POLICY BRIEF

Caring for Our Neighbors in Need and Strengthening Community in Utah

{ Our goal is to create a coordinated private-sector approach to universal, basic, health care for Utah's neighbors in need. }

"WHEREAS, Utah is known for its compassionate people who are generous and kind in helping their neighbors in need..."

— Utah State Legislature, 2005 (unanimous)

In 2004, the Sutherland Institute published a 117-page report on charitable forms of providing medical services. In a nutshell, Sutherland voiced,

- In a free society, private charitable responses to helping those in need are always more preferable than government welfare responses
- While "health care" is not a right, caring for our neighbors in need is a social imperative

In atypical fashion for advocacy groups, Sutherland provided dozens of copies of the *pre-publication draft* 2004 report to stakeholders deeply involved in the health care debate and asked for their sincere and honest input. None responded to the invitation.

In a re-doubling of effort, Sutherland successfully supported a resolution during the 2005 legislative session, sponsored by Rep. Lorie Fowlke, to solicit real feedback on the idea of authentic charity care. The result was the unanimous passage by the Utah State Legislature of HJR 19: *Joint Resolution Urging Health Care for Utah's Indigent and Needy Uninsured*. Part of HJR 19 reads,

> WHEREAS, the Sutherland Institute has released a report recommending that Utah can meet the basic health care needs for all of its indigent and needy uninsured residents while saving the state hundreds of millions of dollars, building true community, and without eligibility restrictions….

The joint resolution also formally challenged all health-care stakeholders to study,

- the projected costs of all state government-provided health care services over the next ten years
- how a proposed authentic charity care system should be governed, administered, and sufficiently financed
- how volunteer medical professionals should be organized, coordinated, and utilized in an authentic charity care system

- the projected capital and operating costs of providing the necessary number of conveniently located, full-service, charity care facilities throughout the state
- how the principle of reciprocity should be administered in the new system, and
- the projected costs of implementing an authentic charity care system over the next ten years

Once again, the call for input fell on deaf ears – none of Utah's health care stakeholders seriously considered the request. Nevertheless, Sutherland has continued to focus its resources on understanding authentic charity care and on creating a viable blueprint for its implementation in Utah.

Its purposes are to find ways to 1) reverse the ever-growing burden on taxpayers from Medicaid and state government-driven health care programs, 2) establish private sector solutions in health care, and 3) build community as we provide medical services to Utah's indigent and needy uninsured population irrespective of financial means.

Broadly, Sutherland's goal is to create a coordinated private-sector approach to universal, basic, health care for Utah's neighbors in need.

LEGISLATIVE RECOMMENDATIONS

The Sutherland Institute recommends that the Utah State Legislature create a state-chartered Community Health Foundation (CHF) as the coordinating private entity to organize, administer, and implement a state-wide network of charity care, or "free," clinics with at least the following characteristics:

- CHF would be he primary locus of charitable health care in Utah
- CHF would be an independent, state-chartered, non-profit entity
- CHF would be governed by a board of disinterested (i.e., no conflicts of interest), uncompensated citizens – community leaders dedicated to the success of authentic charity care in Utah – comprised of no fewer than 29 persons (one citizen from each county) and no more than 51 persons, recommended by the Utah Senate President and House Speaker and appointed by the Governor of Utah
- CHF would organize, administer, and implement a state-wide network of charity care clinics
- CHF would coordinate efforts with other affiliated non-profit or for-profit health care entities for charitable services
- CHF clinics, as well as any charitable services provided by affiliated health care partners, would be covered by an unconditional "Good Samaritan" law
- CHF clinics and affiliates would not accept payment for services
- CHF clinics would be open convenient to the needs of the people, possibly 24/7/365 in some cases, and its services would be available to any resident of Utah in "good faith"
- CHF clinics would be staffed by volunteer medical professionals and other volunteers
- CHF operating revenue would be derived through private sector-donations
- CHF clinics would manage programs of reciprocity wherein care recipients, or their proxies if needed, can express gratitude for services received by giving back to the community that has served them
- CHF would maintain an online database of all medical professionals and other clinic volunteers who provide services, as well as a listing of all community service provided by care recipients

THE ESSENTIALS: STEP-BY-STEP

A. CHF would be the primary locus of charitable health care in Utah.

An objective as large as relying extensively on charitable services to serve all of the basic medical needs of Utah's

neighbors in need requires serious and dedicated coordination and centralization. For over 40 years, the delivery of medical services to our neighbors in need has been so overwhelmingly dominated by government mandates and government insurance programs that authentic charitable medical services have become "crowded out" and proportionally incidental. Reversing this policy of government mandates and government insurance programs will require more than a "thousand points of light" from the private sector. It will require central administration and state-wide coordination.

To operate efficiently, charity care (or "free") clinics require four operational elements: a physical space to serve patients, volunteer medical professionals and assistants, office and case administration, and donations for capital and ongoing operations.

Sutherland recommends the creation of a Community Health Foundation to provide this coordinated leadership and administrative support.

B. CHF would be an independent, state-chartered, non-profit entity.

Independence is vital for authentic charity care to reach its fullest potential. "Charity care," as it currently exists, is naturally tied to the several missions and objectives of operating charitable programs. For instance, the interests, operations, and administration of IHC's charitable programs are different than Shriners Hospital or the Maliheh Free Clinic. The new CHF must exist as an independent entity serving its own unique mission and objectives.

CHF should be state-chartered.[1] Encouraging authentic charity care should be a state priority because lessening the burden on government-driven state health care programs is a state interest. Legislation would authorize and endorse the creation of CHF as a not-for-profit corporation. It would establish its name, purpose, governance structure, corporate powers, and its relationship to the state.

While the CHF would not be regulated by the state beyond standard laws governing not-for-profit organizations operating in Utah – after all, its value and efficacy are driven by its authentic charitable nature and private sector-driven characteristics – it would report its work annually to the state (e.g., to the appropriate committee within the Utah State Legislature and/or the state's Department of Human Services).

C. CHF would be governed by a board of disinterested (i.e., no conflicts of interest) and uncompensated citizens – community leaders dedicated to the success of authentic charity care in Utah – comprised of no fewer than 29 persons (one citizen from each county) and no more than 51 persons, recommended by the Utah Senate President and House Speaker and appointed by the Governor of Utah.

CHF's mission is to provide universal, basic medical services to our neighbors in need on a state-wide basis. It makes sense to structure its governing board in a manner truly representative of the entire state. Typically, most corporate boards are limited in number for efficiency. CHF's mission dictates broader community involvement and, hence, a greater-than-usual number of board members.

As a state-chartered organization, it is proper that the board be recommended and appointed by our elected officials – recommended by legislative leadership and appointed by the Utah State Governor.

Board members should be recommended and appointed based on their sincere desire to see authentic charity care succeed throughout the state. Board positions should be filled by, what America's founding fathers referred to as, "disinterested" persons – citizens who served with objectivity and without personal, business, or political conflicts of interest.

D. CHF would organize, administer, and implement a state-wide network of charity care clinics.

When Utahns think of charitable medical services they should think of the CHF. CHF would provide the organization, administration, coordination, and private funding to serve a state-wide network of charity care clinics.

Existing charitable clinics would choose to be included in this network or not. CHF should not be positioned to do to existing charitable clinics what government-driven health care programs have done to them – CHF should not be positioned to "crowd out" existing private efforts. Even so, an important policy objective of CHF is to effectively compete with government-driven programs, and that objective requires a substantial private investment that will naturally compete for charitable donations. In this sense alone, existing efforts should be encouraged to join with or partner with CHF.

E. CHF would coordinate efforts with other affiliated non-profit or for-profit health care entities for charitable services.

A significant benefit of CHF's operations would be to alleviate current burdens on existing "charity care" programs mandated by federal and state laws. For instance, with CHF running at maximum capacity, other charitable programs currently providing basic medical services to our neighbors in need could free their resources to be used for specialty services. In other words, current operating dollars allotted for basic services could then be used to cover more complicated procedures.

Another significant benefit in this respect would be CHF's role in integrating charitable services state-wide. There would be no reason why a patient in one region of the state couldn't be assisted by charitable efforts in another region of the state – no Utah resident would be isolated from assistance. Our current model of "charity care" is limited in reach of location and scope of services. CHF would close those limitations.

F. CHF clinics, as well as any charitable services provided by affiliated health care partners, would be covered by an unconditional "Good Samaritan" law.

An unconditional "Good Samaritan" law would cover CHF and all its affiliated services. Medical volunteers who provide care would not be open to lawsuit. Patients coming to CHF clinics for assistance would know that they are receiving charitable services and would agree to accept these services without potential legal threats hanging over providers.

Authentic charity care has a reciprocal moral obligation upon each recipient of its generosity – charitable services should not be exposed to lawsuits.

G. CHF clinics and affiliates would not accept payment for services.

Authentic charity care means, if it means anything at all, that providers do not receive compensation for services. The very intent of this policy is to relieve our neighbors in need, who cannot afford medical services, from the financial burden of getting and staying healthy.

H. CHF clinics would be open convenient to the needs of the people, possibly 24/7/365 in some cases, and its services would be available to any resident of Utah in "good faith."

The purpose of CHF clinics is to serve our neighbors in need, and those needs do not often come with convenient timetables. People do not get sick only between the hours of 8 am and 5 pm. CHF clinics, to be truly useful, must be open when people need their services. Hours of operation would be flexible in the local governance of each clinic.

CHF services would be available to any resident of Utah. The CHF board would set guidelines for residency with the strict intent that no Utah resident would ever be turned away. Utah residents would utilize CHF services in "good faith" meaning that there would be no eligibility requirements beyond residency – the assumption being that a patient asking for medical services at a CHF clinic cannot afford medical services elsewhere. Financial "ability-to-pay" forms – including government insurance forms – would not exist in CHF clinics.

I. CHF clinics would be staffed by volunteer medical professionals and other volunteers.

Utah is blessed with a tremendous volunteer spirit. Our volunteer spirit is complemented substantially by the medical profession's innate mission to help those in need. CHF clinics would be wholly staffed by volunteers, both medical professionals and community neighbors looking to help.

CHF's corporate staff, tasked with coordinating, administering, and implementing its services, would utilize paid full-time and part-time staff – and volunteers – just as other not-for-profit organizations.

J. CHF operating revenue would be derived through private sector donations.

One policy function of the CHF is to displace the use of tax dollars on government-driven health care. CHF would be prohibited in its By-Laws from accepting government money. Just as the authentic part of "authentic" charity care demands no payment for services rendered, it also demands that its corporate revenue come from private, voluntary donations only.

K. CHF clinics would manage programs of reciprocity wherein care recipients, or their proxies if needed, can express gratitude for services received by giving back to the community that has served them.

Reciprocity is essential in any effective charitable program, even if the reciprocation is to simply say "thank you." CHF clinics would individually manage programs of reciprocity whereby a patient receiving services would be expected to give something back to the community that so generously assisted him.

Reciprocity in this system would be broadly defined as community service. The service would be commensurate with CHF services rendered – the more extensive the medical services rendered, the more extensive the community services returned.

Patients unable to physically provide community service could name another person, as proxy, to serve in the patient's place. In any event, while reciprocation would represent an integral part of the CHF culture, its inability to be performed should not preclude medical assistance.

L. CHF would maintain an online database of all medical professionals and other clinic volunteers who provide services, as well as a listing of all community service provided by care recipients.

Personal accountability is central to a culture of charity. CHF would maintain an online database of every person who provides medical services in its clinics and of every person who provides reciprocal community service – these names would serve as a monument to the success of the program. This public database also would serve as an important check against fraud and abuse.

A CHANGE IN TAX POLICY

Changing the current culture of "charity care," encumbered as it is by government competition, requires more than wishful thinking. It requires a significant incentive.

Sutherland recommends the establishment of a 2-for-1 non-refundable tax credit for any Utah taxpayer giving voluntarily to the CHF – for every dollar donated to CHF, a Utah taxpayer, individual or business, would receive a two-dollar non-refundable tax credit.

CHF'S TARGET CONSUMERS

Sutherland's authentic charity care proposal is aimed at reducing, where possible, the burden on government-driven medial services, especially Medicaid.

The current average monthly Medicaid enrollment in Utah is 165,000 persons – 100,000 are children, 20,000 are permanently disabled, 20,000 are in long-term care, and 25,000 are comprised of indigents, single mothers, and pregnant women. CHF's target "consumers" would come from the first and last pools.

The typical Medicaid client, or client family, in Utah is white, married with children, and working – these are Utahns who, temporarily, need a helping hand, but who cannot afford medical services.

Each of Utah's Medicaid children cost approximately $200 per month, or about $240,000,000 per year (which, on a 3-to-1 federal match is $60,000,000 to Utah taxpayers). Each of Utah's Medicaid adult, temporarily-in-need, clients cost approximately $350 per month, or about $105,000,000 per year (which is $26,250,000 to Utah taxpayers). The combined pool of potential savings to Utah taxpayers is approximately $86,000,000.

While the savings moving our neighbors in need from Medicaid to authentic charity will NOT be a dollar-for-dollar savings, savings would be significant because authentic charity care is inherently less expensive.

For instance, the per-patient-per-year cost of treating a person at the Maliheh Free Clinic in Salt Lake City is $152.00. For the Volunteer Care Clinic in Provo, it's approximately $156.00; the smaller Doctor's Volunteer Clinic in St. George is approximately $40.00; and, the Utah Partners for Health clinic in Magna is approximately $149.00. This is compared to Utah's Community Health Center system (the least expensive government-driven "charitable" program) of $371 per-patient-per-year cost.

Like the cost of auto repairs, the costs associated with medical services are largely due to labor (big expenses are not typically associated with "parts"). CHF clinics would be staffed by volunteers thereby removing the labor costs. More savings would be created by the absence of malpractice insurance and lawsuits. On top of it all, CHF would work to secure as many donated supplies (or "parts") as possible. All of this means that Utah taxpayers would see significant savings through the transference of Medicaid clients from these two pools to CHF clients.

Essentially, with this new momentum, Utah's Medicaid program then would become highly specialized in the service of its permanently disabled and long-term care clients.

SUMMARY

There is not one reasonable person who wants to see themselves, their families, or their neighbors lack the medical services needed to return them to good health and productivity. There are two choices to serve those who cannot pay for medical services: government programs paid for by taxpayers or charitable programs paid for by voluntary, heartfelt contributions. Obviously the two approaches cannot equitably co-exist because of the "crowding out" factor inherent in every government approach.

Tax-driven programs have an obvious advantage; they also have equally obvious weaknesses (from state-spending limitations to "eligibility" problems). Authentic charity care addresses the best in people, both givers and receivers. Sutherland seeks public policies that promote good government, as well as human decency and dignity. While ideologues throughout time have chosen to condemn charity as an indignity, Utah's own experience and legacy is replete with an opposite conclusion. Many Utahns live by the motto: charity never faileth. Sutherland concurs.

ENDNOTE

1. Government charters are very common whenever the state feels a compelling interest in support of a good cause. Federal charters, of the sort recommended in this paper, endorsing but not regulating a private corporation, are more common. Boy Scouts of America is a federally-chartered, non-profit, corporation, as is the American Red Cross.

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