the new multicorporate entity and that changes in hospital policymaking may result. This conclusion is further supported by our findings related to the legal mechanisms through which parent holding companies exercise control over the hospital. These mechanisms were found to be related to specific features of hospital governance.

Several specific effects are worthy of note. First, hospitals that have been restructured longer exhibit relatively more characteristics of the philanthropic board model than do newly restructured hospitals. Our results may provide fuel for speculation that over time, the hospital board becomes more philanthropic or "hospital"-like as the parent board assumes many of the responsibilities of the newly restructured hospital board. Alternatively, hospitals that restructured during earlier

periods may have moved incrementally toward the corporate model, while hospitals restructuring more recently have had the benefit of observing available models of restructuring, and therefore have been able to take more significant steps toward the corporate approach. A third, and perhaps the most plausible, explanation is that over time the cohorts of hospitals have had different objectives for restructuring. Earlier cohorts, for example, may have hoped to capture more favorable reimbursement formulas prior to the adoption of DRG reimbursement by the Medicare program and many other third-party payers. More recently, hospitals may have been primarily motivated by diversification objectives (Gerber, 1983).

A second consistent finding was the effects of vertical accountability on governing board characteristics. In general, we noted that vertical accountability was positively linked to characteristics of the corporate model governing board.

Many of the conclusions cited above must be tempered by the fact that our study employed cross-sectional data. it may be argued that existing board structures may have predisposed hospitals to undergo restructuring rather than vice versa. For example, a voting CEO on the board may have initiated the move to restructure based on his or her knowledge of the concept or from a desire to increase management efficiency. Issues of causal ordering can be addressed effectively only through longitudinal analysis. However, the policy implications of the study are much the same. Corporate restructuring is clearly associated with particular board configurations and by extension to the way policy is developed in the hospital. Whether the organizational configuration follows or precedes corporate restructuring is less important than the fact that it is substantively different from that of nonrestructured hospitals.

A second implication of our findings relates to the extent of the restructuring phenomenon as it affects future research on hospitals. Thirty-four percent of all hospitals in our sample have undergone restructuring in the past five years. Organizational behavior and performance-related research on hospitals cannot continue, therefore, to isolate the hospital from its corporate context. Doing so will present a misleading picture of hospital operations, performance, and administration. A fundamental task ahead, then, is to redefine the unit of analysis for research on health care delivery organizations.

Additional research is also required to examine relationships among corporations in the multicorporate entity. Issues of division of labor, accountability, and relative power are crucial to understanding how the corporately restructured hospital works as an organization.

Finally, it may be interesting to speculate on the likely course of corporate restructuring in the hospital industry by looking at the experience of the non-health care sector. Recent writings in the business arena have suggested that many corporations are undergoing a decidedly different sort of restructuring. These companies are adopting a "pure form" structure that encompasses a narrower and more homogeneous set of activities. They are divesting themselves of unrelated business at an unprecedented rate. The most common reasons cited for this trend are problems associated with managing a diverse set of operations. The experience of the business sector raises the issue of whether hospitals can manage effectively the diverse range of activities and organizations spawned under corporate restructuring. There is preliminary evidence, for example, to suggest that, at least in the short term, service or product diversification is associated with neither increased profitability nor reduced financial risk among not-for-profit hospitals (Friedman, 1987; Clement, 1987). Both administrators and researchers would be well advised to learn from the experience of other industries as corporate restructuring becomes an increasingly popular vehicle for strategic planning among the nation's hospitals.

NOTE

1. Respondents were instructed that the term "governing board" should be defined, for the purposes of the survey, as that organizational component of the hospital which has responsibility for the overall long-term interest of the organization, and to which the hospital CEO is directly accountable. It was stated further that this definition would apply to boards that must report to a higher authority that holds some reserved powers but expects the subordinate board to make most policy decisions concerning the hospital.

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