
The McNerney Forum

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Helping Those Most in Need

Imagine you are starting your career and have the opportunity to work at one of the more prestigious, resource-rich health care institutions in the country. Funding is readily available for new or expanded services, regular staff raises and promotions, experiments in delivery system changes, and creative recruitment and retention programs designed to attract the best and brightest in all clinical and non-clinical professions, not to mention lucrative executive incentive structures.

Not too far away, however, are several other hospitals whose history, location, and past decisions (like choosing to stay in their respective communities and not move when population shifts occurred) have left them with few, if any, of the paying patients who frequent hospitals like yours.

Furthermore, these other hospitals cannot afford the special capital items you take for granted, like electronic medical records, integrated clinical-financial information systems, and state-of-the-art diagnostic and therapeutic equipment. Moreover, although your “have” hospital contends that it provides its “fair share” of uncompensated care, the fact is that these other facilities are carrying most of the economic burden of increasing amounts of charity care and bad debt. The patients of these hospitals delay treatment; use the emergency department for what primary care they can obtain; and do not have access to a regular source of care, as no distributed primary care system exists.

Even beyond that, state-based payment systems have continued to underfund sponsored and unsponsored patients alike, thereby causing the gap between reimbursement and actual cost to increase dramatically.

What’s the problem? The market, as it is wont to do, has determined the winners and losers, the rich and the poor, the “haves and have-nots.” In too many places across our country, situations like this have increased the gap between resource-rich and resource-depleted hospitals. The communities served by the latter group (what we like to call “safety-net hospitals”) tend to house those at the lower end of the socioeconomic scale. They live in “health care and food deserts,” and their populations typically have the lowest health and functional status in their metropolitan areas.

What are we to do? Allow the market to determine who lives or dies—in terms of both organizations and people—or act to head off or at least minimize this ever-increasing gap?

On the other hand, whoever said that it is the responsibility of thriving hospitals to solve the problems of failing institutions, even if they are neighbors? Is this not a chronic problem of continuous government non-involvement in the growing uninsured problem, whereby most state governments more or less force those hospitals that are most in need to continue to provide most of the care for those patients who are most in need? Years with lack of adequate payment combined with population shifts fueled by—

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take your pick—immigration, racial discrimination, home foreclosures, loss of jobs, no reasonable economic development, and lack of educational resources and adequately supplied schools, take hope and possibility away from the communities surrounding these troubled hospitals. Yet the mission of these facilities is clear, to the extent of their available resources: try to care for all who need care, regardless of their ability to pay. It is a death spiral. How can it be stopped? Or, at least, how can its effects be moderated?

In answering that question, we must first recognize that safety-net hospitals are a subset of the “have not” hospitals, and the necessity of keeping any hospital open differs throughout the community. In other words, perhaps some “have not” hospitals *should* fail, as they do not play the same role as safety-net hospitals. Second, we must appropriately define the safety-net hospital, so that rational policy initiatives can be developed, debated, and implemented—with a shared understanding by all involved as to what constitutes a proper distribution of health care costs and benefits in the community. Third, it will be necessary to develop innovative approaches to solve this problem. Encouraging the broader health care community (including insurance companies, employers, and organized medicine and nursing) to work together to change the landscape would allow more hospitals to “do good as they do well.” Here are a few ideas:

1. For those states that require regulatory approval for major capital items, create a quid pro quo for certificate of need (CON) approval for organizations seeking to expand existing services or to create new ones, with a portion of the total cost being directed to a pool that would fund the capital and physician recruitment needs of safety-net hospitals. In return, the regulatory burden of obtaining a CON would be reduced, and the contributing hospitals would be recognized by the state’s attorney general for providing community benefits.
2. Have thriving hospitals establish a fund that safety-net organizations could access for vital capital and operational needs. Safety-net hospitals cannot easily pay for new equipment (including critical information technology [IT] systems) or finance the recruitment and retention of crucial primary care and specialty physicians. These funds could keep the hospitals afloat until additional public funds became available. The contributing hospitals would be credited on their government community benefit reports for both the capital they provided and the imputed interest they would have lost because these dollars were not invested.
3. Create a “floor and ceiling” process whereby hospitals that do not meet the “floor” requirements for community benefit compliance can “buy” credits through fiscal or other contributions to safety-net hospitals, thus allowing the former to meet statutory or regulatory requirements. These contributions could take the form of funds or in-kind services, based on the needs of the recipient hospitals.
4. Encourage thriving hospitals that have long-standing relationships with vendors to create a pool of equipment/technology for purchase/lease by safety-net hospitals. Normally, these companies donate such equipment to underserved nations; a domestic program would hardly be radical. These charitable contributions could be made to hospitals in underserved communities, affording these companies a tax benefit while allowing them to serve populations in need. Further, providers in general could be encouraged to use these same companies as they look to make purchases, since these companies’ contributions to needy facilities in their communities would aid hospitals whose survival or failure could have major effects on providers. Lastly, thriving hospitals could provide technical knowledge needed for implementing technology, which would benefit both the safety-net hospitals and community as a whole.
5. Construct a version of the Community Reinvestment Act whereby health insurance companies that target primarily healthy individuals and communities would have to meet more stringent regulations and/or make other contributions to ensure that imbalances in coverage and provider payment are minimized. In this way, the

health needs of an entire community would be the unit of analysis for establishing new or revised insurance coverage.

6. If a state has enacted a provider assessment or similar program that results in new (non-general revenue fund) dollars, let safety nets access a portion of these dollars for support of critical capital, technology, and manpower needs. Because these funds come from the hospital community and a federal match, such an arrangement would allow the expense to be spread across all participants, while the benefits could be focused on those most in need.
7. Rebase Medicaid payment so that provider reimbursement (such as it is) for both the poor and the uninsured is adequate to cover costs. Eliminate the patchwork quilt of payment arrangements (e.g., Safety Net Adjustment Payments, Critical Hospital Adjustment Payments) that deflects attention from the core issue: the state's responsibility to pay for care of those in need and to reimburse providers who deliver it. Part and parcel of this would be systems to ensure that the costs of uncompensated care (including bad debt and the need for capital) are accounted for accurately and reimbursed appropriately.
8. Finally, in the spirit of (voluntary) collaboration, encourage regional health planning approaches that could become the basis for new or expanded grant funds. Use health planning information to stimulate cooperative ventures among providers, their medical staffs, and insurers. Programs and services designed to have a major impact on the health and financial status of communities in need could then become the focus of cooperative activities. There is great logic in having so-called competitors work together for the common good. This is both an offensive and defensive strategy— it actively attacks an obvious problem and ensures that vital services are not summarily removed from a vulnerable community.

Why not allow the market *and* government to take care of the ever-widening gap between the “haves” and the “have-nots”? In the past decades, we have learned that delaying such action only delays development of viable solutions. Few of those in power are taking a civic, societal perspective in identifying the flaws of current approaches and seeking solutions from the critical stakeholders. Government, providers, insurers, communities, and employers need to be able and willing to work together. If this can be done in a non-threatening, collaborative way, collective stewardship of community health resources could be realized, and those who hold power in health care could all be recognized for their efforts to positively address community need in a cost-effective fashion.

Microsoft's Bill Gates cites two great forces of human nature—self-interest and caring for others—in his recent *Time* magazine article on creative capitalism. We should heed his advice, and find ways for the market and government to come together to identify creative community benefit.

Call it creative planning, stewardship, social responsibility, leveling the playing field, or anything else; we need to attack the civil injustice embedded in our health care delivery system if we truly wish to achieve a healthy, active, involved society. We cannot continue to allow some of our neighbors and fellow citizens to be denied a bright future simply because of where they live.

In the end, to do any less is a betrayal of our basic mission for hospitals to serve their communities. And given the attention the public is paying to our field, our institutional leaders, and their boards, it would behoove us to define community as broadly as possible to reinforce our status as eleemosynary organizations. A voluntary approach to balancing community need with all available resources certainly would be preferable. Unfortunately, too often it takes a “stick” to get our attention when the “carrot” was right in front of us all the time.

Notes

The author appreciates the valuable contributions made to earlier drafts by Emily Friedman and

Howard Berman. The final product, however, reflects the sole opinion of the author.