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9 The Changing Roles of Public, Private, and Nonprofit Enterprise in Education, Health Care, and Other Human Services

Henry Hansmann

9.1 Introduction

The basic human services—health care, education, day care, and old-age care—are characterized by a strikingly diverse range of organizational forms. All of these industries are populated with substantial numbers of firms exhibiting each of three fundamentally different ownership types: for-profit, private nonprofit, and public (i.e., government-owned). The market shares of these ownership types differ markedly from one service to another, however, as shown in table 9.1. Moreover, those market shares have been shifting in recent decades, and they have been shifting at very different rates in the various services and sometimes even in different directions. For example, the market share of for-profit firms has been growing rapidly in child care and at a modest rate in hospital care, but has apparently been constant or declining in primary and secondary education. The market share of public firms, meanwhile, has been declining steadily in hospital care, remaining quite constant in primary and secondary education, and growing rapidly in higher education.

Finally, there is also substantial diversity and change *within* each of the basic ownership types. In particular, there has been a clear tendency toward increased vertical and horizontal integration among both for-profit and nonprofit firms in all of the human services, and at the same time at least an incipient tendency toward *disintegration* among public firms.

I shall analyze here some of the important factors that have given rise to these ownership patterns, and I shall explore as well some of the ways that public policy can and should affect these patterns in the future. I shall begin with some general observations about the role and behavior of firms in each of the basic ownership types, and then proceed to discuss, in turn, each of the

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Table 9.1 **Distribution of Ownership Forms in the Human Services**
(percentages)

	Public	Nonprofit	For-Profit
Health care			
Hospitals ^a	24	64	12
HMOs ^b	0	48	52
Old-age care			
Nursing homes ^c	8	23	69
Child care			
Day care centers ^d	7	56	37
Education			
Primary and secondary schools ^e	89	10	1
Postsecondary institutions ^f	78	20	2

^aShort-term beds as of 1992 (American Hospital Association 1993–94).

^bNumber of enrollees as of 1993 (Gray and Schlesinger 1994, 15).

^cNumber of residents as of 1985 (National Center for Health Statistics 1989).

^dNumber of spaces as of 1990. Percentage public is based only on programs sponsored by public schools, and may underestimate the total (Kisker et al. 1991, vol. 1).

^eEnrollment as of 1990 (U.S. Bureau of the Census, 1993, table 221). See discussion in text concerning percentage for-profit.

^fEnrollment as of 1990 (National Center for Education Statistics 1992). See discussion in text concerning percentage for-profit.

four principal human service industries. Because the organization of health care has received so much attention recently, I shall try to provide some balance by giving special emphasis to education.

9.2 Nonprofit Firms

One of the most singular facts about the organization of production in the human services is the large number of private nonprofit firms that these industries contain.

9.2.1 The Affirmative Efficiency Role of Nonprofits

The defining characteristic of a nonprofit firm is that it is subject to a “non-distribution constraint” that prohibits the firm from distributing its residual earnings to any individuals—such as members, directors, or officers—that exercise control over the firm. There is general scholarly consensus that the most convincing efficiency rationale for employing the nonprofit form, as well as the apparent reason why nonprofit firms in fact originally arose in most industries in which they are found, is that the nonprofit form serves as a crude but effective consumer protection device in severe situations of asymmetric information (Hansmann 1987a). More particularly, nonprofits restrain producer opportunism where consumers, owing either to the circumstances under which a

service is purchased or consumed or to the nature of the service itself, are unable to evaluate accurately the quantity or quality of the service that a firm produces for them. The advantage of a nonprofit firm in such situations is that, by virtue of the nondistribution constraint, the managers of the firm are limited in their ability to benefit personally from providing consumers with fewer or lower-quality services than promised, and thus have less incentive to do so.

As a normative justification and positive explanation for the role of nonprofit firms, this asymmetric information theory is most obviously convincing when the services involved are either being purchased for third parties or are public goods, as is the case with most donatively supported philanthropies. When a person makes what we call a “donation” or “contribution” to a charity such as the Salvation Army or Oxfam, for example, they are in effect purchasing services from the organization that are to be delivered to a third party. The purchaser, however, has virtually no way of checking whether her payment was in fact used to provide services for the intended beneficiaries, much less how well or in what quantity those services were performed. Similarly, when a person makes a contribution to an organization such as the American Heart Association (which supports medical research), or to Friends of the Earth (which promotes environmental protection), or to a listener-supported radio or television station, they are in effect purchasing public goods for consumption by themselves and others. Yet the contributor has no way of determining whether his payment actually went to purchase an additional increment of the public good, or whether, conversely, the organization would have produced the same quantity even in the absence of his contribution. In these circumstances, the nondistribution constraint provides reasonable assurance that all or nearly all of the organization’s receipts will be used to finance production of additional services of the type that the organization promises to provide. Consequently, donatively supported organizations are almost universally formed as nonprofit firms.

Many nonprofit firms, however, receive no meaningful amount of income in the form of donations, but rather are “commercial nonprofits” whose income derives almost exclusively from fees charged for private goods and services rendered directly to the payor, just as it does for a typical for-profit firm. It is sometimes argued that problems of asymmetric information both explain and justify the existence of commercial nonprofits just as they do donative nonprofits. Today nonprofit hospitals, for example, typically receive no meaningful amount of donative income. Yet, because consumers are frequently in a poor position to judge the quality of the services that a hospital renders to them, it has been suggested that the nonprofit form is appropriate or even necessary to protect patients from the type of opportunistic behavior that could be expected from a hospital organized as a proprietary firm. This assertion remains controversial, however, since both logic and the available evidence give reason to believe that, at least in industries such as the human services, commercial nonprofits do not offer consumers significantly higher quality than do for-profit

firms that provide similar services at similar prices.¹ The nondistribution constraint is, after all, a rather blunt instrument for consumer protection. Moreover, there are a variety of other devices, both public (such as regulation) and private (such as reputation), that can be deployed to provide quality assurance to customers of for-profit firms who would otherwise be vulnerable to exploitation owing to asymmetric information.²

If commercial nonprofits do not provide significantly higher quality services than their for-profit competitors, then what accounts for their presence in such large numbers? One possibility is that they simply represent institutional lag: they were originally formed as donative nonprofits, and then remained in place as the industry's reliance on donative financing declined. Another possibility is that they are a response to public regulation or to public subsidies (such as tax exemption or access to tax-exempt bond financing) that have favored nonprofit firms, including commercial nonprofits, over their non-profit competitors.

In making public policy for the human services, it is important to know which of these contrasting views of commercial nonprofits is correct, since the nonprofit firms in the human service industries are frequently, and increasingly, of a commercial rather than a donative character. We shall review some of the evidence below when we examine the individual service industries.

9.2.2 Potential Inefficiencies

If nonprofit firms only offered potential efficiency advantages over for-profit firms, and no disadvantages, then there would be no reason for concern when they occupy a large market share in any given industry. There are, however, some potentially significant inefficiencies that may accompany the nonprofit form.

Operating Inefficiency

It is frequently argued that, since the managers of nonprofit firms cannot appropriate their firms' net earnings, they have less incentive to minimize costs than do the managers of proprietary firms. The resulting operating inefficiency may be outweighed by the countervailing efficiency advantages of nonprofits where there are severe problems of asymmetric information, as is presumably the case with donatively supported organizations. Where consumers are reasonably capable of policing producer behavior, however, as they may be when patronizing commercial nonprofits providing human services—this incentive problem will render nonprofits less efficient than for-profit firms.

1. Some of the empirical evidence is cited below. See, in addition to those sources, Gray (1986, surveying the literature on health care) and Clarke and Estes (1992, comparing nonprofit and proprietary home health care organizations).

2. This is not to say that commercial nonprofits can never serve as an effective response to problems of asymmetric information. A clear example—though perhaps the only clear example—of an industry in which commercial nonprofits have arisen to serve this function is consumer savings banking in the early nineteenth century. (See Hansmann in press, chap.14.)

On the other hand, it is not obvious that we should generally expect nonprofits to be significantly less effective at cost minimization than are for-profit firms, particularly in industries such as the human services where, owing to low economies of scale, markets are frequently served by a number of competing firms. For-profit firms, like nonprofit firms, are often managed by individuals who have no claim to an appreciative share of the firm's net earnings, but rather serve as fiduciaries for the nominal owners, just as the managers of nonprofits serve as fiduciaries for the firm's customers. Moreover, the managers of nonprofit firms have a strong stake in their jobs and their salaries, and may derive substantial nonpecuniary returns from the success of their organizations, all of which give the managers an incentive to promote their organizations' survival, prosperity, and growth, which in turn call for cost minimization. Perhaps for these reasons, the available empirical evidence has failed to demonstrate clearly that commercial nonprofit firms in the human services are generally inferior to for-profit firms in cost minimization (Pauly 1987; Schlesinger 1994). There is therefore reason to believe that concerns about the operating inefficiency imposed upon the human services through their heavy reliance on nonprofit firms, while not entirely misplaced, are easily exaggerated.

Supply Response

A more serious inefficiency associated with nonprofit firms, arguably, is their sluggishness in expanding or contracting their services in response to changes in demand.

The empirical evidence indicates fairly clearly that, when demand increases rapidly in the human services, nonprofit firms respond by entering or increasing their capacity only slowly; for-profit firms are much quicker in entering or expanding to fill the gap (Steinwald and Neuhauser 1970; Hansmann 1987b). Lack of access to equity capital is probably one reason for this slow supply response; lack of incentives for entrepreneurs who create and manage nonprofits may be another.

Similarly, nonprofit firms appear to be slow to reduce their output, or to withdraw from an industry entirely, when demand for their services contracts. Rather, they continue producing even when their invested capital is producing a very low or negative return. One reason for this may be that legal constraints make it difficult (though not impossible) for a nonprofit firm to withdraw its invested capital from the purposes to which it is currently dedicated (say, provision of hospital care in a prosperous suburban community) and devote it to another purpose (say, child care for the indigent in the inner city). Another and perhaps more important reason is that nonprofit administrators have little incentive to downscale their firms.

This problem is compounded by the fact that, even in the absence of explicit or implicit subsidies, a nonprofit firm can maintain its capacity and even grow in circumstances in which a for-profit firm would not be earning a market rate of return on its capital. Or at least this is the case for nonprofits—such as those

typically found in the human service industries—that have accumulated, either from donations or from retained earnings, some significant amount of net capital. For a nonprofit firm need not—indeed, cannot—pay out a market rate of return on its accumulated capital. Consequently, so long as a nonprofit is earning just a zero net rate of return on net capital (after depreciation), it can continue operating at its current scale indefinitely. And if it earns any positive rate of return, even if that rate is well below the opportunity cost of the capital, the firm will have retained earnings that it can reinvest in expansion of its capacity, or that it can use to subsidize consumption of services provided with its existing capacity.

Imagine, for example, that a given community is served by two hospitals, one investor-owned and one nonprofit. Neither hospital provides any research, education, free care for the indigent, or other public goods; rather, they both just sell private medical services to individuals capable of paying for them. Each hospital has \$100 million in net assets, in the form of physical plant and equipment that could be sold on the market for that amount. The nonprofit hospital, let us suppose, benefits from no explicit or implicit subsidies, private or public. Rather, like the investor-owned hospital, the nonprofit hospital is subject to aggregate federal and state corporate income taxes of 50% on net earnings. The for-profit hospital has annual net earnings of \$15 million, representing a 15% gross rate of return on its invested capital, which yields \$7.5 million dollars, or 7.5%, after taxes. This rate of return is just equal to the market rate of return for similar investments, leaving the firm with no incentive to either expand or contract its investment. The nonprofit hospital is substantially less cost efficient, with annual net earnings of just \$6 million, or 6% of net assets, yielding \$3 million, or 3%, after taxes. If the nonprofit hospital were, instead, an investor-owned institution, this below-market rate of return would presumably induce the firm—if it could not otherwise improve its performance—to sell its plant and equipment to another firm that could make them yield a gross return of at least 15%, either in providing hospital services or in some other activity. But the nonprofit hospital is under little pressure to do this. Rather, its managers are free to, and have some incentive to, invest the hospital's net earnings in further plant and equipment. Thus the nonprofit hospital is in a position to expand by up to 3% per year, taking market share from its investor-owned competitor and ultimately, if it chooses, driving the latter out of business entirely, even though the nonprofit firm is clearly the less efficient producer (and even though it benefits from no publicly provided fiscal or regulatory advantages).

This is not to say that nonprofit firms, no matter how inefficient, will always expand their services so long as they are not actually losing money. A nonprofit may decide to use its net earnings, not to purchase inefficiently large capacity for the provision of private goods, but rather to provide undersupplied public goods such as research or free care for the poor. And, if the nonprofit is not an efficient manager of its existing assets, it may decide to sell those assets and

dedicate the sale proceeds to the provision of public goods, or donate them to another organization that can do that effectively. But there is good reason to believe that the managers of nonprofit firms, like the managers of investor-owned firms, often have an inclination toward empire building. And, while investor ownership by no means provides a perfect check on this tendency, the nonprofit form provides very little check at all.

The result is that nonprofit firms can act as traps for capital. Although nonprofits may be slow to accumulate capital, the capital they have accumulated tends to become embedded.³

In service sectors that are populated by both nonprofit and for-profit firms, and that present no artificial barriers to entry by for-profit firms, the inability of nonprofits to respond quickly to increases in demand need not be a serious problem: entry or expansion by for-profit firms can fill the supply gap. When demand for an industry's services is declining, however, or when demand shifts to types of services significantly different than the existing institutions have been providing, for-profit firms may be an inadequate buffer for the slow response of the already-existing nonprofits: once all the for-profit firms have exited in a given service area, the nonprofit firms may still remain.

In sum, although nonprofit firms may often manage their existing capacity at costs that are not conspicuously higher than those that a for-profit firm would incur in like circumstances, nonprofit firms appear to be much more prone than for-profit firms to operate with either too little or too much capacity, or capacity of the wrong kind.

9.3 Public Firms

Although debate about the respective roles of public and private enterprise has been a central issue in political economy for the past 150 years, and although privatization is at the top of the economic agenda throughout the world today, there is remarkably little consensus on either normative justifications for governmental ownership or on positive explanations of why, in fact, public enterprise has come to play a large role in some industries—such as the human services—and not in others. Those gaps cannot be adequately filled here. Rather, we can only point to some considerations that appear particularly important in the human services.

9.3.1 Subsidization

There are a number of potential justifications for governmental subsidies to private consumption of particular goods and services. For example, there may

3. The excess capital that a nonprofit accumulates is sometimes not invested in the firm's own productive assets, but is instead held in the form of financial reserves. The large endowments accumulated by well-established private universities are an example (Hansmann 1990). Since these reserves are invested in the debt and equity of other firms, they need not result in substantial inefficiency.

be positive externalities associated with private consumption, or the private risk involved in consumption may be lower than the social risk, or capital market imperfections may threaten underconsumption by consumers who are not highly liquid, or paternalistic concerns may cause redistribution to the poor to be limited to specific goods and services.

Whether the government subsidizes a given service for these or other motives, one way to provide the subsidy is to produce the service directly, through government-owned and -operated firms, either without charge or at prices that are below cost. In the past, simple subsidization of this sort has apparently often been the motivation for governmental ownership of enterprise. Public hospitals, which in the United States have frequently been designed to treat the indigent, are an example.

But public subsidies need not necessarily be confined to public firms. One alternative is to channel the subsidies to private nonprofit firms, where the non-distribution constraint serves to assure the government that the value of the subsidies will ultimately be passed through to consumers of the firm's services. In the three decades following World War II, for example, the federal government provided extensive capital subsidies directly to nonprofit hospitals and universities. Why would governmental ownership ever be superior to a system of nonprofit firms supported by public subsidies? Better supply response is one apparent reason. If government wants to expand supply of a service rapidly, it may be easier to create or expand a system of governmental firms than to seek to encourage expansion of the nonprofit sector, as I shall discuss further when I focus on higher education. Similarly, it appears easier to induce *contraction* of a sector when the firms are publicly owned than when they are private nonprofits, as I shall discuss further in connection with hospitals.

Another alternative to governmental ownership is to structure public subsidies as demand-side subsidies that consumers can use to purchase services from private firms that are either nonprofit or for-profit. In fact, over recent decades, one of the most distinctive changes in the production of human services in the United States has been a strong tendency for government to move from supply-side to demand-side subsidies. A need for public subsidies therefore translates into a justification for public ownership only when there is some reason that the subsidies cannot or should not be structured as demand-side subsidies.

One such reason may be that the transaction costs of administering public subsidies are high. Decreases in those transaction costs over recent decades, as systems of public administration have become sophisticated, may be one important reason for the current trend toward privatization.

9.3.2 Information Asymmetry

Whether or not there is a justification for public subsidies, governmental enterprise can serve the function commonly ascribed to nonprofit firms: to protect consumers from opportunistic supplier behavior in situations of severe asymmetric information. Might there ever be a reason to prefer governmental

enterprise over nonprofit firms in this role? Better supply response is again the most apparent answer.

9.3.3 Equality of Consumption

Another reason to favor governmental enterprise over private firms, whether for-profit or nonprofit, is to encourage or enforce equality of consumption. With private-sector firms as suppliers, it is difficult to prevent individuals from choosing very different quantities or qualities of consumption. Also, it is difficult to prevent consumers from segregating themselves among different supplying firms according to various socioeconomic or personal characteristics. Where, for some reason, such self-sorting of consumers appears particularly undesirable, governmental enterprise has the advantage that it can be organized to avoid sorting—or at least this is the case if, through subsidies or other legislative preferences, public firms achieve a near monopoly. As I shall discuss below, this rationale for socialization is particularly strong for “associative” goods and services, such as education.

9.4 For-Profit Firms

The essential efficiency virtues and vices of for-profit enterprise are familiar. It is helpful to keep in mind, however, that there are various tactics available to for-profit firms to cope with the problems of asymmetric information that would otherwise lead consumers to prefer to patronize nonprofit or governmental firms. The most obvious is to offer a reputational hostage. Horizontal integration, which offers the reputation of all units in the system as assurance for the performance of each of the individual units, is one method. Franchising offers a similar reputational hostage while retaining strong incentives for cost minimization at the level of the individual service unit. Not surprisingly, both of these approaches have become common among proprietary firms in the human services in recent years.⁴

9.5 Health Care

There are three principal types of institutions that market health care to consumers: primary care providers, such as health maintenance organizations and

4. Consumer cooperatives are another ownership form that is sometimes successfully used to deal with problems of asymmetric information between consumers and producers. The form is sometimes found in the human services. Group Health of Puget Sound, for example, is a well-established health maintenance organization organized as a consumer cooperative, and there are apparently also a number of day care centers organized as consumer cooperatives. Aside from these examples, however, consumer cooperatives have made few inroads in the human services. An important reason for this, probably, is that governance costs (including both the transaction costs of decision making and the costs of inefficient decisions) are relatively high in cooperatives that provide goods or services as complex as those in the human services that concern us here. In general, consumer cooperatives achieve substantial success only in supplying relatively simple, homogeneous goods and services (Hansmann 1988, in press).

primary care physicians in solo practice or partnerships; hospitals; and insurers. It is convenient to begin with hospitals, which have been the subject of the most intense study in the literature on ownership.

9.5.1 Hospitals

Until late in the nineteenth century, hospitals were almost exclusively charitable institutions—in essence, sick houses for the poor, supported heavily by philanthropic contributions. It was therefore natural that nongovernmental hospitals were organized as nonprofit firms, in order to cope with the problems of asymmetric information facing their donors.

Over the past century, however, advances in medical technology have transformed hospitals into places where persons of means also go for treatment. Moreover, with the development during the twentieth century of first private and then public health insurance, the overwhelming majority of Americans have become capable of paying for the hospital services they consume. As a consequence, charitable donations no longer represent a significant source of income for most short-term acute-care hospitals; rather, nonprofit as well as investor-owned hospitals now rely almost exclusively on patient fees for their income.

There have been substantial numbers of for-profit hospitals in the United States throughout the twentieth century. Until twenty-five years ago, however, these proprietary hospitals were often small clinics owned by the doctors to whose practices they were connected (Steinwald and Neuhauser 1970). With the implementation of Medicare and Medicaid in 1966, the average hospital became a profitable enterprise, more than able to cover its costs with patient fees. As a consequence, large publicly held business corporations began entering the industry, creating substantial chains of hospitals by acquisition and construction. After twenty-five years of aggressive efforts at expansion by these proprietary chains, the market share of for-profit hospitals has expanded noticeably, though not spectacularly, from 6% of all short-term beds in 1971 to 12% in 1992. Nevertheless, nonprofit hospitals continue to account for the great majority of all beds. In fact, the market share of nonprofit hospitals has actually *increased* slightly over this period, from 63% in 1965 to 64% in 1992 (American Hospital Association 1971, 1993–94).⁵ In terms of overall market share, the growth of the large for-profit hospital chains has come at the expense of smaller proprietary hospitals and of government hospitals.

Given the transformation of the hospital industry from a charitable to a fee-for-service basis, why do nonprofits continue to have such a large market share? There appear to be two potential rationales that are attractive in terms of social welfare. The first is that the nonprofit form protects consumers against

5. Prior to 1971, counts of short-term beds in federally owned hospitals are apparently unavailable. Among nonfederal hospitals, however, the market shares of nonprofit, for-profit, and governmental hospitals remained constant from 1960 to 1971, at 70%, 6%, and 24%, respectively.

opportunistic exploitation of informational advantages. Empirical scrutiny has failed, however, to produce clear evidence that the quality of care in nonprofit hospitals is, on average, higher than that in proprietary hospitals (Gray 1986). This is not surprising. It is not obvious that problems of asymmetric information are so severe in this sector that the nonprofit form is likely to be a useful antidote. Hospitals generally provide relatively simple services, such as room, board, medical supplies, and nursing care; it is the doctors that practice in the hospitals that provide the most complex services, and those doctors are generally independent contractors rather than employees of the hospital. Indeed, the doctors serve as sophisticated purchasing agents for their patients in the consumption of hospital services. Moreover, the large for-profit hospital chains have an important reputational stake in providing high-quality service.

The second potential justification for the continuing survival of nonprofit hospitals is that the nonprofit form is needed to assure that the remaining indirect public subsidies to the hospital sector, such as tax exemption, are actually utilized to finance the public goods for which they are intended, such as research, education, and subsidized care for those members of the population who remain uncovered by health insurance. Yet most nonprofit short-term hospitals undertake no meaningful amount of research or teaching (in particular, they generally have no interns or residents), and the available data do not demonstrate convincingly that nonprofit hospitals on average provide significantly more uncompensated care than do proprietary hospitals.

All of this suggests that the nonprofit form is largely anachronistic in the hospital industry, and that if that industry were to be re-created today from scratch, nonprofit firms would represent a much smaller share of total capacity than they do now. This suggests, in turn, that the continuing large market share of the nonprofits is in large part the result of capital embeddedness.

This holdover of large numbers of nonprofit firms does not necessarily result in serious inefficiency in the hospital industry. As we noted above, there is reason to believe that the operating efficiency of such commercial nonprofits is relatively high in a competitive industry such as hospital care. Rather, if there is inefficiency, it may well lie more in the maintenance of excessive capacity among the nonprofits, and in the use of that capacity to provide excessive services.

What problems does this create for public policy? If nonprofit hospitals are no longer providing a quantity or quality of service that is unavailable from proprietary hospitals, then it is hard to justify continuance of subsidies such as tax exemption. And, in fact, the tax exemption of nonprofit hospitals has already come under serious assault at both the local and national levels. Removal of tax exemption will not itself, however, solve the problem of capital embeddedness. As we noted above, even in the absence of such subsidies, nonprofit firms can survive and grow even if the implicit rate of return on their invested capital is well below its opportunity cost.

This suggests that there is reason to seek a method to facilitate the transfer

of invested hospital plant from nonprofit to for-profit firms. Legislation forcing conversion of nonprofit hospitals to the for-profit form, even if it were politically feasible (which it probably is not), seems an unnecessarily strong step. An alternative is to impose on the managers and directors of nonprofit hospitals (and, indeed, of nonprofit corporations generally) stricter fiduciary duties in responding to purchase offers, similar to the duties that the courts have imposed on the managers of business corporations, over the past decade, in responding to takeover bids. Indeed, since the directors of most nonprofit hospitals are self-appointing, rather than (as in a business corporation) elected by the individuals whom they serve as fiduciaries, there is good reason to impose on those directors fiduciary duties that are significantly stricter than those imposed on the directors of business corporations. In particular, one could place a substantial burden on the directors of a nonprofit hospital to justify any decision not to sell their assets to another firm, nonprofit or for-profit, that makes a serious bid to purchase them, and give the bidders standing to bring suit to enforce that duty. (The money that the nonprofit received from such a sale of assets would presumably be placed in a fund to be used for charitable purposes, such as financing medical care for indigents or promoting medical research.)

We observed earlier that an apparent advantage of public over nonprofit firms is that public firms can sometimes exhibit faster supply response. The hospital industry offers evidence of this. The shift from supply-side to demand-side subsidies represented by Medicare and Medicaid, as we have noted, deprived both nonprofit and public hospitals of their unique role in providing subsidized services to the poor. Moreover, in the 1980s, hospital usage in the United States as a whole began to decline. Presumably as a response to these developments, the rate of capacity expansion in both public and nonprofit hospitals slowed in the 1970s, and by the mid-1980s the aggregate number of beds in both types of hospitals actually began to decline. This reduction and ultimate reverse of the growth rate was conspicuously more rapid in public than in nonprofit hospitals, however, with the result that, while the aggregate market share of the nonprofit hospitals remained roughly constant, the market share of the public hospitals contracted from 31% of all short-term beds in 1971 to 24% in 1992 (American Hospital Association 1971, 1993–94).

Does there remain a potential role for public ownership of hospitals? Cost control is the justification most forcefully argued today. Unavoidable imperfections in the market for health insurance, the argument goes, create strong incentives for excessive consumption of health care, and these incentives are amplified by public subsidies. The only way to avoid overconsumption, therefore, is to ration supply, and the easiest way to do this is simply to make the government the owner of the hospitals. Whether the extensive governmental ownership of hospitals characteristic of other developed economies has helped control costs in those countries is, however, a matter of dispute (Aaron 1991, 94).

9.5.2 Primary Physician Care

Prior to the early 1970s, primary care physicians were organized almost entirely in proprietary practices owned by the physicians themselves, either as sole proprietorships or as partnerships. Investor ownership was effectively illegal under state legislation sponsored by the medical profession, as was any form of prepaid group practice except for plans operated by nonprofit firms. The federal Health Maintenance Organization Act of 1973 swept away this restrictive state legislation, and created as well some affirmative incentives for the creation of health maintenance organizations. Initially, however, those federal incentives favored HMOs incorporated as nonprofits.

As a consequence of these developments, all HMOs established before 1973, and most HMOs created in the decade following 1973, were nonprofit. As HMOs became better established, however, and as the federal legislation was modified to be neutral concerning forms of ownership, for-profit HMOs gained market share rapidly. As of 1981, only 12% of all HMO enrollees were in for-profit plans; just twelve years later, in 1993, the figure had increased to 52% (Gray and Schlesinger 1994).

Unlike nonprofit hospitals, nonprofit HMOs in general have no history of donative support, but rather have been purely commercial nonprofits since they were founded. The only efficiency rationale that can be offered for the nonprofit form among these organizations, therefore, is apparently that problems of asymmetric information are so severe for the customers of HMOs that for-profit HMOs could not be trusted. This argument, *a priori*, seems more persuasive for HMOs than the similar argument is for hospitals, for several reasons. First, HMOs provide actual physician services and not, as is often the case with hospitals, just ancillary services that are ordered by a patient's doctor. Second, the financial structure of an HMO, unlike a hospital, gives the organization a strong incentive to economize on the care given a patient, since the organization itself, and not the patient or the patient's insurer, bears the full cost of the care it administers to its customers. Third, hospitals are more capital-intensive institutions than are HMOs, and consequently are handicapped more severely than HMOs by being denied access to equity capital, as nonprofits necessarily are. The fact that for-profit firms have a much larger market share among HMOs than among hospitals, therefore, offers further support for the conclusion, suggested above, that if the hospital industry, like the HMO industry, were to be created anew today, the ratio of proprietary to nonprofit firms would be much higher than it presently is.

To be sure, the large proportion of for-profit HMOs might be a disequilibrium phenomenon that simply reflects the slow supply response of nonprofits. Once the total supply of HMOs has matched demand, so that the rate of new entry and expansion is much smaller than it is at present, the market share of the nonprofit HMOs may begin rising again. But there is reason to believe that this will not be the case. Large chains of proprietary HMOs have begun to

arise—the six largest chains together now have 25% of all HMOs (Gray and Schlesinger 1994)—and their reputational stake promises reasonable protection against opportunistic behavior. Moreover, many of the customers of HMOs are not individuals but rather large employers and unions that have considerable sophistication in purchasing medical care and thus are unlikely to feel that they will obtain important protection from patronizing nonprofit firms.

On the other hand, the substantial heterogeneity of structure among HMOs, and the ambiguity of the categories to which firms are assigned in the available data, make it difficult to draw clear conclusions about the recent evolution of the industry. Much of the growth in for-profit HMOs has been among independent practice associations (IPAs), which now account for 40% of all HMOs. But IPAs, unlike the more traditional group and staff model HMOs, maintain little direct control over their affiliated physicians, serving principally just as insurers rather than as direct providers of care. Consequently, IPAs arguably have less ability to engage in opportunistically excessive cost cutting than do pure group and staff model HMOs, which as of 1993 remained 80% nonprofit (InterStudy 1994).⁶

9.5.3 Insurance

Health insurance in the United States first became important with the advent of Blue Cross hospital insurance in the late 1920s. Blue Cross was originally established by nonprofit hospitals as a means of increasing the ability of patients to pay their hospital bills. Since the hospitals were themselves nonprofit and were more interested in having their own bills paid than in seeking profits in the insurance business, and because a nonprofit provider was more likely to convince consumers that they could trust this new insurance product, it made sense to organize Blue Cross on a nonprofit basis. Subsequently, Blue Shield plans to provide insurance for physicians' services were organized on the same model.

In the following decades, for-profit firms entered the health insurance business and captured a majority of the market from the Blue Cross/Blue Shield plans. This development brought some difficulties, however, since the resulting increased competition aggravated the problem of adverse selection by consumers and selective rating by insurance companies, recently forcing Blue Cross to abandon its traditional policy of broad community rating.

Elimination of these selection problems, and of the reduction in risk spreading to which they give rise, may have been one reason why the government itself stepped in as the insurer when, in 1965, the national government decided to subsidize health insurance for the elderly and the poor through the Medicare and Medicaid programs. (Administrative simplicity was perhaps another justification for socialization.) The selection problem remains a central issue now,

6. A particular difficulty is that the Interstudy data, which appear the best available, assign roughly a third of all HMOs to the ambiguous "network" and "mixed" categories.

as the nation debates the appropriate scope of direct governmental involvement in extending coverage to the remaining groups of uninsured Americans. Complete socialization in the form of universal federal health insurance, would greatly mitigate the problems involved in creating appropriately large insurance pools, potentially allowing health risks to be spread as broadly as the society chooses (although the nature of the political process might limit substantially the types of pooling that could realistically be chosen). But, to be effective, governmental health insurance would presumably have to place substantial limits on consumer choice concerning the types of coverage, and hence treatment, to obtain. The mandatory government-managed regional insurance pools featured in current health care reform proposals are an effort at an intermediate solution.

9.6 Nursing Care

As of 1971, nonprofit nursing homes accounted for only 18% of all nursing care, with most of the rest provided by for-profit homes. Fifteen years later, in 1985, the size of the nursing care industry had nearly doubled. Nevertheless, nonprofit nursing homes not only retained but even expanded their market share over that period, from 18% to 23% (National Center for Health Statistics 1974, 1989). This expanding market share in the context of a growing industry provides some evidence that, for at least a substantial minority of consumers, nonprofit firms are perceived as providing a meaningful degree of protection against opportunistic producers. In part, however, it may also be a consequence of indirect subsidies and of favoritism toward the nonprofit form among state licensing and regulatory authorities.

The nursing care industry provides evidence of a problem presented by nonprofit firms that is, in a sense, simply an exaggeration of their virtue: they have a distinct bias in favor of high-quality service. Nonprofit nursing homes serve disproportionately the high-quality high-cost end of the market (McKay 1991). This is presumably because nonprofit homes tend to serve the nonpecuniary goals of the professionals who manage them, seeking to provide the highest-quality service possible and choosing to provide no care at all rather than care of low quality—and hence failing to serve the large segment of the market that can afford to pay only for minimal care.

9.7 Day Care

It would seem that problems of asymmetric information are less serious in day care than in nursing care, since families presumably are much more willing and able to monitor closely the quality of care that is provided to their children than that which is provided to their parents. Consequently, one might expect that nonprofit firms would play a smaller role in day care than in nursing care. It is therefore interesting that the reverse is the case: as table 9.1 shows, non-

profit firms have more than twice the market share in day care that they do in nursing care.

The interpretation of the market-share data for day care centers is clouded, however, by the fact that the distinction between the nonprofit and for-profit organizational forms is much less clear in the case of the very small-scale, labor-intensive firms such as individual day care centers than it is in larger-scale and more capital-intensive enterprise. The nondistribution constraint ceases to have much bite when most of a firm's income goes to salaries, and in particular when a substantial fraction of that income goes to the wages of the persons who control the firm: the salaries paid by a small, nominally nonprofit firm, and particularly the salaries of the administrators, can simply be adjusted at intervals to absorb the bulk of the firm's income as that income rises and falls. Consequently, many small day care centers may have adopted the nonprofit rather than the for-profit form simply because the choice would have little effect on the way in which the center was operated, but might bring some benefits in attracting consumers, in taxation, and in regulation. When a firm operates a substantial chain of day care centers, in contrast, the nondistribution constraint imposes important limits both on the ability of managers to appropriate a substantial fraction of potential net revenues and on the ability of the firm to obtain additional capital. This may help explain why the larger child care organizations tend strongly to be for-profit. As of 1992, for example, seven of the eight day care firms that had a total capacity of more than 5,000 children were for-profit. The tendency toward larger size among the for-profit firms may also, of course, reflect an effort to use the system's reputation as assurance of quality. In any case, the largest for-profit firms are now quite large. The biggest of them, KinderCare, operated over 1,200 centers as of 1992, with a total capacity of 145,000 children (Neugebauer 1992; Stephens and Neugebauer 1992).

Although there has been much controversy over the expanding role of for-profit day care centers, to date neither quantitative nor qualitative surveys suggest that, on average, the for-profit centers provide a lower quality of care than do nonprofit centers with the same level of income per child (Kagan 1991). (As with nursing homes, nonprofit day care centers on average provide more expensive care than do for-profit centers, and for this reason on average provide higher quality care [Neugebauer 1992, table 2].)

There is reason to doubt, then, that nonprofit day care centers serve an important role in providing parents with reassurance about quality care. On the other hand, they may serve an important role in capitalizing on the willingness of parents and organizations to donate materials, space, and (most importantly) labor to day care. The value of these donations is substantial, and, although some of them go to for-profit centers, for reasons rehearsed in section 9.2 the nonprofit centers naturally attract most of the donative support (Coelen, Glantz, and Calore 1979).

Publicly owned and operated day care centers, as table 9.1 shows, constitute only about 7% of the total. This figure contrasts strongly with the large role of public enterprise in primary and secondary education. An even more striking contrast between day care and grade school is evident in the way that public funding, and particularly federal funding, influences patterns of consumption. The politically and academically popular national Head Start program currently pays for 6% of all children in day care (Kisker et al. 1991, table 3.5). The Head Start program itself does not own or operate day care centers; rather, it provides subsidies to private nonprofit centers that meet the program's qualifications (and sometimes as well to centers operated by local governments). Among the requirements that a day care center must meet to receive Head Start funding is, in effect, that the center serves only children whose care is subsidized by Head Start—which is to say, very poor children, and disproportionately members of minority groups. As a consequence, the Head Start program strongly promotes the segregation of preschool children, *de jure* by class and *de facto* by race. As I shall discuss below, the most consistently argued and perhaps the most persuasive argument for publicly provided primary and secondary education is that public schools help avoid the severe segregation of children by class, capacity, and previous acculturation that might be expected in a system of private schools. Consequently, public policy toward preschool children seems to be strongly inconsistent with policy toward children in grade school and high school.

This inconsistency is not an administrative necessity. It appears that no appreciable accounting burden would be placed on the Head Start program if day care centers serving Head Start-subsidized children were to enroll other children as well, so long as those other children were entirely paid for by fees or other income sources. Why, then, are Head Start children segregated in separate centers? One explanation that has been offered is that, since Head Start has never been funded at a level sufficient to provide day care to all children who nominally qualify for the program, some form of rationing must be employed. And it is relatively easy to deny access to the program on the grounds that all spaces at the local Head Start centers are occupied, while it would be harder to explain why there are quotas on the number of poor children that the government will sponsor to attend centers that also serve more affluent children, even when those centers have space available. Or, put differently, so long as Head Start centers are segregated from other day care centers, it is easier to maintain the principle that day care, unlike primary and secondary school education, is a privilege and not an entitlement.

Head Start is not, however, entirely typical of public subsidies to day care. Many state programs of day care subsidy, both demand-side and supply-side, are explicitly structured to encourage centers to enroll children from a range of income classes.

9.8 Primary and Secondary Education

Primary and secondary education is notable as the human service sector in which the role of public institutions is the largest, and the role of for-profit firms is the smallest.

9.8.1 For-Profit Schools

Nobody seems to know, even approximately, how many for-profit primary and secondary schools there are in the United States. Statistics collected at the national level break down primary and secondary schools simply into public and private, without distinguishing between private schools that are nonprofit and those that are for-profit. Moreover, out of ten states surveyed for this essay only one—California—maintains statistics on the number of private schools that are for-profit. Those data show that currently 1,273 out of 4,005 private schools in California, or 32%, are for-profit, and that those for-profit schools enroll 58,336 out of 574,243 private school students, or about 10%.⁷ Given that California appears to have larger proportions of proprietary institutions in other service sectors than most states, it seems likely that the ratio of for-profit to nonprofit schools in the U.S. as a whole is lower than 10%, but at present there seems no way of knowing. The figure of 1% for nationwide proprietary primary and secondary school enrollment given in table 9.1 is a guess, based on the California data.

We have even less information on the characteristics and quality of proprietary schools. From the California figures, the proprietary schools are generally small, with only 46 students on average (as compared with an average of 189 students for the nonprofit private schools). This is consistent with anecdotal evidence suggesting that for-profit schools nationwide are predominantly small academies that are often run as family businesses.

Unlike the other industries discussed above—hospitals, HMOs, insurers, nursing homes, and day care centers—in primary and secondary education there are no large for-profit firms that have constructed regional or national chains of institutions. Recently, however, two firms have begun to try: Whittle Communications and Educational Alternatives, Inc. Neither of these firms has had significant success to date, and both are scaling back their ambitions for the moment, seeking only to obtain contracts from local governments to administer publicly owned schools rather than, as they initially planned, constructing or acquiring schools that the companies will own themselves. Possibly these companies made their plans in the anticipation that publicly funded school voucher plans will be widely implemented by national, state, or local government, and that this will create the same type of opportunity for proprie-

7. Telephone interview with Ron Reid, Demographics Office, California Department of Education, August 4, 1994. The other nine states surveyed were Connecticut, Florida, Illinois, New York, North Carolina, Massachusetts, Minnesota, Texas, and Wisconsin.

tary schools that Medicare and Medicaid created for proprietary hospitals and nursing homes a generation earlier. If so, it now appears that they must be patient.

9.8.2 Nonprofit Schools

Even in California, nonprofit schools strongly outnumber proprietary schools. It may be that this is a reflection of parents' concerns about quality—the problem of asymmetric information. Parents might well doubt their ability to evaluate the education that their child is receiving. On the other hand, it is not clear that this should be, or is, an important factor. The content and methods of primary and secondary education are not so esoteric as to be beyond many parents' ability to evaluate. Moreover, schools develop substantial reputations over time.

Another reason for the predominance of nonprofit firms may be that which I suggested above for day care centers. For small institutions, such as the forty-six-student proprietary schools in California, there may be little practical difference between operating as a sole proprietorship, partnership, or closely held corporation on the one hand, and incorporating as a nonprofit corporation on the other; the individuals who manage the school will be able to derive roughly the same income from it either way. But the nonprofit form has the benefit of tax exemption, a better public image, and probably easier accreditation. Indeed, there is anecdotal evidence that private schools are often founded as proprietary firms, and then convert to the nonprofit form once they become established.⁸

Another reason for a school to adopt the nonprofit form is to attract private donations and public grants. Surely this is a factor among the elite preparatory schools, which solicit contributions from their alumni. It is also obviously a factor among religiously affiliated schools, which often receive financial support from their parent churches. Whether donations and grants are a significant source of income for nonprofit schools in general, however, is unclear. It seems a reasonable guess that most are, instead, almost purely commercial nonprofits.

9.8.3 Public Schools

The market share of public primary and secondary schools has long been relatively constant in the United States. It was 91% of enrollment in 1930, fell

8. Note that this transaction can be accomplished with little sacrifice of control or earnings. The individuals who own the proprietary school—whether through a sole proprietorship, a partnership, or a closely held corporation—simply form a nonprofit corporation, with no assets and with themselves as directors and officers. They then sell the school's assets to the nonprofit corporation at a generous price, providing 100% financing and taking back long-term notes at a substantial rate of interest for the purchase price. They continue to control the school and pay themselves salaries for the services they render to it, as they did with the proprietary school. And they continue to derive a return from the capital they originally invested in the school, through the payments on the notes. Prior to the 1960s, this pattern—formation as a for-profit firm, and then a controlled sale to a nonprofit—was apparently also common for hospitals.

to 86% in 1960, and returned to 89% by 1990 (U.S. Bureau of the Census 1970, 1993).

It is not easy to offer a clear normative justification for this large public sector. Surely there has been, at least in the past, an efficiency justification for public subsidy. Education is presumably a worthwhile investment for most children, but in many families both the children and their parents (who are usually not yet in their peak earning years) may be relatively illiquid and, for familiar reasons, unable to borrow to finance the child's acquisition of human capital. Thus, without subsidy, there could be substantial underconsumption. And, at least until recently, it has probably been difficult for governments to administer school subsidies on a demand-side rather than a supply-side basis, so that governments had to own and operate the schools they financed. This argument does not, however, provide a strong justification for public schools if, as advocates of voucher plans have been arguing for some years, demand-side subsidies are now feasible.

In any case, there is an increasingly prominent debate today as to whether this large public share should continue—a debate that has been fueled by the popular concern with the seemingly low quality of American primary and secondary education. Most reform proposals call for putting more competition into the system. Comparison of American higher education, which is outstanding by world standards, with American primary and secondary education, which is not, offers some support for this judgment, since the most distinctive characteristic of the American system of higher education is its highly competitive character. Empirical comparisons of the quality of differently organized schools, and particularly of public and private schools, also tend to support the call for more competition. Although it is difficult to distinguish clearly between the effects of different types of schools and the consequences of the self-sorting of families among those schools, there is evidence that more autonomous schools, and particularly private schools, provide a better education (Chubb and Moe 1990).

The most conspicuous of the recent reform advocates, Chubb and Moe, call for maintaining public ownership of schools while decentralizing administration and giving families freedom to choose the public school they prefer, with funding to take the form of a demand-side subsidy. Those authors do not, however, explain their reasons for advocating public ownership. All the arguments they offer for structural reform seem strongly to favor private schools over public schools, and arguably also favor for-profit schools over nonprofit schools.

Does there then remain a justification for maintaining schools under public ownership? The best argument, it appears, and the one that has been most prominently offered in various forms, is that public schools are justified as a means of avoiding excessive stratification of schoolchildren across schools in terms of socioeconomic class, aptitude, and educational attainments. Rich chil-

dren, or gifted children, or white children, it is argued, will tend to congregate together in schools, separated from their less privileged contemporaries.

Why is stratification more of a concern with education than it is with health care? Why, that is, do concerns about segregation and stratification not argue as well for public ownership of hospitals and primary health care clinics? An important answer, evidently, is that stratification is a much stronger phenomenon in education because education is, to an unusually pronounced degree, an “associative” good—that is, a good whose utility to a consumer depends, not just on the quality of the producer’s performance, but also upon the personal characteristics of the other customers who patronize that same producer (Hansmann and Klevorick 1994; Hansmann 1985). Membership in a country club is a prototypical associative good: the attraction of membership in a given club depends not just on the quality of the golf course and the food in the club’s dining room, but also, and often much more importantly, on the qualities of the other members, such as their personalities, skill at golf, socioeconomic status, and business contacts.

Similarly, when attentive parents pick a school for their child, they are interested not just in the quality of the classrooms, the curriculum, and the abilities of the teachers, but also, and importantly, in the other students who will be attending the school. The reason, of course, is that a child’s classmates will have a strong influence on the education, reputation, motivation, values, and bruises that the child acquires from the school. When one chooses a doctor or a hospital to perform one’s appendectomy, in contrast, one has little reason to put much weight on the personal characteristics of the doctor’s or the hospital’s other patients.

When associative goods are produced by private firms in the market, there is a strong incentive for consumers to sort themselves across producers. More particularly, to the extent that consumers share similar tastes, there is an incentive for consumers to become stratified across producing firms, with one producer serving all the individuals who make the most desirable customers, a second producer serving the second most attractive stratum of consumers, and so forth. Moreover, although this incentive for stratification exists whether the producing firms are for-profit or nonprofit, it is especially strong among nonprofit firms. Also, stratification is likely to be particularly pronounced if individuals’ incomes are positively correlated with the characteristics that make the individuals particularly attractive as fellow consumers (as generally seems true in education), or if all individuals are constrained to pay the same price for the good or service (as they would be under some voucher plans).

A voucher-supported system of private schools could thus be expected to lead to substantial stratification of students across schools. Public schools are arguably less prone to such stratification, since (at least in the absence of freedom-of-choice plans) they generally throw together all children who inhabit a given geographic area. On the other hand, public education already permits the

substantial stratification that results from parents' choice of the school district in which to live, and the additional stratification that comes from a system of largely private schools might not represent a qualitative change.

But is stratification such a bad thing? There are several potential arguments against it. First, stratification may lead to social inefficiency in education. Less talented students, for example, may gain more from attending school with other students who are more talented than the latter would lose from the association. (Perhaps talented students will gain a good education regardless of their environment, but less talented students need the challenge and example of talented students in order to learn.) Second, whether or not it is educationally efficient, stratification may tend to reinforce income inequality. And third, whatever the educational and distributional consequences of stratification, it may harm noneducational goals such as political integration of the population. At present, however, we do not seem to have a very clear idea of the potential seriousness of these concerns.

9.9 Postsecondary Education

Postsecondary education, like primary and secondary education, is heavily socialized in the United States. What is more, in contrast to primary and secondary education, and to the other service industries discussed here as well, the market share of public institutions has increased markedly in recent decades. The fraction of college and university students enrolled in public institutions was 53% in 1920, and still only 51% in 1950. After the latter date, however, the public share began rising rapidly and continuously, as shown in table 9.2.

9.9.1 The Role of Public Institutions

What accounts for this growth in the public sector? Perhaps the best explanation is the rapid expansion of the industry. A demographic bulge and rapidly increasing prosperity swelled demand for higher education quickly beginning in the 1950s. Given the sluggish supply response that characterizes nonprofit institutions, it would have been difficult to meet this demand through expansion of the nonprofit sector, regardless of the generosity of the demand-side or supply-side subsidies that government made available. A faster and more dependable way to expand supply was simply to have government build and operate most of the needed new capacity. Thus, as table 9.2 shows, the five-year period that brought the most rapid rate of increase in enrollments, 1960–65, also brought the greatest expansion in the public sector—from 57% to 66% of all students.

There has also been substantial expansion in spending on health care in recent decades, and particularly in public spending. Yet, unlike public higher education, the market share of public hospitals did not increase during this period; rather, it declined substantially. What accounts for the difference? A

Table 9.2 Public and Private College and University Enrollments, 1920–1975

Year	Public	%	Private	%
1920	315,382	53	282,498	47
1930	532,647	48	568,090	52
1940	796,531	53	697,672	47
1950	1,354,902	51	1,304,119	49
1955	1,484,000	56	1,177,000	44
1960	1,832,000	57	1,384,000	43
1965	3,624,000	66	1,902,000	34
1970	5,112,000	72	2,024,000	28
1975	6,838,000	76	2,185,000	24

Sources: U.S. Bureau of the Census 1960, 1977.

critical factor, perhaps, is that, despite the expansion in expenditure on health care, hospital usage never increased at the same rate as did college enrollment, so that there was much less need for rapid creation of new capacity in hospital care than in postsecondary education. The five-year period in which college and university enrollments expanded most rapidly, 1960–65, was also the period in which hospital usage expanded most rapidly. But the growth in average daily hospital occupancy over those five years totaled only 18%, while college and university enrollments expanded at four times that rate, or 72%, during the same period (American Hospital Association 1989). Indeed, the major problem during the 1960s and 1970s was not to encourage the construction of more hospital capacity, but rather to *prevent* hospitals from adding new capacity that was unneeded, a problem that led to the widespread adoption of hospital certificate-of-need regulation by the states.⁹

If the major reason to expand the public sector in higher education was to meet a sudden bulge in demand, then perhaps it is not necessary to maintain that large public sector when demand is no longer increasing quickly. Moreover, whether we maintain public ownership of the now-extensive state university systems or not, there are strong arguments for converting those systems from their current heavy reliance on supply-side subsidies to demand-side subsidies. Those supply-side subsidies, as commentators have long noted (McPherson and Schapiro 1991), are distributionally regressive (since they give the same tax-free tuition subsidy to rich students as to poor, and since the rich are also more likely to attend the universities). Moreover, the supply-side subsidies reduce competition among colleges and universities and limit student opportunities by making it much less expensive for students to attend their

9. To be sure, there may also have been other important factors that caused the public sector to expand in higher education but not in hospital care. One of these, suggested by Victor Fuchs (in private communication), is that doctors, who were self-employed independent contractors under the prevailing system of private nonprofit hospitals, feared becoming employees in publicly owned hospitals, while university professors already had the status of employees and thus had less, or perhaps nothing, to lose.

home state's university than to attend an out-of-state university or a private university in their home state.

Indeed, while most of the recent debate about expanded voucher programs has focused on grade school and high school, there seems to be better reason to shift from supply-side to demand-side subsidies, and from public firms to private firms, in higher education than in primary and secondary education. The market for higher education is effectively national, with thousands of colleges and universities potentially in competition with each other, while markets for primary and secondary education outside of major cities are likely to remain local oligopolies. Moreover, prospective college students and their families are probably, on average, much better informed consumers than are the families that patronize primary and secondary schools.

This is not to suggest, however, that there is no rationale for public higher education outside of the need to expand capacity rapidly. Like primary and secondary education, higher education is an associative good. And, in fact, one can see clearly the stratification of students among the elite private colleges, which has resulted in a clear and highly stable prestige ranking among those institutions. In contrast to these private colleges, which have generally remained relatively small, the state universities commonly operate huge campuses that are relatively unstratified, bringing together a broad spectrum of students both academically and socioeconomically. If, as we speculated above, stratification has costs in terms of efficiency or equity, then the present public university systems may have some virtues worth preserving.

9.9.2 For-Profit Higher Education

We are left to ask, finally, why private institutions of higher education have been overwhelmingly nonprofit, and whether there might be a larger role for for-profit institutions in the future.

The fact that private colleges and universities have always depended heavily on donative financing, either in the form of private contributions or public grants, is presumably the principal reason why those institutions have been nonprofit. And, why have they had to depend on gifts and grants? The reason is apparently much the same that we offered above for public subsidies to primary and secondary education. Although a college education has evidently been a worthwhile investment for most students, even in the narrow sense that it increased the present value of their lifetime earnings by more than its cost (McPherson and Schapiro 1991), capital market imperfections prevent many students from borrowing the amount needed to pay the full cost of such an education. Consequently, there has been a strong need for subsidy. Indeed, the pattern of the private college financing that has prevailed for the past century, under which the college makes up the gap between costs and tuition revenues by soliciting donations from prosperous alumni, can be thought of as a form of implicit loan program under which students pay less than the full cost of their education under the understanding that, if successful, they will make con-

tributions to the college to repay generously the risky loan they were in effect given (Hansmann 1980).

If this is the principal reason that colleges have been nonprofit, however, then a sufficiently generous system of public demand-side subsidies should obviate the need for private and public grants, and hence eliminate as well the need for the nonprofit form. It is, in fact, hard to find other compelling reasons why proprietary colleges and universities could not succeed. University students and their families seem sufficiently sophisticated consumers, and institutional reputations a sufficiently strong signal of quality, that problems of asymmetric information should not be a fatal obstacle. Nor need the research functions served by universities necessarily suffer from organization of higher education on a proprietary basis. Most colleges, after all, conduct no significant amount of scientific research as it is. And, even for those institutions that find there are economies of scope in combining research with teaching, research could presumably continue to be financed through the current system of competitive federal grants even if the receiving universities were proprietary.

There is already a substantial amount of for-profit postsecondary education in the United States, consisting of roughly four thousand institutions that largely specialize in vocational training. Unfortunately, detailed information on these institutions is difficult to find. It appears, however, that many offer full-time courses of study of up to two years' duration, including some amount of general education. Moreover, students at these proprietary institutions now account for about one-quarter of the grants and one-third of the loans made under the federal student aid programs, demonstrating the high responsiveness of proprietary institutions to demand-side subsidies (Apling 1993).

Other countries, moreover, have gone substantially further than the United States in developing proprietary higher education. In the Philippines, for example, a majority of college and university students attend proprietary institutions. This is not a trivial example, since the Philippines not only has the highest rate of higher education among developing countries, but has apparently been sending about the same fraction of its youth to college as have Belgium and France. Some of the for-profit postsecondary institutions in the Philippines are merely trade schools. Several, however, are substantial universities with broad curricular offerings. And, although the smaller institutions tend to be family-owned, the largest have stock that is publicly traded (Geiger 1986).

One cannot know how successful for-profit firms can be in providing general higher education until further experience has been accumulated. But it is hard to see a priori reasons why the experiment should fail.

9.10 Conclusion

The recent expansion of proprietary firms in the human services forces us to ask what role is played by the public and nonprofit firms that so heavily populate those industries, and whether the latter firms remain efficient. The

answers to these questions, it appears, differ somewhat from one service industry to another. In all of these industries, however, it appears that further evolution toward proprietary firms is in store. Most importantly, the continuing dominance of education at all levels by nonprofit and, particularly, public institutions, which sets the sector apart from the other human services, seems to lack a strong efficiency rationale. Consequently, education as an industry may be on the verge of dramatic changes in the ownership and structure of firms much like the changes that have swept health care over the past twenty-five years.

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Comment Joseph A. Grundfest

Henry Hansmann's fine paper makes several significant points about the evolution of nonprofit institutions in the human services sector. Hansmann's observations regarding the presence of "trapped capital" in the nonprofit sector may, however, deserve more prominence than he suggests. Billions of dollars of trapped capital present in the nonprofit sector pose a significant threat to nonprofit's efficiency and present a fundamental challenge to the continued vitality of the nonprofit sector, particularly in the rapidly changing market for health care services.

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Hansmann explains that as long as a nonprofit entity earns a rate of return on its capital that is at least equal to real economic depreciation, the nonprofit can continue in operation at its current scale indefinitely. There is no pressure on the institution to strive for a competitive, risk-adjusted rate of return that recovers the opportunity cost of its capital had that same capital been invested in the for-profit sector. Indeed, even if a nonprofit fails to recover its economic depreciation, it can continue in existence for many years longer than an equivalent for-profit firm that would be required to earn a positive return on its capital.

Nonprofit institutions are thereby insulated from market signals that discipline the private sector and that provide powerful incentives for the efficient allocation of capital. In addition, because nonprofits cannot tap private equity markets and cannot provide equity-based incentives for their management teams, nonprofit firms typically do not respond to market signals as rapidly as for-profit firms. Hansmann also points out that nonprofit managers have incentives to preserve the size of their institutions, even if market forces signal that downsizing or reallocation of capital is in the best interests of the social purpose that the nonprofit was created to serve.

As a consequence of these forces, Hansmann explains, nonprofit organizations can become pools of “trapped capital.” These trapped capital pools are inefficiently managed and are either too large or too small for the purposes they are designed to serve. They also cannot be reallocated to alternate purposes absent extraordinary events.

The dangers of trapped capital are obvious. When capital loses its flexibility and shifts from “putty” to “clay,” its ability to contribute to economic growth is sharply diminished. Alternatively, viewed from the perspective of modern option theory, capital that cannot be reallocated in response to new information has a low “option value” and therefore is not as productive as capital that is invested in identical ventures but that can be reallocated in response to subsequently acquired information (Dixit and Pindyck 1994).

The adverse consequences of trapped capital are most significant at times of rapid technological and demographic change because those are precisely the times at which optionality is most valuable. Those are also the times when the costs imposed by trapped capital are greatest. Now is one of those times, particularly in the provision of health care services.

There are, no doubt, substantial advantages to nonprofit provision of human services. Yet, as Hansmann ably points out, these benefits must be balanced against the inefficiencies inherent in the nonprofit sector. This balancing exercise need not be conducted in the abstract because, despite the prevalence of trapped capital in the nonprofit sector, the market can send two distinct types of signals about the relative costs and benefits of nonprofit versus for-profit organizational forms. The power of these signals may be muted by a variety of factors described below, but when market forces favoring one institutional form over another are sufficiently strong, the market’s message is unambiguous.

The first signal arises in expanding markets. When a market for human services is growing and when new capital entering the market is disproportionately of the for-profit form, the market may be sending a signal that the comparative disadvantage of the nonprofit form is substantial. Hansmann's data illustrating a shift to for-profit providers in the health care field is at least broadly consistent with this observation (Sacks 1994).

The second signal is sent by nonprofit organizations that seek to abandon their nonprofit status and transform themselves to for-profit enterprises. This signal is far less ambiguous and is a powerful indicator that the monitoring, tax, and other benefits associated with the nonprofit form are insufficient to overcome the costs imposed by trapped capital, by the lack of access to equity market, and by the inability to provide competitive, equity-based incentives for employees.

The power of this signal is compounded by the fact that a combination of federal and state restrictions make such transitions extraordinarily expensive and effectively require that the nonprofit enterprise leave all of the equity value of its operations in the nonprofit sector as the price of its conversion to for-profit status. Put another way, "you can't take it with you" when it comes to shifting capital from nonprofit to for-profit status, and the decision to invest capital in the nonprofit form is effectively an irrevocable election of an organizational form, at least as to the current value of that capital.

At the federal level, tax law provides that a tax-exempt foundation may terminate its tax-exempt status either by transferring all of its assets to another qualified tax-exempt organization, in which case all of the foundation's capital remains in the nonprofit sector, or by agreeing to pay a termination tax.¹ The termination tax is generally described as the lesser of (1) the aggregate tax benefit received by the foundation, its substantial contributors, and others with interest therein, or (2) the value of the net assets of the foundation. Thus, the bargain with the federal government is that a foundation and its major affiliates must repay to the government the value of all benefits received as a consequence of its tax-exempt status.

If marginal tax rates are 50% or more, and if all substantial contributors are in the top bracket, then the amount of tax to be paid by the foundation will equal at least the amount donated by substantial contributors. Thus, unless the value of the fund's assets have increased by an amount greater than the sum of the rate of interest charged by the government and the payout rate to beneficiaries, there would likely be nothing left to distribute after payment of tax. Indeed, it is commonly observed that "the aggregate tax benefit can exceed the fair market value of the property transferred, particularly when interest on all increases in taxes is added on" (Cesare 1994).

State law establishes yet another barrier to the free mobility of capital across

1. For a detailed explanation of the relevant provisions of the Internal Revenue Code, see Cesare 1994.

institutional forms. In California, for example, nonprofit enterprises wishing to convert to for-profit status “are required by state law to donate to charity an amount equal to their total assets . . . to repay the benefits the business derived while operating as a nonprofit, tax-exempt corporation” (Ellis 1995). A nonprofit seeking to convert to for-profit status can satisfy this requirement either by establishing a new charitable foundation to which the value of the converting enterprise’s assets is transferred, or by donating the value of its assets to existing charities.

The incentives to convert to for-profit form in some sectors of the health care industry are apparently quite powerful. In the past decade, ten to fifteen California HMOs have converted to for-profit status, leaving only six nonprofit HMOs in the state (Ellis 1995). As part of this trend, Blue Cross, the state’s largest health insurer, created a for-profit enterprise, Well Point Health Systems, and then sold a 20% equity stake to the public through an initial public offering of common stock. In addition, Blue Cross has proposed converting entirely to for-profit status and is in negotiations with the state corporations commissioner over the form of the transaction, which may require a contribution of the remaining 80% stake in Well Point to a new charitable entity as well as contributions to existing nonprofit institutions. The value of the Well Point equity still to be contributed has been estimated as in excess of \$2 billion, and the required additional charitable contributions are in excess of \$100 million (Ellis 1995; Garrison 1994; “Blue Cross” 1994).

The benefits of for-profit operations are evidently quite powerful if Blue Cross is willing to forgo so much capital as the price of a transition to the for-profit form. Indeed, this transaction, along with dozens of other conversions from nonprofit to for-profit operations, is perhaps the strongest evidence that the inefficiencies of the nonprofit form have become quite large—particularly in the dynamically changing health care sector.

This trend toward for-profit operation in a market that already has substantial nonprofit investment raises significant policy issues. In particular, what, if anything can be done to facilitate the efficient flow of capital back from nonprofit to for-profit structures? Also, how can nonprofit institutions coexist in markets with potentially more efficient for-profit competitors? Ideally, nonprofit institutions will recognize their comparative advantages and redefine their missions so as to capitalize on services that they can perform better than for-profit enterprises. Subsidies for the poor, support for certain forms of research and public health education, and measuring the quality of services provided by the for-profit sector so that informed consumers can promote efficient competition are among the services that nonprofits might be able to offer while retaining a comparative advantage over their for-profit competitors. The bricks and mortar business of actually providing health care coverage may not, however, be the best use of the nonprofit dollar. This transformation of the nonprofit mission in health care—a transition looking toward the intricate coexistence of

nonprofit and for-profit forms—promises a series of practical and intellectual challenges ripe for further research.

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