LET'S MAKE DONATIONS MORE EFFECTIVE

Don't Waste These Important Efforts

BY BRUCE COMPTON

The medical surplus category is a huge one for charitable donations and ranges from relatively inexpensive exam gloves and syringes to anesthesia or imaging equipment worth many thousands of dollars. These kinds of surplus supplies and equipment in good working order can be repurposed to provide health and healing to people in need around the world. That's what donors intend.

But too often, these donations do little or no good at all. The distribution effort is wasted, the donated material itself becomes waste — an environmental liability for the recipients — and worst of all, people go without the lifesaving benefits the donations were meant to provide.

SURPLUS DONATION STUDY

In 2010, CHA initiated a research project to learn how our member organizations could best alleviate suffering in the developing world through a responsible medical surplus donation program using efficient, environmentally conscious processes.

The study examined responses from CHA-member hospitals (432 of approximately 600 organizations) that collect medical surplus from hospital donors and distribute it to beneficiaries; and beneficiary organizations that deliver health care to the poor in the developing world.

As part of the project, CHA made site visits to 10 organizations that collect and distribute medical surplus. We also interviewed 26 individuals from a group of 15 organizations that provide services to those in the most need, including five groups in Haiti. The Gerard Health Foundation, a private charity foundation based in Massachusetts, provided a grant for the research.

There is no way to measure the amount of medical surplus all U.S. hospitals donate annually, but CHA data indicates approximately 600,000 tons of medical surplus donations flow from Catholic health care organizations every year to organizations that collect and distribute the donations. The collection/ distribution organizations, known by the acronym MSRO (medical surplus recovery organization), work under such significant restraints as a three- to six-month backlog

of unsorted donations — indeed, sorting usable donations is a key bottleneck— and a significant gap in biomedical expertise; limited financial resources for shipping donations; an inconsistent ability to effectively assess and meet needs.

After evaluating these limitations, CHA concluded:

- There's a failure of many donations to accomplish their lifesaving objectives
- Environmental liabilities are substantial. Surplus materials often wind up in landfills or are donated without assurances that they can be used in an environmentally sound manner.
- There is substantial wasted effort.

Sixty percent of member hospitals say they have donated broken equipment. Nine out of 10 member hospitals report donating supplies soon due to expire, and recipients of donations repeatedly report that they receive expired supplies. Yet according to the World Health Organization (WHO) guidelines for health care equipment donations, "There should be no double standard in quality. If the quality of an item is unacceptable in the donor country, it is also unacceptable as a donation." In almost all countries, importing expired medical supplies is prohibited by law.

We can't overstate the need for all Catholic health care organizations to work with a medical surplus recovery organization — and to learn to select the right one — to handle donating unused medical items to the developing world.

The research, however, showed as few as 1 in 12, or 8 percent, of CHA-member hospitals work with organizations capable of ensuring the donations they collect and distribute are both functional and appropriate. It will be an important step for members to collect data about their surplus donations so they can understand where gaps occur and what they can do more effectively.

THE NATURE OF THE NEED

Thousands of health care organizations across the U.S. and individual medical professionals are committed to alleviating the medical supply shortages that plague many countries within the developing world.

They have the resources. Today, the task of equipping America's health care facilities with adequate, conveniently packaged and state-of-the-art supplies and equipment unintentionally contributes a significant amount of medical surplus destined to be discarded.

As donations, these are the kinds of medical supplies and equipment that can be life-changing in developing countries — assuming the donations are appropriate and useful. Currently, best-in-class medical surplus recovery organizations ship more than 250 cargo containers holding thousands of tons of essential medical surplus each year, demonstrating the tremendous demand.

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It's not that these donations necessarily have long-lasting impact, said WHO's Jennifer Barragan. They instead can serve as critical stop-gap measures so countries can ramp up and improve their health care systems while developing their own more sustainable procurement systems. The key is improving the way donations are made so recipients get what they need and can use, including maintenance support and training, said Barragan, who is technical officer, diagnostic imaging and medical devices, in WHO's department of essential medicines and health products.

"Changing the status quo will be challenging, but it starts with providers considering needs of the recipient and with solicitors [recipients] enforcing strict rules on what should be permitted as donations," she said.

THE ROLE OF MSROS

Medical Surplus Recovery Organizations have many challenges that contribute to the overall issue of low-quality medical surplus donation.

TO REVIEW A COPY of the Catholic Health Association's *Medical Surplus Donation Study, How Effective Surplus Donation Can Relieve Human Suffering*, go to **www.chausa.org/International_Outreach_Overview.aspx**. There, you will also have access to additional resources and updates on CHA's International Outreach activities and upcoming events.

These overburdened organizations, while helpful in many instances, generally are in desperate need of staff and volunteers with medical/clinical backgrounds. When CHA visited 10 self-described MSROs during the course of its research, it quickly became clear that no across-the-board industry standards exist. In fact, every medical surplus recovery organization operates differently. CHA used nine criteria to evaluate MSROs across organizational, relationship and operational lines. Using these guidelines, CHA assessed that not all MSROs were adept at ensuring donations are dependably distributed in ways that are genuinely useful and appropriate.

Here is the simple truth: There just aren't enough high-functioning MSROs to meet the needs of America's health care organizations. While the pressing need to create new MSROs is essential, CHA is encouraging its members to work with organizations that have a history and process for ensuring high quality donations.

Nationally a number of regions lack access to a quality medical surplus recovery organization. CHA has identified strategic locations for new MSROs to serve its members and will collaborate with them, current MSROs and others to look into feasibility for new ventures to aid this outreach of Catholic health care ministry.

Catholic health care is proud of its centuries-long tradition of international outreach with hospitals, relief organizations and humanitarian organizations — all in the spirit of achieving a higher standard of global health. In the spirit of that tradition, our member hospitals must compel better results and accountability from the donation organizations with which they collaborate. They must ask the difficult questions and make changes as required. By partnering with both established and emerging MSROs, CHA members will be well-positioned to develop stronger long-term strategies.

THE SOLICITOR'S ROLE

In my own experience as a former director of an MSRO, I often was surprised at the lack of feedback I received from recipients. I believe the reason is that people in dire need are so very grateful for what they *do* receive that they don't want to discuss the parts of the process that aren't successful or effective.

We must shift to a paradigm whereby recipients become and are acknowledged as solicitors of the equipment they are to receive, and those of us who are donors ensure that we provide high-quality items as they are requested.

The World Health Organization strongly concurs. Says Barragan, "The latest WHO document regarding donations is titled 'Medical Device Donations: Considerations for Solicitation and Provision.' The title indicates that the guidelines are not only intended for those who provide the equipment but also for those on the receiving end, who should be active solicitors. No donation should ever be provided without significant consultation with the recipient. Hence, the term should not be 'recipient' but 'solicitor.'

"It is the role of solicitors to tell donating organizations what they require and also to turn away anything that does not meet their needs. Solicitors are entitled to demand quality from the donations they receive, thus essentially forcing those organizations with bad donation practices to change their strategies."

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To address donation problems more specifically, CHA is developing an educational tool accompanied by a video that will outline the most effective next steps. They will be available by the end of 2012. Also, the 2012 Global Summit to be held June 5 in Philadelphia, directly after before CHA's annual Assembly, will address the challenges of medical donations.

There is no expiration date on taking a deep, long and realistic look at the limitless need for medical surplus versus the genuine impact of what current practices are accomplishing. Most organizations that make medical donations are sincerely motivated by good will. However, we must donate strategically and according to mutually understood and uniform standards so that outcomes live up to good intentions.

BRUCE COMPTON is senior director of international outreach for the Catholic Health Association, St. Louis. Contact him at bcompton@chausa.org.

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