Comparisons between the Delivery of Healthcare and the Delivery of Charitable Services

May 19,2008 Richard G. Wendel

In 2002, I authored a book titled *Independence Day: Revolutionizing the Physicians Role in Healthcare* published by the American College of Physician Executives. This manuscript analyzes the healthcare system in the light of the extraordinary high costs and inconsistent delivery of healthcare in America and offered systemic solutions through the empowerment of physicians and patients. In my research for a book on volunteerism, I found the Independent or Third Sector to have many parallels and similar characteristics to the American healthcare system. This paper compares and contrasts the two systems.

During recent years, healthcare and nonprofit organizations have been the major economic drivers of our economy. In 2006, healthcare costs accounted for roughly 16 percent of Gross Domestic Product (GDP) while tax exempt organizations accounted for approximately 12 percent. Both segments are rapidly growing, and, if you subtracted their contribution to the 1.7 million jobs created by the U.S. economy between 2001 and 2006, you would have had negative job growth.

Cost Efficiency

As a proportion of GDP, Americans spend about twice as much for healthcare as any other developed country. But we can't brag that pricey healthcare has produced a healthier citizenry. In fact, the Commonwealth Fund's Commission on a High Performance Health System in using 37 national healthcare indicators found no evidence that Americans enjoy healthier or longer lives than in other developed countries. Obviously, the American healthcare system lacks competitive forces and streamlined processes to restrain costs.

But, how cost effective and efficient is the nonprofit sector? According to Michael Porter, a management guru at the Harvard Business School, "billions are wasted on ineffective philanthropy and philanthropy is decades behind business in applying rigorous thinking to the use of money." Dr. Porter obviously believes that the world of altruism needs transforming by adopting better business practices.

Both healthcare and the nonprofit sector have few competitive forces such as Adam Smith's invisible hand of perfect markets that rewards good investments with good returns. In truth, philanthropic boards rarely discuss the competitive benchmarks of performance and cost efficiency. If a dialog about competition does occur, it usually relates to securing next year's funding ahead of the pack rather than astute resource management and superior service.

Of the 1.6 million nonprofit agencies, there are few that have the size to enjoy economies of scale and with a plethora of small agencies, service redundancy is rampant and many agencies ride the same wagon and reinvent the same wheel.

Proactive Prevention

Historically, medical schools have emphasized diagnoses and treatment of disease rather than a systemic focus on health promotion/disease prevention. And 49 million Americans have no health insurance coverage that results in a delay in seeking medical care with the consequence of a higher percentage of catastrophic events.

Charitable services also focus on treating the symptoms of poverty rather than solving the core problems that lead to impoverishment. The pure survival needs of the destitute are often met with short-term fixs. The result is that when addressing hunger, dollar after dollar is spent on larger and more efficient food banks, canned-food drives, soup kitchens, community gardens and other measures that relieve hunger but ignore the poverty that is the root cause of hunger. Poverty needs to be addressed through early intervention with a focus on a stable home environment, quality education, adequate medical care and opportunities to succeed.

The crucial formative years of early childhood are the time of greatest risk for our underprivileged children. Unfortunately, the government and Third Sector tend to grapple with childhood problems too late. Ninety-five percent of all public funding for youngsters is applied after kindergarten, from ages 6-18. If society pursued corrective programs to prevent the scars of prenatal, infant, and preschool neglect, it would save on remedial and correctional programs later on. One in four children lives in poverty and a single-parent home, and nearly a quarter of all pregnant women in America, many of whom are adolescents, receive little or no prenatal care.

Herding Cats

Medical care services are provided by a cottage industry of thousands of mostly small medical practices, each with its unique culture and autonomous group of physicians, practicing within an 'expert culture.' No local, state, regional or national body has the agency to coordinate supply of medical services or dictate standards of care. The majority of nonprofit organizations also are small 'storefront' enterprises operating autonomously within a neighborhood or city with no local, state, regional or national agency responsible for regulating supply, quality or access to services.

In the nonprofit sector the extensive IRS listing and cataloging of tax-exempt organizations is inadequate to convey the fragmented nature of Philanthropy. Curiously, there is little financial information published in the public domain for over two-thirds of all nonprofit organizations. Moreover, nonprofit executives and managers enjoy extraordinary independence, free from the oversight of owners and investors. They are accountable to just a volunteer board what may or may not meet with any degree of regularity.

A favorite expression among hospital administrators is that managing physicians is like 'herding cats.' This metaphor is appropriately applied to nonprofits as well.

General Planning

America has the only employer-based healthcare delivery system in the developed world. The provider groups such as hospitals, drug manufactures, insurance companies, laboratories, and medical practices have powerful lobbies to protect their turf and aggressively compete for a larger share of the healthcare dollar with limited government intervention. The individual doctor and the patient have been displaced outside the loop of control.

The nonprofit sector is called the Independent Sector for good reasons. The majority of nonprofits exists under the radar of government oversight and this, coupled with worthy missions, shield them from critical scrutiny. This benign environment has encouraged nonprofits to multiply without quality guidelines and indefinite boundaries. Few nonprofits reach capacity to be self-sustaining, and the majority gets stuck in the middle between needed niche roles and the major philanthropies, enjoying neither the benefits of specialization nor size.

With little outside guidance, the individual preferences, missionary zeal and special agendas of founders and chief executives often drive the service programs of nonprofits with limited regard for the needs of the community. Market research and assessment often follow program failure rather than precede it.

More frequent mergers among small nonprofits would seem a logical approach to decrease these dislocations. But tax-exempt status confers a competitive subsidy that circumvents the pressing need to consolidate, merge or even disappear. And it is a challenging process to merge due to a lack of positive incentives to move the negotiations along within these culturally diverse organizations. Golden parachutes, stock options and rich severance packages are not options to sweeten a deal that would reshuffle authority and dilute the autonomy of the directors.

Planning Complexity

The Over-the-Rhine inner-city area in Cincinnati is home to 6,500, mostly poor, residents. In this area, there are over 80 agencies and ministries serving the homeless and working poor, of which 30 offer almost identical services. The resources to serve this population are sufficient and even redundant, and yet, no interface exists to coordinate social services and track the homeless night-after-night to monitor their multifaceted needs.

Recently, religious congregations and faith-based organizations have come together to address this continuity of care problem by developing a "one stop shop" or "campus of care," at a single location called the CityLink Center. It would house facilities for treatment of substance abuse, job training, educational support, health services, overnight shelter, temporary housing, and child care. This 'resource hub' for the under-resourced has many supporters, but strong objections have arisen from local residents and property owners who generally agree the project is a good idea, but don't want it in their backyards. Currently, the initiative is stalled due to zoning restrictions. Moreover, influential developers and the Cincinnati City Council have a vision to revitalize downtown Cincinnati through urban renewal projects with new residential housing and business infrastructure in this district. Thus, the CityLink Center's good intentions are paddling upstream against the current of city management, local homeowners and developers.

Information Technology

Vendors of leading edge medical information systems aggressively market to the medical community the benefits of transforming medical practices into paperless offices. The arguments in favor of the electronic office are irrefutable and include increased physician productivity, better documentation, fewer medical mistakes, improve quality of care and reduced office expense. By some estimates, broader use of automation could decrease total healthcare expense in the system by $170 billion per year, but market penetration has been slow due to physician resistance.

Nonprofit organizations also have been slow to pursue modern information technology to streamline operations. Often the software is proprietary, written in outdated computer languages, and the computers are on closed systems that do not interface either with the operating systems or software used by other agencies. These early version management systems may be adequate to maintain mailing lists, perform basic accounting processes and provide access to the Internet and e-mail, but not much more.

Analogous to the medical field, the newer operating systems and software programs can provide persuasive benefits to nonprofits.

The most compelling argument for charities to invest in IT is that it helps monitor the population served. In the soup kitchens, homeless shelters and medical clinics that I have visited, no one seems responsible for the holistic case management of this indigent population. The homeless shelter is often just a warehouse of humanity and doesn't track and coordinate follow-up medical care, medications, job and transitional housing placement.

Unfortunately tracking and following the hardcore destitute is difficult. Many of the chronically homeless have privacy issues such as criminal records, outstanding warrants, illegal immigration, delinquent child support payments, multiple aliases, as well as impairments such as mental illness, drug abuse, retardation and a need to game the system and maintain anonymity due to income sources and organized crime, all of which make them reluctant to share personal information. Ironically, if it were possible to better track this population, more would qualify for an umbrella of services that would expedite

rehabilitation and reentry into mainstream society while at the same time eliminating some of the slack in the duplication of services.

Some Pigs are More Equal than Others

Within our employer-based health care system, 49 million Americans have no insurance. Indeed, those uninsured persons typically delay necessary care and pay a premium price for service, if they get sick. This reflects the 'cost shifting' to the uninsured that occurs because health insurance companies negotiate deep discounts and Medicare pays highly discounted fees to providers.

Research grants and private donations to medical causes are often influenced by politics, personal preferences and special lobbies rather than a logical system based on the incidence and overall costs of a particular medical problem to society.

Also, in the nonprofit sphere, there is asymmetry and a hierarchy of access, distribution and wealth. On one side are the heavyweights that include large, financially sound institutions such as colleges, universities, hospitals and large national organizations that receive a sizeable portion of their revenues from fees and are quite corporate in their structures and behaviors. This top tier controls all but a small part of the 2 trillion in net assets in the Third Sector. In the lightweight class reside 70 percent of all nonprofits, those that have revenues under $500,000 a year. About 40 percent of nonprofits are financially precarious with net worth that is less than three months of operating expenses.

> With some regularity, even large, well-known institutions whine about operating losses and rising costs, and annually hint that they might need to scale back programs or even close their doors. But large philanthropies such as those in education, the arts, museums and health care have many competitive advantages that make these threats vacant. They can fall back on loyal alumni, affluent patrons, grateful patients, municipal bond issues, foundations and corporate partners willing to address dire needs and come to the rescue. Moreover, a large donation can get a name etched in granite on a university buildings or research center, or naming rights to a department chair, museum wing or sports arena.
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> Donor recognition also conforms to the idea that "some pigs are more equal than others." Donors to a specific charity are typically listed by size of the donation. Platinum ($10,000), Gold ($5,000), Silver ($1,000), and Copper ($500) and Members

($50) are printed in descending order in quarterly newsletters, annual reports and special event folders.

Cost versus Benefit

A patient undergoing a medical intervention should have a full understanding of the potential benefits, the relative risks, the costs of the procedure and how the aftereffects might impact the quality of life. Curiously, in medicine, cost is rarely discussed as a consequence of treatment.

A parallel cost-benefit analysis gets lost in social services provided by nonprofits. To illustrate this disconnect between cost and benefit, let's take a look at the expenses of just two charities to grasp the wide variation in costs versus benefits.

Lighthouse Youth Services in Cincinnati provides comprehensive services to abused and neglected children. It has a budget of $15.5 million and in 2005 served the needs of 4,692 school-aged children. On a day-to-day basis more than 250 children are provided residential care at an annual cost per resident per year of $62,000, or $170 per day. Two percent of its budget goes toward fundraising, and greater than 80 percent of revenues are spent in support of seven major programs.

Contrast this resource utilization with the The *Shriners Burns Hospital* in Cincinnati. It is a magnificent 30-bed hospital for children with an average occupancy rate or census of less than 50% or between 10 and 15 children. The hospital does not bill the families of burn victims for care and it provides six live-in accommodations for out-of-area families to be with their children. The ambience is cheerful and bright, the staffing extraordinary and the hospital has a large pool of volunteers involved in ancillary services. A research laboratory adjoins the inpatient area of the hospital and there are dedicated areas for classroom instruction and a range of rehabilitative activities. It is easily appreciated that this hospital is one of the finest centers for burn treatment in our nation.

The Shriners do not officially publish annual cost figures, but a board member confirmed that the hospital's budget runs well in excess of $30 million per year. Using conservative estimates, this averages out to $1.2 million per inpatient per year, or around $3,288 per day for chronic care.

These two organizations illustrate the asymmetry in resources and dollars consumed to achieve altruistic goals. We are not questioning the mission, but only the ethical dilemma raised by opportunity costs or the next best alternative use, when viewed from the perspective of scarce resources and social justice in the spectrum of altruism. In medicine, the same cost issues are omnipresent and cause complex ethical concerns. How much is one year of quality life or a life compromised by persistent pain and suffering worth?

The Numbers Game

In response to the unsustainable rise in healthcare costs, Medicare, Medicaid, and managed care organizations have reacted by deeply discounting all fees and paying hospitals a set fee linked to an arbitrary coding system. As a consequence, for physicians to maintain income, they must see more patients per unit time and hospitals must focus on decreasing hospital stays. This assembly line model has eroded the sanctity of the doctor/patient relationship, because it encourages the physician to minimize the listening and emotional support inherent in the visit to see the doctor.

In charity, the number of widgets produced also plays a key role in reimbursements and performance evaluation. In fact, few charities collect data other than outputs such as the number of visitors, number of hours of instruction, clients interviewed, counseling sessions, number of volunteers, tons of food distributed, number of families sheltered, and pounds of clothing processed.

Of much greater significance are outcome measures and impact such as improved childhood nutritional status, behavioral change, recidivism rates, test scores, graduation rates, and the rate of teenage pregnancy. Making a difference and social impacts are the real holy grail of mission success.

In general, public agencies accept process measures as surrogates for performance. The compulsion to meet the numbers encourage charities to shortchange the client and to refer out the more intractable problems.

Hype & Promotion

Years ago, before the Federal Trade Commission (FTC) intervened, organized medicine, including the American Medical Association (AMA) and state medical societies, prohibited physicians from advertising their services because of ethical concerns. Typically, a small announcement in the local newspaper when a physician entered practice was all that was allowed. The years have brought dramatic change to these restrictive professional norms. As a consequence, we all are experiencing promotional overload in healthcare due to a barrage of direct to the consumer advertising that inappropriately biases medical decision making and increases utilization.

In nonprofits, classy marketing and advertising techniques have also taken hold and now are budgeted line items. Before the dramatic rise in the number of nonprofits seen in recent years, promotion occurred mainly by word-of-mouth, and mission preempted the need to waste money on advertising. But times have changed. Postcard announcements, invitations to fundraisers and brochures seem to give more bulk to the mail than for-profit mailings. Larger nonprofits now have catchy media clips produced for paid advertising on community and public TV. Celebrity telethons, radiothons and droning fund drives have become annual fare. Billboards and painted buses, newspapers and magazines, coupons and discounts, pens and stick-on address labels, prizes and athletic contests are creatively used to make a dazzling appeal to support good works.

A headline containing the words “children” and “death” are consistent grabbers that appeal to deeply rooted sentiments. Charities that serve children or do research for the cure of a deadly disease have a head-start in gathering private support. Emotion often trumps any consideration of what the money is actually used for.

Corporations give about $1 billion to the arts annually, and the benefits flow in both directions from this engagement. The arts are symbols of civic pride with which to associate and burnish a posture of good corporate citizenship. Coincidentally, art galas and stage performances are great places to entertain customers and to socialize with influential figures. Board membership and committee work in the arts supports an impressive resume and nurtures a broad network of high profile acquaintances. The bonds between corporations and the arts are truly a marriage made in heaven, and, not surprisingly, a marketing bonanza that unleashes a network of influence, affluence and good deeds within a tax-free environment.

Employment

At the post-graduate level, it takes about nine years of formal training to become a practicing physician, and, once in practice, there are annual requirements for continuing medical education (CME) and periodic recertification. The medical license is an absolute barrier to entry for competitors and, excluding unforeseen tragedy, more or less guarantees lifelong employment.

By contrast, top executives in nonprofits have no formal training requirements. A mere 6 percent of MBA graduates plan on pursuing careers in the social sector and few business colleges offer majors in nonprofit administration and social entrepreneurship.

The basic character traits of nonprofit executives and managers are extremely variable and do not fit into distinct categories. Those I have interviewed seem genuinely motivated by humanitarian concerns. Often early life experiences impact their decision to link their careers to civic and social service. Coming from an impoverished environment, being the victim of an alcoholic parent, seeing the ravages of an incurable disease, or perceiving social injustice may generate a passion to address social ills.

Aside from altruistic motivations, the milieu and feel of working in philanthropy is attractive. The work environment is more casual and caring with a slower pace. This permits greater leeway to balance work with family and outside interests. The flat hierarchy without investors that characterizes small and midsized charities affords a greater degree of independence and autonomy. Most nonprofit jobs are tied to local activities and do not require extensive travel. With worthy causes come instant trust and generally little need to play political hardball.

Working in nonprofits connects mission with a double bottom line of operational success and social impact. Charitable services to mankind have a warm and fuzzy feel, and, as one convert from the for-profit world commented, “in the passionate world of philanthropy, people always give you a hug and an unqualified thank you.” It is easily understood why some extraordinary managers, that have sampled both the for-profits and nonprofits worlds, become permanently captivated by the privileges of working in nonprofits.

There is a high employee turnover rate in charitable organizations. This relates to many factors, including lower pay scales, skimpy retirement packages, modest long-term

incentives, few perks and a limited number of top executive positions. Additionally, over 70% of nonprofit workers are female, usually young, who bring with them the complexities of family planning, child rearing, financial necessities and spouses whose place of employment might change. Moreover, new hires are often fresh out of training; a time of greatest transition and change for young adults.

Regulation

The healthcare field is regulated at the federal level through the Department of Health and Human Services and many agencies such as the FDA, NIH, DEA and OSHA. The states exert influence through insurance regulations, medical licensing and Medicaid programs.

For the most part, the nonprofit sector is self-regulating with few reporting requirements aside from the tax filing of a Form 990 with the IRS. To be designated as a 501(c) (3) tax exempt entity is a relatively simple process and 95% of those who apply are accepted.

Criteria to be recognized as a 501 © philanthropy include a mission that advances the "common good and general welfare" and "seeks civic betterments and social improvements." In the certification process, there must also be broad understandings as to legal structure, demographics, governance and how the financial resources will be used. Having fulfilled these requirements, the nonprofit is then governed by a volunteer board that is usually assembled from the network of friends and acquaintances of the founders. Once appointed, it becomes self-perpetuating.

Other agencies in the federal government beside the IRS tangentially or through specific public programs, oversee the nonprofit area including the Department of Justice, the Department of Housing and Urban Development, the Department of the Treasury, the Federal Communications Commission, the Federal Election Commission, the Federal Trade Commission, the U.S. Postal Service and the Securities and Exchange Commission. No agency specifically dedicated to nonprofits has global supervisory control or Federal government standing.

Candidates running for public office generally do not include nonprofit funding and regulation as campaign issues, since overt criticism of philanthropy is a losing proposition with little appeal or traction to an electorate that is not politically engaged

with the issues of nonprofit subsidies and public funding. Likewise, the perception of "trust" and "lack of self-inurement" shield nonprofits from the close scrutiny of investigative reporters looking to uncover fraud and abuse.

There is little incentive for government to more closely regulate the Third Sector, since nonprofits do not pay taxes and the costs to regulate would exceed the administration fees and penalties for noncompliance. But nonprofits are still a sizeable part of our economy and worth a closer look.

The Unintended Consequences Hall of Fame

In the medical field, the most notorious example of unintended consequences stemmed from the legislation that created Medicare in 1965. At the time, the cost projections for Medicare were conservative and considered consistent with a balanced federal budget. For doctors and hospitals that traditionally gave free service to the elderly poor, it was a windfall, because now they were reimbursed for these elderly patients that often had chronic conditions. In the initial provisions of the Medicare program, the Federal Government agreed to pay doctors 'usual, reasonable and customary fees' based on a fee schedule crafted by the physicians and their professional societies. Curiously, Medicare was strongly opposed by organized medicine that, correctly, deemed it a step toward "socialized medicine." The unintended consequence of Medicare was that it opened the flood gates of escalating healthcare costs that we see today.

Unintended consequences occur in social programs as well and perhaps, even more so. Altruistic zeal coupled with limited accountability may cause fiduciary responsibility, good business sense and rational behaviors to get lost in a maze of special agendas, wishful thinking and eternal optimism.

The 2001 Elementary and Secondary Education Act or "No Child Left Behind Act" (NCLB) is one of the Bush Administration's notable domestic achievements. The law mandates that each state devise annual performance tests and curriculum standards to test public school students in reading and math every year from third through eight grades, plus once in high school. The law imposes consequences for failure based mainly on adequate yearly progress (AYP) with an eye toward closing the achievement gap between rich and poor, and minority and white students. Another basic goal was to bring all students up to grade-level in math and reading proficiency. If a school misses AYP

benchmarks two years in a row, the school must offer the students a chance to transfer out. If the school underperformed for three years, it must provide tutoring services for lagging students, and after five years, if no progress was made, the school must undergo "reorganization."

In my volunteer work in inner-city elementary schools, I have observed a dramatic change in principal and teacher orientation due to this legislation. Six weeks before the proficiency tests are to be administered, classroom work becomes exclusively focused on passing the tests. The basics of reading and math sucked up all the energy at the expense of social studies, history, art, gym, classroom projects, assemblies and field trips. For the states, NCLB mandated testing has been expensive and difficult to develop, score, and report in a fair, expedient and balanced fashion. Errors in scoring, delays in test result reporting and the system-wide demands on the testing industry have been problematic. Many educators argue that the NCLB program has distorted and stressed the system without compensatory benefit. Results on national math and reading tests are mostly flat and the reliance on a single, pass-fail system for assessing adequate yearly progress is questionable. A secondary effect has been to hurt the very students it was designed to help by driving good teachers away from failing inner-city schools where student progress is measured in small increments.

However simple and straightforward a proposal may seem, the outcomes always contain some surprises that were not anticipated.

As I have viewed medicine and philanthropy side-by-side, it is apparent that both need improvement. I have solutions for most of the problems in both sectors, but, since time tonight will not allow, we will reserve those for a later paper.