ARTICLES

In Health Care Reform, Who Cares for the Community?

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ABSTRACT: Health care reform has again focused the issues of ownership and mission of organizations in the health care field. Some believe that universal entitlement will eventually make both charitable patient care and the nonprofit form of organization obsolete. Others believe that special treatment of nonprofit organizations does not depend on charity at all; rather that the nonprofit form has social value in and of itself. The authors reflect a different point of view. They suggest that with reform, community benefit as the modern expression of a charitable mission will become ever more important in achieving the nation's health care goals. They believe that nonprofit organizations will continue to be entitled to special treatment only if their missions and programs extend beyond care of patients and entitled populations to focus also on care of communities.

Any health organization's investment in disciplined community initiatives encompasses all the people in targeted communities, including those served by competing organizations. Without tax exemption, an organization committed to community care initiatives will be at a competitive disadvantage under the proposed community rated capitation payment system. Rather than abandoning the community benefit standard for tax exemption, health care reform calls for more systematic management of community care initiatives by nonprofit organizations and also of tax-exemption eligibility by the IRS.

In the rapidly escalating evolution of America's health care sector, called "health care reform," questions of auspice or ownership are making their way toward the forefront of the debate. Hot shot for-profit entrepreneurs

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are declaring the rationale for the existence of nonprofit hospitals dead, and members of Congress are questioning the same public policies (*Washington Post* 1993; *Wall Street Journal* 1994; Subcommittee on Select Revenue Measures, 1994). In this discussion, some have suggested that it makes no difference whether a hospital, health care system or network, or other organized method of providing health care and coverage is formed and operated as a nonprofit, charitable institution or as a strictly for-profit enterprise (Pauly and Redisch 1973; Clark 1980; Hansmann 1980; Herzlinger and Krasker 1987). Others maintain that these distinctions still have validity, especially—and perhaps only—for those organizations that are genuinely and demonstrably committed to serving communities and striving to improve community health care systems, as well as overall health status (Seay and Sigmond 1989; Kovner and Hattis 1990; Seay 1992; *Frontiers* 1992). And there are others who maintain that, when all is said and done, the nature of the ownership of a hospital really *does* matter, for reasons apart from notions of community orientation (Gray 1993). Certainly, these issues are made more complex by the intricate banding together of hitherto disparate segments of the health care financing and delivery systems. Maybe the time has come when looking only at ownership and profit status is no longer enough, and that a more exacting measure is needed to differentiate the public-serving from the others.

Nonprofit hospitals, long the dominant force in the provision of health care services in America, are now competing for power and prominence, capital and market share, with those who approach the issue from the point of view of finance rather than health care. Risk is being borne increasingly by all parties, creating both the parallel incentives of efficiency and profit maximization, and the risks of undertreatment and misappropriation of valued resources.

Against this backdrop, some thoughtful commentators have concluded that "ownership matters" after all. At least one scholar, sympathetic to the plight of the voluntary hospitals in the face of increasing tax-exemption attacks, has argued for removing organizations in the health care field from the "charitable" classification of tax-exempt entities in the Internal Revenue Code, and placing them instead in a new classification called "health services," similar to educational or religious organizations that are not required to be "charitable," in the relief-of-poverty sense, in order to be tax exempt (Gray 1993). We would like to differ, and argue for a renewed and sharper focus on the charitable mission of such organizations, emphasizing the work done by the United Hospital Fund in this area a few years ago with "Mission Matters" and *In Sickness and In Health: The Mission of Voluntary*

Health Care Organizations (Seay and Vladeck 1987; 1988). We believe that to conclude "ownership matters" is certainly a step in the right direction, and an important one. Some attributes of ownership form make a difference in how corporations are governed and managed. But to conclude that ownership, alone, matters misses the point of "Mission Matters." A focus on the mission of voluntary hospitals, rather than their form, places these discussions back on the right track in what may well emerge as a very important debate.

This might appear at first to be a semantic quibble, not worth fussing about in the real world of policy making in the current era of health care reform. But these two theses lead in quite different policy directions.

To create a new category of organizations that are not required to be "charitable" calls for a basic change in Section 501(c)(3) of the Internal Revenue Code by the Congress, no simple matter. And to carve out a special category for hospitals in this day and age simply may not be a politically feasible, nor an intellectually compelling, approach. By contrast, the "mission matters" approach is based squarely on the current charitable standard, which has been in effect for 25 years (Rev. Rul. 69-545, 1969-2 C.B. 117), and has common law roots which are even older (Statute of Charitable Uses, 1601, 43 Eliz. ch. 4; Seay 1994). This theory is not "trying to stuff fully commercialized nonprofits into the 'charitable category'," as has been suggested (Gray 1993). Rather, it steers the entire field and the Internal Revenue Service toward greater specificity in the processes and judgments about achievement of charitable mission. Rather than stuffing the fully commercialized nonprofits in, our suggestion is to have them "exclude themselves out," as Sam Goldwyn would say, by consequence of their own actions and decisions.

How can these two considered and thoughtful positions, reflective as they are of an understanding of the ambiguities of the American health care sector, come to such divergent judgments and policy positions? Perhaps the difference lies in the understanding of the significance of the Internal Revenue Service's shift 25 years ago, when it decided to broaden its interpretation of the word "charitable" as it applies to hospitals and health service organizations (Rev. Rul. 69-545, 1969-2 C.B. 117).

Until 1969, "charity" was interpreted to mean "charity care," pure and simple. But that interpretation went out the window when the IRS adopted the centuries-old definition of "community benefit," a much broader concept of a charitable contribution to an entire community, not just to a particular group, even the disenfranchised. A better understanding of this concept will support the "mission matters" formulation.

That calls for a discussion of why the IRS decided to broaden its definition of charity, how the Service handled this shift, and how President Clinton's health care reform proposal not only supports the community benefit standard, but even spells out a broader commitment to community in the legislation itself (Health Security Act, H.R. 3600 and S. 1757 at Title VII, Subtitle F, Section 7601).

Similarly, a fuller discussion of why integration of managerial approaches to caring for communities with approaches to caring for patients and enrolled populations is key to achieving the most successful outcomes of the "accountable health plans," or managed care entities of other names, in the reformed American health care system. Serious thought about community benefit programs may be an important key to improved health care results in the evolving era of reformed and limited resources for the health care sector.

The Internal Revenue Service made the change from "charity care" to "community benefit" following the enactment into law of Medicare and Medicaid. The IRS anticipated, perhaps reasonably at the time, but unfortunately incorrectly in hindsight, that with the enactment of Medicare and Medicaid, it would not be long before the benefits to which old folks and the poor were becoming entitled would be extended to everyone else. Surely the old and the poor would not be treated better than everyone else for very long. The anticipation of universal entitlement was around the corner, and charity care, the criterion for hospital tax exemption, would be a thing of the past.

Few at the time thought that nonprofit hospitals should lose their tax-exempt status, but there also did not seem to be a need to ask the Congress to amend the Internal Revenue Code to create a new category for "health services." So they studied the basic concept of charity and found within the very rich history of the common law the notion of community benefit, defined over the years as a contribution to an entire community, rather than to a narrower segment of the population. This took the Service beyond charity care, not just to a broader concept of community service as it was defined at the time, but to a much more focused idea of community service that was actually designed to benefit the community (Bromberg 1970; Boisture 1994).

At that time, in the hospital field, the traditional notions of community service—embracing such ideas as medical education and research, and care for the poor—hardly ever had any direct relationship to the notion of *community*, as that term is used in public health circles. That is, community as defined as all the people and all the organizations in a loosely defined geographic area who feel some sense of identity and interdependence.

Those pushing at the time for programs designed to benefit these kinds of communities, building on the Kennedy-Johnson initiatives and grant funding, got precious little support from most of those involved with traditional hospital community service. To most hospital leaders of the 1960s, community service meant any service beyond service to paying patients, service that reflected quite different goals than service designed to benefit targeted communities.

For some, community service meant little more than support for medical education as then organized. To others, it meant fulfilling a deeply felt professional responsibility to serve patients in need, irrespective of their place of origin. To some managers, community service meant service that was not charged for or service that was not paid for, in full or in part. The notion of specific services designed to benefit specific communities seemed foreign and was resisted by most hospitals, as indicated in part by the small number of hospitals that applied for and received any of the widely available grants for which they were eligible under the "Great Society" legislation enacted at the time.

The IRS staff who were developing the community benefit idea had little use for the notion that community service embraced any and all nonmarketplace activities of a hospital, a simplification of the view of community service held by most hospital executives at the time. They endorsed the concept that hospitals should go beyond traditional community service and support activities explicitly designed to benefit a community; they also believed that the activities, to qualify as charitable, should result in some specific benefit to the *community*, not only to the individuals served and those providing the service (Bromberg 1970). In modern health policy language, the IRS viewed community benefit as community service with an outcome orientation, measured in terms of impact on the community as a whole.

A great deal of what hospitals were doing as community service, then as now, reflects the desire of staff to carry out their professional commitments beyond care of inpatients. But these valuable services generally were not organized in a manner in which any community was actually better off as a result. In opting for community benefit, the IRS staff, whether they knew it or not, were ahead of their time in anticipating measurement of outcomes as a major management theme in health care, especially with respect to community care. But it soon became apparent that they were looking too far ahead—the universal entitlement they anticipated was at least 30 years away, and the sector's curiosity for outcomes research has just been raised in recent years. And virtually none of the promising and innovative Great

Society programs that were moving in the community-focused direction survived the Reagan-Bush years.

Those at the IRS involved with the new notions implicit in the shift from charity care to community benefit moved on to other things, and the Service never adopted guidelines or educational programs about the new application of community benefit. However, virtually all of the court decisions and revenue rulings involving tax exemption of hospitals and health service organizations have been consistent with the concept of community benefit.

With the likelihood that universal coverage is again imminent, and with the newfound interest in outcomes measurement, now is an excellent time to develop and implement the community benefit concept systematically, as the standard for charitable status in the health care field, rather than to abandon it as some have suggested.

One of the reasons for this review of the changing concept of charity in American public policy is that there is good reason to fear that some of our best thinkers may have missed—or some of the rest of us might have failed to sufficiently emphasize—the significance of these changes. Even the sympathetic commentators still have trouble separating the notions of charity and relief-of-poverty when, for example, it is observed that universal coverage "... would seem to leave little room for organizations whose rationale lies . . . in the domain of charity" (Gray 1993). And in recent Congressional hearings, Representative Charles Rangel of New York questioned the need for continued tax exemptions for hospitals if universal coverage eradicates medical poverty and, along with it, the need to provide "charity care" (Subcommittee on Select Revenue Measures 1994).

Can it be that there is a trap here, that is dangerously difficult to avoid, of assuming that entitlement can solve all of the problems of accessibility to health care services in the absence of community-oriented programs? Those with experience with the Indian Health Service, for example, may know differently. Native Americans on reservations have been entitled to the most comprehensive services for nearly a century or more, and still have among the worst health records in the nation.

Health care services are not only a commodity, they are part of the fabric and culture of communities. It may be telling that the Clinton administration was going to solve the problem of low rates of immunization for preschool children through a new entitlement program, until they learned that the states with such programs already in existence had not much better success than other states.

As the IRS may have figured out a quarter century ago, universal entitlement will focus the importance of community benefit programs, not

make them irrelevant. Mere entitlement is not enough; benefits for enrolled populations must be linked with programs designed to benefit the different communities of which the enrollees and their health services are a part. Absent that critical linkage, costly and inefficient service provision will persist and community health will continue to suffer.

Likewise, reference to important research and educational functions, and care for undocumented aliens and incarcerated individuals, similarly miss the point about community benefit. Although vague on how it would work, the Clinton Health Security Act (H.R. 3600 and S. 1757, at Title VII, Subtitle F, Section 7601) is enlightened in that it reinforces the community benefit standard and adds a specific requirement that the organization periodically and systematically develop, with community input and involvement, a community benefit plan of action . This clearly represents a step in the right direction, albeit a small one.

Three Policy Approaches

Implicit in all of the discussion of new visions of health care reform—managed competition, accountable health plans, community care networks, integrated delivery systems, and so on—is better integration or coordination of what is now, at best, a loosely coordinated assemblage of disparate elements of the health care sector. Much attention is focusing, as it should, on coordination or integration of service and finance, urban and rural resources, and acute or other types of services, including long-term, home, and mental health care services (Connors 1992). So far, less attention has focused on the key element involved in the tax-exemption debate: achieving improved health status through better integration and coordination of *patient care*, care of *enrolled populations*, and care of *communities*. It is important to understand the basic differences among these three policy and management approaches, and the key relationship between the effort to care for communities and the issue of tax exemption.

CARE OF PATIENTS

Care of patients is the self-evident and most important approach to health care policy and management. It always takes priority and is best understood by health professionals and others associated with health services organizations. An emphasis on the care of patients focuses a hospital's attention only on those who come through the door seeking out the hospital's services. A strict care-of-patient approach does not have the hospital reaching out to people, except perhaps in a purely self-serving marketing strategy. Although care of patients may be improved by closer attention to outcome

objectives and to the basic principles of total quality management, the goal is always to provide better care and to enhance the outcomes of individual patients. Patients are the basic denominator for evaluation, and management focuses sharply on the individual patient. This dimension of the new integrated delivery systems will not change significantly. And from a private, personal health point of view, this is not such a bad thing; but from the public health and tax-exemption points of view, there may be legitimate expectations for something more.

CARE OF ENROLLED POPULATIONS

Care of enrolled populations involves a broader focus on the health status of a defined population to which the health service entity has a contractual and professional responsibility. To a large extent, the enrolled population as a whole, rather than the individual patient, becomes the basic denominator for planning, management focus, and evaluation. Although the delivery of service is still focused on specific patients most of the time, it is done so decidedly within the larger context of the enrolled population base, resulting in markedly different allocations of resources, information systems, professional expectations, and management incentives and review. In areas where the market shares of these enrolled populations are large enough, public health as well as private health concerns may be met simultaneously. However, such instances may be few and far between, and such outcomes the result more of default than design.

CARE OF COMMUNITIES

Care of communities also involves the broader perspective of a population denominator, but in a much wider focus than is the case with enrolled populations. Here the focus is not on who happens to come through the door of the hospital or who signs up for a particular HMO or other coverage plan, but rather on all of the people who live and work in a specifically targeted community, and all of the organizations with which they are associated which affect their life styles and health status. Population is again the denominator, but this is a clearly identified population grouping with which the health system has an explicit contractual relationship. The focus is broader, but also less sharp. For example, some of the population in the targeted community may well be associated with a competing accountable health plan which has no special commitment to the community, creating competitive disadvantages for the public-serving plan and perhaps other anomalies as well (Cox 1994).

A crucial management challenge for the emerging managed health

plans—at least those that are really accountable—will be developing the most effective coordinated allocation of resources and management support services among these three approaches, with respect to almost all health problems. There is substantial evidence, for example, that when immunization entitlement for preschool children is backed up by community initiatives to encourage and assist all families to have their children immunized, the immunization rates rise to a level comparable with other developed nations.

Whether it is immunization, heart disease, HIV/AIDS, trauma and violence, care of the infirm aged, the various addictions, or stroke, the case can be made that the greater allocation of resources to community care, closely integrated with care of patients and care of enrolled populations, will achieve the most effective results, both with respect to health outcomes and access, as well as costs (Hattis 1993).

However, there are obstacles to meeting this challenge, and measurable results are usually observable only in the longer run. Managed health plans financed by capitation payments in a competitive environment, and without a quite explicit community benefit commitment or obligation, would have no incentive—really no excuse—to give much thought to the long run. As a result, most accountable health plans, as they are now conceived, would have a much more immediate point of view and little reason to develop longer-term community benefit programs.

Some have also questioned the fairness of granting tax exemptions to some types of health care providers and not others. However, those who pose this question as one of unfairness to the for-profit hospitals seem to miss the main point. Without the advantages of tax exemption—including not only relief from the burden of supporting government but also eligibility for grants, tax-exempt gifts and donations, and other forms of community support—those health plans or providers with a commitment to community benefit programs which cost money will be at a significant disadvantage relative to their competitors who do not possess a similar commitment to the public good. Rather than focusing on unfairness to organizations that pay taxes, the issue becomes one of fundamental fairness to those with a community benefit commitment or obligation. The most intense competition may well be with the so-called "fully commercialized nonprofit" as opposed to the for-profits. In this context, an exemption from taxation for the community benefit organizations remains compelling.

As the field gets more complex and harder to sort out by such traditional measures as ownership, acceptance of risk, capitation, the business of insurance, corporate practice of medicine, and so on, the need for clearer

criteria for determination of tax-exempt status becomes even more acute. That is why a better understanding of the concept of community benefit can be so very helpful. And it is also why everyone should understand the distinction between care of the community as contrasted with care of patients and care of enrolled populations. That is why we conclude that in health care reform, the form of ownership may indeed be a relevant concern, but even more important to achieving measurable improvement in community health outcomes—caring for the community—mission matters most.

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