

# A Proposal to Redistribute the Cost of Hospital Charity Care

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**T**HE PROBLEM OF HOW TO FINANCE HOSPITAL CARE for those unable to pay has received considerable attention (Feder, Hadley, and Mullner 1984; Bazzoli 1986; Blumstein 1986; Reinhardt 1986; Sloan, Valvona, and Mullner 1986; Sherlock 1986; Lewin and Lewin 1987; Short, Monheit, and Beauregard 1988; U.S. General Accounting Office 1990). To finance this care, proposals have been made for a universal health-insurance program, for mandatory employer health-insurance coverage, and/or for expansion of existing government welfare and insurance programs to cover the needy population. At the moment, the prospects for implementing these programs are slim due to rising federal budget deficits, strong resistance from some segments of the population, and uncertainties facing the national economy. By default, it falls on the nation's hospitals to finance a portion of the hospital costs that patients cannot pay for themselves. We refer to this portion as "charity care."

In this article we outline a plan to distribute the cost of the charity care provided by nonprofit and public hospitals more equitably. Based on the assumption that a pressing need exists for a rational distribution of charity care among hospitals, our approach urges immediate reform of the present system to remedy the perverse effects resulting from the current skewed distribution of charity care (Feder, Hadley, and Mullner

1984; Chang and Tuckman 1990a). We propose a redistribution plan that requires hospitals to quantify the charity care they finance and to make this information publicly available. We provide in this proposal specific guidelines for defining charity care and encourage state legislatures to review information on hospital-financed care and to set priorities for the proportion of unmet need to be financed by the state on the one hand and by the hospitals on the other.

The proposal's redistribution formula takes into account the benefits that a hospital receives and its ability to pay. Hospitals that finance more charity care than required would be rewarded for each dollar they spend, whereas those providing less would be taxed for each dollar of shortfall. Within defined limits, a voluntary incentive is thereby created for hospitals to provide additional charity care. Each hospital can then decide whether to provide charity care itself or to finance other hospitals to offer this care. Although the pool of funds the proposal calls for can be used for more than one purpose, the primary goal is to have all nonprofit and public hospitals share in financing charity care. In so doing, we eliminate some of the incentive that hospitals have to forgo charity care when competition increases.

We begin with the question of why some analysts believe that hospitals should play a role in financing charity care. We then present a definition of charity care, discuss several principles of equitable finance, and introduce a proposal for more equitable distribution of the costs of such care. The proposal starts with a discussion of how an acceptable level of charity care is determined. We then suggest theoretical approaches to the question of fairness and offer a formula that draws elements from each approach. We pursue several issues created by the proposal and conclude by examining some indigent pools currently in operation and discussing a congressional proposal designed to improve the distribution of charity care.

### Why Are Hospitals Expected to Finance Indigent Care?

Strong arguments can be made to support the position that hospitals should *provide* care to those who cannot pay. For example, some would maintain that it is unfair and morally wrong to deny treatment to anyone when hospitals possess the means to alleviate suffering. Similarly,

hospitals have an obligation to aid those in need of treatment with understanding and compassion because hospitals offer life-and-death types of services. However, the issue of whether hospitals should *finance* the care for charity patients is largely unresolved today, despite a number of attempts to clarify the issues. (For a survey of the ethical issues surrounding access to health care, see the introduction to the study by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research [1983].)

The logic of asking hospitals to be responsible for financing the treatment of those unable to pay is usually premised on one of four arguments. First, hospitals are charitable institutions and, as such, should be responsive to those in need of medical treatment (Starr 1982; Lewin and Lewin 1987). Historically, most hospitals supported at least part of their work from church funds, gifts and bequests, and/or voluntary contributions of labor and other resources. Over time, the expectation has developed that they will continue to finance a portion of the services they provide, even though their operations have become more businesslike (Herzlinger and Krasker 1987). However, recent increases in competition have made it more difficult for them to do so (Lewin and Lewin 1987).

Second, it can be argued that the obligation to finance charity care stems from an "implicit contract" between hospitals and society (Rosner 1982). Society expects hospitals to finance charity care in return for the right that it grants them to dispense health services. Presumably, this contract is justified by the unique role that health-care providers play. However, one can question whether health-care provision requires a special contract. A third argument has been made that, as recipients of many forms of public support, hospitals should earn the special treatment they receive (Herzlinger and Krasker 1987; U.S. General Accounting Office 1990). Hospital finance of charity care demonstrates to society that subsidies are used for socially desirable purposes and relieves the public sector of some costs that it would otherwise bear. We must then ask whether hospital actions that benefit social groups other than the medically needy are equally valuable to society.

Finally, many nonprofit hospitals (and a few public ones) have large equity balances and substantial operating surpluses (U.S. Department of Health and Human Services 1986; Chang and Tuckman 1988). It can be argued that these balances should be used to provide care for the uninsured because nonprofit hospitals should not make profits.

Unfortunately, this argument does not recognize the distinction between the need to accumulate equity balances for normal business needs and excess accumulation (Tuckman and Chang n.d.). If non-profit hospitals were forced to spend down their equity, inadequate capital would be available to them for investment and growth.

### *Do Other Charitable Institutions Have a Similar Obligation?*

A number of other charitable institutions are expected to provide some free or reduced-cost services. Nonprofit colleges and universities, for example, are treated as charitable by federal, state, and local taxing authorities. Their mission statements often suggest that they exist to serve a broad constituency, they are recipients of public aid, and many have large equity balances (Chang and Tuckman 1990b; Tuckman and Chang n.d.). Although most of these institutions give away services through scholarships, fellowships, and related programs, they differ from hospitals in several important respects: Because the marginal cost of serving an additional student is considerably lower than the cost of treating one more patient, a decision to provide below-cost services to the student carries a lower price. A decision not to admit a student has less serious consequences than for a patient. Because scholarships are usually based on merit, denial of entry to a student is more likely to be perceived as based on cause than denial of a hospital admission to a very ill person. Alternatives for obtaining a degree are available to a person wishing to improve his or her educational level through correspondence courses, military or on-the-job training, and part-time enrollment. Rarely, however, can a patient denied entry to a hospital for a serious illness find alternative treatment. Finally, although many in society view health care as a "right," higher education is more likely to be considered a privilege.

If the services provided by hospitals are compared with those offered by churches, homeless shelters, and other charitable organizations, it is clear that the limited substitutes available for hospital care make this industry unique. Because hospitals' unwillingness to treat a patient can have serious consequences, they are expected to refuse care to the needy prudently.

### *Hospitals Do Not Bear the Full Burden of Charity Care*

Hospitals finance the care of charity patients, but they do not pay the full costs themselves; at least some of the costs are passed onto others. Pass-through can occur in many ways (Tuckman and Chang 1990b). One means is to finance charity care by reducing the salaries and wages of hospital staff. This process occurs over time, largely by offering raises that fail to keep up with inflation. Hospital employees then bear a part of the charity-care cost because their purchasing power has decreased. Patients also incur part of the cost in the form of a decline in quality of services received. Another way that hospitals share the burden is by deferring building or equipment maintenance and/or by cutting back on new purchases and construction. This shifts part of the cost forward to future patients and staff in the form of reduced support and inadequate capital. Yet a third way is to reallocate the costs of charity care to those who can pay, a practice widely described as cost shifting. Private-pay patients and third-party payers, like insurance companies and government agencies, end up with larger bills than they would otherwise. Although cost shifting is widely recognized, it is not clear that the other forms of finance are well understood by practitioners (e.g., Lewin and Lewin 1984).

Because hospitals do not bear the full burden of charity care, some analysts may be tempted to ignore the distribution of this care as unimportant. We plainly cannot do so, however, because hospitals that finance a large amount of charity care are at a distinct disadvantage relative to those that do not. This is true for several reasons: A cost is involved in finding ways to finance the treatment of those who cannot afford to pay. This planning takes the form of time spent by staff in formulating finance strategies, tracking the charity-to-pay-patient ratio, seeking alternative finance sources, and accounting for the care provided. They must also devote more attention to liquidity ratios and to cash-management strategies. Hospitals that are unable to shift their costs may find themselves operating with negative margins. This deficit spending will affect their ability to borrow funds and to use internal funding in order to upgrade the physical plant. As competition increases and third parties shop for the best prices at a given level of quality, hospitals that cost shift find themselves at a competitive disad-

vantage. Market forces create a pressure on them to reduce the amount of charity care they provide and/or to accept a less secure financial position (Tuckman and Chang 1990a).

Hospitals that become known as major charity-care providers can suffer a loss of paying patients. The combination of declining quality of care, a less desirable atmosphere, and increased cost shifting worsens their financial and competitive positions, with one result being that doctors refer their patients to other facilities.

These arguments suggest that requiring hospitals to finance their own charity care can have important consequences for their competitive and financial positions and for the quality of services that they provide. Clearly, the system used to distribute the costs of charity care is important, not only to the individual hospitals but also to society at large.

## The Proposal

The existing system for distributing hospital-financed charity care is haphazard, inequitable, and largely the product of random events rather than of conscious thought. This system must be altered to allocate the treatment costs of charity patients more rationally. An improved distribution of these costs is not a substitute for universal health insurance or for other proposals that offer health-care coverage to all. What it can do is to make explicit the amount of charity care that each hospital provides and to create a framework for determining how much care these hospitals should offer. Our proposal, which has three parts, suggests a procedure for generating and reallocating what have been called indigent-care funds or pools (Lewin and Lewin 1987). The first part discusses how to define and determine an acceptable level of charity care, the second offers a formula for distributing charity-care costs among hospitals, and the third explores particular design questions.

### *Part 1: Definition of Creditable Charity Care*

The uncompensated care that hospitals deliver each year results from a number of sources. Some medically needy persons receive treatment even though the provider hospital knows that they will not pay for their care. Others with the resources to pay receive free or reduced-cost

care as a professional courtesy or for political, religious, or other reasons. Still others, treated with the expectation that they will pay for their care, default on payment because of financial exigencies or because they can get away with nonpayment. Some bills go unpaid, too, because a hospital does a poor job of collection. Third parties disallow certain items, moreover, and the hospital is forced to absorb the balance. Finally, the difference between what hospitals charge and what they receive from third parties is sometimes treated as a form of charity care.

Our proposal counts only the charity care resulting from hospitals treating patients who cannot pay for services, which we refer to as charitable uncompensated care (CUC). Policy makers, in our view, need to recognize the efforts of hospitals to fill the gaps in financing left by existing public and private insurance programs. It is necessary, furthermore, to create incentives to encourage hospitals to provide charity care.

Uncompensated care provided to the nonneedy does not meet this goal because most of the individuals who receive such care could have financed it from other sources. Moreover, such care has value to a hospital in its own right. Care provided to doctors or staff as a professional courtesy is a form of compensation to employees. Similarly, care given to religious sponsors can be viewed as a reward for their service. If such care were eliminated, it is unlikely that major changes would occur in the availability of health-care treatment for this group.

It also makes little sense to offer incentives to hospitals that allow large debts to accrue. Uncollected debt and debts that result from defaults or criminal behavior are a reflection of poor administration rather than of charitable behavior. Society would not gain if hospitals were rewarded for allowing bad debt to increase.

The shortfalls that result from disallowances arise because hospitals agree to a contractual arrangement under which certain charges will not be reimbursed if the third-party payer considers them unacceptable. Denials are usually based on prevailing norms as to which treatments are needed and how much they should cost. It is not in society's interest to allow hospitals credit for unnecessary procedures or excessive costs. Moreover, it makes no sense to treat these shortfalls as "charitable" because these denials are unlikely to make the medically needy worse off.

Reimbursement shortfalls from Medicare and Medicaid are also not

charitable payments. A hospital's decision to discount its prices to federal and state governments is based on the expectation that this will generate more revenues than costs. This decision is similar to one by an airline to provide discounts to businesses with lucrative travel accounts or by a hotel chain to bring in convention business by discounting rooms. The dollar value of the discount is not a charitable payment to the patient, but rather a recognition that more people will seek treatment at that hospital when it lowers its prices. Any savings government may accrue through compelling hospitals to discount should not be treated as charitable care because it is not clear that this accrues to charity patients. If the discount brings in more patient revenue than it costs, the hospital benefits. If it does not, the hospital made a bad business decision. Moreover, discounts can benefit persons of any income and wealth level so that their inclusion as charity care overstates the amount of such care financed.

*The Acceptable Level of Charitable Uncompensated Care.* Our proposal begins with the need to identify the amount of unmet need both publicly and explicitly. This step could be taken by revising existing legislation to require that the federal Health Care Financing Administration (HCFA) estimate annually the dollar amount of charity care needed in each state. The results of its findings would be published annually and would provide the initial information to be used by the states in implementing their programs.

When these data are available, a suitable state agency is charged with the responsibility of conveying them, with recommendations for how to meet this unmet need, to the legislature. In some states, the appropriate agency may be the rate-setting commission, in others the cost-containment agency, and in still others the agency administering Medicaid. The designated agency provides its state legislature with an estimate of the costs of meeting the CUC needs estimated by HCFA. The agency can estimate the costs of different levels of need to provide the legislature with data on the consequences of its choices.

Under our proposal, a state legislature makes two critical decisions: First, it decides whether the total CUC provided by nonprofit and public hospitals in the state is either too high or too low. If the total CUC level is judged to be too high, the legislature appropriates funds and assumes part of the CUC costs that hospitals bear. If it is too low, the legislature uses its authority to compel a larger CUC contribution from nonprofit and public hospitals. A legislature can choose not to use its



authority, and in this case, total CUC is determined by their individual decisions. The aggregate hospital contribution will be judged to be too low when it falls below the value of the implicit and explicit benefits that hospitals receive or some fraction thereof, as the legislature determines. We discuss these benefits in more detail below.

Second, the legislature decides how much unmet need it will fund, either through increases in Medicaid or by direct payments to a pool used to reimburse hospitals for the charity care they provide. This requires a legislature to address explicitly the question of how to deal with charity care.

### *Part 2: A Fair Distribution of Charitable Uncompensated Care*

Four approaches to the distribution of CUC costs might be perceived as fair: *the voluntary approach*, *the egalitarian approach*, *the benefits approach*, and *the ability-to-pay approach*. Examples of the practical application of these principles exist in the public-finance literature, but, to the best of our knowledge, these principles have not been utilized in the charity-care literature (Musgrave and Musgrave 1984). Because ethical and moral precepts are the basis for the individual and public opinions that ultimately structure an acceptable proposal, it is unlikely that any one approach will be embraced by everyone concerned with what constitutes a fair system (Reinhardt 1986).

*The Voluntary Approach.* This approach is based on four underlying assumptions: (1) Hospitals (other than those owned by public entities) are essentially private institutions and, as such, should be free to decide how to spend their own funds. (2) Although it is true that hospitals are in the business of saving lives, the high cost of health care requires that it be rationed in ways that imperil the lives of some individuals. Choices must be made in a society with scarce resources and these adversely affect some unfortunate individuals. (3) Hospitals have the same right as other businesses to deny services to those who cannot afford them. (4) Although any charity care a hospital wishes to deliver is desirable, society should not compel a hospital to deliver free care because compulsion is inimical to the operation of a market-based economy.

The voluntary approach can be supported by several additional arguments. For example, hospitals are in a better position than outside par-

ties to know how much care they can finance. Policy makers often lack the information and expertise to design a system that adequately captures either the contribution a hospital makes to the community or the magnitude of the financial burden that it incurs. Hence, it may be best to let the professionals who run the hospitals determine what level of CUC they will offer. The United States has a long tradition of voluntary charity, which has worked fairly well. Because the system works, albeit imperfectly, there is little reason to change it. *Laissez-faire* is the best policy.

*An Egalitarian Approach.* Egalitarians also make several assumptions to support their argument: (1) Hospitals, in their view, have an obligation to provide care to those in their service area, irrespective of whether their patients can afford their own care. This obligation emerges from their charitable origins and from their contract with society. (2) Because hospitals have an equal chance to grow and prosper in society, fairness requires that they contribute an equal proportion of their wealth to care for charity cases. (3) Considerations such as the amount of taxes or subsidies received by hospitals, their financial condition, and/or the level and type of community services that they offer should not influence how CUC is distributed among hospitals because all hospitals ought to be treated in a similar manner. However, for-profit hospitals should be asked to bear the burden of financing charity cases only if the taxes they pay are less than the benefits they receive from society.

Although this philosophy requires that hospitals be treated equally, it offers little practical guidance for defining equal treatment. For example, should CUC be allocated according to a formula based on revenues, net income, assets, or equity? Moreover, how should the contributions that hospitals make toward the general welfare be treated? In its pure form, this approach makes no allowance for the financial condition of hospitals because it assumes that the question of what are appropriate taxes and subsidies should be addressed separately from the amount of charity care that hospitals should finance. To our knowledge, no general application of the egalitarian approach to the problem of how to finance care to charity cases has been made in the United States. This approach would create a CUC distribution considerably different from the present one.

*The Benefits Approach.* The benefits approach is derived from contract theories expounded by seventeenth-century political theorists

(Musgrave and Musgrave 1984). In its original form, it argued that taxpayers should contribute to government relative to the benefits they receive from it. Applied to the present context, it suggests that the amount of public largess that hospitals receive should correspond to the amount of CUC they provide, a point we will elaborate on below. The underlying assumptions of this approach are: (1) The grants and subsidies that hospitals receive from society, whether explicit or implicit, are benefits to them. (2) The CUC that hospitals provide should expand with the amount of social benefits that hospitals receive. (3) The period of time that hospitals are expected to provide CUC should increase with the length of time that they receive benefits. (4) Although finance schemes based on the benefit principle can make allowance for a number of hospital activities, including medical education and community service, the amount of CUC financed must correspond to the benefits received from the public.

The benefits approach has been tried in a variety of forms; the best-known example is the Hill-Burton program (Rosenberg 1971; Blumstein 1986). State indigent care-pooling schemes that raise revenues by taxing hospitals based on the benefits they receive could also be said to employ this approach. The logic is that because hospitals benefit from insurance payments, this service base is fair game for taxation. A problem with this line of reasoning is that it assumes that the full value of an insurance payment is a benefit to the hospital. In fact, the net value is a better measure, particularly if the payment is inadequate to cover the treatment costs.

*The Ability-to-Pay Approach.* A fourth approach drawn from the literature on public finance involves ability to pay. As applied to the finance of charity care, it requires that each hospital bear a CUC burden in relation to its financial resources. Fairness is achieved when hospitals with more ability to pay bear a larger share of the CUC in a state than those with less.

At least five arguments can be made for this approach: (1) Wealthy hospitals gain the most from the opportunity that society grants them to operate. It follows that they have the greatest obligation to offer society something in return. (2) Care to charity cases is important to society for the reasons expressed above. If hospitals are to be asked to fund this care, they should do so according to their financial ability. (3) Wealthy hospitals are less likely to be affected by the costs of financing CUC than are poorer hospitals. The burden to society of supporting charity

care is minimized if a larger proportion of CUC is imposed on wealthier than on poorer hospitals, because this distribution of costs causes the least amount of collective pain (Musgrave and Musgrave 1984). (4) CUC should be apportioned so that those who bear the burden are not driven out of business. If this step is not taken, some efficient hospitals may be forced to close down simply because they treat charity patients. (5) A program that finances CUC by taxing the wealthy is consistent with the philosophy that underlies other redistributive programs in the United States.

Application of this principle requires that each hospital finance an amount of CUC based on its income and/or wealth. The gross-receipts tax that some states impose on hospitals can be regarded as an example of an ability-to-pay tax, with either patient revenues or total gross revenues as the tax base. For example, Florida imposes a tax on hospital net revenues and Tennessee assesses a fee based on hospital beds. The implicit assumption is that the greater the revenues of a hospital, the greater its ability to pay. Operating surplus or net income can also be used as a tax base. These are more realistic measures because they net out expenses in determining ability to pay. A third measure uses wealth rather than income to determine ability to pay. The implicit assumption for the use of this tax base is that wealthy hospitals should pay more than poorer ones.

Ability-to-pay approaches have several features in common with benefits approaches. Both implicitly assume that hospitals have an obligation to society for what it offers them. The benefits approach considers explicit and implicit subsidies as tangible measures of what society offers, whereas the ability-to-pay approach chooses operating surplus or equity as appropriate indicators of what a hospital can afford. Both assume that fairness is achieved when CUC is distributed in direct relation to a particular measure. In the former case, this is the dollar value of the benefits that society provides; in the latter, net income and equity. Neither approach provides guidance for the "best" formula or set of tax rates.

*The CUC Apportionment Formula.* Our proposal uses the most defensible elements of these four approaches to apportion total CUC costs equitably among hospitals by formula. Hospitals that exceed the expected amount are rewarded by direct payments from a pool created by assessing hospitals that provide less CUC than expected. In addition, both the state and the federal government have the option of al-

locating more funds to the pool. These additional funds can be used to reduce the share of hospital-provided charity care directly or they can be used to reduce charity case loads through expansion of Medicaid. The reporting, calculation, and distribution of expected CUC is administered by the appropriate state agency. Aspects of the voluntary and egalitarian approaches are employed in that no hospital is forced to provide care to charity patients, while all hospitals incur CUC costs. Aspects of the benefits and ability-to-pay approaches are also used because hospitals that gain more from society pay a larger share of CUC, as do those with higher net earnings.

At the heart of the proposal is a two-part formula that takes into account both ability to pay and the implicit and explicit subsidies that a hospital receives from federal, state, and local governments. The first part of the formula is:

$$w_i = (M_i + B_i)/(M + B), \quad i = 1, \dots, N \quad (1)$$

where  $w_i$  is the distributional weight assigned to the  $i$ th hospital and  $N$  is the number of public and nonprofit hospitals in a state. The numerator on the right-hand side of equation (1) is computed by calculating the net operating surplus or deficit (e.g., the amount that remains after operating expenses are subtracted from operating revenues) of the  $i$ th hospital ( $M_i$ ) and the benefits ( $B_i$ ) that it receives in a year. These are divided by the total benefits ( $B$ ) and net income of all hospitals ( $M$ ) in the state in that year. The distributional weight  $w_i$  can be thought of as a hospital's percentage share of the total "beneficence" that society provided to hospitals in that year. The larger a hospital's weight, the larger its share of total CUC. The second part of the formula is:

$$\text{CUC}_i = w_i \text{CUC} \quad (2)$$

where the hospital's obligation ( $\text{CUC}_i$ ) is computed by multiplying the weight figured from equation (1) by total CUC net of state contributions.

A simple example will illustrate how redistribution of charity-care costs takes place under the formula. Assume that a state has four nonprofit hospitals serving its population with an indigent pool of the type described here. The state chooses to make no contribution to the pool

that is not used for any purpose other than to redistribute CUC care. For various reasons, hospital 1 initially finances \$35,000 of charity care, hospital 2 finances \$15,000, and hospitals 3 and 4 each provide \$25,000, with the result that \$100,000 of total CUC is financed in the state. After a careful computation of the elements of the formula, the state assigns hospital 1 a weight of .25, hospital 2 a weight of .20, hospital 3 a weight of .25, and hospital 4 a weight of .30. At the end of the year, the state settles accounts among the hospitals. Hospital 1 receives \$10,000 from the pool, hospital 2 pays \$5,000, hospital 3 neither receives nor pays, and hospital 4 pays \$5,000. The total CUC financed by hospitals in the state remains at \$100,000, but finance costs are redistributed, primarily to hospital 1. We discuss the redistributive consequences of the formula further below.

*The Distributional Weight and the Ability-to-Pay Principle.* A hospital's net operating surplus ( $M_i$ ) is a reasonable proxy for its ability to pay.

- Operating surplus measures cash on hand at the end of a year. Profitable hospitals are usually in a better position to incur CUC costs than those with limited or negative cash flow.
- Operating surplus more accurately reflects the current financial position than other financial indicators such as total assets and equity. A hospital with large asset and/or equity holdings may have a bad year due to decreases in its admissions or in length of stay. Its operating surplus reflects the immediate effects of the bad year whereas its equity is affected only gradually.
- If assets or equity are used to determine CUC, hospitals with limited cash flow and large equity may be forced to sell assets to meet their CUC obligation. This is not desirable from society's point of view.
- In most instances, a correlation exists between operating surplus and equity. On average, if a net-surplus measure is used, wealthy hospitals will pay more than poor ones.

One objection to imposing a CUC cost based on operating surplus is that operating surplus is used to accumulate equity and is a major source of expansion capital, especially for nonprofit hospitals (Chang and Tuckman 1990b). Thus, a hospital's ability to grow, diversify, and upgrade the quality of its services can be affected by a proposal that

taxes its surpluses. Our proposal has a zero net effect on aggregate capital investment because it redistributes CUC from hospitals currently contributing more than what is required of them to those contributing less. It does change the surplus balances of individual hospitals, however. Only in the case where a state requires all hospitals to contribute more than the current level of CUC is there a possible effect on capital accumulation.

Another objection is that depreciation of hospital buildings and equipment is not allowed in the computation of net operating surplus. It can be argued that this is unfair because it does not treat capital replacement as a legitimate business expense. It is our view that depreciation should be excluded for two reasons: First, depreciation allowances are based on the assumption that hospitals replace expended or obsolete assets with funds from a depreciation fund. In fact, nonprofit hospitals often finance their new construction either through bond finance or capital funding campaigns. Their need for depreciation allowances differs from that of for-profits. Similarly, most public hospitals receive state funding for new construction. In this case, careful circumspection is required before allowance is made for depreciation. Second, the method chosen to depreciate assets varies among hospitals so additional regulations are required to ensure that hospitals report in a similar manner. For example, rules must be adopted concerning whether to use acquisition or replacement value, how to compute asset life, and how to treat certain classes of assets. This complicates administration of the proposal and creates an issue of whether to use historical or replacement costs in the computation. To address these issues requires a much more complex set of calculations than what we propose here.

Some hospitals have operating deficits and the question then arises as to how they should be treated. To the extent that hospitals incur deficits because they offer more than their fair share of charity care, our proposal improves their financial conditions. However, the proposal is designed to redistribute CUC costs rather than to subsidize inefficient hospitals. Consequently, a hospital with a negative operating surplus is assigned a zero value for  $M_i$ , but is still assigned a weight based on the benefits ( $B_i$ ) it receives, thereby preventing mismanaged institutions from being subsidized by those with net surpluses. Some hospitals may fail, but our implicit assumption is that hospitals should not be allowed to stay in business if they are inefficient.

Revenue and expense items to be included in computing net operat-

ing surplus are those relating to inpatient and outpatient care, nonpatient care, and unrelated business activities. The treatment of funds transferred to corporate parents as well as the surpluses of for-profit subsidiaries may also be questioned. The pro-rata share of a parent organization's operating surplus can be credited to the individual hospitals in a system to determine each hospital's ability to pay. This prevents a hospital system from using inter-entity transfers to mask its ability to pay. The net income of for-profit subsidiaries is excluded from the computation because these entities contribute to society through tax payments.

*The Distributional Weight and the Benefits Measure.* The  $B_i$  term consists of the internal and external subsidies that society makes to each hospital. Its computation requires several steps. First, a dollar value is obtained for the explicit subsidies by requiring each hospital in the state to report the dollar value of the public and nontaxable private gifts and grants it receives. Research funds are exempted from the calculation on the assumption that these benefit the community rather than the hospital. Financing from city or county governments for general support, for specific support of care to the medically needy, or for non-charity-related programs is counted. When funds provided to hospitals for construction are included, the share of recipient hospitals during those years is drastically altered; exclusion means that the measure does not capture all of the benefits received by the hospital. A reasonable approach is to use an averaging method to spread capital funds across a number of years to avoid wide swings in hospital shares.

Step 2 requires the computation of implicit subsidies. These include the dollar value of the property-tax exemptions offered by tax authorities and the dollar value of exemptions from state and federal corporate-income and sales taxes. Our proposal requires that hospitals compute the value of their property-tax exemption by multiplying the applicable property-tax rates for their jurisdiction by the current assessed value of their properties. This procedure may require that hospital properties be assessed by a city or county appraiser. In states that tax equipment as well as structures, an argument can be made for including the value of the tax exemption on the equipment. The critical issue is whether the benefits of such an action outweigh the costs. An estimate of corporate income-tax savings is made by multiplying the hospital's net income by its applicable corporate tax rate after adjusting for the exclusions and deductions that state and federal tax laws would normally allow if the entity were for-profit. A value for the sales-tax ex-



clusion is obtained by applying the applicable city and sales-tax rates to hospital operating expenses net of personnel costs.

*The Redistribution Effects.* It is instructive to explore how the CUC share of each hospital changes under different circumstances. A state that decides to reduce the charity-care burden of its hospitals assumes a portion of their CUC costs by contributing to the pool. Total CUC is reduced, causing each hospital's CUC share to fall. Hospitals as a group finance less CUC than they otherwise would and those that voluntarily provide more care than required by the formula receive compensation. If a number of hospitals increase their charity care, either because they choose to or because they face an upsurge in visits from charity patients, total CUC rises and each hospital in the state shares in the cost of providing additional care. Alternatively, if several hospitals in a state decide to provide less CUC, the amount paid by every hospital falls. Thus, the decisions of individual hospitals affect the total. Finally, if each hospital provides CUC equal to its formula-determined level, no funds are transferred.

Several limitations of this proposal should be noted. First, it makes no allowance for a hospital's historical CUC experience. Existing obligations are based solely on the CUC offered by the hospitals in a state in the prior year rather than on a weighting of several years. It can be argued that a proposal that takes into account multiple years of CUC is preferable because it smooths out fluctuations caused by unexpected changes in demand. Second, the proposal does not provide a strong incentive for states to assume the CUC burden of their hospitals. Instead, reliance is placed on the judgment of the legislature to determine when the burden is too great. This objection can be corrected if a legislature agrees to add funds to the pool whenever the dollar value of the CUC approaches some fraction of the dollar value of the subsidies that hospitals receive from government, on average. For example, whenever the total CUC financed by hospitals in the state exceeds 100 percent of the value of their subsidies, the state could be required to add funds.

The proposal contains no provisions to deal with the quality of the care that charity patients receive because we view the problem of maintaining quality of care as one that should be treated in the context of hospital regulation. It also does not deal with issues of access because the proposal provides an incentive for hospitals to finance their fair share of charity care, but it does not require them to provide it. Consequently, hospitals can choose not to take on charity cases in their service area. Although this is an unfortunate byproduct of voluntarism,

we believe that access is best attained through programs that properly fund the treatment of charity cases.

### *Part 3: Other Issues Raised by the Proposal*

Many design questions are raised by our proposal, but only a few can be addressed here.

- What is the best political unit to administer the proposal?
- Is the reporting burden placed on hospitals excessive?
- Who should audit the data provided by hospitals?
- Should payments be ex-post or ex-ante?
- How should for-profit hospitals be treated?
- Should the community services offered by hospitals be included in evaluating effort?
- Should the pool be used to obtain matching funds from the federal government?

*The State as the Applicable Unit.* Several considerations lead to the suggestion that this proposal should be administered at the state level. Federalization of the program requires states to give up authority over the provision of CUC by the hospitals they charter. This is likely to cause considerable opposition from state and local governments and it may violate the social-benefit principles discussed above by adding a role for the federal government to the contract. Constitutional objections can be raised to a proposal that allows federal authorities to impose a selective "tax" on state and local public hospitals. A related issue is whether the federal government is setting a precedent by taxing nonprofit institutions. Reasons exist, too, for the differences in the level of unmet needs allowed by states. These relate not only to differences in state resource bases, but also to variations in cost of living, preferences for public services, and types of illnesses treated. To incorporate these into a federally administered program unduly complicates the proposal and makes it less responsive to regional differences.

The proposal, furthermore, calls for a state that adopts it to review on a yearly basis both its unmet medical needs and the dollar level of CUC care paid by hospitals. The federal government is assigned a research function, namely, to present data on the unmet needs in all states and this provides assurance that a common set of criteria will be

used in assessing need across states. However, the states themselves are given the responsibility for implementing the proposal because they are more likely to be familiar with the demands placed on their hospitals than a federal entity. There is, finally, the question of which entity is best able to finance unmet needs and/or to assume a portion of the hospital finance costs. Given the budgetary demands placed by the Medicare and other federal health programs, it is unlikely that the federal authorities will offer relief to the hospitals in the next decade.

A national program would make it easier to create an equitable distribution of CUC costs by spreading them across all states. If the goal is to have a fair distribution of CUC among hospitals, administering this program at the federal level is preferable because interstate inequalities can be reduced through a redistribution of resources across states. Moreover, national administration of this program would reduce the power of large hospitals and multihospital systems in negotiations with state and local administrative authorities.

An argument can also be made for distributing CUC costs across regions rather than states. For example, a number of states in the Midsouth region (Tennessee, Missouri, Arkansas, and Mississippi) lack the resources to fund adequately treatment for the medically needy in the Mississippi Delta. Such an arrangement can be accommodated within a regional authority. Regionalization also solves the problem of charity patients who cross state borders to take advantage of superior care in other states while preserving the differences in preferences for public goods prevailing in the several regions of the country. It also spreads CUC costs across a broader area and creates a stronger argument for supplemental federal funding.

Unfortunately, the creation of a regional authority does not guarantee that it will be funded at adequate levels. For example, all of the states in the Midsouth have a lower resource base than states in the Northeast and some states have higher per capita levels of unmet need. At present, a Midsouth regional authority would not be able to finance adequately its unmet medical needs from the tax base available in this area. Would the relevant state legislatures, moreover, be as willing to finance a regional body as they would an entity that functions within their own borders? With several states involved, it may be difficult to gain support for increases in public funding.

*The Reporting Burden on Hospitals.* Our proposal increases the reporting burden on hospitals by requiring them to quantify benefits not currently measured. It also mandates hospitals to provide assessed val-

ues for property-tax computations, federal corporate income-tax estimates, and state and local tax estimates. Chief financial officers or their agents must familiarize themselves with a variety of tax laws that they presently do not deal with. Because much of the work can be done by the accounting firms that many hospitals hire to complete their federal form 990s and Medicare cost reports, the compliance costs are not likely to be excessive. Moreover, these costs should decrease substantially after the first year because the largest cost involves setting up a system for complying with the new requirements.

Much can be gained if hospitals are informed of the implicit subsidies that society provides to them each year. At present, these are considered to be a matter of right and hence are not taken into account when decisions are made regarding a due level of charity care. Furthermore, the data required by our proposal should be of considerable interest to public policy makers.

*Audit of the Data.* The data used for computing CUC are meaningful only if they are reliable and accurate. Considerable opportunities exist for hospitals to define how their expense items are calculated and these affect their reported operating surplus. Moreover, transfers among hospitals within a system can significantly alter the surpluses of these entities. A separate levy may be required on parent corporations that do not dispense CUC directly if their surplus is not completely allocated to the hospitals in the system. Moreover, careful instructions are needed to calculate operating surplus, to define the property tax base, to identify the sales-tax base, and to treat exclusions and deductions.

Audit of the amount reported by the hospitals is essential and this can be accomplished one of three ways:

- State auditors review the amounts reported by each hospital on a biennial basis.
- Medicare cost-report auditors verify the figures filed by the hospitals when they audit the cost reports.
- The state allows accounting firms to certify the data reported by their hospital.

The decision of which method to adopt should be left to the state.

*Ex-Post Transfers.* To take into account the unpredictability of patient-care costs, our proposal utilizes ex-post payments based on data from the prior year. This provides a more accurate distribution of the

finance costs than is possible if operating surpluses, benefits, and total CUC are estimated for the current year. A problem with using prior-year data is that hospitals delivering large amounts of CUC must wait for what could turn out to be a long period to receive reimbursement, thus incurring a cost in the form of delayed use of the funds. We partially offset the costs of delay that emerge in an ex-post system by considering interest on the amount that hospitals receive as subsidy. A major advantage is that a state determines the equitable distribution only once a year and hence saves on administrative costs. However, an ex-ante approach can be adopted if a state prefers the approach. In this system, states levy penalties and distribute incentive funds initially and then adjust after actual data are available. A major problem with this approach is that hospitals may be forced to give back funds that they thought were available to finance charity care.

*Treatment of For-profit Hospitals.* The fact that for-profit hospitals are not included in this proposal raises at least two questions. First, what should be done in states where the CUC costs of some hospitals are so great that it becomes advantageous for them to convert to for-profit status rather than pay the CUC required by the formula? To address this, it is essential that the state health authority compare the CUC required of each hospital with the benefits that hospital receives and the taxes that it would pay if it were for-profit. If any hospital has CUC costs in excess of the sum of the subsidies that it receives and the taxes that it would pay if it were for-profit, the formula should be adjusted to reduce its burden. If necessary, the state can finance this reduction by raising business taxes. This would both provide a source of revenue and reduce the incentive for hospitals to become for-profit.

A second question involves how to treat the CUC provided by for-profit hospitals. At present, this is not a large amount, but it could be argued that an incentive should be afforded to for-profits to offer CUC. It is not wise to subsidize the care provided by for-profit hospitals with funds from nonprofit and public hospitals. If a state wishes to create incentives to its for-profit hospitals, it can finance these directly from its general fund or by allowing the for-profit to take a deduction or tax credit under its corporate income tax.

*Allowances for Services Provided the Community.* Nonprofit hospitals argue that credit should be granted for services they provide to the community at a reduced or zero cost. The U.S. General Accounting Office (1990) classified hospital-provided community services into broad categories:

- health-screening services
- health services education
- clinic services such as those offered to women and children
- community services such as meeting rooms, senior citizens programs, and lifelines
- housing of family members of sick patients
- patient transportation services
- food and clothing drives
- basic science or clinical research subsidies
- other

Although some of these services help charity patients, many are of benefit to nonpoor members of the community and to the hospital that provides them.

In deciding whether the dollar value of these services belongs in a computation of a hospital's CUC share, we must ask whether a state considers these services to be of sufficient value to warrant inclusion. If the answer is positive, then the question arises as to which items should be included. For example, some hospitals argue that medical-education activities belong in this measure. We need to consider whether these activities are of sufficient value to the community to be included; one way to address the problem is to require them to be of a type that differs from activities provided to the community by for-profit hospitals. This does not avoid the possible argument about whether a service is of sufficient benefit to treat it as a substitute for charity care. Another aspect of the question is whether to assess the full value of each community service or to value it at a fraction of the cost that hospitals claim. Two factors support the use of net value: Medical education, for one, has considerable private value to both students and the hospital and is frequently produced jointly with other hospital services. Screening tests performed by medical students have advertising value. To cite another example. The use of net cost seems to be more appropriate.

The question of whether to include community benefits in a formula designed to redistribute charity costs is not easy to answer. At a minimum, serious discussion of the issues requires a separate article. We favor a distributional scheme based solely on the charity care that hospitals provide because this simplifies the proposal and makes its intent clearer. It also avoids the arbitrary judgments that must otherwise be made. Our formula can be modified, however, to add the dollar value of whatever community services a state wishes to credit.

*Use of Pools for Matching Purposes.* Several states have created indigent-care funds to deal with charity care and related problems; Lewin and Lewin (1987) offer a noteworthy review of these. The pools can be used for many purposes: to support Medicaid expansion; to offset differences in the CUC provided by hospitals; to subsidize state-mandated high-risk insurance pools; to support grants for primary or preventive care, for special studies, or other programs. The most frequent use is to obtain federal matching funds for Medicaid. In Florida, for example, a task force estimated that a \$50 million contribution from hospitals and an addition of \$20 million of state appropriation would produce \$55 million in federal matching funds (Lewin and Lewin 1987). In states with limited revenue bases or with large claims on their resources, hospital contributions to these pools have been justified on the grounds that both the state and the hospitals "win." Increases in Medicaid funding cause a reduction in the amount of charity care that both parties would otherwise have had to finance.

Several considerations are worth noting when evaluating the validity of this argument. Many medically needy patients are not covered by Medicaid. This raises the question of whether enough charity patients can be covered under Medicaid to reduce the demand for CUC care by hospitals, thus rendering distributional issues moot. Such an outcome is unlikely at existing Medicaid funding levels. As long as a large number of charity patients exists, the demand for hospital-financed CUC is not likely to abate and this poses a problem. Funds provided by hospitals to fund Medicaid matching are not available to allow redistribution among hospitals. Although the total amount available for Medicaid increases, the disproportionate distribution of charity-care costs persists. For example, at least until recently, both Florida and Tennessee have been successful in increasing Medicaid funding through the use of pooling arrangements. They have not succeeded, however, in creating a rational distribution of charity costs among their hospitals.

With the onset of the 1991 recession, many states are considering cutbacks in the state contribution to their pools. These cutbacks have created doubts among the contributing hospitals as to the wisdom of this Medicaid matching strategy because it is seen as failing in its goal of bringing additional matching funds into the states. At the same time, unfortunately, the issue of the rationality of the existing distribution of charity-care costs has been largely forgotten. When an indigent pool is designed to achieve multiple goals (e.g., to increase federal Medicaid matching funds, to foster competition, and to reduce indigent-

care disparities among hospitals), an unintended side effect is that a tradeoff must ultimately be made among these goals.

When evaluating the so-called "win-win" argument, the use of a pool to provide Medicaid matching funds shifts the costs of charity care from a state's taxpayers to its sick, employees of health-care institutions, and to payers of health-insurance premiums. The problem is particularly serious when the tax falls on persons who finance their hospital care out of pocket. The logic for asking these people to bear a large share of the cost of charity care is weak. In contrast, when the pool is used to redistribute costs, the major effect is to ensure that the hospitals treating charity cases are not disadvantaged in dealing with the entities that finance hospital care.

### The Proposal and Existing Indigent-Care Pool Arrangements

Florida, Massachusetts, New Jersey, New York, South Carolina, and Tennessee have all established so-called indigent-care pools. Florida's Medically Indigent Fund was established in 1984 to finance expansion of the state's Medicaid program and to promote fair competition among hospitals. The state levied a 1.5 percent tax on hospital net patient revenues and assigned the responsibility for administering the program to the Florida Cost Containment Board. The proceeds of this tax were used primarily to attract federal matching funds, which, in turn, were employed to expand its Medicaid program. Approximately \$10 million in grants were also made to county public-health units to provide or oversee the delivery of primary and preventive care for underserved areas. Medicaid expansion was implemented very slowly and federal/state revenues were less than initial estimates. As a result, the program failed to shift cases off the charity rolls and onto Medicaid at the rate initially forecast. Because the state collected the tax on hospitals on schedule, a large surplus balance developed in the Fund. The accrual caused the governor to recommend a reduction in state spending for Medicaid in 1986. His recommendation was quickly overturned by the legislature, but not before a backlash developed against the indigent-pool concept.

Tennessee created its Indigent Health Care Risk Fund in July 1989. Administered by the Commissioner of Finance and Administration, the fund is financed from license fees. A flat rate is levied per bed based



on the sum of the institution's charity, medically indigent, and bad-debt costs. These define a base charity amount. A tax is then imposed on this amount, which is graduated by size. The initial rate is 14 percent up to \$15,000 per bed, 12 percent from \$15,000 to \$25,000, and 10 percent above \$25,000. Minimum and maximum fees have also been promulgated by the commissioner for acute-care, general, and specialty hospitals.

Other states differ in their choice of means to finance the pool. New York and Massachusetts tax health benefits rather than hospital revenues. In contrast, a 1985 South Carolina law funds the pool from hospitals and counties. New Jersey taxes hospital revenues. A common logic or practice does not govern how these pools are financed. States that use health-care expenditures as a tax base are susceptible to the charge that they are utilizing a "sick tax." Although this tax is partially passed on to third-party insurers and, from there, to payers of insurance premiums, one can still question whether a broader tax base might be fairer.

No state has fully met its unmet hospital-care needs, and most do not plan to expand Medicaid coverage in the next few years (Brown 1990). The states have had limited success in redistributing CUC costs among hospitals and, to date, none has succeeded in creating a rational allocation of CUC costs among hospitals. Some hospitals have had relief under these arrangements. Conversations with several presidents of hospitals delivering disproportionate amounts of CUC in Tennessee suggest that the pool did help to alleviate the funding problems they incurred due to charity-care delivery. Nonetheless, financing inequities persist.

Evidence is lacking with respect to whether pool arrangements significantly improve the competitive environment of hospitals. Two questions then arise: Do hospitals cut back on the CUC they provide as a result of competition, despite the presence of these pools? Have these pools improved the competitive position of hospitals that deliver large amounts of CUC? Neither question, unfortunately, has been adequately explored.

The goals of our proposal are similar to those of the state pools in that they are devised to redistribute CUC costs and neutralize the effects of charity-care delivery on a hospital's competitive position. Our proposal differs in design from these pools in several respects. It involves no additional taxes, whereas most state programs impose a tax to increase the amount of available matching funds. It also redistributes

CUC costs among hospitals using a formula based on established principles of fairness. This is important because the lack of agreement on how to redistribute fairly the available funds from existing pool arrangements has slowed progress toward improving CUC distribution costs.

A congressional initiative designed to make the existing distribution of hospital-based charity care fairer was proposed in June 1990. Motivated by a report by the U.S. General Accounting Office (1990) and by a growing number of court challenges to the tax-exempt status of non-profit hospitals (Hudson 1990), Congressman Edward Roybal (D-CA) introduced HR 5686, "Charity Care and Hospital Tax-Exempt Status Reform Act." GAO found that about 57 percent of the nonprofit hospitals it studied provided charity care amounting to less than their tax exemption, that significant disparities exist in the level of charity care that nonprofits provide, that the "least prosperous" hospitals provide much of the charity care, and that many nonprofits have strategic goals resembling those of for-profit hospitals.

The goal of the Roybal bill is to restore fairness among hospitals and a commitment to charity care. It requires hospitals to serve a "reasonable number" of Medicare/Medicaid patients and to provide documentation that they have done so. They must also annually provide an amount of charity care (measured at cost) equal to 50 percent of the value of their tax-exempt status and document community benefits equal to at least 35 percent of the value of their tax-exempt status. The bill requires written justification of how the community benefits provided differ from those of for-profit hospitals. The Internal Revenue Service (IRS) is required to revise its form 990 to capture the new information mandated under this bill. Failure of a hospital to comply with the provisions of the bill is punishable in the first year by public notice and in subsequent years by either (a) application of a 100 percent excise tax on the amount by which the value of the tax-exempt status exceeds the value of charity care and other community benefits provided, or (b) loss of its tax-exempt status.

Our proposal, unlike the Roybal bill, does not compel provision of charity care. Instead, it creates an incentive for hospitals to provide such care. Each nonprofit hospital could then decide whether it is more efficient for it to offer services or to finance another provider to do so. Our proposal also includes public hospitals in the finance scheme whereas the Roybal bill deals only with nonprofit institutions. Moreover, the Roybal bill establishes defined cutoff points of 50 percent for

charity care and 35 percent for community benefits. Hospitals that finance care below these points are punished; those above these points receive no reward for additional effort. Clearly, these “targets” are not conducive to efficient decision making. The bill’s definition of charity care includes the CUC defined in this article, care provided at a discount to people with limited ability to pay, care written off as bad debt (but not for third parties), and Medicaid shortfalls. We have discussed the issues involved in the choice of these items, but it is useful to note that the addition of ability to pay as a criterion complicates both the task and costs of hospital administration.

The Roybal bill puts the IRS in charge of overseeing compliance. The IRS is overburdened and understaffed, its expertise in the area of charity care is limited, and it is not well positioned to make decisions dealing with hospital administration. Hence, we question the wisdom of using this agency to administer what is essentially a complicated redistributive scheme. Finally, although the program is administered at a national level, it will not redistribute resources among regions. Instead, its successful implementation would mean that those nonprofit hospitals that currently do not provide “fair” levels of charity care would be compelled to do so. It is similar to our proposal in that it seeks to rationalize the distribution of CUC care, but it accomplishes its goal differently. The bill focuses on the benefits that hospitals receive and takes no account of their ability to pay. It also does not take into account the connection between the amount of charity care provided and the amount needed. Although the bill is an important step in the direction of fairness, it is less effective at addressing the issues than our proposal.

## Conclusion

With competition growing, insurance companies becoming less generous with reimbursements, and recession on the horizon, an increasing number of hospitals will look for ways to cut costs. Unless a national solution is found, these hospitals will limit their treatment of charity patients, leaving higher levels of unmet need. State budget shortfalls are likely to give rise to Medicaid cutbacks, further increasing the population of the medically needy. The growth in the number of Americans receiving inadequate health care will almost surely give rise to fresh demands for national health insurance, employer-provided health

insurance, and/or other programs that pass the costs of charity care to nongovernmental entities. Such programs will be difficult to fund adequately, given the many demands on the public fisc.

Will the proposal outlined in this article be needed if a national initiative is enacted? Even if a national program is mandated, we must ask whether it can be funded at a level that ensures providers will not be left with residual costs. Because a limited number of hospitals serve a large number of charity cases, an underfunded national initiative will allow differentials among hospitals to persist.

It is useful to consider the circumstances under which a state might adopt our proposal. Hospitals under pressure to justify to the public the charity care they finance, for example, might decide to support a rational distribution of charity-care finance costs. Such a decision could result from congressional initiatives such as the Roybal bill. Alternatively, recession might disproportionately worsen the finances of hospitals providing disproportional amounts of charity care, placing them under severe financial stress. These providers could be forced to cut back on charity care unless they receive additional assistance; this could lead a state to "do something" to help those who were threatened by the loss of charity care. Under a different scenario, public policy makers could propose another solution to the charity-care question that is less palatable to hospitals than the one offered here. In this case, our proposal might be viewed as the lesser of the two evils. Finally, pressures from competition could put disproportionate charity-care providers in such a difficult position that they might be forced to reduce financing of such care. A crisis could be precipitated in which other hospitals are compelled either to adopt a new distribution scheme like ours or face a large number of charity cases filling their emergency rooms.

At present, there are a number of obstacles to the immediate adoption of the proposal. Administrative systems must be developed to identify implicit and explicit benefits accruing to each hospital. Similarly, accounting and reporting systems must be established to identify accurately the costs that hospitals incur for charity care.

Perhaps most important, hospitals themselves must recognize that the public expects them to finance at least some charity care. Society is unlikely to change its view as long as hospitals receive public subsidies. Nothing is inherent in any of the national proposals that will reduce or eliminate this expectation. If hospital administrators more fully appreciate such a perspective, they are apt to seek a more rational system than the present one. If not, those who stand to lose from a change in

the status quo will fight a system aiming to redistribute charity costs. In the long run, hospital executives will have to come to understand that much can be gained from a system that sets forth a well-defined set of rules, rather than from one that leaves their institutions vulnerable to more random forces.

## References

- Bazzoli, G.J. 1983. Health Care for the Indigent: Overview of Critical Issues. *Health Services Research* 21(3):353-93.
- Blumstein, J.F. 1986. Providing Hospital Care to Indigent Patients: Hill-Burton as a Case Study and a Paradigm. In *Uncompensated Hospital Care*, ed. F.A. Sloan, J.F. Blumstein, and J.M. Perrin. Baltimore, Md.: Johns Hopkins Press.
- Brown, Lawrence D. 1990. The Medically Uninsured: Problems, Policies, and Politics. *Journal of Health Politics, Policy and Law* 15(2): 413-26.
- Chang, C.F., and H.P. Tuckman. 1988. The Profits of Not-for-Profit Hospitals. *Journal of Health Politics, Policy, and Law* 13(3):547-64.
- . 1990a. The Distribution of Indigent Care among Hospitals. *Hospital Topics* 68(3):7-13.
- . 1990b. Why Do Nonprofit Managers Accumulate Surpluses and How Much Do They Accumulate? *Nonprofit Management and Leadership* 1(2): In press.
- Feder, J., J. Hadley, and R. Mullner. 1984. Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982. *Milbank Memorial Fund Quarterly/Health and Society* 62(4):544-66.
- Herzlinger, R.E., and W.S. Krasker. 1987. Who Profits from Nonprofits? *Harvard Business Review* (January/February):93-105.
- Hudson, T. 1990. Not-for-Profit Hospitals Fight Tax-exempt Challenge. *Hospitals* (October):32-37.
- Lewin, M.E., and L.S. Lewin. 1984. Health Care for the Uninsured. *Business and Health* (September):10-14.
- . 1987. Financing Charity Care in an Era of Competition. *Health Affairs* 6(Spring):47-60.
- Musgrave, R., and P. Musgrave. 1984. *Public Finance in Theory and Practice*. New York: McGraw-Hill.
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. 1983. *Securing Access to Health Care*. Washington.

- Reinhardt, U.E. 1986. Charity Health Care. In *Uncompensated Hospital Care*, ed. F.A. Sloan, J.F. Blumstein, and J.M. Perrin. Baltimore, Md.: Johns Hopkins Press.
- Rosenberg, C.E. 1971. The Hospital in America: A Century's Perspective. In *Medicine and Society: Contemporary Medical Problems in Historic Perspective*. Philadelphia: American Philosophical Society.
- Rosner, D. 1982. *A Once Charitable Enterprise*. Cambridge: Cambridge University Press.
- Sherlock, D.B. 1986. Indigent Care in Rational Markets. *Inquiry* 23:261-67.
- Short, P.F., A. Monheit, and K. Beauregard. 1988. *Uninsured Americans: A 1987 Profile*. Rockville, Md.: National Center for Health Services Research and Health Care Technology Assessment.
- Sloan, F.A., J. Valvona, and R. Mullner. 1986. Identifying the Issues: A Statistical Profile. In *Uncompensated Hospital Care*, ed. F.A. Sloan, J.F. Blumstein, and J.M. Perrin. Baltimore, Md.: Johns Hopkins Press.
- Starr, P. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.
- Tuckman, H.P., and C.F. Chang. 1990a. How Vulnerable Are Nonprofit Charitable Corporations? *Proceedings of the 1990 Conference of the Association of Voluntary Action Scholars*, Vol. 2. London.
- . 1990b. Who Bears the Burden of Indigent Care. *Journal of Health and Social Policy* 2(1):9-20.
- . n.d. Nonprofit Equity: A Behavioral Model and Its Policy Implications. (Forthcoming in 1992.) *Journal of Policy Analysis and Management*.
- U.S. Department of Health and Human Services. 1986. Financial Impact of the Prospective Payment System on Medicare Participating Hospitals—1984. Washington.
- U.S. General Accounting Office. 1990. Nonprofit Hospitals: Better Standards Needed for Tax Exemption. A Report to the Chairman of Select Committee on Aging, House of Representatives, GAO/HRD-90-84. Washington.

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*Acknowledgments:* The authors acknowledge the partial support of the Avron B. and Robert F. Fogelman Academic Excellence Fund and the comments of E. Kathleen Adams, Carol Babb, Gary Shorb, Shelley White-Means, and four anonymous referees.

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