Guest Editorial

From Charity Care to Community Benefit

Community benefit has a curious history in the hospital field, having first surfaced at the Internal Revenue Service (IRS) in the 1960s. Reflecting extraordinary foresight, the charity standard for tax exemption of nonprofit hospitals was changed from a narrow concept of charity *care* to a much broader concept of charitable activity labeled community *benefit*. With the passage of Medicare and Medicaid, IRS staff anticipated that it was only a matter of time until Congress recognized that the whole population is entitled to the same favorable treatment as the very poor and the aged, but that if there were universal entitlement, charity care as the basis for tax exemption would be undermined. In order for the IRS to stay in the tax-exemption business in health care, it appeared that the time had come to shift to the broader concept of a contribution to the total community, not simply to the less advantaged.

Not only did the 1960s' IRS staff act on a vision of health care financing that was at least 30 years ahead of the times; they also anticipated the current emerging commitment to outcome measures. Instead of shifting from charity care to the traditional concept of community *service*, they went the extra mile to the idea of community *benefit*. The difference between the two was not as clear then as now—that community benefit is community service with an outcome orientation. The community benefit standard cries out, "Don't just serve; plan and manage the service so that the community will be better off as a consequence." Similar to universal entitlement, outcome orientation is just beginning to become a reality.

When universal entitlement did not occur in the 1960s or 1970s, the IRS staff never bothered to define the new community benefit standard in the form of regulations supported by an educational program. Most hospital officials, legislators, policy experts, and academicians had no idea that the standard for tax exemption had changed.

In the 1980s, interest was renewed in the community benefit concept as a result of different forces. Some legislators seeking alternatives to universal entitlement wanted to abandon the community benefit standard and return to a charity care standard that would help finance care for those who could not or would not carry health insurance. Others observed that hospitals had not developed systematic programs to benefit their communities and tried to divert the government funds lost through tax exemption back into the general revenue streams of governments, which were having more trouble balancing their budgets than most hospitals. Countering this development, various hospital groups attempted to demonstrate that the hospitals were heavily involved in activities that benefited their communities. Many hospitals focused on community benefit activities as a support for tax exemption, as opposed to focusing on tax exemption as a support for community benefit programs! Finally, others saw community benefit programs in the context of the inevitability of health

care reform, believing that with limited resources, managed programs to care for and benefit communities systematically are necessary elements of reformed delivery systems—as necessary as managed programs for enrolled populations and patients.

This issue of the Journal features three articles related to community benefit that together reflect the diversity of approach to the subject by the academicians during the late 1980s.

William Buczko's article is the most recent response to the 1980s' interest in turning back to the charity care standard. Buczko demonstrates again that, as classified by hospitals, the vast majority of uncompensated care represents failure of the hospital collection departments, rather than fulfillment of charitable mission. This article reminds us of the classic definition of a bad debt—an account for which the cost of further collection effort is estimated to exceed the amount that will be collected. Buczko argues forcefully against treating "deadbeats" and the worthy poor together.

The article by Jan P. Clement, Dean G. Smith, and John R.C. Wheeler is the most eloquent in defense of the community benefit record of nonprofit hospitals. The key feature of this article is the imaginative definition of community benefits, including not only (1) uncompensated care, but also (2) education programs and research projects, (3) services in which published charges are deliberately or accidentally set below cost, (4) the extent to which prices are set at a level below what the hospital would have charged if operated for profit, and (5) net income. One can only speculate about how many hospital executives would be bold enough to use this definition of community benefit in confrontations with community activists!

By contrast, Anthony R. Kovner's article describes an approach to community benefit designed to prepare hospitals for an expanded community role in the era of reform. This approach calls on the hospital to develop a systematic, managed community benefit program with intensive community collaboration to improve the health status of the community (with special attention to the disadvantaged) and to contain the community's health care costs. Kovner's concept of community benefit is based on the American Hospital Association's (AHA) guidelines on the ethical responsibilities of health care institutions to their communities—guidelines developed almost 25 years ago and continuously updated since. Variations of the Kovner approach are found in the reform visions of the AHA, the Catholic Health Association, and most recently, the Clinton reform legislation.

These three articles expose the readers of the Journal to the wide range of studies surrounding one of the most exciting concepts current in the health care field today.

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