INDIGENCY, ETHNICITY, AND HOSPITAL VIABILITY

The Growth of Racially Diverse Communities Challenges Catholic Providers and Sponsors

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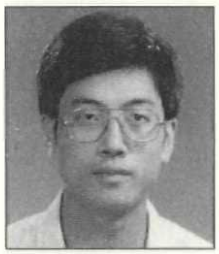

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The evidence of disparities among racial and ethnic groups in indigence, health status, and access to healthcare is overwhelming. For example, a 1990 study published in the *New England Journal of Medicine* reports Harlem residents have a mortality rate equal to that of the population of Bangladesh.[1] A Catholic Health Association (CHA) study conducted in the same year found a similar pattern of excess mortality among residents of East St. Louis, IL[2] (see **Box**, p. 48). Evidence also indicates that predominantly black and Hispanic communities are more likely than predominantly white communities to have a limited number of physicians, forcing many residents to depend on hospitals and community health centers for primary care.[3]

The increased concentration of lower-income minority groups in urban neighborhoods has been one of the major demographic developments during the past two decades.[4] To get a clearer picture of the implications of these trends for Catholic healthcare providers, we analyzed correlations between the racial and ethnic composition of communities served by Catholic hospitals and those hospitals' viability and capacity to serve their communities. In particular, we were interested in determining:

- The extent to which Catholic hospitals serve communities with racially homogeneous populations and with racially or ethnically diverse populations
- How Catholic hospitals that (1) serve communities with high percentages of indigent black and Hispanic residents and (2) provide high levels of care for the poor differ from Catholic hospitals that (1) serve more affluent communities with few racial minorities and (2) provide low levels of care for the poor
- What, in terms of patient mix and service-area demographics, characterizes many of the hospitals experiencing the most severe financial difficulties

Summary A Catholic Health Association study analyzes correlations between the ethnic and racial composition of communities served by Catholic hospitals and these hospitals' viability and capacity to serve their communities. It also describes the extent to which Catholic hospitals serve racially homogeneous communities, on the one hand, and racially and ethnically diverse communities, on the other.

For comparison, the study focuses on hospitals in two groups. Group A consists of hospitals in the top quartile based on their proportion of care for the poor and top-quartile percentages of black and Hispanic residents in their local communities. Group B consists of hospitals with bottom-quartile levels of care for the poor and bottom-quartile percentages of black and Hispanic residents.

The study found that, from 1985 to 1990, group A hospitals continued to provide high levels of care for the poor (between 28 percent and 32 percent on average) while average margins fell from about 4 percent to below 1 percent. During the same period, the amount of care group B hospitals provided to the poor remained between 5 percent and 6 percent; although their margins declined, these hospitals were significantly more profitable than group A hospitals.

The financial stress currently being experienced by many hospitals that serve communities with relatively high percentages of ethnic and racial minorities is troubling. Without basic reform of the healthcare system, many of these facilities may have to close, leaving many in their communities without access to adequate healthcare.

Our findings have implications for strategic planning for facilities with a mission to serve indigent populations. The study also provides data that will support public policies to increase poor minorities' access to care, such as those advocated in the healthcare reform proposals presented by CHA[5] and others.

Methodology

Using data provided by the 599 Catholic hospitals that responded to the 1990 American Hospital Association Annual Survey, we compared hospitals in the top quartile—based on their proportion of care for the poor (defined as charity, bad debt, and Medicaid valued at full charges as a percentage of gross patient revenue)—with those in the bottom quartile. The 149 hospitals in the first group, identified as high-proportion providers, allocated more than 16.7 percent of their gross patient revenue to care for the poor. In the second group, 150 hospitals, identified as low-proportion providers, allocated less than 9.0 percent of their gross patient revenue to care for the poor.

Based on the percentage of black and Hispanic residents in their local communities, we further divided these two groups into top-quartile (more than 15 percent) and bottom-quartile (less than 1 percent) hospitals. The local community was defined as the ZIP code area in which an urban facility was located and the county in which a rural facility was located in 1990. The result was four groups, identified as follows:

- *Group A:* 83 hospitals with top-quartile proportions of care for the poor and top-quartile percentages of black and Hispanic residents.
- *Group B:* 65 hospitals with bottom-quartile proportions of care for the poor and bottom-quartile percentages of black and Hispanic residents.
- *Group C:* 85 hospitals with bottom-quartile proportions of care for the poor and top-quartile percentages of black and Hispanic residents. These hospitals tended to be located in smaller urban areas, more heavily concentrated in the South, and less concentrated in the West.
- *Group D:* 66 hospitals with top-quartile proportions of care for the poor and bottom-quartile percentages of black and Hispanic residents. Hospitals in this group tended to be rural, more heavily concentrated in the West, and less concentrated in the Midwest.

Groups C and D will not be discussed in this article because they do not relate to the study's objective, which was to determine if differences in viability and other characteristics exist between hospitals having both high burdens of care for the poor and high concentrations of nonwhite residents and hospitals having neither high concentrations of nonwhite residents nor high care for the poor burdens.

Racial and Ethnic Composition

The communities served by Catholic hospitals vary widely in racial and ethnic composition (see **Table**, below). Of the hospitals studied, 319 (53.3 percent) serve in communities where nonwhite minorities constitute more than 10 percent of the population.

Communities in large urban areas tend to have more ethnically and racially diverse populations, whereas rural communities tend to be more homogeneous. Regional differences also exist. Communities in large urban areas in the Midwest

DISTRIBUTION OF CATHOLIC HOSPITALS (N = 599) BY PERCENTAGE OF RACIAL AND ETHNIC MINORITIES IN THEIR LOCAL COMMUNITIES

	White	Black	Hispanic	Asian	American Indian
< 1%	0	162	194	289	489
1 - 9%	0	243	293	290	107
10 - 19%	3	83	49	14	1
20 - 49%	40	91	51	5	1
> 50%	556	20	12	1	1

Data from the 1990 U.S. Census.

and South have the highest proportions of black residents. Communities in both large and small urban areas in the West have the highest percentages of Hispanics and Asians.

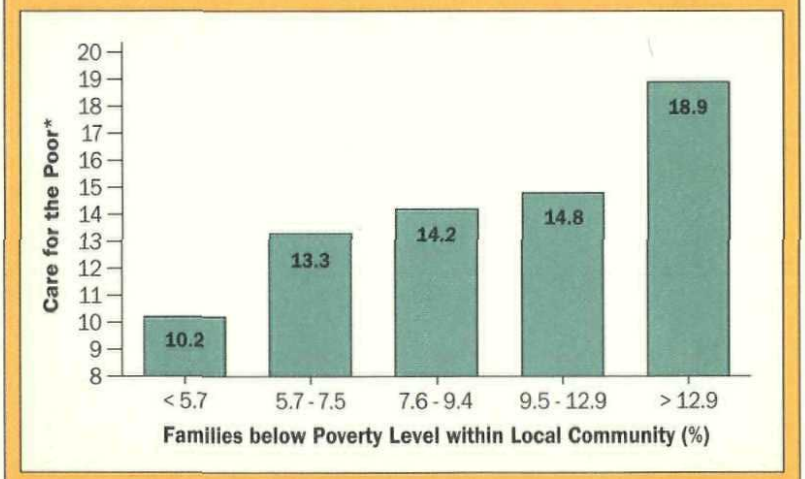
Communities with Relatively Large Black Populations Of the 599 Catholic hospitals studied, 20 are in communities where blacks represent more than 50 percent of the total population. Fifteen of these hospitals are in large urban areas (Baltimore; Washington, DC; Cincinnati; Detroit; New Orleans; Jackson, MS; Memphis; Chicago; Milwaukee; and Dayton, OH), and five are in smaller urban areas (Suitland, MD; West Palm Beach, FL; East St. Louis, IL; East Chicago, IN; and Southfield, MI).

Communities with Relatively Large Hispanic Populations Twelve Catholic hospitals serve communities where more than 50 percent of the population is Hispanic. Five of these facilities are in California, two in New Mexico, four in Texas, and one in Florida.

Predominantly White Communities Thirty-seven Catholic hospitals serve communities where less than 1 percent of the population is nonwhite. All these hospitals are rural, and the majority are in the Midwest.

Communities with Relatively Large American Indian Populations One South Dakota hospital serves a community whose population is more than 66 percent American Indian. Only two other hospitals—one in Alaska and the other in Montana—are in areas where more than 10 percent of the population is American Indian.

CATHOLIC HOSPITALS' CARE FOR THE POOR



Data from the American Hospital Association and the U.S. Census Bureau.
*Resources allocated to care for the poor (Medicaid, bad debt, and charity as a percentage of gross patient revenue).

Communities with Relatively Large Asian Populations Ten hospitals serve in communities where Asians represent more than 15 percent of the population. Nine of these hospitals are in California and Hawaii; one is in New York City.

Ethnically or Racially Diverse Communities A number of communities served by Catholic hospitals have relatively high percentages of more than one racial or ethnic minority:

- Eight Catholic hospitals—in Los Angeles; Long Beach, CA; Stockton, CA; New York City; Evanston, IL; Chicago; Jersey City, NJ; and Jamaica, NY—serve communities whose Asian, Hispanic, and black populations each exceed 10 percent of the total population.
- In California eight hospitals serve communities in which more than 10 percent of the population is Asian and more than 20 percent is Hispanic.
- Catholic hospitals serve communities in which more than 20 percent of the population is Hispanic and more than 20 percent is black in Texas (three hospitals), Illinois (four), New Jersey (two), and Florida (one).
- In Seattle one hospital serves a community in which almost 12 percent of the population is Asian and more than 20 percent is black.
- In Duarte, CA, one Catholic hospital serves a community in which almost 12 percent of the population is Asian and almost 43 percent is Hispanic.

Financial Viability and Care for the Poor

Analysis of the socioeconomic and demographic characteristics of the communities served by Catholic hospitals revealed that:

- The rate of poverty tends to be higher in communities with high percentages of black or Hispanic residents.
- The level of care for the poor provided by Catholic hospitals tends to vary with the level of poverty in the local community (see **Figure**).

Study results indicate that some Catholic hospitals have sustained their commitment to care for the poor, despite declining financial health. *Between 1985 and 1990, group A hospitals continued* to provide high levels of care for the poor (between 28 percent and 32 percent) while their margins declined (from about 4 percent to less than 1 percent).

For group B hospitals, on the other hand, the amount of care for the poor stayed between 5 percent and 6 percent. And although these hospitals' margins fell, they remained well above those of group A hospitals. To a large degree, differences in patient mix accounted for these disparities in margin.

As the **Table** on p. 47 indicates, group A hos-

pitals tended to treat more Medicaid patients and fewer commercially insured patients than group B hospitals, making them less able to generate surplus revenue from patient care to subsidize free care and compensate for Medicare and Medicaid shortfalls.

Capacity to Care for the Poor

Group A hospitals, a higher percentage of which tended to be major teaching facilities, were on average equipped to treat a wider variety of medical conditions than group B hospitals. As a result, they had a greater capacity to serve their communities and devoted a greater proportion of their resources to serving the poor than did group B hospitals. Group A hospitals also tended to provide a broader scope of services and had higher percentages of specialists and registered nurses on staff.

On the other hand, group A and group B nonteaching hospitals were similar in size, occupancy rates, average length of stay, breadth of services provided, and staffing levels of general practitioners and specialists. However, among nonteaching hospitals, group A performed less well financially than did group B.

Although margins for group A hospitals as a whole were low, significant differences existed between hospitals within the group. To get a clearer picture of the roots of these differences, we compared 21 group A hospitals identified as *stressed* because their margins were chronically low with 10 hospitals labeled *consistently sound* because their margins were consistently high.

We found no significant differences between the stressed and the sound facilities with regards to efficiency measures such as occupancy, average length of stay (total hospital, Medicare, and Medicaid), and full-time equivalents per bed. Nor were there significant differences in size, location, or teaching status.

But the hospitals differed significantly in three major areas. First, stressed hospitals depended more on Medicaid revenue, which accounted for 21 percent of their gross patient revenue, compared with 13 percent for sound group A hospitals. Second, the local communities of the stressed hospitals averaged a significantly higher percentage of black residents (30.3 percent versus 15.7 percent). Finally, the stressed hospitals offered a much narrower range of services.

Clearly—and disturbingly—the probability that a hospital will be financially stressed increases as the level of care the facility provides for the poor increases. Higher percentages of indigent minority residents in the local community also increase the probability that a hospital will experience financial difficulties.

COMPARISONS OF INDICATORS FOR SELECTED GROUPS OF CATHOLIC HOSPITALS (1990)

Indicator	Group A*	Group B†
Financial Characteristics		
Average total margin (%)	1.5	5.2
Deductible ratio	0.29	0.21
Days in accounts receivable	77.8	69.1
Cash flow/total debt ratio	0.14	0.36
Average payment period (days)	77.0	56.3
Long-term debt/asset ratio	0.38	0.30
Bad debt and charity care as a percentage of gross patient revenue	6.6	2.4
Care for the poor as a percentage of gross patient revenue	26.1	6.7
Source of Revenue		
Medicare (%)	39.1	47.8
Medicaid (%)	19.5	4.3
Self-pay (%)	7.2	6.7
Third-party payers (%)	23.7	36.2
Capacity and Utilization		
Number of beds	310	176
Full-time equivalents per bed	4.1	3.8
Occupancy rate (%)	72.6	56.2
Number of emergency visits per admission	3.1	2.7
Location		
Rural (%)	8.4	50.8
Located in 100 largest cities (%)	55.4	10.8
Northeast (%)	29.6	10.8
South (%)	18.5	9.2
West (%)	27.2	3.1
Midwest (%)	24.7	76.9
Other		
Involved in teaching (%)	49.4	15.4
Affiliated with Council of Teaching Hospitals (%)	15.7	0.0
Affiliated with a system (%)	76.3	65.6

* Higher level of care for the poor and higher percentage of black or Hispanic residents in local communities.
† Lower level of care for the poor and lower percentage of black or Hispanic residents in local communities.

Sharing the Burden

Financial handicaps such as those experienced by group A stressed hospitals limit the types and severity of medical conditions these facilities can treat. Many hospitals serving in communities with a heavy concentration of indigent minorities are in critical need of help. As the numbers of poor and medically indigent grow, some stressed hospitals may be forced to either restrict the number of indigent and Medicaid recipients they admit, convert from an acute care function, or close and forsake or redirect their commitment to care for the poor.

Despite deteriorating financial health and limited capacity, these facilities have struggled to fulfill their mission of care for the poor—and their presence adds to the community's quality of life. Their closure would further reduce access to care by indigent minorities in areas that may already be underserved, and it would remove an important source of social and employment opportunities for minority populations.

The question is, How can we reduce the cost of healthcare for the poor while maintaining the quality of care and viability of the hospitals that serve them? And how can we more fairly spread the burden of caring for the poor? Short of major healthcare reform, such as the proposals presented by CHA and others, workable responses to these challenges may not exist. □

NOTES

1. Colin McCord and Harold P. Freeman, "Excess Mortality in Harlem," *New England Journal of Medicine*, January 18, 1990, pp. 173-177.
2. *A Comparative Report on Demographics, Socioeconomic Status, Hospital Performance, and Community Health Status for East St. Louis and Selected Geographic Areas and Hospital Groups*, Catholic Health Association, St. Louis, July 1990 (unpublished report).
3. Karen Davis et al., "Health Care for Black Americans: The Public Sector Role," *Milbank Quarterly*, vol. 65 (Suppl. 1), 1987, pp. 213-247.
4. James W. Fossett et al., "Medicaid in the Inner City: The Case of Maternity Care in Chicago," *Milbank Quarterly*, vol. 68, no. 1, 1990, p. 113.
5. *Setting Relationships Right: A Working Proposal for Systemic Healthcare Reform*, Catholic Health Association, St. Louis, 1992.

PROFILE OF A DISTRESSED HOSPITAL

For many residents of East St. Louis, IL, St. Mary's Hospital is the only source of critical health services available. No other hospital in the county offers a freestanding outpatient center or a drug and substance abuse rehabilitation service. And a number of other programs the hospital offers—including hospice, psychiatric services (including a 10-bed stress unit), certified trauma center, home health service, and psychiatric geriatric service—are available at only one other hospital in St. Clair County. Although no renal dialysis service is yet available, St. Mary's is applying for a certificate-of-need to implement a seven-station program.

Given East St. Louis's population and needs, it is especially important that such programs be available locally. Ninety-five percent of East St. Louis residents are black. More than half the city's population is under 19 or over 64 years of age. And although the population of East St. Louis declined more than 14 percent between 1980 and 1988 (from 55,200 to 47,260), the number of elderly actually increased by almost 9 percent. Forty-three percent of the city's residents are below the poverty level, according to 1980 census data.

These figures characterize a population with both limited means and limited mobility, people who need a facility like St. Mary's in their community. Yet the demographic data that explain the hospital's importance to the city's residents also explain the facility's financial distress. Medicaid patients make up 48 percent of St. Mary's admissions, compared with 12.2 percent for hospitals in the St. Louis metropolitan area as a whole (which includes counties in both Illinois and Missouri).

The hospital lost $6.4 million in fiscal year 1990. Special state programs to increase reimbursement for indigent care (plus staff cuts of 20 percent) helped reduce losses to $1.1 million in fiscal 1991. However, absent legislation or policy changes that would guarantee long-term improvement in reimbursement for St. Mary's, the hospital's future viability remains questionable.

Meanwhile, the health status of the city's residents is alarming. A black person in East St. Louis is more than twice as likely as a white person in the overall U.S. population to die of cardiovascular disease, almost three times as likely to die as a result of an accident, more than four times as likely to die of diabetes, and more than twelve times as likely to be a victim of homicide. The figures suggest not only that the city's residents have inadequate access to a full range of healthcare services but also that they need economic development and a panoply of outreach programs to help them achieve healthier life-styles.

Despite these problems, St. Mary's Chief Executive Officer Charles Windsor looks forward to better times. "With the mission commitment of our sponsors, the Poor Handmaids of Jesus Christ, we are confident that the future of St. Mary's is ensured," he says. "The needs are too great to be ignored, the people too important to be denied services. East St. Louis is a community on the move, and St. Mary's is a key player in that movement as an employer, healthcare provider, and symbol of the city's positive growth."