

Commentary for HealthLeaders

Demonstrating True Hospital Leadership in Community Benefit

By Howard Berman and Bruce McPherson

Whatever directions are taken to reduce the federal budget deficit, we in health care must show what we can do, individually and in collaboration with others, to live within those parameters and help our country live within its means. That is demonstrating true value.

In health care, economic and fiscal circumstances make it clear that hospitals and other health care providers serving as the true “safety net” are increasingly endangered under the weight of community service demands from uninsured and low-income patients. Does anyone really believe that all of the coverage expansions provided for in the federal health care reform law will be implemented or sustainable given the current state of federal and state government finances?

In order to demonstrate true leadership in community benefit, those hospitals doing relatively less should do more by reaching out to their community’s safety-net providers, offering monetary and/or in-kind support (e.g., managerial, clinical) to enable the safety-nets to carry out their vital missions.

If the “haves” don’t help the “have-nots,” the “haves” will ultimately bear the burden, one way or another, that the “have-nots” are carrying. It may not happen today, but it will happen.

One possible scenario, which to us does not seem out of the realm of possibility, is that policymakers will seek to use hospital tax-exemption requirements to leverage greater support by the “haves” to the safety nets. Here’s the progression:

- First, as federal, state and local governments obtain more community benefit investment data from hospital filings of Form 990 Schedule H (as well as from separate reporting in many states) government analysts could find significant variations across hospitals in the percentage of total net revenues or costs being devoted to community benefit—by any definition. Can anyone doubt that such variations will be found?
- Next, that finding could lead to legislative proposals to establish a quantitative threshold of hospital community benefit as a condition for federal income-tax exemption. With government looking in every nook and cranny for ways to reduce their budget deficits and/or help fund other services, can anyone doubt the attractiveness of such proposals? Look at what is happening in Illinois. Governor Pat Quinn has put a hold on further denials of property-tax exemptions for nonprofit hospital—but only in exchange for cooperation by the state hospital association in

establishing a more definitive legislative standard for community benefit that is fair to both hospitals and taxpayers.

- Next, those legislative proposals could be amended so that in measuring compliance with such a threshold, “extra credits” would be given for monetary and/or in-kind support provided to safety-net health care providers. Other amendments might call for tax credits to be given to those nonprofit hospitals whose community benefits significantly exceed the threshold (typically the safety-net hospitals). Does this sound too outlandish?

The right answer is voluntary leadership at the community level, with those providing less community benefits proactively reaching out a hand--individually or collectively--to help protect the safety nets.

In that vein, although he can be criticized for thinking in too narrow terms about community benefits, U.S. Representative Dennis Kucinich has just called on all of the major hospitals in the Cleveland area to cooperate in providing care to the poor. Doesn't collaboration on community benefit at the community level make sense?

As a group of nonprofit health care providers and health plans, we must all hang together—to not only ward off being hung separately but also to be our Brother's Keeper.

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