Managing Competition in Public and Private Mental Health Agencies: Implications for Services and Policy

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INCREASINGLY, STATE AND LOCAL GOVERNMENTS ARE contracting with private organizations for health services formerly supplied by public agencies. This trend toward privatization has sparked a vigorous debate over the relative merits of public and private organizations, particularly regarding their ability to serve society efficiently and equitably (Dorwart and Epstein 1993; Arrington and Haddock 1990; Paulson 1988; Keepers and Dunn 1988; Hertzlinger and Krasker 1987; Schlesinger and Dorwart 1984). How public or private ownership of community mental health facilities affects the delivery of outpatient care is an especially urgent question today because virtually all proposals for reforming our health care system rely on greater use of ambulatory treatment for mental disorders. The increasing popularity of encouraging competition among providers—for example, the managed competition approach favored by many federal policy makers—raises important questions about how public and nonprofit agencies respond to competitive pressures. Will this trend weaken private agencies' resolve to serve the public good? Are public providers immune to market forces?

Proponents of privatization often argue that private providers are more efficient and can serve more people than public agencies can because

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they are better at generating revenue from both governmental and private sources. Opponents of contracting with privately owned facilities charge that private organizations are more concerned with their own financial health than with the public interest, leading them to restrict access for potential clients who cannot afford their services. In fact, both sides lack the empirical data to substantiate their contentions, particularly when the debate concerns provider behavior in community mental health care, an area that, compared with inpatient treatment, has seen relatively few studies.

To learn more about this complex issue, we analyzed data from a national survey of more than 450 community mental health agencies. We developed a model for comparing management and treatment practices in public and private mental health agencies, taking into account external forces like financing and competition that might influence the behavior of agencies. We paid special attention to how ownership and competition from private practitioners affect practices related to maximizing private revenues, improving efficiency, and serving the community. Finally, we examined the implications of these comparisons for public authorities who are considering contracting with private agencies.

Economic and Political Influences on Mental Health Agencies

Proponents and opponents of privatization speak as if the behavior of public and private organizations is fixed. Agency behavior, however, is closely tied to financial (Gronfein 1985) and political forces (Rumer 1978)—both of which have made their mark on mental health agencies.

Financing of nonprofit mental health agencies has changed radically since the 1950s. Originally a small group almost totally dependent on charitable donations and client fees, the ranks of mental health agencies grew rapidly after direct federal grants became available through the Community Mental Health Acts of 1963 and 1965. Private insurance then contributed a trivial proportion of total revenue in most agencies, and nonprofit providers resembled public ones: their budgets were funded directly through grants; responsibilities for the types of services they offered and the populations they served were defined broadly; and productivity demands were relatively low. Federal reasons for favoring nonprofit over public mental health centers seem to have had more to

do with avoiding state legislatures and bureaucracies than with any perceived differences in how they operated (Foley and Sharfstein 1983). Because the federal grants were given as "seed money," decreasing by a specified amount each year, many agencies began looking to private sources for funding, which led to more apparent distinctions between nonprofit and public providers.

Program consolidation and reductions in federal funding during the Reagan administration added more distance between public and nonprofit agencies. A number of nonprofits responded to the changes by increasing their contracts with states or counties, but, instead of awarding grants to the agencies, many localities chose to buy treatment on a fee-for-service basis similar to the way private health insurers purchased care. As states expanded their use of fee-based Medicaid funds for mental health services in the 1980s, the tie between agency productivity and funding was further strengthened. Nonprofit agencies looked more and more like profit-maximizing firms as they came to depend on clients for a significant proportion of their revenues. Public agencies still received most of their revenues directly from the government rather than through clients.

Somewhat different forces impinged on public agencies. In the late 1970s, heightened concern over state and county spending, tax revolts, and the resulting budget cuts began pressuring public agencies to become more efficient and, in some cases, to seek alternative sources of revenue. Over the next decade, public agencies, too, began to rely more heavily on Medicaid and on other fee-based payments. In many locations, stereotypes of public agencies as rigid and inefficient had become inaccurate by the late 1980s.

At the same time that economic forces were pushing both public and nonprofit agencies to behave more like profit-maximizing firms, political forces were applying countervailing pressure on them to be more responsive to people with severe mental illnesses, to maintain a comprehensive array of services, and to provide free or below-cost care. This pressure took the form of threats from the Department of Health and Human Services, which demanded repayment from agencies that had received federal Community Mental Health Center (CMHC) grants and were out of compliance with federal requirements (U.S. Department of Health and Human Services 1991). Advocacy groups like the National Alliance for the Mentally Ill also held mental health centers to high standards of public service and criticized them when they failed to meet expectations (Torrey 1988).

Changes in the political and economic environment have been critical in shaping the behavior of public and nonprofit agencies, but it is not clear whether these changes have sharpened or blurred distinctions between the two organizational forms. To add further complications, state policies toward nonprofit agencies have evolved differently over time. Some states have maintained a high degree of control over day-to-day operations, treating nonprofits almost like extensions of government. Others have preferred to maintain more distant relations with nonprofit and proprietary organizations.

Should a Community Mental Health Agency Be Run like a Business?

A great deal of the hope for improved performance through privatization—as well as fear for the policy's failure—is based on the assumption that private organizations operate more like profit-maximizing businesses than do their public counterparts. This premise is debatable in community mental health because over 95 percent of all private agencies are nonprofit and therefore are prohibited from distributing excess revenues to shareholders. Even if private nonprofits were more market oriented than public agencies, however, opinions are divided about the desirability of operating a mental health center like a business. Some policy makers and administrators believe clients will benefit from agencies that are run more efficiently (Brotman 1992; Roundy, Kasner, and Kasner 1988; Edwards and Mitchell 1987); others fear clients will be denied treatment or will be served poorly (Kane 1989; Levine et al. 1989; Woy, Wasserman, and Weiner-Pomerantz 1981); still others urge administrators to find some balance between private and public orientations (Zelman et al. 1985; Pardes and Stockdill 1984).

Mental health clients, advocates, and policy makers usually value access to treatment and continuity of care. Not only do these factors improve the lives of people with mental disorders, but they also represent core values that shaped the community mental health movement. The Community Mental Health Acts, which helped initiate about one-third of the more than 2,200 community mental health agencies now in existence, sought to make comprehensive mental health services available to all who needed them without regard to their financial means (Foley and Sharfstein 1983). In addition to serving those who could not otherwise

have purchased treatment, community mental health centers were to coordinate and integrate treatment services for people who had previously been housed for long periods in state mental hospitals. In many cases, this required centers to work closely with hospitals or with other providers to ensure continuity of care when patients were released to the community after brief hospital stays (Dorwart and Hoover 1994). Even though direct federal funding of community mental health centers ended in 1981, these original goals have continued to be the standard against which all community mental health agencies, even those not initiated with federal funds, are measured. Over the years, at least three studies have concerned themselves with the degree to which mental health centers fulfilled these and other publicly valued duties (Woy, Wasserman, and Weiner-Pomerantz 1981; Naierman, Haskins, and Robinson 1978; U.S. General Accounting Office 1979).

It is not clear how the incentives of health care markets affect agencies' fulfillment of these public expectations. Even though nonprofit organizations are subject to nondistribution constraints, which reduce the possibility of personal gain from excess revenues, they are still susceptible to a variety of market influences. Salamon (1993) described vulnerability to such factors, coupled with recent increases in the number of nonprofit and for-profit providers of human services, as "the marketization of welfare." Because their survival is closely tied to their economic performance, private agencies may be more likely than public organizations to emphasize efficiency in operations and to maximize fees collected from insurers, clients, and other private sources of revenue. Efficiencies like these may help stretch scarce public dollars, but the forces that lead to greater efficiency may also weaken agencies' commitment to publicly valued goals of ready access to needed care. The more strongly economic incentives in the private market influence nonprofits (e.g., the need to emphasize billable services, to maximize private revenues, to reduce administrative costs, and to monitor free care), the less committed they may be to providing treatment that is accessible to all or to working collaboratively with other providers for the good of clients. One area that is often cited, but about which we know very little, is the existence, in some agencies, of separate facilities or services for publicly funded clients and for those with private health insurance. Separating clients on the basis of income reinforces a two-tier system of care and could outweigh any benefits that might otherwise accrue from contracting with private agencies.

To address these concerns, we must know more about the comparative performance of public and private agencies. For example, we need to know about differences in efficiency that are related to ownership. It is also important to learn how the two groups respond to external pressures, how these forces affect agencies' treatment of financially disadvantaged clients, and whether these pressures influence their willingness to coordinate services with other providers. To help answer these questions, we asked agency administrators to tell us about their use of various management practices, and we combined their responses with information on characteristics of their agencies and service areas. We were particularly interested in practices that might be related to efficiency or orientation toward public service.

Management Practices and Public Values

Direct measures of efficiency and commitment to public service are difficult to obtain for a number of reasons. It is difficult to evaluate efficiency thoroughly without controlling for the quality of services offered and the type of service needed based on client characteristics (Weisbrod 1988). Controlling for the quality of mental health treatment is not easy. There is little consensus about what constitutes quality in mental health services or what services are most appropriate for which types of clients. In the absence of direct quality measures, we looked at some management and clinical practices that might indicate how agencies differ in efficiency, in their ability to maximize private revenues, and in their commitment to publicly valued goals.

We examined practices such as cutting administrative costs or using financial incentives to increase employee productivity that might improve efficiency. As indicators of public service orientation, we chose the amount of care given at rates below cost; acceptance of referrals from public hospitals, social service agencies, schools, and courts; and willingness to work with other providers in serving clients. We measured revenue-maximizing behavior by asking whether agencies had increased their emphasis on billable (to private or public payers) services or on efforts to reduce unpaid fees or missed appointments. Using these practices could conflict with commitment to serve all who need treatment. For example, Woy, Wasserman, and Weiner-Pomerantz (1981) speculated that emphasis on private revenues may have led community mental

health centers to neglect or stray from their original mission of providing comprehensive, integrated services to all members of the community regardless of their ability to pay. Even those agencies emphasizing services that are reimbursable through public sources may restrict or deny treatment for people who are ineligible for categorical assistance. If this is true, then agencies that stress the maximizing of revenues should give less free care and be less inclined to coordinate treatment with other providers.

External Forces and Agency Characteristics

The history of nonprofit agencies suggests that the tendency to behave more like a for-profit business is not solely a feature of ownership status. Arguments for privatization typically rely on market discipline imposed by competition to achieve desirable results (Donahue 1989). Critics of privatization see pressures to abandon traditional goals of community service as the inevitable result of increasing competition from private practitioners and for-profit corporations, and of decreasing public funding for mental health care (Goplerud, Walfish, and Broskowski 1985; Zelman et al. 1985; Jerrell and Larsen 1985). However, there is little evidence of competitiveness in bidding for mental health contracts (Schlesinger, Dorwart, and Pulice 1986). Although other forms of competition seem to influence mental health agencies, it is not clear that the results always serve the public good. For example, Clark and Dorwart (1992) found that competition from other providers reduced the amount of subsidized care given by community mental health centers.

In addition to ownership and competition, a variety of other factors may affect management practices. For example, states differ in the extent to which they regulate and rely on nonprofits. In states like Ohio and California, counties use their taxing authority to fund mental health treatment and, consequently, play a more direct role in policy making than in other areas where most funding comes from the state. Local economic pressures such as unemployment, poverty, and high percentages of people without health insurance in an agency's market area could affect both management practices and the demand for treatment (Holzer et al 1988; Seawright, Handal, and McCauliffe 1989). Agencies that were initiated with federal funds may, because of statutory requirements, be more publicly oriented than others that opened without fed-

eral aid. Agencies that provide a wide range of services—outpatient, day, residential, and emergency services—may, because outpatient services are only a small portion of their total budget, be less aggressive in managing these services than are other agencies whose outpatient treatment constitutes a larger portion of their revenue. Finally, an agency's size may affect its ability to bid on private contracts with managed care organizations, to subsidize free care, or to mount a direct fund-raising effort (Jerrell and Jerrell 1987).

Understanding differences in the ways public and private mental health agencies conduct themselves requires some knowledge of how organizational and service area characteristics contribute to their behavior. To assess the importance of these public/private differences for mental health clients, we need to know how observed differences in conduct affect important institutional outcomes such as acceptance of public referrals, willingness to work with other agencies, and provision of subsidized care.

Methods

We examined the organizational characteristics, service area environment, and administrative practices of 452 community mental health agencies to determine how public and private agencies differed. The data used in this analysis are from a national survey conducted jointly by the Center for Social Policy, John F. Kennedy School of Government, Harvard University, and the National Council of Community Mental Health Centers (NCCMHC) in 1989.

Sample

A total of 633 (59 percent) out of 1,070 multiservice mental health agencies and outpatient clinics returned questionnaires. Agencies from all 50 states responded. Of these agencies, 452 gave complete data on management practices, 426 reported on subsidized care. Private nonprofit agencies comprised the majority (68 percent) of respondents, an additional 28 percent were publicly owned, and 4 percent were for-profit organizations. These percentages compare favorably with those obtained by the National Institute of Mental Health's Inventory of Mental Health Organizations (National Institute of Mental Health 1990). Further anal-

ysis of respondents revealed small biases in favor of NCCMHC members, CMHCs initiated with federal funds, and agencies located outside the Northeast. To correct for the nonrandom response pattern, we computed a hazard rate based on differences between respondents and the sampling frame (Clark and Dorwart 1992; Berk 1983). This rate was included in our analyses as an independent variable to correct for sample bias.

Defining Market Areas

There are varying ways to define health care market areas: geopolitical boundaries, distance between competitors, and patient origin (Garnick et al. 1987). Because we lacked data on individual client origin, we asked agency administrators to name each county from which their organization drew 10 percent or more of its clientele; we used those counties to construct market areas for each agency. The smallest possible market area was one county. This method could have led us to overestimate market size in some cases; however, because 75 percent of the agencies responding to the survey told us they defined their service area as a county or group of counties, we concluded that it was accurate for most agencies. We eliminated from the analysis ten mental health centers located in Alaska, where county divisions are not relevant. Using counties as our smallest geographic unit allowed us to match data supplied by agencies in the remaining 49 states with information on sociodemographic and economic demand characteristics from the Commerce Department's Area Resource File (U.S. Department of Commerce 1988), the Inventory of Mental Health Organizations (National Institute of Mental Health 1990), and other geographically based data sources.

Analysis

Using *t*-tests corrected for multiple comparisons, we first compared public and private (nonprofit and for-profit) agencies on the following variables: the number of full-time equivalent outpatient staff, total outpatient visits in the previous fiscal year, number of subsidized visits provided (those for which clients paid less than the cost of treatment), the percentage of all outpatient visits that were subsidized, total outpatient revenues, outpatient revenues from fees paid directly by clients (not by their insurers), and outpatient revenues from private health in-

surance. For the outpatient visit variables, agencies were asked to report all outpatient mental health and substance abuse visits but to exclude services provided by case managers. Next, we compared the number of agencies of each ownership type that reported increased use of a variety of management practices during the previous year. These included use of financial incentives to encourage employee productivity, increased efforts to collect fees from clients, emphasis on billable services, and reductions in administrative costs. We also compared agencies according to whether they did any of the following: charged fees for missed appointments (a common practice among private practitioners), required prepayment from clients for some services, served clients who were also in treatment elsewhere, or operated separate facilities or waiting rooms for insured and uninsured clients.

To determine whether differences in the amount of subsidized care provided were masked by other characteristics of the agencies or of the areas they served, we constructed a logistic regression model that included the following variables: the natural log of per capita income in each agency's service area; the percentage of the population living in urban areas; whether the agency was initiated with federal funds under the Community Mental Health Act; whether the agency offered multiple services (outpatient, day, residential, and emergency services); ownership status; agency size (the number of full-time outpatient staff); and administrators' ratings of the amount of competition they faced from private practitioners for insured clients (0 = none or to some extent, 1 = a great deal). We chose competition from private practitioners because it was the type of competition reported most frequently by mental health centers. Finally, to determine the specific effects of competition on public agencies, we created a binary variable for public agencies facing high competition.

Using this model in a logit analysis, we predicted the likelihood that an agency would use the practices described above and that an agency would receive more than 5 percent of its referrals from any of the following sources: self (client), social service agencies and courts, private hospitals, public hospitals, private practitioners, managed care organizations, and employers.

We used a similar ordinary least-squares regression model to predict the number of subsidized visits each agency supplied. To test the idea that use of revenue maximization strategies, rather than ownership itself, reflects an agency's willingness to serve low-income clients, we

added to the regression model variables indicating whether an agency used various revenue-maximizing practices. Agency size was removed from the model to satisfy assumptions of statistical independence.

Results

On basic measures of size and performance, shown in table 1, public and private agencies differed significantly in the amount of private revenues collected and in the percentage of subsidized outpatient care provided. Private agencies earned significantly more money from clients and private insurance companies than did public agencies. A higher percentage of the care provided by public agencies was given at rates below the actual cost of the care, but the total amount of subsidized care (percentage times total visits) was not significantly different. In the multiple regression model (adjusted $R^2 = .126$, $F = 7.881$, $df = 9,422$), public agen-

TABLE 1
Public/Private Comparisons: Agency Characteristics and Performance

Variable	Public $n = 124$ (SD)	Private $n = 328$ (SD)
Outpatient full-time employees	37 (58)	27 (32)
Percent of all care given at rates below cost[a]	84 (28)	76 (21)
Below cost visits (in thousands)	19 (22)	19 (44)
Outpatient visits (in thousands)	31 (132)	25 (47)
Outpatient revenue (in thousands)	936 (1,856)	982 (1,543)
Outpatient client fees collected (in thousands)[a]	93 (123)	135 (239)
Outpatient insurance revenue (in thousands)[a]	152 (297)	244 (619)

[a] Means are statistically different using t-tests for unequal variance, $p < .05$.

cies in general showed a nonsignificant ($p < .21$) tendency to provide more subsidized care than private agencies. This did not apply, however, to public agencies facing high levels of competition; these actually tended (again, nonsignificantly) to provide less free care than other agencies. Multiservice agencies, those that had been started with federal funds, and agencies located in an urban environment or that served low-income areas provided significantly larger amounts of subsidized care ($p < .02$).

The simple bivariate comparison of agency practices shown in table 2 indicates some additional differences. Private providers were significantly more likely than public agencies to have reduced administrative costs and to have used financial incentives to increase employee productivity in the year prior to the survey. Techniques for maximizing revenues also seemed to be used more often by private agencies. During the prior year, they were more likely to have amplified their emphasis on billable services and to have increased efforts to collect fees from payers. Private agencies were also more likely to charge fees for missed appointments, to require clients to pay in advance for some services, and to use a collection agency for past-due fees.

The public/private differences found in the bivariate comparison remained statistically significant for all practices except increased emphasis

TABLE 2
Public/Private Comparisons: Management Practices

Management practice	Public (%)	Private (%)
Financial incentives to employees[a,b]	9	29
Increased efforts to collect fees[a,b]	74	82
Increased emphasis on billable services[a,b]	64	77
Reduced administrative costs[a,b]	22	34
Charges a fee for missed appointments[b]	30	45
Requires clients to pay for some services in advance[b]	7	17
Uses a collection agency for past due fees[b]	35	46
Serves clients who are also in treatment elsewhere	40	41
Separate facilities or waiting rooms for insured clients	3	5

[a] Increased in past year.
[b] Difference statistically significant, χ^2, $p < .05$.

on fee collection when agency size, federal initiation status, array of services offered, service area variables, competition from private practitioners for insured clients, and the variable for public agencies reporting high competition were taken into account in the logit model. High levels of competition from private practitioners were associated with higher probabilities of using financial incentives, of emphasizing fee collection, of using a collection agency for past due accounts, and of having separate facilities for insured and uninsured clients. Public agencies reporting high competition from private practitioners were significantly different from other agencies in two areas: they were more likely to use financial incentives for employees and they were more likely to charge fees for missed appointments. Although these agencies were not statistically different from all others on the remaining practices, it is interesting to note that, for five of the eight practices studied, the signs of the coefficient for public agencies that reported higher levels of competition from private practitioners were different from those of public agencies in general. Full results of these analyses are shown in table 3.

To examine how using management practices associated with revenue maximization affects an agency's willingness to serve clients who cannot pay for services, we added to the regression model we used earlier variables indicating whether an agency engaged in each of the practices described above. The model (adjusted $R^2 = .121$, $F = 4.94$, $df = 15, 431$, $p < .0001$) failed to show a statistically significant relation between the use of any single practice and the amount of subsidized care given by an agency.

Although no single practice was associated with less subsidized care, we wondered if the combination of several revenue maximization practices might be sufficient to affect the number of reduced price visits. To test this hypothesis, we substituted a variable indicating the number of revenue-maximizing practices each agency employed for the separate variables used above. Again, the model (adjusted $R^2 = .126$, $F = 7.81$, $df = 9, 422$, $p < .0001$) failed to show a significant relation between the use of more practices and the number of subsidized visits ($b = -.06$, $t = -0.995$, $p < .32$).

There were no differences in other indicators of public orientation such as acceptance of referrals from public hospitals or social service agencies, although there was a nonsignificant tendency among private agencies ($p < .06$) for more referrals from managed care organizations (health maintenance or preferred provider groups).

TABLE 3
Factors Associated with Management Practices in Mental Health Agencies[a]

Independent variables	Financial incentives for employees[b]	Increased collection efforts[b]	Emphasis on billable services[b]	Reduced administrative costs[b]	Fee for missed appointments	Prepayment required	Uses collection agency	Separate facilities for insured and uninsured
Public agency (1 = yes)	−0.486[c]	−0.070	−0.197[c]	−0.219[c]	−0.249[c]	−0.245[d]	−0.134[d]	−0.096
	(7.061)	(1.328)	(2.206)	(2.411)	(2.725)	(2.681)	(1.715)	(1.470)
Competition from private practitioners for insured clients (1 = to a great extent; 0 = none to moderate)	0.057	0.150[d]	0.015	−0.046	0.006	0.104	0.212[c]	0.327[d]
	(0.803)	(0.561)	(0.945)	(1.192)	(0.976)	(0.669)	(0.442)	(0.283)
Publics facing competition (1 = public facing competition to a great extent; 0 = other)	0.190[d]	−0.104	0.049	0.036	0.143[d]	−0.002	0.021	−0.024
	(0.263)	(2.081)	(0.711)	(0.777)	(0.365)	(1.014)	(0.862)	(1.180)
Number of full-time employees	−0.084	0.006	−0.017	0.066	−0.037	−0.091	−0.070	−0.070
	(1.004)	(1.000)	(1.001)	(0.997)	(1.002)	(1.004)	(1.003)	(1.003)
Federally initiated (1 = yes)	−0.071	0.016	0.142[d]	0.115[e]	−0.076	−0.100	0.126[d]	0.088
	(1.297)	(1.060)	(0.593)	(0.653)	(1.323)	(1.446)	(0.629)	(.724)

Multiservice (1 = yes)	0.253[c]	0.130[e]	0.063	−0.047	0.106	0.029	0.082	0.366[c]
	(0.392)	(0.618)	(0.793)	(1.189)	(0.675)	(0.898)	(0.739)	(0.258)
Per capita income (log)	−0.052	0.052	0.094	−0.171[d]	0.186[c]	0.122	0.069	0.082
	(1.613)	(0.619)	(0.421)	(4.801)	(0.181)	(0.325)	(0.532)	(0.470)
Percent urban population	0.059	−0.287[c]	−0.149[e]	0.003	−0.195[c]	−0.044	−0.117[e]	0.092
	(0.960)	(1.220)	(1.109)	(0.998)	(1.144)	(1.031)	(1.084)	(0.938)
Hazard rate for sample bias	−0.154[d]	0.045	−0.083	0.064	−0.008	−0.023	0.026	0.031
	(1.057)	(0.984)	(1.031)	(0.977)	(1.003)	(1.008)	(0.991)	(0.989)
−2 log likelihood χ^2	57.85[c]	26.38[c]	23.60[c]	21.62[c]	33.43[c]	18.83[d]	36.76[c]	21.34[d]
Percent correctly predicted	70.9	65.2	62.4	62.2	63.9	64.8	64.4	74.2

[a] Computed with the SAS LOGISTIC procedure. Coefficients are standardized betas, items are reverse coded (0 = agency engaged in the practice) so that a positive number indicates a positive association with the dependent variable. Odds ratio are in parentheses. The model for serving clients who also received treatment elsewhere did not pass tests of model fit (−2 log likelihood χ^2, $p > .05$) and therefore is not reported.
[b] Use of practice increased during the previous year.
[c] Wald χ-square significant, $p < .01$.
[d] Wald χ-square significant, $p < .05$.
[e] Wald χ-square significant, $p < .10$.

Employing the same logistic regression models used to predict management practices, we determined the likelihood that a provider would derive more than 5 percent of its referrals from any of these sources. Only the equation for public hospital referrals had sufficient predictive power to meet acceptable standards on goodness-of-fit measures (χ^2 for -2 log likelihood = 27.26, $df = 9$, $p < .002$). Although there were no ownership differences in the likelihood of public hospital referrals, urban agencies were more likely than others to have such referrals ($p < .005$).

Discussion

Our analysis shows clear differences between public and private mental health agencies in their sources of revenue and in the extent to which they use management practices that are associated with profit-maximizing firms. However, on performance measures related to public access—such as the amount of subsidized care provided, willingness to treat clients being served elsewhere, or acceptance of referrals from public hospitals and social service agencies—there was no conclusive evidence of differences. Public agencies did not appear to be any more accessible than nonprofits.

The greater dependence of private agencies on client fees and insurance illustrates differences in financing. These variances may explain the fact that, whereas a significantly greater percentage of the total outpatient care in public agencies is provided to clients at subsidized rates, the two groups do not provide significantly different numbers of subsidized visits. Because public agencies derive a larger percentage of their total revenues from government sources, a higher proportion of the care they provide is directly subsidized with state, county, and/or Medicaid funds. Private agencies appear to depend on a more varied mix of public and private revenue and, thus, must use private as well as public revenues to subsidize free care. The ability to subsidize care with private funds requires that agencies first serve people who have health insurance or who can pay full price; only then are excess revenues available to subsidize treatment for those with fewer resources. Paradoxically, private agencies that serve more insured clients may also be able to serve more low-income and uninsured clients. If rates are at least sufficient to cover fixed

costs, these agencies may also have greater incentives to make sure eligible clients are enrolled in Medicaid or Medicare.

Although differences in the percentage of subsidized care probably reflect variations in financing mechanisms rather than a different orientation toward public service, the nonsignificant trend for more subsidized visits in public facilities suggests that dependence on private revenue to cross-subsidize care may not be a reliable strategy. Depending on cross-subsidies to finance indigent care makes access dependent on agencies' ability to bill for a significant amount of services at rates above cost. Increasing competitive pressure is likely to decrease profit margins, forcing agencies to reduce the amount of subsidized care they give.

Both bivariate comparisons and the multiple variable logit analyses indicate that ownership is related to most, but not all, management strategies. The standardized coefficients in table 3 show that ownership exerts a comparatively stronger influence than other agency or service area characteristics on the following practices: using financial incentives to improve productivity, emphasizing billable services, reducing administrative costs, charging fees for missed appointments, and requiring prepayment for some services. On the other hand, agencies located in cities were associated with a lower emphasis on collecting fees and were less likely to charge a fee for missed appointments.

Agencies offering a wide range of services, rather than being less entrepreneurial as we had hypothesized, were actually more likely to use employee financial incentives and separate facilities for insured clients. They were also associated with a nonsignificant tendency ($p < .06$) to emphasize fee collection and to charge fees for missed appointments. Interestingly, they also provided more subsidized visits than did their counterparts. Possibly, the larger amounts of outpatient care were simply a function of agency size, but they might also reflect a greater reliance on case management. Although agencies were asked to exclude case management from reported outpatient visits, case managers are likely to encourage increased use of outpatient services as substitutes for hospitalization. Unfortunately, we were not able to control for the presence or the intensity of case management.

Size, as measured by the number of full-time equivalent outpatient staff, did not affect significantly the use of any management practices we measured. Surprisingly, federally initiated agencies were more likely to have increased their emphasis on billable services during the past year

and were more likely to use a collection agency for past due accounts than were agencies not started with federal funds. These agencies also showed a nonsignificant ($p = .07$) tendency to have reduced administrative costs during the preceding year. This suggests that rather than serving as an indicator of public service orientation, federal initiate status may indicate that an agency is a "market survivor" with more experience or skill than others in maximizing private revenues and in controlling spending. Because federal funding to CMHCs was limited to roughly seven to ten years, those centers were explicitly encouraged to be self-supporting. More adaptable agencies are likely to have prospered in the selection process.

Although ownership status was a primary factor in predicting use of most management practices, market forces also played an important role. In all agencies, high levels of competition from private practitioners were associated with more aggressive fee collection strategies, including use of separate facilities for insured and uninsured clients. Contrary to some views, public agencies were far from immune to these influences. Public agencies were even more likely than others to use employee financial incentives and to charge fees for missed appointments when they faced high levels of competition from private practitioners. Because it would be illegal to charge clients enrolled in Medicaid fees for missed appointments, this finding suggests that these public agencies placed greater emphasis on private revenues than did their counterparts in less competitive areas.

Analysis of referral patterns offers no support to the contention that private agencies are less likely than publics to accept referrals from public hospitals or social service agencies. In the multivariable logit model for public hospital referrals, only location in an urban area was related to a greater number of referrals. The two ownership groups also appeared equally willing to work cooperatively with other agencies, as indicated by their acceptance of clients who are receiving services elsewhere (table 2).

Including management practices in the model used to predict the number of subsidized visits provided a test of the idea that, rather than ownership per se, use of certain individual business practices or a combination of such behaviors is associated with an agency's willingness or ability to subsidize care. The results of this model did not reveal any significant connections between management practices and the amount of subsidized care provided by an agency. These findings support neither

the argument that aggressive revenue practices improve an agency's ability to serve the community nor the contention that they detract from it, and they call into question simplistic notions that more businesslike behavior is either good or bad.

The widespread use of more aggressive management techniques by private agencies, coupled with the lack of evidence for ownership differences in public orientation, suggests that the political forces we described earlier may have had a countervailing influence on economic incentives. Without pressure from government and from advocacy groups to continue subsidizing care and to serve a broad range of constituencies, agencies may have jettisoned these goals in order to weather cuts in direct public funding. Their responsiveness to such political pressures may set nonprofits apart from their for-profit counterparts.

Public agencies are often assumed to be highly susceptible to political pressure but relatively unaffected by events in the private market. Rarely do policy makers propose increased competition as a means for improving the performance of public agencies. Yet our findings suggest that public as well as private agencies may alter their behavior in response to competition. Whereas it appears that competition increases the likelihood that public providers will use some revenue-maximizing practices, public agencies do not seem to respond as broadly to such pressures as do private agencies. Whether these differences in the response to competition stem from legal constraints or from financing is unclear; still, it appears that competition may be thought of as a policy tool for changing public as well as private agencies.

Because of their complexity, we were unable to examine how relations between government bodies and mental health agencies, both public and private, affect management practices and delivery of services. Intuitively, it seems that in states or counties that regulate them more stringently, mental health agencies would be more constrained in their entrepreneurial behavior. Further research on government–provider relations might provide some useful insights.

Supporters of privatization frequently claim that private agencies can provide the same service at lower cost. Insufficient data on the costs and quality of outpatient services provided by study participants prevented us from addressing this issue directly; however, the finding that private agencies were more likely than public agencies to have reduced their administrative costs in the past year is evidence that they may be more

likely than public providers to minimize operating costs. Efficiency in operations should translate into lower costs, but we have no concrete evidence that this was the case.

It is important to note that the relatively large standard deviations shown in table 1 indicate a substantial degree of variability among both public and private agencies in size, volume of service, provision of subsidized care, and revenues. These indicate significant diversity in the characteristics and performance of agencies and suggest that caution should be exercised in applying the findings of this study to a particular subgroup of mental health agencies. Any given agency or group of agencies may deviate in important ways from the average agency we have discussed. On the other hand, where competition from private practitioners is high, differences among agencies may be less pronounced than in areas with less competition.

Given the wide variations in performance and practice within both groups, it is entirely possible that a private agency in one area may operate in much the same way as a public facility in another area, and vice versa. This is especially likely in highly competitive areas. In such a context, it is difficult to draw conclusions about the general merits of public versus private provision of community mental health care or the reasons for observed differences between public and private agencies. What accounts for differences? Is it legal or regulatory influences, unmeasured market characteristics or, as Hansmann (1980) has observed, differences in the characteristics and role perceptions of administrators? Whatever the reasons, it seems that ownership may be a better predictor of process or style than of outcomes.

Implications for Contracting and Policy

Although there are clear differences in the extent to which public and private agencies use various practices associated with improved efficiency and revenue enhancement, it is not at all clear that these practices affect significantly an agency's commitment to serving low-income clients or those already in the public system. The absence of performance differences is an argument for contracting with private agencies. Because of their greater proficiency in securing revenues, contracting with nonprofits could provide some relief for beleaguered public budgets by allowing state or county governments to shift some of the burden for subsidizing

care to insurers and other private payers or to the federal government through Medicaid. If private agencies can be encouraged through contracting to increase Medicaid billing or to use even a small amount of excess revenue from private sources to subsidize treatment, state mental health authorities might mitigate the effects of budget cuts or of level funding. Even if this strategy works in some cases, however, its utility is likely to be limited to areas where there is sufficient private revenue, relatively little competition, and reasonably good Medicaid coverage. These may be the areas that need treatment subsidies the least. Even in areas where the strategy is successful, the gains are likely to be short-lived. Increasing pressure from employers and government is likely to drive down both public and private prices for mental health treatment—effectively eliminating any excess revenues now available for cross-subsidization. In such a situation, the benefits of privatization are less obvious.

Advocates for private agencies might argue that their more frequent use of revenue-maximizing and cost-cutting practices is evidence of their greater efficiency. If such management practices are the key to improved functioning, then policy makers who advocate privatization should not overlook the fact that many public agencies use them and many private agencies do not. Similarly, those who distrust management practices that are designed to reduce costs or enhance revenues cannot rely on public ownership to prevent such activities. Choosing an agency on the basis of ownership alone does not guarantee more businesslike behavior—in either the positive or negative sense.

Competition for insured clients seems to obscure some ownership differences. In the absence of sufficient competition, ownership may be the most important predictor of agency behavior. But where there is a great deal of competition, issues of ownership may be relatively less important.

Smith and Lipsky (1992, 1993) argue that contracting is popular with government officials because program changes do not involve hiring or firing public employees, and cuts or increases in human service funds can be obscured. Although it is unlikely that this is the only reason state and local governments are attracted to private agencies, the perception that private agencies have greater flexibility than public providers in programming and in personnel management has probably contributed to the privatization of community mental health services. Specifically, Smith and Lipsky believe that it is the greater flexibility in negotiating salaries that has attracted government to private agencies. In part because private agencies are less constrained by civil service regulations and

labor unions, they often pay lower salaries than public agencies. Lower personnel costs might well produce significant one-time savings and might also reduce pension liability, but it remains to be seen whether these savings can be sustained over time.

We have a great deal to learn about the relevance of ownership to access, quality, and efficiency of community mental health services. Differences in process abound, but it is not clear that they affect performance in any meaningful way. Those who formulate and implement policy are well advised to consider the benefits of contracting on a case-by-case basis. In doing so, they should consider the capacity of public agencies to change in ways that make them more efficient or more effective as well as environmental factors such as location, need for treatment in the service area, and competition from private providers. Additional incentives or regulatory measures such as performance contracting may be necessary to achieve specific goals (Dorwart and Epstein 1993; Davidson et al. 1991; Gaynor 1990). Policy makers should have a clear sense of what they hope to gain by purchasing services from a private agency. Given the potential disruption in their lives and the lack of strong evidence for benefits to clients, the decision to shift the locus of treatment from one provider to another should not be made lightly.

Summary

There were clear differences in our study between the management strategies employed by public agencies and those favored by private agencies. These differences, however, appeared to reflect the realities of financing rather than any fundamental differences in their orientation toward public service. There was no clear evidence that particular management practices affected an agency's performance on measures of financial access or acceptance of referrals from public hospitals. Government regulation and pressure from advocacy groups probably helped to maintain private agencies' focus on these and other public goals.

From a public policy perspective, choosing a provider solely on the basis of ownership status is, at best, a naive approach to providing public mental health treatment. Not only is there great variation in process and practices within both private and public groups, but external factors such as competition from private practitioners may also exert a stronger influence on agency behavior than does ownership status. Because most

current proposals for health care reform rely heavily on increased competition among providers to achieve their goals, the importance of ownership status as a predictor of conduct or performance may be further diminished. The emphasis on competition could increase differences between urban agencies and those in rural areas where there is less competition and, therefore, require different contracting approaches. As we move toward a health care system based on competition, administrators and policy makers will be forced to abandon their reliance on stereotypical public/private agency behavior as guides for policy decisions. Instead, they will have to consider more carefully the effects of political and market influences as well as agency characteristics when choosing community mental health providers.

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