Health Care for the Poor and Uninsured: Strategies That Work
Nellie P. Tate, PhD, and Kevin T. Kavanagh, MD, editors
Haworth Press, Binghamton, NY, 1992, 101 pp., $24.95

This text is a compilation of papers from the Second Annual Conference on Health Care for the Poor and Uninsured (1990). The book is intended for planners, policy designers, and healthcare professionals involved in the planning and implementation of state healthcare programs that serve the medically indigent, especially children and pregnant women.

Six chapters address various aspects of maternal-child health: the increasing availability of obstetric care through utilization of nurse midwives, a maternity waiver program, the channeling of high-risk mothers and infants, the cost-effectiveness of screening selected newborns, a reduction in the infant mortality rate of blacks, and perceived barriers in the use of a comprehensive prenatal care program. The final paper explores long-term home care for the frail elderly and the needs of their care givers.

The authors of the first chapter discuss a successful program using nurse midwives in Alabama. However, they leave many questions unanswered: Was the availability of nurse midwives the main reason 89 percent of area women utilized these services? How did program administrators determine that "public health nurses did not have the time to add the case management function to their list of duties" (p. 17) and therefore that social workers should be incorporated into the prenatal care system in public health? What changed as a result of case management with social workers? What was different about the experiences of the 11 percent of clients who did not use the services?

Chapter five, which describes three demonstration projects in Tennessee aimed at reducing the infant mortality rate of blacks, also leaves many questions unanswered. Although these programs used alternative approaches to outreach and patient care and enhanced reimbursement methods, the authors do not discuss these. They instead discuss need, target population criteria, and some results and then recommend that "circumstances surrounding insufficient care should be analyzed" and "the issues or categories of barriers should be..."
explored" (p. 77). Eighteen months is offered as "a relatively small time period to determine the documented impact on such a multi-dimensional problem" (p. 77). Even some initial hypotheses would have been helpful to providers and planners in this area.

Chapter six discusses a study on perceived barriers in the use of prenatal care networks. The study examined factors associated with the use of community-based networks by black women in three high-risk Chicago communities and found that "convenience factors" (job demands, travel time, and child care) did not differentiate those who used the network providers from those who did not use them. Traditionally, these factors have been viewed as influencing healthcare use. The authors do not discuss how to address the lack of private providers' specialty training. In addition, two other potentially important barriers—lack of provider respect toward patients and inadequate time with the provider during the office visit—are not explored.

Even though many issues remain unexplored, the book does present several worthwhile ideas. The authors of the second chapter describe the maternity waiver program in Alabama and offer many specific examples of their primary provider network, home visits, and ways their maternity care coordinators provide nonmedical support services.

Chapter three authors discuss a South Carolina project in which high-risk patients are channeled to designated clinics. They offer many valuable insights through a description of the problems they encountered: unavailable vital records; lack of completed risk-screening forms; lack of medical support services. Chapter four discusses Mississippi's cost-effective model of newborn screening for phenylketonuria, hypothyroidism, and hemoglobinopathy and the value of shared regional screening with Tennessee.

The author of the final chapter focuses on persons who care for an elderly parent or grandparent. The writer reflects on 10 years of personal care-giving experience that formed the basis for establishing the not-for-profit Long Term Home Care of the Frail Elderly Foundation in New York City. Three major gaps filled by foundation programs are discussed: respite for the caregiver; a centralized national outlet for training, information, education, advice, and support; and advocacy for families providing long-term home care. Two tax-law reforms that address the concerns of many families about assets and long-term care expenses are proposed.

Despite these valuable ideas, on the whole I was disappointed with the book. As a healthcare professional with experience in medical indigency issues, I had hoped to find some innovative models for approaching clients, some discussion of ideas and concepts that might be replicated or at least that would evoke further reflection. Although the papers attended the conference, as a reader, I often felt excluded from the heart of the matter. The almost-terse discussions surrounding the programs moved me to ask, How did these programs make a difference? I found few responses. I was left wondering whether the presenters were asked follow-up questions that the editors omitted.

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BOOKS RECEIVED

Contemporary Environments for People with Dementia, Uriel Cohen and Kristen Day, Johns Hopkins University Press, Baltimore, 1993


Lights in the Darkness: For Survivors and Healers of Sexual Abuse, Ave Clark, Resurrection Press, Mineola, NY, 1993

if the new system adjusts payments for these needs. Catholic healthcare and other mission-driven community service organizations have traditionally reached out to these populations. The necessity for this will continue.

It is also likely that the new system of care will not meet all the health and health-related needs of enrolled persons. Even a fairly comprehensive benefits package may not include needed over-the-counter medicines and appliances, transportation to health services, counseling, and some desired, but not lifesaving, procedures and treatments. Low-income persons enrolled in a healthcare network are likely to continue to need some free and discounted services and supplies.

Catholic and other mission-driven healthcare organizations holding to the principle that "the poor have a moral priority" will continue to be needed in our healthcare system. These providers, whether they sponsor healthcare delivery networks or are part of such networks, will continue to need and deserve tax exemption.

COMMUNITY BENEFIT

Providing benefits to the broad community can also characterize a tax-exempt IDN and its component organizations.

Although a network will primarily focus on persons who are enrolled, it can and should show concern for the broader community. This community may be the overall geographic service area, or it might include an area remote from the network and most of its enrollees, such as an underserved rural or inner-city area. Benefits to the broader community include policies and programs that:

- Improve the health of persons in the community (helping them get and stay well)
- Improve the overall health within the community (preventing widespread disease and injury and acting on societal problems that tend to cause disease and injury)
- Contain healthcare costs and conserve scarce resources (avoiding unnecessary duplication of services and equipment and providing services in the most cost-effective and economic setting)

The Catholic Health Association's (CHA's) Standards for Community Benefit (see Box) present a framework for describing how an integrated delivery network can demonstrate it is meeting a charitable purpose as a community benefit organization.
Mission and Philosophy  The standards suggest that mission statements and other descriptions of philosophy should speak to the organization’s commitment to community service. The mission statement of the Alexian Brothers Medical Center (see Box, below) is an example that an integrated delivery network could use as the basis of a community benefit statement.

The CHA standards suggest that policies, as well as mission statements, can reflect an organization’s community benefit orientation. These could include policies on:

- Financial assistance for enrolled and nonenrolled persons
- Advocacy for improved public policies
- Physicians’ and employees’ role in community benefits
- Employee benefits and the work environment
- Selection of contractors and other partners
- Treatment of poor and other minority persons
- Selection and participation of board members
- Energy and resource conservation and the environment
- Decision making, considering impact on community
- Planning and budgeting, incorporating community health concerns and community benefit

Community Benefit Plan  A growing number of community-oriented healthcare organizations are developing an annual community benefit plan, as suggested by CHA’s standards. This can be an excellent way both for ensuring that the healthcare organization is being adequately responsive to community needs and for documenting commitment to community well-being.

Community benefit plans can include:

- The organization’s mission and tradition of service
- A description of the community served
- Identification of unmet healthcare needs in the community
- How the organization intends to address, directly and in collaboration with others, particular or unique healthcare problems of the community, and the healthcare and related needs of the poor, frail elderly, minorities, and other medically underserved and disadvantaged persons
- How community members, organizations, and businesses were involved in identifying the needs and developing the plan

Provision of Services  The ultimate demonstration of meeting a community benefit purpose is the provision of services. CHA’s standards describe community benefit services as those designed to improve health status in the community, to promote access to healthcare services to all persons in the community, and to contain healthcare costs.

Some examples of community benefit services include:

- Being part of community-wide efforts to decrease infant mortality and morbidity, to protect children against vaccine-preventable disease, to address the problem of violence in the community, or to help homeless families.
- Reaching out to minorities, the poor, and other underserved persons, whether or not they are enrolled in the integrated delivery network. This could include providing multilingual information on child health or offering employment opportunities to persons who are developmentally disabled.
- Implementing programs that promote health and avoidance of injury and illness through campaigns to decrease teen drinking, promote the use of car seats for toddlers, and institute surveillance systems that detect unusually high incidences of cancer, certain infections, or other possible indications of systemic community health problems.

Community Benefit Report  Finally, CHA’s standards suggest frequent and regular reports on what the organization understands to be the healthcare needs in the community and how it is responding to those needs. This reporting is not a self-promotion. Rather, it is a way of being accountable to those in the community responsible for tax policies, to those who volunteer their time in governance and direct service, to those who contribute financial support, and to the medical staff and employees who want to be part of a mission-oriented organization.

MISSION STATEMENT OF ALEXIAN BROTHERS MEDICAL CENTER, ELK GROVE VILLAGE, IL

The mission of Alexian Brothers Medical Center is to serve the health care needs of the community with a constant striving for the highest quality care, innovative and responsible use of resources and an abiding regard for the individual.

The health care provided here is the outward sign of the Alexian Brothers’ enduring vision, holistic perspective and sensitivity to the dignity of every person, advantaged and disadvantaged. It is care illuminated by the teachings of Christ and his Church.

We deliver health care in partnership with those who would share our ministry. Only with and through the community can we fully and faithfully serve those who come from the community to find healing and blessing.