ADDRESS

“THE IMPORTANCE OF NOT FOR PROFIT HEALTH CARE”

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I am becoming increasingly concerned that our healthcare delivery system is rapidly commercializing itself, and in the process is abandoning core values that should always be at the heart of healthcare. These developments have potentially serious consequences for patients and society as a whole. (Joseph Cardinal Bernardin, “Making the Case for Not-For-Profit Health Care” in Celebrating the Ministry of Healing., The Catholic Health Association of the United States: St. Louis, MO, 1999, pp 83-84)

It was twelve years ago that Cardinal Bernardin, the late Archbishop of Chicago, spoke these words towards the beginning of an address to the Harvard Business School Club of Chicago. The special focus of his remarks was to celebrate the importance of not-for-profit healthcare. At that time not-for-profit healthcare was being challenged by the consolidation of for-profit hospitals into large systems as well as by the economic pressures emerging from managed care insurance.

Though this was not the first time not-for-profit healthcare had experienced significant challenges, many felt that it was the first time that not-for-profit healthcare’s right to exist was on the line. As the Cardinal said:

The not-for-profit presence in health care delivery is also threatened by a body of opinion that contends there is no fundamental distinction between medical care and a commodity exchanged for profit. It is argued that healthcare delivery is like other necessary economic goods such as food, clothing and shelter and should be subject to unbridled market competition. (Ibid, p. 84)

Fortunately, for a variety of reasons, not all internally generated, not-for-profit healthcare survived these challenges. Unfortunately, the core argument has not gone away and has returned with a new vengeance. Whereas previously it had been argued that the efficiencies of market forces would force not-for-profit healthcare out of business, today it is being argued that there is no real difference between the two modes of healthcare delivery. And, therefore, not-for-profit healthcare should not enjoy the special public policy protection afforded other charitable organizations. Obviously the assumption
behind this argument is that because healthcare is a commodity like all other commodities the organizational structures and public policy that supports it should be the same as for any other business. Accordingly the tax-exempt and not for profit structure is without justification.

Though it is true that there also are challenges to not-for-profit health care delivery coming from other fronts such as labor unions and attorneys general, the premise of this presentation is that the most important challenge we must address is about the nature and significance of not-for-profit healthcare. In today’s reflections we will move forward in four stages. First, we will place the current moment in a broader historical context. Second, we will reprise the main points argued by Cardinal Bernardin. Third, we will engage a recent study in Health Affairs entitled “Why Not-for-profit Health Care Matters.” And finally we will look to some recent reflection by Jim Collins of Good to Great as we consider future direction. As a result of this analysis we will propose four propositions:

- In light of internal and external changes to not-for-profit healthcare the current questioning of not-for-profit healthcare is both understandable and reasonable
- If one accepts certain a-prioris, then there is a coherent rationale for maintaining not-for-profit healthcare
- Because of conflicting a-prioris, there is need of empirical evidence to support the distinctiveness of not-for-profit healthcare. Unfortunately, the external evidence that currently exists while compelling, is not conclusive
- The language of greatness provides faith-based not-for-profit healthcare an opportunity to demonstrate its distinctive contribution to the well being of society.

**Historical Context**

Before getting to the substance of our reflections it would be good to remind ourselves of the context for the current challenges. To put it simply, I would suggest that healthcare delivery has radically changed since the time when it first utilized the legal structure of a not-for-profit organization and was first provided with exemption from taxation as a charitable work.

As we know the very remote origins of medicine were associated with priestly and sacred cults. Though in time the practice of medicine was informed by what today would be considered to be primitive scientific knowledge, medicine was more of an art than a science. In time the distinctive identity of the physician emerged and, as exemplified in the Hippocratic Oath, a special relationship of responsibility and trust developed between physician and patient. Eventually a locus of medical care, the hospital, came into existence. While originally defined more by the provision of care for the dying and the indigent, in time the hospital came to have a distinctive identity. The hospital was the place where local doctors provided for some of the health needs of the community. A hospital was a special place and a community was fortunate when it had a hospital in its midst.
In summary I would propose that the context in which not-for-profit structures and tax exempt provisions emerged was one in which health care had a special status consistent with its sacral origins, where it was characterized by the physician’s special relationship of responsibility and trust, and where the hospital was an essential element of the public or common life of a local community.

By the middle of the last century this began to change. As we know there has been a revolutionary transformation of medical resources and knowledge. Though there is no replacement for the intuitive skills of a physician, health care in large measure is experienced as being defined by the scientific advances associated with pharmacology and technology. The classical relationship between physician, and many other clinicians, and those they serve has been strained by variety of factors with the result that the historic special meaning of the word “patient” is increasingly replaced with the word customer. And the hospital has been increasingly defined by the demands of business and reimbursement and supported by ownership arrangements that often are not located in the community. In fact, if one looks at the continuum of health care resources and providers from manufactures of equipment, to producers of medicine, to physician practice groups, to a large proportion of insurance companies, to a significant number of companies that provide long term care and a stable minority of companies that provide acute care it can be argued that the not-for-profit hospital is an exception if not an oxymoron.

It would be my suggestion that these almost cosmic shifts from the sacral to the scientific, from special relationship to business relationship, from an essential community resource to an economic reality largely associated with the world of market forces cannot be ignored. Though in our heart of hearts we firmly believe that we are still motivated by a Gospel imperative of service and defined by the spirit of the common good of the communities in which we are present, the presumption of many is that it is that we are just like the rest of healthcare delivery. If that it true, then it should not surprise us that many would question whether the special status of being not-for-profit and the privilege of being tax-exempt is still appropriate.

The Case for Not-For-Profit Status

In response to the challenges of the 90’s Cardinal Bernardin sought to “make the case” for not-for-profit healthcare. His argument was quite straightforward. He proposed that the business sector of society had a distinctive and important purpose: to earn a growing profit and reasonable rate of return for those who own the business. In contrast he argued that there are other institutions in society whose purpose was not a reasonable rate of return. As examples he cited the family as well as educational and social service institutions whose end purpose is a non economic goal: the advancement of human dignity. He noted, and I quote:

…”the purpose of the family is provide a protective and nurturing environment in which to raise children. The purpose of education, at
all levels is to produce knowledgeable and productive citizens. And
the primary purpose of social service is to produce shelter,
counseling, food and other programs for people and communities in
need. (Ibid, p. 86)

In making this proposition he made his own the teaching of Servant of God Pope John
Paul II that there exist some goods which by their nature are not and cannot be mere
commodities. (Idem)

The Cardinal went on to argue that healthcare delivery was one of those distinctive social
goods. He cited three reasons for this proposal. Let me highlight two of them

First, it is distinctive because “healthcare involves one of the most intimate aspects of our
lives – our bodies, and in many ways our, our minds and our spirits as well. The quality
of our life, our capacity to participate in social and economic activities, and very often
life itself are at stake in each serious encounter with the medical care system.” (Idem)

Second it is distinctive because “the availability of good healthcare is also vital to the
character of community life.” (Ibid, p. 87) He made this proposal for the theoretical
reason that “most Americans believe society should provide everyone access to adequate
healthcare services just as it ensures everyone an education through grade twelve.”
(Idem) He also made it for the practical reason that “we all benefit from a healthy
community; and we all suffer from a lack of health, especially with respect to
communicable disease.” (Idem)

In light of this reasoning the Cardinal asserted that “Given this special status, the primary
end or essential purpose of medical care delivery should be a cured patient, a comforted
patient, and a healthier community, not to earn a profit or a return on capital for
shareholders.” (Ibid., p. 88)

The Cardinal then expanded his argumentation by making his own the thought of
management expert Peter Drucker. For Drucker “…the distinguishing feature of not-for-
profit organizations is not that they are non-profit, but that they do something very
different from either business or government.” For Drucker not-for-profit institutions are
“human change agents. Their “product” is a cured patient, a child that learns, a young
man or woman grown into a self-respecting adult; a changed human life altogether.”
(Idem.)

In summary, for Cardinal Bernardin not-for-profit healthcare is distinguished by the fact
that it is one of society’s non-economic social goods that promotes human dignity by
being an agent of human change that advance the well being of individuals and
communities. I believe it is fair to say that the Cardinal presented a coherent rationale if
one accepts the premise that there are certain goods that are non-economic in nature.
Validation of Being a Social Good

As noted previously there are many who question the general premise that there are social goods and more specifically whether the actual way not-for-profit healthcare is provided is consistent with its being a social good. This questioning has resulted in various attempts to both verify the distinctiveness of not-for-profit healthcare and to prove that it is not different from for-profit delivery. Clearly the work of the Catholic Health Care Association and many healthcare institutions in the area of community benefit planning and reporting has made a significant contribution to this important discussion.

Having read numerous studies and reports on this question I recently was impressed by a study in the June 20, 2006 online edition of Health Affairs entitled “How Nonprofits Matter in American Medicine, And What To Do About It.” (Mark Schlesinger, Bradford Gray, “How Nonprofits Matter In American Medicine, And What To Do About It” Health Affairs 25 (2006), pp. 287-303; published online 20 June 2006; 10.1377/htlhaff.25.w287) The study did not necessarily break new ground but seemed to concisely summarize the complexity of the discussion.

First, the authors argue “supporters and critics of nonprofit health care agree that ownership related differences regarding cost, quality and accessibility vary across studies.” (Schlesinger and Gray, p. 2) Their literature review also indicated that the “effects of ownership manifest in different ways for different services.” (Ibid., p. 3) There were, however, three other attributes where being not-for-profit had an advantage:

- for profit organizations more aggressively mark up prices over costs
- non-profit organizations appear more trustworthy in their delivery of service
- non-profits “are typically incubators of innovation” (Ibid., p. 4)

When one considers the question of community benefit and utilizes indigent care as the sole criterion for such benefit, then the authors say that “Under this criterion, the performance of non-profits appears far from adequate…If one does not count bad debt, the amount of uncompensated care provided for as many as three-quarters of nonprofits is less than their tax benefits.” (Idem.)

The authors then enter into an interesting discussion that moves beyond the uncompensated care of particular institutions to the significance of non-profit health care at the macro level. They propose that

- if nonprofit hospitals were to provide uncompensated care at the same level as for-profits, then the cost of uncompensated care for government hospitals would double
- if the for-profit rates of post discharge mortality were translated into the nonprofit sector, the result would be tens of thousands of additional deaths
- if the for-profit average 5 to 10% excess mark up of charges would apply across the board, there would be a dramatic impact on societal spending on healthcare. (Idem)

They then go on to say something that many of us have said:

Even if one concludes that the aggregate uncompensated care in nonprofit hospitals does not greatly improve access, the combined effects of nonprofits propensity to offer unprofitable or sporadically profitable services, to locate in lower-income communities, to provide service to the poorest neighborhoods, to persist through adverse economic conditions and to avoid policies that screen out less profitable patients can in combinations powerfully shape access. (Ibid, p. 6)

(A s an aside, I should note that these conclusions are quite similar to those of a 2002 Catholic Health Association of the United States study entitled Commitment to Caring: The Role of Catholic Hospitals in the Health Care Safety Net.)

It seems to me that the value of this and many other studies is that they remind us that if we agree that the only criterion of our distinctiveness is some metric of direct dollar value compared to some other dollar value such as uncollected taxes, then most likely we will never be able to conclusively justify our special privileges. In effect we would be accepting the suspicion of many that we are no different then any other business in that our goal is to meet a certain rate of return. The only difference is that our rate of return is defined by the singular criterion of how well we meet or exceed the cash value of forgiven taxes. Once we enter this mindset then the focus of our public discussion will be what should or should not be counted.

My friends, if we fall into this trap, then we will have accepted the commercialization of healthcare with the only difference being that for us the commodity is exchanged for the value of tax exemption. It seems to me the question before us is how we develop a vocabulary of accountability and transparency that is adequate to capture the dollar wise intangible contributions we make to individual communities but also to society as a whole. We need a vocabulary not of the market but of health care as social good that allows us to demonstrate how we fulfill our mandate to promote human dignity by being an agent of social change as we provide for the health of individuals and communities.

The Language of Greatness

Fortunately, as I have been reflecting on this need for a new vocabulary, Larry Minnix President and CEO of the American Association of Homes and Services for the Aged (AAHSA) made me aware of Jim Collins’ work entitled Good to Great and the Social Sectors: A Monograph to Accompany Good to Great. (Privately published, Jim Collins: 2005) In this short work Collins rejects the assertion that “the primary path to greatness in the social sectors is to become ‘more like a business’.” (Collins: p. 1) Rather he proposes that the “critical distinction is not between business and social but between
great and good. We need to reject the naïve imposition of the ‘language of business’ on social sectors, and instead jointly embrace a language of greatness.” (Ibid, p. 2.)

In developing this assertion he argues, “In business money is both an input (a resource for achieving greatness) and an output (a measure of greatness). In the social sector money is only an input, and not a measure of greatness.” (Ibid, p. 5) For Collins “in the social sector, the critical question is not ‘How much money do we make per dollar of invested capital?’ but “How effectively do we deliver on our mission and make a distinctive impact, relative to our resources.” (Idem) For Collins the challenge is to hold a social sector institution accountable for progress in outputs “even if these outputs defy measurement.” (Idem) He proposes, “It doesn’t really matter whether you can quantify your results. What matters is that you rigorously assemble evidence – quantitative or qualitative – to track your progress.” (Ibid., p. 7)

As regards “outputs for greatness”, he proposes three criteria: delivers superior performance, makes a distinctive impact and achieves lasting endurance.

I would suggest that a careful study of the CHA approach to social accountability and community benefit reporting would reveal that the CHA approach is similar to what Collins proposes What Collins adds is a broader perspective or philosophy for the CHA approach. Our mission is expressed in performance, impact and endurance vis-à-vis our mission not just in the amount of charity care dollars we provide – no matter how we count them.

Having spent over twenty years in the world of government and public policy I know that an approach as philosophical as this would not be easy to sell. But if we do not seek to change the vocabulary of the conversation to one that is more consistent with whom we are, then I fear we will become the vocabulary we use.

To that end I have been exploring with some of my colleagues at Resurrection Health Care what we are calling the human dignity quotient. The denominator of the quotient is the health needs or health status of the individuals and community we serve. The numerator is what we have done distinctively to respond to that need and how effective we have been in those efforts. In other words we are trying to capture how well we are fulfilling our responsibility to be an agent of change to advance human dignity. The denominator of a disproportionate share community obviously will be different from that of an affluent community. That being said, would the only human dignity criterion for a DSH community be charity care however you count it? Is this the most enduring positive contribution to advancing human dignity in that community? What about obesity reduction that would impact the number of persons with diabetes? In an affluent community is the provision of specialized high-end services or paying a provider tax the most needed distinctive impact or the most enduring contribution? What about the large number of seniors with multiple chronic illnesses whose medical care is not being effectively coordinated?
We are still at the early stages of this project, so I am not certain whether we will be able to capture the information in a way that will be effective both internally and externally. I do know that I have found it a helpful example of a different approach to the public conversation. That being said this attempt also has demonstrated the difficulty of developing a systemic approach to assembling qualitative evidence. For example even in a relatively modest sized system it is not easy to actually track what we are doing let alone evaluate the quality of such service. There also are not agreed upon measures by which to evaluate the overall impact of such services on the life of a local community. Despite these difficulties our conversations has reinforced for me the importance of our determining what we do distinctively in each of the communities we serve to advance human dignity, to be agents of human change, and how effective we are in those efforts.

I also should note that in a world of scarce resources some might question whether we can afford to take the time and capital needed to plan, serve and evaluate our services in the context of Collins’ philosophy. To this skepticism and resistance to change, which at times sounds quite similar to previous opposition to measuring clinical outcomes, I would reply that the train of accountability and transparency has left the station. The question is whether the train’s destination will be the conversion of all health care to a for-profit model or a new moment of greatness for not-for-profit healthcare in general and faith based healthcare in particular.

In closing as I look across this room I see a microcosm of the Catholic health care ministry in this country. For nearly 280 years, motivated by the desire to carry forward Jesus’ healing ministry, we have made important and valuable contributions to our communities and to our nation. We have faced challenges in the past and there will be more in the future. In recent years our nation has struggled with two competing forces. In the world of public policy there have been attempts to move the provision of healthcare from the world of social goods to the world of market forces. On the other hand in light of the number of uninsured and underinsured there is a growing public awareness that healthcare is not the same as widget making. In this environment perhaps our contemporary prophetic service is to continue to be an unwavering witness to the primacy of human dignity, a voice for the voiceless and an effective articulator of the role of not-for-profit healthcare as an agent of change by speaking a language of greatness through superior performance, a distinctive impact and an enduring presence.