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THE COMMUNITY BENEFITS COLUMN

Outcomes and Inputs

BY ROBERT M. SIGMOND

The approach promoted in this column focuses on Outcomes, reflecting institutional initiatives with measurable goals to benefit targeted communities. The emphasis is on explicit institutional projects designed and managed to improve community health, narrow the differences between the health status of more and less disadvantaged populations in the community, and/or control community health care costs. While this approach necessarily involves collaboration with other community organizations, institutional management is held accountable for outcomes.

The other two approaches focus much more explicitly on inputs, rather than outcomes. One highlights institutional inputs to healthy community collaboratives, reflecting a commitment to subordinate institutional community interests to more broadly defined community interests. Those supporting this approach believe that the institution is not in the best position to decide what outcomes will benefit a community or to take the lead in activities to achieve community outcomes. This approach calls for enthusiastic support and input into community collaboratives while exercising discipline in avoiding domination.

The second input approach focuses sharply on money inputs, with less explicit attention to community outcomes. The emphasis is on expenditures that justify continuation of tax exemption of not-for-profit hospitals. The subjects of interest are subsidized, mission-driven community services that are not focused on the marketplace and that adversely affect the bottom line.

With the many strong attacks on tax exemption throughout the United States, the money input approach is probably more common than either the community outcome or the community input approaches.

The community benefits program of the Washington State Hospital Association is clearly one of the best examples of the money input approach. The excellent methodology and the outstanding results of this collaborative effort, involving 32 participating urban hospitals and health systems, is well documented in their recently released 22-page annual report. Michigan is also an excellent example and includes all hospitals in the state in their results.

This report provides information about $175 million spent on community benefits last year. This compares with an estimated value of little more than $100 million in taxes that the institutions avoided because of their exemption.

The largest share ($90 million) of the community benefits was unbilled charges to charity patients. A second major category was the cost of Medicaid payment shortfalls ($33 million). Community service was the third category accounting for the remaining $52 million.

The community services category includes expenditures for community health activities as well as health professional education and research. Community health programs included expenditures for health education and outreach; screening; support groups; immunizations; school-based, mobile and other clinics; day care for seniors; and much more.

The Washington report illustrates the extent to which direct community benefit initiatives will have to be expanded as the efforts to overcome the coverage and reimbursement inadequacies of government programs for the uninsured become successful. For a copy of the annual report of the Community Benefits project, write to Elaine Ganoulis at the Washington State Hospital Association, 300 Elliott Avenue West, Suite 300, Seattle, WA 98119-4118.

ROBERT M. SIGMOND IS A MEMBER OF THE BOARD OF DIRECTORS FOR NORTHLAND HEALTH GROUP, SOUTH PORTLAND, MAINE, AND A SCHOLAR-IN-RESIDENCE AT THE DEPARTMENT OF HEALTH ADMINISTRATION AT TEMPLE UNIVERSITY, PHILADELPHIA. HE CAN BE REACHED AT (215) 561-5730 OR E-MAILED AT RSIGMOND@THUNDER.OCIS.TEMPLE. EDU.

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