IOWA ADVISORY COMMITTEE

TO THE

U.S. COMMISSION ON CIVIL RIGHTS

A STATEMENT ON THE REPRESENTATION OF MINORITIES AND WOMEN ON GOVERNING BOARDS OF IOWA HOSPITALS

ATTRIBUTION:

The contents of this statement are those of the Iowa Advisory Committee to the U.S. Commission on Civil Rights and, as such, are not attributable to the Commission.

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Representation of Minorities and Women on Governing Boards of Iowa Hospitals

Background

In September 1978 the Iowa Advisory Committee to the U.S. Commission on Civil Rights voted to conduct a limited survey concerning representation of minorities and women on the governing boards of major private non-profit hospitals in Iowa. It surveyed communities where the proportion of minorities in the population approximate the proportion of minorities in the State population (1.8 percent). Further, the Committee sought to identify the amount of Federal monies received by the hospitals under Medicaid, Medicare and Hill-Burton programs; and to determine what civil rights obligations or guidelines exist that might encourage greater representation of minorities and women on hospital policy making boards.

The American Hospital Association (AHA) headquarters offices in Chicago, Illinois, the Iowa Hospital Association (a member organization of AHA), and Iowa Health Systems Agency indicated that to the best of their knowledge no studies had been conducted nor were aggregate data available that would answer the Committee's questions on membership composition by race and sex.[1]

The Advisory Committee chose to investigate this subject because it believes that hospitals have a responsibility to seek out minorities and women as constituent elements on their governing bodies. The Advisory Committee felt it should try to confirm or dispel the common perception that board membership has tended to come primarily from the male business-civic-professional segments of communities (except some hospitals operated by religious orders). However unintentional, such a tradition would result in a negligible representation of women and minorities because most business and civic leaders are white males. For example, of the seven hospitals in Des Moines (5 private non-profit and 2 public) only one has

even one minority member on its governing board (Des Moines General Hospital).[2]

A review of the existing literature finds some support for the Advisory Committee's initial premise. For example, a 1971 survey in Detroit showed that 76 percent of the board members were business and professional people.[3] A report on the composition of New York County hospital boards of trustees in 1973 for hospitals with 300 or more beds showed that 87 percent of board members were male, 67 percent were business people or non-health professionals and another 3 percent were health professionals.[4] Michael Enright and Steven Jones have commented that generally "boards of trustees cannot be considered broadly representative of the communities their hospitals serve."[5] Jones and his colleagues state that "in fact, non-representation of major sectors of society is almost universal." They commented that "those who argue for broader representation on boards say that the wishes and value systems of the vast majority of persons in the community are represented only to the extent that upper-and-middle class board members understand those wishes and value systems, and choose to pay attention to them."[6] Kaufman, and others, note studies that show "hospital board membership tends to be concentrated in the hands of the upper middle class business and professional community," and "as a result, lower class income and minority groups tend to be substantially underrepresented." This is a subject of controversy within the health care industry. Some contend that "representation must be equalized among competing interest groups...others maintain that the current composition of the board is necessary if the non-profit hospital is to survive."[7]

In 1974, the American Hospital Association's Committee on Hospital Governing Boards issued revised guidelines on Governance of Health Care Institutions. They describe recent alterations in the traditional configuration of hospital boards. In the first decades of the 20th century, boards were commonly composed of community representatives from fields such as law, business and religion. The AHA guidelines

say "Now, many hospitals and other health care institutions have adopted a broader board structure that includes representatives of the institution's patient community, volunteers, administration and physicians."[8] Other guidelines adopted in 1977, Identification, Selection and Orientation of New Hospital Trustees, include a section titled "Who Should Serve" which states "it is most desirable to achieve balanced community representation through the selection of residents from the hospital's service area when possible." However, "board members should not be selected as representatives of special interest groups." (emphasis added)[9]

According to the American Hospital Association's listing of health care institutions, Iowa had a total of 145 hospitals; a little less than one-half (45 percent) were non-government, non-profit.[10] In 1970, the total minority population in the State was 1.8 percent. Twelve cities and towns in Iowa have minority populations of 1.5 percent or above; their minority populations range from Waterloo and Des Moines with 9.0 and 6.2, respectively, to Cedar Rapids with 1.5 percent.[11] In these 12 communities, there are 25 hospitals, 80 percent of which operate under non-government, not-for-profit auspices.

To expedite this project the Committee selected a sample of nine hospitals to be surveyed by questionnaire.[12] Completion of the brief survey was voluntary. Thus the willingness of private sector hospitals to cooperate could be measured at the same time the question was being researched.

The cities of Waterloo, Des Moines, Davenport and Cedar Rapids were selected as project locations. More than 80 percent of the 15 hospitals in these four communities are non-government sponsored. These cities have minority populations of 9.0, 6.2, 4.5, and 1.5 percent, respectively and include 4 of the 5 largest cities in the State and the top three minority concentrations.[13] The survey sample of nine includes three hospitals in Des Moines, two in Waterloo, two in Davenport and two in Cedar Rapids. Publicly sponsored hospitals were excluded

because their boards are for the most part chosen by public election rather than by the appointive process. The hospitals to which requests for information were sent are: Iowa Lutheran, Des Moines; Iowa Methodist Hospital, Des Moines; Mercy Hospital, Des Moines; Mercy Hospital, Cedar Rapids; St. Luke's Methodist Hospital, Cedar Rapids; Mercy Hospital, Davenport; St. Luke's Hospital, Davenport; Allen Memorial Hospital, Waterloo; and Schoitz Memorial Hospital, Waterloo.

In the following pages the Advisory Committee shows the results of its review of Federal laws regarding Federal funds to the hospitals. The Advisory Committee also reports the extent to which minorities and women are represented on the hospitals' boards.

II. Federal Assistance to Iowa Hospitals and Civil Rights Obligations

The Advisory Committee began with the assumption, mentioned earlier, that the hospital needs of minorities and women can be met better when they participate in the decisions that affect them. Three Federal programs: Hill-Burton Act, Medicare and Medicaid all require equality in the provision of services. The Advisory Committee review explores the extent to which these are significant sources of hospital funding and a basis for requiring broader representation.

Table I shows the dollar value of Hill-Burton Act funds received by the nine hospitals during the history of the program (1948-1973) and the amounts of Medicare and Medicaid payments received for calendar year 1977. It is clear that both individually and collectively these hospitals received a lot of Federal money. In Medicare funds alone the nine hospitals surveyed received an average of $5,785,422.00 during FY 1977. They received an average of $966,465.70 in Medicaid funds for the same year. In aggregate, each hospital received more than one million dollars from the U.S. government just during the periods for which data was provided. But do these dollars provide a basis for requiring representation by minorities and women?

Table 1

Federal Funds to Selected Iowa Hospitals

	Latest Hill-Burton Grant Date	Hill Burton 1948-1973	Medicare FY 1977	Medicaid FY 1977	Total
Mercy Hospital Cedar Rapids	1969	$3,290,000.00	$5,124,642.93	$ 776,785.41	$ 9,191,428.34
Methodist St. Luke's/Hospital Cedar Rapids	1966	3,287,000.00	6,456,620.63	1,177,383.72	10,921,004.35
Mercy Hospital Davenport	1951	845,000.00	4,081,862.53	766,745.35	5,693,607.88
St. Luke's Hospital Davenport	1962	809,000.00	3,007,165.97	377,287.20	4,193,453.17
Iowa Lutheran Des Moines	1963	836,000.00	7,367,677.13	1,435,362.96	9,639,040.09
Iowa Methodist Des Moines	1971	2,807,000.00	10,418,603.81	1,325,731.76	14,551,335.57
Mercy Hospital Des Moines	1956	1,149,000.00	8,481,689.15	1,808,443.89	11,439,133.04
Allen Memorial Waterloo	1961	256,000.00	4,166,815.54	590,442.17	5,013,257.71
Schoitz Memorial Waterloo	1965	1,343,000.00	2,963,720.30	440,008.85	4,746,729.15
TOTAL		$14,622,000.00	$52,068,797.99	$8,698,191.31	$75,388,989.30

Source: DHEW (Region VII), U.S. Public Health Service, Health Facilities Branch

The Hill-Burton Act of 1946 provided Federal assistance to support State hospital planning and construction of public and private non-profit facilities. During the first 20 years of the program, construction projects assisted with Hill-Burton funds accounted for an estimated 30 percent of hospital beds in the country.[14]

The U.S. Department of Health, Education and Welfare's Public Health Service has described the obligation of medical facilities which have received Hill-Burton Act funding assistance to provide a reasonable volume of services to persons unable to pay for those services. Such services, provided at no charge or at less than the normal charge, are referred to as "uncompensated care." A hospital can satisfy this requirement for each year of its obligation by electing one of three options:

1. "provide an amount (of uncompensated care) equal to three percent of operating costs less Medicare and Medicaid reimbursements."

2. "provide an amount equal to 10 percent of the total of all Federal assistance received."

3. "agree not to deny admission to any individual because of that person's inability to pay and make services available at no charge or at less than normal charge."[15]

Under the present regulations, adopted in 1974, this obligation extends for 20 years from the date on which the facility built with government funds was put into service. Enforcement of the "presumptive compliance guidelines" was the responsibility of State agencies under Title VI of the Public Health Services Act.[16] Under the Health Planning and Resources Development Act of 1974 (P.L. 93-641, Section 1612 (c)) which included and modified certain aspects of the Hill-Burton program, enforcement responsibility is transferred to the Secretary of Health, Education and Welfare.[17]

Proposed regulations for charity care and community service obligations to implement the law, announced in October 1978, have not been made final.

Seven of the nine hospitals surveyed were under a current obligation to provide "uncompensated care."[18] All stated they post the signs in patient admission areas and business offices that explain their Hill-Burton obligations.[19] The annual compliance reports to the State Health Department show that two hospitals which chose to provide compensated care valued at not less than 10 percent of their Hill-Burton grant did provide more uncompensated care than was required. (They provided an average of $216,367 in uncompensated care vs. a requirement of $177,150.) Five hospitals agreed not to deny admission to anyone because of inability to pay. They provided an average of $85,751 in uncompensated care. (Had they chosen to satisfy Hill-Burton requirements under the 10 percent rule they would have had to provide an average of $181,700 in uncompensated care.)[20] Since the language of the regulations does not require an assessment of the number of patients receiving such care, only the dollar volume is reported. The number of patients provided assistance and the number of minorities and women within this population could not be determined from this survey.

The only possible obligation vis-a-vis the representation of minorities and women on hospital governing boards is provided in the section of DHEW's Hill-Burton Act regulations (42CFR 53.112(c)) which refers to Title VI regulations, discussed below.[21]

There is a dispute as to whether all parts of Medicaid and Medicare are grants covered by Title VI.[22] However, all hospitals which have received Hill-Burton Act funds within the past 20 years are subject to the Title VI regulations of the Department of Health, Education and Welfare. These regulations state that among the discriminatory practices prohibited under Title VI is to "deny a

person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program."[23]

The meaning of this prohibition has not, to date, been clarified. Melvin Leventhal, Deputy Director of HEW/OCR states that within the next few months it is probable that the Department will issue revised Title VI regulations which will make clear that governing bodies, such as hospital boards, are subject to the same prohibition as planning or advisory bodies. It is Mr. Leventhal's view that governing bodies always have been included. He believes that the inclusion of advisory groups in the regulations reflects a view by the drafters that the right of participation on such bodies is not obvious. He suggests that it is not logical to believe that simply because governing boards are not explicitly mentioned, participation is not reviewable under Title VI, while participation on advisory and planning bodies is reviewable. When the regulations are revised, the Office for Civil Rights expects to begin enforcement activities, and membership on governing boards then would be reviewed.[24]

Conclusions

Responses to the Advisory Committee's questionnaire of October 24, 1978, were returned by five of the nine hospitals. Four hospitals did not respond. All four, Mercy and St. Luke's Hospitals of Cedar Rapids, Allen Memorial Hospital, Waterloo and Iowa Methodist Hospital, Des Moines, said they would not participate in the survey since it was not mandatory.[25] A representative of Mercy Hospital (Cedar Rapids) commented that he was refusing all requests for survey information unless they were judged to be beneficial to patient care.[26] Iowa Methodist Hospital refused to cooperate on the grounds that the information might be used to develop new government regulations, whereas the existing regulations were already a burden.[27]

Table 2 shows the composition by race and sex of the five respondent hospitals' boards. Because the two Mercy hospitals are run by religious orders, which require that a substantial proportion of the members of hospital boards be Religious Sisters of Mercy, women are well represented on their boards and executive committees.[28] At the other three hospitals women are a very small proportion of the board membership and not represented on the executive committees of two.[29]

Only one hospital in the survey, Mercy Hospital (Davenport), has even one minority member on its hospital board.

The methods by which individuals are selected for hospital board membership are similar for all the hospitals. Generally, a slate of potential members is submitted by a nominating committee. The slate is then voted upon by the incumbent board of trustees.[30]

Table 3 shows board representation by occupational category. Representatives of the business and religious communities predominate.

Advisory Committee staff met with officials of the Iowa Health Association. The latter indicated that the Association is not in a position to establish policy on composition of governing boards. However officials recalled that, in several orientation sessions for hospital trustees, IHA has informally advocated that boards be representative of the communities served. One of the services provided member hospitals is review of information requests such as that made by the Advisory Committee. At least one hospital included in the Advisory Committee's survey consulted withIHA for advice on whether response was mandatory. IHA reported that it took no basic position on the merits of the survey in terms of recommending approval or disapproval of providing information. The Association did advise that a response would not be mandatory.[31]

Table 2

Composition of Hospital Boards and Executive Committees
(By Race and Sex)

	Hospital Board			Executive Committee		
	Total	Female	Minority	Total	Female	Minority
Iowa Lutheran (Des Moines)	26	3	0	5	0	0
Mercy (Des Moines)	14	9	0	4	2	0
Mercy (Davenport)	21	10	1	6	2	0
Scholtz Memorial (Waterloo)	11	1	0	6	No Response	0
St. Luke's (Davenport)	29	2	0	8	0	0

Source: Replies by the five hospitals to CSRO questionnaire, on file in CSRO.

Table 3.

Hospital Board Representation by Occupational Group*

	Totals	Medical Staff and/or Health Care Professionals	Religion	Business	Other
Iowa Lutheran	26	NO NUMBERS WERE PROVIDED. ALL CATEGORIES ARE REPRESENTED.			
Mercy Hospital (Des Moines)	14	1	8	5	0
Mercy Hospital (Davenport)	21	2	10	8	1
Schoitz Memorial	11	1	0	8	2
St. Luke's	31	2	2	25	2*

*Where possible, double counting has been eliminated.

Source: Replies by the five hospitals to CSRO questionnaire, on file in CSRO.

The data assembled by the Advisory Committee illustrates that hospital boards are constituted of persons who represent "special interests groups", e.g. business, religious, health care professionals. Except in a few instances, boards lack adequate representation of women and minorities.

The Advisory Committee appreciates the cooperation of the five hospitals which responded to its inquiry, and the information provided by the Iowa Hospital Association and the Iowa Health Systems Agency. All nine hospitals, the Iowa Hospital Association, American Hospital Association, Iowa Health Systems Agency and U.S. Department of Health, Education and Welfare have been given an opportunity to make corrections of fact and comment on the contents of this statement prior to publication. The comments of the American Hospital Association have been incorporated in this statement. None of the hospitals provided a formal comment, although they did comment to the Des Moines Register on March 22, 1979.

Findings and Recommendations

Finding #1: The Advisory Committee found that of the five respondent hospitals only one had a single minority member on its board. On two of the five hospital boards and their executive committees, females were well represented. This seemed to be a consequence of the institutions' religious sponsorship. On the remaining three hospitals' boards, women had only token representation.

Recommendation #1: The Advisory Committee urges all Iowa hospitals to examine the compositions of their governing boards with a view toward making them broadly representative of the social, economic, linguistic and racial populations of their service areas. When underrepresentation is found steps should be taken to increase the numbers of minorities and women on the governing boards.

Notes

1. Richard Umbdenstock, American Hospital Association, telephone interview, Oct. 3, 1978; Judy Davis, Iowa Health Systems Agency, telephone interview, Oct. 19, 1978; and H. Mel Willits, Phillip LaTessa, Noreen Thomas, Iowa Hospital Association, interview in Des Moines, January 10, 1979.

2. Data provided by Iowa Health Systems Agency, on file at CSRO.

3. Health Perspectives, (November 1973 - January 1974) Tables II (a) and (b).

4. Ibid.

5. Steven Jones and contributors, Health Care Delivery in the U.S., (Spring Publishing Company, 1977), p. 186-187.

6. Ibid, p. 187.

7. Kenneth Kaufman and others, "The Effects of Board Composition and Structure on Hospital Performance", Hospital and Health Services Administration (Winter 1979), p. 37.

8. American Hospital Association, Guidelines - Governance of Health Care Institutions (Chicago: American Hospital Association, 1974).

9. American Hospital Association, Guidelines - Identification, Selection and Orientation of New Hospital Trustees (Chicago: American Hospital Association, 1977).

10. American Hospital Association, Guide to the Health Care Field (Chicago: American Hospital Association, September 1978).

11. U.S. Department of Commerce, Bureau of the Census, General Population Characteristics, Iowa (PC(1)-B 17), Table 16.

12. The American Hospital Association has commented, in a letter dated April 24, 1979:

> The draft report raises serious concerns for the American Hospital Association. These concerns relate to...the extremely small number of hospital boards reviewed for the purpose of this report...we would submit that the "findings" of the report are highly suspect and seriously misleading, given the extremely small number of hospitals that were examined. Such a report would not merit publicizing unless a representative sample of hospitals had been used as the basis for any conclusions or recommendations.

The Advisory Committee limited the sample to comply with U.S. Office of Management and Budget which requires that agencies limit their data requests of outside groups to the maximum extent possible. The Advisory Committee agrees that additional data would be helpful, and might lead to somewhat different findings. But the organizations best equipped to undertake such a survey are the American Hospital Association or the Iowa

Hospital Association. A comparison of the Advisory Committee's data with that available in the research literature suggests that, despite a limited sample, the findings cannot be dismissed for methodological reasons.

13. U.S. Department of Commerce, General Population Characteristics, Iowa, Table 16.

14. Laurens H. Silver, "Medical Care Delivery Systems and the Poor - New Challenges For Poverty Lawyers", Wisconsin Law Review (1970), No. 3, p. 663.

15. U.S. Department of Health, Education and Welfare, Public Health Service, Health Resources Administration, Bureau of Health Planning and Resources Development, Facts About the Hill-Burton Uncompensated Care Program, DHEW Publication No. (HRA) 78-14000.

16. Phillip Patterson, DHEW, U.S. Public Health Service, interview in Kansas City, Missouri, Mar. 6, 1979.

17. Jane R. O'Connell, "Civil Rights Issues in Health Care" U.S. Commission on Civil Rights, Staff Paper (April 1978).

18. Determination based on data supplied by U.S. Public Health Service, on file in CSRO.

19. Robert G. Ott, credit manager and Stephen Harris, controller, St. Luke's Hospital (Davenport), telephone interview, Mar. 7, 1979; Mr. Chuck Bittick, assistant administrator, Iowa Lutheran Hospital, telephone interview, Mar. 7, 1979; David Ramsey, administrator, Iowa Methodist Hospital, telephone interview, Mar. 7, 1979; James Walter, administrator, Allen Memorial Hospital, telephone interview, Mar. 7, 1979; Roland Enos, administrator, Schoitz Memorial Hospital, telephone interview, Mar. 8, 1979.

20. Data provided by H.W. Stricker, Health Facilities Engineer, Iowa Department of Health, letter to staff, Mar. 21, 1979.

21. Neither Title VI of the Civil Rights Act of 1964 nor any other Federal statute prohibits discrimination based on sex in health and welfare programs. Some Federal agencies have, in the absence of a statutory prohibition, issued orders or regulations prohibiting sex discrimination in the programs they fund. U.S. Department of Health, Education and Welfare has not issued a prohibition against sex discrimination in the selection of members on hospital boards, be they advisory, planning or governing boards. (The Federal Civil Rights Enforcement Effort-1974, Vol. VI, pp. 120-124)

22. U.S. Commission on Civil Rights, Federal Civil Rights Enforcement Effort Vol. VI, (November 1974), p. 118.

23. 45 CFR 805(b)(vii).

24. Melvin Leventhal, Deputy Director, Office for Civil Rights, DHEW, Washington, D.C., telephone interview, Mar. 12, 1979. The American Hospital Association has commented, in a letter dated April 24, 1979:

The AHA would not regard as advisable or lawful any mandated governmental program to specify categories of individuals for membership on such boards. After all, self-governance and the selection of its own leadership are the chief elements of ownership that are available to not-for-profit organizations. It is our belief that any such attempt by government would constitute nothing less than the unlawful acquisition of private property without due process or just compensation.

25. Bernard Grahek, administrator, Mercy Hospital (Cedar Rapids), telephone interview, Nov. 22, 1978; Ms. Verla Gunderson, secretary to Albert Curtis, administrator, St. Luke's Methodist Hospital (Cedar Rapids), telephone interview, Nov. 22, 1978; Roy Ortlip, assistant administrator, Allen Memorial Hospital (Waterloo), telephone interview, Nov. 17, 1978; David Ramsey, administrator, Iowa Methodist Hospital, telephone interview, Dec. 12, 1978.

26. Bernard Grahek, administrator, Mercy Hospital (Cedar Rapids), telephone interview, Nov. 22, 1978.

27. David Ramsey, administrator, Iowa Methodist Hospital, telephone interview, Dec. 21, 1978.

28. Data supplied by Mercy Hospital (Davenport) and Mercy Hospital (Des Moines).

29. One hospital did not supply the information.

30. Replies by the five hospitals to CSRO questionnaire, on file in CSRO.

31. Interview with officials of Iowa Hospital Association, Jan. 10, 1979.