Defining the Value Of Community Benefits

Analyzing the Kinds of Goods Society Produces Clarifies Hospitals' Charity Care Contribution

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Summary Community benefits occur when a hospital bears all or part of the relatively *unquantifiable* costs of promoting, sponsoring, or engaging in religious, educational, scientific, or health-related activities designed to improve community health.

By the very nature of their health-related activities, not-for-profit hospitals make extensive and varied contributions to community benefit. When a hospital free clinic inoculates a child for measles, the community as a whole benefits because the inoculation reduces the chance that measles will spread. Not-for-profit hospitals also provide many goods that are "undersupplied" by the for-profit private sector or the public sector, such as research, trauma centers used disproportionately by self-pay patients, and advocacy to rid the community of health hazards.

Moreover, a number of factors impose a legal and normative obligation on not-for-profit hospitals to engage in activities that benefit the community. These include Internal Revenue Service rules governing tax exemption, hospitals' fiduciary responsibilities to philanthropic donors, their obligations as "institutional actors" in their communities, and their mission to reach out to the poor and underserved.

Research into the behavior of not-for-profit hospitals often focuses on the charity care they provide. In light of the current debate over whether not-for-profit hospitals should continue to be tax exempt, this emphasis is understandable. However, a hospital's charity care contribution is only one factor the Internal Revenue Service (IRS) uses to determine whether it deserves tax exemption. English common law, U.S. case law,[1] and a 1983 revenue ruling[2] make it clear that a not-for-profit hospital can also merit tax exemption by engaging in health-related activities that benefit the community as a whole.

Community Benefits: A Definition

Community benefits occur when a hospital bears all or part of the relatively *unquantifiable* costs of promoting, sponsoring, or engaging in religious, educational, scientific, or health-related activities designed to improve community health. As this description suggests, neither the individual nor society directly bears the true costs of these efforts.

Activities that fit this definition satisfy both the IRS's tax-exemption criteria (i.e., the exemption of educational, religious, and scientific activities) and the not-for-profit hospital's traditional mission to serve the community. Thus the definition recognizes that hospitals engage in many activities that do not necessarily break even, much less generate a profit. Moreover, this definition implies that community benefits, given current hospital cost-accounting procedures, are difficult to quantify financially.

The increasing demand to justify not-for-profit hospitals' tax-exempt status compels providers to produce empirical evidence of the community benefits they make available. Consequently, hospitals must not only define but also operationalize community benefits—that is, develop measurable indicators of the strength of their community orientation.

Efforts to define, develop, and quantify indicators of a not-for-profit hospital's community-benefit activities have been undertaken by the Catholic Health Association, in the form of the *Social Accountability Budget*; by the American Hospital Association, in *Community Benefit and Tax-Exempt Status: A Self-Assessment Guide for*

Hospitals; and through the research efforts of J. David Seay and Robert M. Sigmond.[3] This research, coupled with the Internal Revenue Code itself, suggests six dimensions of community benefit activity:

1. Scientific, religious, and educational activities
2. A hospital's community orientation as stated in its mission and policy statements
3. Efforts to work with other organizations that affect a community's health status, including linkages between a hospital and its governing board, the members of the local community, and other local healthcare providers
4. Public advocacy efforts on behalf of the local community's general healthcare needs
5. Special policies, provisions, and efforts on behalf of the poor
6. Contributions of non–revenue-producing services, especially those targeted toward the poor

Indicators of each of these dimensions have been developed,[4] but they continually need to be refined to measure the nature and extent of a hospital's ever-changing community-benefit activity. Only then will it be possible to know how much community benefit a hospital provides.

Classifying Community Benefits

By the very nature of some of their health-related activities, not-for-profit hospitals—and perhaps some for-profit hospitals—make extensive and varied contributions to community benefit. Why are certain health-related services "automatically" beneficial to the community at large and not just to the individuals who receive them? The answer can be found in an economic analysis of the types of goods and services that society produces, healthcare being among them. Economists often divide these goods and services into three categories: private goods, public goods, and mixed goods.

Private Goods Private goods include those over which an individual has property rights. Private goods have owners who determine who may "consume" the benefits they offer. For example, an automobile is a private good because its owner can determine who may benefit from its use.

> Individuals cannot be excluded from the benefits of public goods.

Generally, the market supplies private goods because individuals are willing to bear the costs to receive the benefits.

Public Goods Public goods, on the other hand, are not "owned" by an individual. Individuals cannot generally be excluded from the benefits of public goods and services, even when they do not pay for them. Moreover, one person's consumption of a public good does not directly preclude or diminish another's enjoyment of its benefits. Government-provided national defense or the guiding light from a lighthouse are examples of public goods. No one individual "owns" national defense or the light from a lighthouse. If the protection of the light is available to one, it is available to all, including those who do not pay.

Mixed Goods The third type of economic good, mixed goods, is a combination of public and private goods. Healthcare services are mixed goods because they are provided for consumption by and benefit specific individuals but produce benefits that also "spill over" into the community at large.

For example, when a child is inoculated for measles at a hospital free clinic, he or she directly benefits from immunity to the disease. Other individuals are "excluded" from the direct private benefits of the service. In this sense, an inoculation is a private good.

Inoculations also have a public-good dimension, however, because they reduce the probability that measles will spread to those who did not receive an inoculation. Free inoculations create a benefit that a community receives at the expense of the hospital that provided the service. Those who do not pay for the inoculation cannot be excluded from its community benefit. Neither does one's benefiting from the reduced probability of incurring the measles diminish the probability of a similar benefit occurring to another who has not been inoculated.

Health education is another example of a mixed good with public- and private-good dimensions. Health education promotes public knowledge about healthcare, hygiene, personal fitness, and disease prevention. However, even though only a few people may use a hospital's

educational services directly, healthcare information can quickly spread throughout the community through informal exchange among community residents.

Another reason healthcare services are mixed goods is they contribute to a larger pool of productive labor. Specifically, economists argue that a larger labor pool allows workers to become more specialized, thus enhancing productive efficiency.

> Not-for-profit hospitals may provide services the private sector undersupplies.

Unfortunately, because of their public-good dimension, community benefits are difficult to quantify. Nevertheless, this aspect cannot be overlooked in assessing the community benefits a hospital provides.

Undersupplied Goods and Services Not-for-profit hospitals, like many other not-for-profit organizations, contribute to a community's well-being because they produce many goods and services that are undersupplied by either the private market or the government. Traditionally, citizens and private philanthropists have often called on not-for-profit organizations to fill the gap created by the private sector's refusal to supply private goods that do not make a profit and the public sector's undersupply of some types of public goods and services. In addition, citizens have often turned to not-for-profit organizations to supply higher-quality services than those available from the public sector. Here, private, not-for-profit education comes to mind.

Not-for-profit hospitals provide a number of goods and services that private-sector hospitals avoid because they are unprofitable. These include research, physical examinations and inoculations for nonpaying schoolchildren, trauma centers or burn units used disproportionately by self-pay patients, and advocacy to rid community areas of such health hazards as rats, garbage, lead, and pollution.

When the private sector fails to produce "goods" such as clean air (i.e., "public goods," in the economic sense), citizens usually look to the government to fill the gap. However, even governments, with their power to tax and coerce, do not always fund the production of some types of public goods to the satisfaction of their citizens because political processes often work against implementation of programs the majority favors. Thus some societal goods such as education, a clean environment, and healthcare may be undersupplied in the public sector as well as in the private sector.[5]

A not-for-profit hospital also responds to market incentives that create an oversupply of some services in a community. Nevertheless, it plays an important role in supplying services that are undersupplied by either the profit-maximizing for-profit sector or the politically driven governmental sector. As the sole provider of certain goods and services that the community or groups of individuals within it desire, a not-for-profit hospital creates a community benefit.

Obligations of Not-for-Profit Hospitals

Two major reasons not-for-profit hospitals are required to engage in community-benefit activities are that the IRS requires them to do so to maintain their tax-exempt status and that not-for-profit hospitals themselves have a fiduciary responsibility to steward the resources entrusted to them to carry out activities that benefit the commonweal.

The IRS Requirement The IRS requires that not-for-profit organizations engage in "exclusively . . . charitable . . . purposes."[6] This phrase's meaning remains open to interpretation, and the IRS has largely left it to the courts to determine what behavior is appropriate for tax-exempt organizations. Despite this ambiguity, not-for-profit hospitals must determine how their behavior manifests "exclusively charitable purposes."

At one time, both the public and the IRS simply assumed that a not-for-profit hospital's activities were community-benefit activities. Thus, until recently, neither the IRS nor the courts had much to say about the nature or the amount of community-benefit activities a not-for-profit healthcare facility must undertake to retain its tax-exempt status.

However, the community orientation of the not-for-profit hospital is no longer taken for granted, as seen in an increasing number of judicial challenges to tax-exempt status from state and local governments. These challenges will continue as long as governments believe that

revoking certain not-for-profit organizations' tax exemption will generate additional revenue, as long as local entrepreneurs believe that not-for-profits hold an unfair competitive advantage, and as long as the public sees little difference between not-for-profit and proprietary hospitals in orientation, operating style, or outcome. Thus not-for-profit hospitals, both individually and collectively, will be increasingly called on to "prove" their community orientation as a justification for their tax-exempt status.

Fiduciary Responsibility Traditionally, not-for-profit hospitals in the United States have enjoyed the unquestioned trust and support of the communities they served. Throughout the nineteenth century and through most of the twentieth century, religious and secular groups' capacity to provide hospital-based healthcare was greatly enhanced by the beneficence of many local individuals. By donating their private resources to these groups on the assumption that they would serve the common good, these benefactors endowed those who sponsored not-for-profit hospitals with fiduciary responsibility.

Today, private philanthropic contributions to the healthcare sector are much smaller proportionately than they were earlier. By 1984, private contributions made up only about 8 percent of the annual funds of not-for-profit health services, whereas private payments and government payments constituted 48 percent and 35 percent, respectively.[7] Nevertheless, the not-for-profit hospital continues to have a fiduciary responsibility to act on behalf of the local community that entrusts it with its donations and, in most cases, continues to invest it with community resources in the form of tax exemptions.

Normative Obligations

Apart from the fact that not-for-profit hospitals are legally required to engage in community-benefit activities, they are also bound by a normative imperative: Not-for-profit hospitals *ought* to engage in community-benefit activities if they do not already do so. There are two reasons for this. The first concerns the nature of the not-for-profit hospital as a corporate institutional actor. The second derives from the mission of the not-for-profit hospital and, for Catholic providers, the healthcare mission related to their Judeo-Christian principles.

> Institutions have the power to shape the futures of local communities.

Institutional Imperative Without a doubt, institutional actors control more "normative, economic, and influence resources" than do either most individuals or most other noncorporate groups in a community.[8] Because they have more resources, institutions have the power to shape, for better or worse, the futures of the local communities. This is especially true when their governing boards make decisions about whether to remain in the neighborhood or to relocate.

Thus, as one type of institutional actor, not-for-profit hospitals have the potential to exert enormous influence over a community. For example, not-for-profit hospitals have the power to advocate on behalf of those who have neither the money nor the organizational skills to advocate for themselves. They might mobilize the city government to provide needed services, use components of state and federal programs, or marshal opinion to create the proper normative climate for promoting the area.[9] Moreover, by actively investing their time, energy, and money, not-for-profit hospitals can create and support community voluntary organizations by soliciting the participation and investment of individuals throughout the community. In effect, not-for-profit hospitals help launch important community-benefit activities by removing obstacles to community groups' participation in them.[10] Consequently, they can make it safer for individuals to risk their own resources to work together on behalf of the local community, thereby promoting its stability and well-being.

Not-for-profit hospitals have these capabilities, but what would compel them to put their resources at the service of the local community? An answer to this question is suggested in the rights, privileges, and responsibilities of a not-for-profit hospital corporation. As a legal "person," corporations presumably share social responsibilities similar to those of human persons. Among the responsibilities of the human person, at least according to social contract theory, is the responsibility to further the common good. According

to this argument, then, a corporate institutional actor such as a not-for-profit hospital not only has the capacity but also the obligation to use its resources for the benefit of the community.

Religious Imperative Organizations that derive from a Judeo-Christian religious tradition have a special responsibility. This religious framework suggests that human beings—and the organizations they create—have been endowed with resources that are ultimately God given. As such, these corporations are called to steward these resources and to share them with others who, for whatever reason, do not have access to what they need to live a full human life. Consequently, for both religious and social reasons, the founders of religious not-for-profit hospitals were compelled to engage in healthcare activities of benefit not only to themselves but also to the community.

> Gospel values compelled religious communities to care for the sick.

The vast majority of Catholic hospitals were founded, and continue to be supported by, institutes of women religious. The history of these efforts has only recently begun to be chronicled in books such as *Pioneer Healers*.[11] Their commitment to Gospel values compelled many religious communities to undertake the care of the sick—irrespective of economic status, religion, or race.

Thus grounded in the teaching mission of the Gospel, the traditional healthcare mission of not-for-profit hospitals became synonymous with engaging in community-benefit activities. In urban areas, not-for-profit hospitals were often established to provide healthcare to the poor and to other members of the local community, especially those who were without access to healthcare because of ethnic, religious, or racial discrimination. In rural areas, where healthcare of any sort was relatively scarce, not-for-profit hospitals were established to serve the general need for healthcare.[12]

The "Reality" and the "Ought"

By the nature of the services it provides, a not-for-profit hospital *does* make contributions to the community beyond those reflected in charity care figures. This is the "reality" of the not-for-profit hospital's mission.

From another perspective, however, a not-for-profit hospital *must* make community-benefit contributions: IRS rules—along with the hospital's fiduciary responsibility to the local community, role as a corporate institutional actor, and religious and historical mission—compel it to do so. This is the "ought" implicit in the not-for-profit hospital mission.

Although the value of a hospital's community-benefit activities is difficult to quantify, these contributions are robust and reliable justifications for a not-for-profit hospital's claim to tax exemption. Unfortunately, recognizing the value of these contributions is not the reality for most researchers and policymakers. However, it certainly ought to be. □

NOTES

1. See 71 Am. Jur. 2d State and Local Taxation, sec. 385 (1973); *Evangelical Lutheran Good Samaritan Society v. County of Gage* (Nebraska, 1967); and *Ould v. Washington Hospital for Foundlings* (1877).
2. Rev. Rul. 83-157, 1983-2, C.B.
3. *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, Catholic Health Association, St. Louis, 1989; *Community Benefit and Tax-Exempt Status: A Self-Assessment Guide for Hospitals*, American Hospital Association, Chicago, 1988; J. D. Seay and R. M. Sigmond, "Community Benefits Standards for Hospitals: Perceptions and Performance," *Frontiers*, vol. 5, no. 3, 1989, pp. 3-39.
4. S. M. Sanders, "The Measurement of Charity Care and Community Benefit in Catholic Nonprofit Hospitals: Implications for Tax-Exemption Policy," unpublished dissertation, University of Chicago, 1991.
5. See B. Weisbrod, *The Nonprofit Economy*, Harvard University Press, Cambridge, MA, 1988.
6. Internal Revenue Code, Section 501(c)(3).
7. V. A. Hodgkinson and M. A. Weitzman, *Dimensions of the Independent Sector: A Statistical Profile*, 2d ed., Independent Sector, Washington, DC, 1986, p. 117.
8. R. P. Taub, G. Taylor, and J. Dunham, *Paths of Neighborhood Change: Race and Crime in Urban America*, University of Chicago Press, Chicago, 1984.
9. Taub et al., p. 183.
10. Taub et al., p. 122.
11. M. U. Stepsis and D. Liptak, *Pioneer Healers: The History of Women Religious in American Health Care*, Crossroad, New York City, 1989.
12. P. Starr, *The Social Transformation of American Medicine*, Basic Books, New York City, 1982.