All of these efforts by hospitals to develop systematic relationships in the community interest will proceed more rapidly if the Congress would grant community benefit hospitals qualified exemptions from antitrust laws. Indeed, in developing community benefit programs, the real problem is not antitrust, but lack of trust exacerbated by the procompetitive ideology of recent years. Antitrust exemption legislation would send an important message to communities and hospitals about the necessity to develop effective coordinated community health systems. Such systems hold out great promise for controlling wasteful expenditures, particularly in the Medicare and Medicaid programs.

Structural Elements of a Community Benefit Standard

A standard for a community benefit hospital will call for broader responsibilities on the part of all three key structural elements of the hospital (the governing body, the medical staff, and the management), beyond those set forth in the Joint Commission's authoritative sections of AMH/88 covering the hospital structure.

The Governing Body. In a community benefit hospital, the governing body has primary responsibility for assuring that the hospital is playing a leadership role in achieving cost-effective, accessible, comprehensive, continuous quality care for all the people in the designated service area (GB.1). The governing body devotes a significant proportion of its time to assuring that the goal of community benefit, the goal of quality patient care, and other goals reflecting the hospital's mission are appropriately balanced with respect to allocation of resources (Kovner and Neuhauser 1987). Members of the governing body necessarily reflect their interest in and concern about the health status of the people in the designated service community, a fundamental criterion for membership on the governing body (GB.1.2.3.1). The hospital's orientation program for new trustees gives special attention to the health status and health problems in the hospital's designated geographic service area (GB.3.1).

"Antitrust exemption legislation would send an important message to communities and hospitals about the necessity to develop effective coordinated community health systems."

At least some of the meetings of the governing body or of board committees are open and held at a convenient time and place for attendance by residents of the community (GB.1.2.4.3). In addition, community representatives, other than governing board members, are included in the membership of board committees con-

cerned with improving and protecting the health of the designated community (GB.1.2.4.5). The governing body gives special attention to those aspects of the institutional planning process that relate to the institution's obligations to the health service requirements of the designated geographic service area (GB.1.8). Representatives of the community, other than board members, and advisors from collaborating health care institutions necessarily are involved in the planning process (GB.1.8.1). Such planning identifies feasible quantitative goals with respect to measurable characteristics of the health status of the people in the community, their satisfaction with the hospital's commitment, and the cost effectiveness of their health services (GB.1.20).

In carrying out the responsibility for appointing and evaluating the chief executive officer, the governing body assures itself of the incumbent's adherence to appropriate codes of ethics, commitment to the institution's community benefit goals, and capability of working effectively in the community. At the same time, the governing body requires mechanisms to assure provision of care to people from the designated geographic service area, irrespective of ability to pay, as well as the necessary financial support for this commitment (IPD.1.1.7).

Finally, the governing body requires regular reports reflecting the degree of progress in achieving its community benefit goals.

The Medical Staff. The medical staff of the community benefit hospital is organized to assure the quality of the professional services provided both on the inpatient services and on the hospital-sponsored ambulatory services as well (MS.1). Professional criteria for membership on the staff are designed to assure that all patients from the designated service area receive accessible cost-effective quality care (MS.1.2.3.1.2.1). Other criteria will be considered, including the practice location of the medical staff members in the hospital's designated geographic service area (MS.1.2.3.1.2.3.4.).

The medical staff organization includes a mechanism, such as a section or committee on community medicine, to coordinate and monitor the development of hospital-sponsored community-focused medical service programs and to assure appropriate medical staff input in such hospital activities (MS.3.12). If such a mechanism takes the form of a community medicine section, that section has neither managerial nor clinical responsibilities, but rather is responsible for monitoring, evaluating, and making recommendations from the medical staff organization with respect to the various programs of the hospital designed to improve and protect the community's health (MS.3.12.1 and MS.3.12.3).[11]

Management. The chief executive officer of a community benefit hospital is committed to the mission and values of the hospital, as well as to the highest ethical standards of the profession. The chief executive officer also helps to provide institutional leader-

ship in responding on a cost-effective basis to the health service and other human service needs in the designated service area of the hospital and in community advocacy of those needs (MA.1.1 and MA.1.3).

The chief executive officer takes all reasonable steps to implement special initiatives for the poor and disadvantaged in the hospital's community and assures equitable and compassionate handling of the dispensation of charity care (MA.1.6.3).

Overview of the Community Benefit Standard

The key elements of a community benefit standard for hospitals have been set forth in quite specific terms and following the language and style of the Joint Commission. This was done to demonstrate that the basic ideas that are reflected in the notion of "community benefit" are not necessarily soft or ambiguous. The intention was to demonstrate that such a standard can be written, incorporating approaches and notions with which all experienced and knowledgeable hospital leaders are familiar.

At the same time, we wish to make clear that we hold no brief for every detail of every element of the standard that we have set forth. In our opinion, the standard included in this article is practical and can be implemented, but the details are set forth here for illustrative purposes only. Other formulations of the elements of a community benefit standard could easily be constructed that might omit much of what we have written and include a great deal that is omitted from our construct.

A community benefit standard should be developed through a carefully designed process, involving input and interaction of many thoughtful individuals representing a wide variety of disciplines and points of view. Our hope is that the standard that we have presented here will serve to stimulate that type of process, rather than a debate over the merits of particular details herein.

Administration and Sponsorship of a Community Benefit Standard

A community benefit standard may be administered by a wide variety of organizations and can be sponsored by the same organization that administers it. It could also be sponsored and supported by a wide variety of related or unrelated groups.

There is much to be said for having the standard administered nationally by the JCAHO, which could develop a different program of validation of community benefit programs to be governed and managed separately from their current program of accreditation. At this time, however, the JCAHO appears to be pursuing other priorities that absorb the resources that might be devoted to a community benefit standard.

With this in mind, we believe that this country would benefit most from a separate nationally administered, voluntary community benefit performance standard and validation program. It would be supported by (if not sponsored by) representatives from government, community financing agencies, purchasing, business, labor, consumer groups, community organizations, coalitions, community programs for affordable health care, and philanthropic foundations, as well as hospital organizations, HMOs, hospital trustees, and a variety of professional groups that include physicians, nurses, health care executives, and social workers.

All of the groups mentioned above should have the opportunity to sponsor or endorse a national performance standard and a validation program for community benefit hospitals. Each is in a position to provide some form of preferential incentive, financial or nonfinancial, to those voluntary hospitals that meet the standard in whole or in part.

In the short run, a wide variety or organizations would benefit from a national demonstration that a community benefit standard and validation program for hospitals is feasible and useful. Sufficient incentives, both negative and positive, are available to assure that such a validation program would be taken seriously by at least some hospitals.[12]

"With this in mind, we believe that this country would benefit most from a separate nationally administered, voluntary community benefit performance standard and validation program."

A great deal can be learned from studying the origins and development of existing hospital standardization programs in the United States that will be of value in developing a community benefit standard and validation program.[13] Examination of this history suggests that a community benefit standard for hospitals can be developed to be both challenging and acceptable to leading community institutions and have increasingly significant impact on the accessibility, relevance, and cost effectiveness of the services provided to the communities served by hospitals attempting to conform to the standard.

Such a community benefit standard can be endorsed and successfully implemented by any local, state, regional, or national organization with effective leadership commitment and credibility. Such organizations, including individual community hospitals, should be encouraged to do so, until a nationally credible program is developed.

This history also indicates that a community benefit standard should be set to reflect the highest level of community

responsibility and commitment so that complete conformance may continuously challenge and lie beyond the grasp of any institution.

Compliance with the community benefit standard by an individual hospital should be based on the degree of progress achieved within specific time frames, reflecting the unique environment of every community hospital that is openly attempting to conform, rather than on uniform levels of compliance. Decisions with respect to compliance should be based on an intensive site visit with active involvement of community representatives and community organizations in the process. The site visit team will assess the relevance and feasibility of the hospital's goals, the programs to achieve those goals, and the outcomes.

The history also suggests that compulsory governmental community benefit standards will be most effective if based on prior experience with credible voluntary standards that are set at a much higher level than the compulsory standards. Since compulsory governmental standards, with teeth, appear to be inevitable in the foreseeable future, credible voluntary standards should be implemented as expeditiously as possible.

Finally, key economic and noneconomic incentives for conformance should not be administered by the accrediting body, but rather by agencies, payers, philanthropists, professional organizations, community coalitions, business and labor, and other organizations that can identify hospitals that meet the community benefit standard and reward them. Economic incentives are crucial at this time despite the evidence that the key incentive for compliance with accepted standards is probably the sense of accountability of most hospital trustees and other leaders of voluntary hospitals to their community and their desire for community recognition as meeting the highest existing standards of excellence. Nevertheless, as Rufus Rorem (1930) pointed out, "Money is the prince of coordinators."

"Since compulsory governmental standards, with teeth, appear to be inevitable in the foreseeable future, credible voluntary standards should be implemented as expeditiously as possible."

For this reason, it would be most helpful if other incentives can be redesigned to encourage and support the desire of voluntary hospital trustees "to do the right thing." Of these, the most important probably are local, state, and federal tax exemption; antitrust exemption; continued availability of tax-exempt bonds; preferred provider status with key payers in the community, especially Blue Cross, government, and large employers and unions; continuing access to government grants; and continuing access to tax-exempt

philanthropy. All of these incentives historically were available to voluntary hospitals during the period when their commitment to community service was not really questioned—the period that began to change drastically about 20 years ago, after the enactment of Medicare and Medicaid legislation. Obviously, it is not possible or even desirable to attempt to move backwards to that time, but the lessons of history can be applied to the unique period that we are currently facing.

Potential loss of these incentives by hospitals that do not meet community benefit standards will present these hospitals with a difficult, potentially character-building decision as to which road they wish to follow. Of all the financial incentives, possibly the most important is the preferential payment provided to "sole community hospitals" by Medicare. The definition of a community hospital for purposes of this preferential payment is currently in terms of geographic distance from other hospitals, with no consideration of the respective community commitments and responsibilities of the hospitals involved in the incentive determinations. There appears to be no recognition of the fact that the economic risk of being the sole community hospital (as defined in this article) in a multihospital area is much greater than in a geographically isolated situation. Would it not make a great deal more sense to provide a significant "federal budget neutral" payment differential between all community benefit hospitals and all other hospitals, regardless of geographic configuration?

REALITY AND PERCEPTIONS: THE NEXT STEPS

Tax exemption for voluntary hospitals, until recently, has always meant more in terms of the implicit obligations of the institutions than the dollar value of the avoided taxes. This was particularly evident during the first 150 years when voluntary hospitals had little net income or even gross receipts and the value of contributed assets were not usually recorded (Rorem 1930). In fact, during the years in the nineteenth century when the Pennsylvania Hospital, the nation's oldest voluntary hospital, was required to pay federal and state taxes, there is no evidence that the amounts paid (under protest) materially influenced that hospital's mission or mission accomplishment (Williams 1976).

With today's greatly enlarged potential tax bases of voluntary hospitals, the dollar value of tax exemption has become a significant sum—particularly property and gross receipts taxes, but for some hospitals, net income taxes as well. It appears to be inevitable that tax exemption will soon become a thing of the past unless voluntary hospitals demonstrate that their current social commitments—and hence their communities—would be adversely affected to an extent exceeding the value of the taxes to be paid.

If this test is applied to voluntary hospitals as a group as they are perceived in the current competitive environment, that perception will indeed take on a reality of its own and all voluntary hospitals will probably lose their tax exemptions, with significant impact on their economic capacity (and possibly their commitments) to pursue community benefit goals.

If that test were to be applied on an individual, hospital-by-hospital basis, some hospitals easily will be able to demonstrate that the value of their social benefits far exceed—and would be threatened by—tax payments. Others might be relieved to have to pay taxes and avoid explicit community obligations. Still others will require a systematic self-assessment to determine their position on the nature of their commitment to community benefit goals; whether that commitment is reflected in current programs that are likely to justify tax exemption; and if not, whether the hospital wishes to maintain tax exemption; and if so, what changes are required to strengthen the hospital's case for continued tax exemption.

"Individual hospital trustees are only beginning to assume leadership in this effort. Their role is crucial because it is their stewardship that is really being examined."

The steps that should be taken to face the tax-exemption issue constructively appear to be clear.

First, self-assessment activity—and any indicated adjustments—should be going forward at all voluntary hospitals at this time. Individual hospital leaders should be aided in this important activity by self-assessment tools now being developed by the American Hospital Association.

Second, this process may be accelerated by an extensive awareness and educational effort to help those associated with individual voluntary hospitals to understand more fully or even, in some cases, rediscover the basis of their existence. The United Hospital Fund of New York, the American College of Healthcare Executives, and other organizations have already initiated this process, but there is more to be done. Individual hospital trustees are only beginning to assume leadership in this effort. Their role is crucial because it is their stewardship that is really being examined.

Third, those voluntary hospitals that are convinced that their commitment and activities justify continued tax exemption should take steps to gain or sustain support and understanding from community leaders and others involved in public policy formulation.

Fourth, development of a feasible, credible community benefit standard for voluntary hospitals, comparable to the JCAHO Accreditation standard (AMH/88), will greatly assist individual hos-

pitals in their self-assessment and, where indicated and desired, their remedial programs. This activity could be funded by a philanthropic foundation, following the example of the Carnegie Foundation in funding the hospital standardization program of the American College of Surgeons in 1917.

Following the development of a credible community benefit standard, a demonstration program should be initiated, involving voluntary inspection by a credible group, of those hospitals that believe that they measure up to the community benefit standard. Public approbation would follow for those hospitals judged to be in conformance with the standard.

Fifth, if there is success in gaining public and payer acceptance of rewards for the value contributed by those hospitals identified as meeting the community benefit standard, the demonstration program can be converted into a permanent ongoing effort of the JCAHO or another appropriate voluntary organization.

Finally, those who recognize the value of the new program of approbation for voluntary community benefit hospitals can encourage the development of "deemed status" legislation, similar to the deemed status provisions applicable to the JCAHO standards of hospital quality and safety in the Medicare legislation.

The steps outlined above will take time and, therefore, should be initiated as expeditiously as possible. If carried out in time, however, these steps are likely to postpone, if not completely avert, the loss of tax exemption by deserving voluntary hospitals and to validate the hypothesis that not all hospitals are alike. Thus, the future for voluntary hospitals can be shaped by performance rather than the perceptions of others.

Notes

1. Authorities in at least 12 states are questioning the tax-exempt status of nonprofit hospitals. In general, these tax challenges are made in efforts to raise new revenues, respond to complaints from the small business community of "unfair" competitive advantage by nonprofits, and to satisfy increased demands for charity care. These states include California, Iowa, Kansas, Minnesota, Mississippi, Pennsylvania, Tennessee, Utah, Vermont, Virginia, Washington, and West Virginia.
2. These additional benefits have included lower postage rates available to public charities, the ability to receive tax-deductible contributions under I.R.C. Sec. 501 (c)(3), the exemption from unemployment taxes on wages paid to employees under I.R.C. Sec. 3306 (c)(8), and the access to tax-exempt capital financing made available under I.R.C. of 1954, Sec. 103 (a)(1) and as interpreted by I.R.S. Rev. Rul. 63–20, 1963–1 C.B. 24.
3. While the emphasis in this paper is on tax exemption of voluntary hospitals, there is no reason why investor-owned and government hospitals

pitals should not also strive to meet community benefit standards, and to be so identified when they succeed.

4. The term "community benefit hospital" is used in this article to identify a hospital that meets a community benefit standard. This term is not to be confused with the American Hospital Association's definition of a "community hospital" which includes all nonfederal, short-term general, and allied special hospitals without regard to their mission or identification with any community.
5. Partially funded by the Hospital Research and Educational Trust and the Robert Wood Johnson Foundation.
6. This and other similar parenthetical abbreviations refer to the reformulated AMH/88 mentioned in the text and available from the author at Temple University.
7. In its recent revision of *Guidelines for Ethical Conduct for Health Care Institutions*, the American Hospital Association (1987a) emphasizes that hospitals "should be concerned with the overall health status of their communities, while continuing to provide direct patient services. . . .Not-for-profit institutions, in consideration of their community service origins...and tax status, should be particularly sensitive to the importance of providing and designing services for their communities."
8. Using a sample survey of community services of 200 nonprofit hospitals, the American Hospital Association is developing a self-assessment document to assist nonprofit hospitals in evaluating their community benefit policies and practices.
9. John Griffith (1981) has taken a somewhat different approach to measuring community outcomes in important work based on his Michigan experience.
10. A paper analyzing approaches to setting boundaries in multihospital areas and by specialized and tertiary teaching hospitals is available from the author at Temple University.
11. See the *Report of the Blue Ribbon Panel on Physician Relationships*, Vol. 2 (Farmington Hills, Michigan: Sisters of Mercy Health Corporation, 1986).
12. For a detailed discussion of hospital incentives, see *Challenging the Profession* (Chicago: Pluribus Press, 1983), 191–205.
13. A paper outlining the lessons of the American experience with hospital standards during the past 70 years is available from the author at Temple University.

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